DAVIS-BESSE NUCLEAR POWER STATION

SAFETY CULTURE AND SAFETY CONSCIOUS

WORK ENVIRONMENT

Open Meeting

January 30, 2003

10:00 o'clock A.M.

801 Warrenville Road, Lisle, Illlinois

PRESENT FROM NRC REGION III:

MR. JACK GROBE
MR. JIM DYER
MR. DAVID HILLS
MR. DAVID PASSEHL
MS. CHRISTINE LIPA
MR. GEOFF WRIGHT

PRESENT FROM NRC HEADQUARTERS (via videoconference):

MR. BILL DEAN
MR. TONY MENDIOLA
MR. JON HOPKINS

PRESENT FROM FIRST ENERGY:

MR. ROBERT SAUNDERS
MR. LEW MYERS
MR. BILL PEARCE
MR. RANDY FAST
MS. CONNIE LINCOLN
MR. FRED GIESE
DR. SONJA HABER
MR. DAN BRINDLEY
MR. RANDY PATRICK
MS. KATHY FEHR
MR. DAVE ESHELMAN
MR. TIM RIDLON
MR. STEVE FRANTZ
MR. PAT NORDEN

MS. LIPA: Welcome to FirstEnergy and to members of the public. I'm Christine Lipa, and I am the ~~grounds~~ branch chief in NRC Region III, which is here, and I have responsibilities for the NRC inspection program at Davis-Besse, and I'm also a member of the Davis-Besse oversight panel, and I'll go through the rest of the introductions of the NRC table here.

To my left is Geoff Wright, and he's a team leader and a lead inspector, for the management human performance area. To my right is Jack Grobe. He's a senior manager in the Region III office, and he's also chairman of the oversight panel. To his right is Jim Dyer, and he's the regional administrator here in Region III. And to Jim's right we have Dave Passehl. He's a project engineer for Davis-Besse. And to Dave's right we have Dave Hills. He's a branch chief in our mechanical ~~chemical~~ engineering branch here in Region III.

We have some panel members participating by videoconference. We have Bill Dean. He's a deputy director of the division of engineering in NRR, and he's located in Rockville, Maryland, and

he's the vice chairman of the oversight panel. Also we have Tony Mendiola, and he is a section chief responsible for licensing actions. Also Jon Hopkins, and he's the specific NRR project manager in headquarters for the Davis-Besse facility.

Here in the region we have other folks. We also have Victoria ~~Mitlin~~ Mitling, public affairs, and John ~~Strassma~~ Strasma , public affairs. And I also wanted to acknowledge public officials. I know I saw Jerre Witt. Any other public officials here in the room? Or at headquarters?

Okay. What I had was a one-page agenda and I'll just go through for everybody's benefit. The plan is to go from ten 'til noon, break at noon for about an hour for lunch, regroup at one o'clock, and then finish up at three o'clock. And all these times are in Central Time.

And the purpose of today's meeting is to discuss FirstEnergy's plans and efforts on improving and assessing the safety culture and safety conscious work environment at Davis-Besse. For folks that have been following the Davis-Besse vessel head

issue, you may be aware of other meetings, such as an August 15th public meeting that we held here in Region III where we discussed the management and human-performance-related root causes on the head corrosion; and some specific root causes that FirstEnergy identified were a less-than-adequate nuclear safety focus, focus on production over safety, minimal compliance with regulations, inadequate implementation of several programs, and diminished rigor in assessing issues for the potential impact on safety.

So that meeting was then followed up by a meeting on September 18th that we held at the Davis-Besse facility, another public meeting, where FirstEnergy described their management and human performance improvement plan. And during that meeting the licensee presented the results of a survey that the utility had performed to assess the safety conscious work environment. Since that meeting a portion of each of our monthly public oversight meetings that we hold near the Davis-Besse facility, a portion of each of those meetings has

focused on the initiatives that the licensee has taken and is taking to improve nuclear safety culture.

Today's meeting is an important step in the panel's assessment of licensee performance and the plans that they have to improve the safety culture at Davis-Besse. We also have three special inspections that will cover this area. Today's meeting is open to the public, and the public will have an opportunity before the end of the meeting to ask questions of the NRC. This is considered a Category I meeting, in accordance with the NRC's policy in conducting public meetings. Before the meeting is adjourned, there will be opportunities for members of the public to ask questions of the NRC or to make comments for the record.

We are also having this meeting transcribed to maintain a record of the meeting. The transcription will be available on our Web page several weeks after today's meeting. So it will be important during this meeting that all speakers use the microphones and be sensitive to the fact that we

have people videoconferencing with us from headquarters. We also have a number of folks that have called in on the bridge lines that are participating that way.

In the foyer on the way in we had the brief agenda for today's meeting, handouts that Davis-Besse brought with them, and we also have public meeting feedback forms; and those feedback forms will help us to make these meetings better. So any members of the public or participants in this meeting feel free to fill out a feedback form and provide your comments to us.

Next on the agenda I'll turn it over to you, Lew, and let you introduce your staff and begin your presentation.

MR. SAUNDERS: Thank you, Christine. Bob's in charge today, trying to help Lew out a little bit. But I'm Bob Saunders, president of FirstEnergy Nuclear Operating Company, and I would like to introduce the table here.

To my right, of course, is Lew Myers, our chief operating officer and also serving in the

capacity as vice president for Davis-Besse. Next to him is Bill Pearce, our vice president of oversight. And beside him is Randy Fast, our general manager at the Davis-Besse plant. Next to Randy is Connie Lincoln, a consultant in human relations working for us. Next to her is our new member, I would say, Fred Giese, who is our manager of human resources. And next to him is Dr. Sonja Haber, who is consulting with us on human performance issues and measurements. And I believe next to Sonja is Pat ~~McCluskey~~ McCloskey, our manager of licensing.

We also have some other folks in attendance here, not at the table. I would like to introduce them as well. Todd Schneider, our manager of public relations. Where are you, Todd? Stand up, please. As I call each of you, please stand up and be recognized. Randy Patrick, an operational shift manager; Dan Brindley, a mechanic; Pat Norden, another mechanic; Tim Ridlon, of our engineering organization; and Kathy Fehr and Kevin Spencer. And you already acknowledged that Jerre Witt is here. Jerre does not work for us, but Jerre is a member of

our restart oversight panel. So we're certainly pleased to see Jerre here today.

MS. LIPA: Bob, if I could interrupt for a moment, if you could pull the microphone a little bit closer. I want to make sure that the people on the bridge lines can hear.

MR. SAUNDERS: That's as good as I can do. I have just some opening comments. We do appreciate this opportunity to share with you all of the things that we have been busy with over the past many months to improve our safety focus. And believe me, we have been working hard on this, and we also believe that we have made significant progress, so we are happy to share that with you today.

The agenda, I'll start off with just a few comments. Then I want to turn it over to Lew to give us a retrospective view, and then Lew and Bill together will walk us through on how we're going to anchor all these changes and ensure we never go back over this territory again. Fred Giese, our new manager of human resources, is going to talk about our Leadership in Action program. Then Dr. Sonja

Haber is going to talk to us about the methodology that we're going to apply in trying to measure this beast, and then Lew and Bill will talk about how we're going to monitor our improvement as we go forward. And then, of course, I'd like to conclude.

What we'd like to accomplish today, we want to underscore that we are totally committed to nuclear safety. There is no other way to have a nuclear program than to have one that has a total commitment for nuclear safety. We want to update you on the progress that we've made on our safety culture and safety conscious work environment, and we think that the progress is significant. And then, of course, lastly, we want to hear back from you exactly what your thoughts are.

So our commitment starts with our board of directors, and the board passed a resolution last year recognizing the company's responsibility for public safety and health in the operations of its nuclear facilities and that safe nuclear operations are a first and a foremost importance. And Jim, I want to give you that resolution. Todd, would you

give that to Jim, please? And that's a signed copy to attest to its originality. But I think that sends a very strong message that this corporation is very serious about the operation of its facilities. And that's not something I went on bended knee and begged the board to do. That was spontaneous from the board. I think that makes it all the more noteworthy.

And let me tell you, our board is fully engaged and I report to the board, the full board, every meeting; and the board meets monthly, with the exception of one month, I think, in July they don't meet. Otherwise, I report to the board every month. And of course, the major topic is Davis-Besse and the progress that we are making, but then they also want to know how the other facilities are operating as well.

We have a nuclear committee of the board and I'm going to tell you, they are also fully engaged. It's chaired by Mr. William Conway. I don't know if you know Mr. Conway or not. He has probably 40 years of nuclear experience, plant

manager of INPO. He retired from Palo Verde, ultimately. So he chairs the nuclear committee, and he visits all of our ~~cites~~ sites on a regular basis, and recently we have had the full nuclear committee at Davis-Besse and just recently at Perry. So they are well engaged. They're very credible individuals, and they challenge us and challenge us well.

Next is our chairman and CEO's commitment. Pete ~~Burke~~ Burg has been to Davis-Besse three times last year since March, and you think this is a man over a $14 billion utility, and he has made the time to get there three times and talk to all of the people at the station. And the message that he drives is safe nuclear operations require an unrelenting, uncompromising commitment to safety, and he has personally delivered that message. And I think that speaks very highly of Pete's commitment.

And the other thing Pete says and says quite well is that the highest levels of productivity are meaningless -- meaningless -- if they're not achieved with a strong focus on safety. Those are Pete's words; and when he delivers them, he is

sincere. And believe me, I just agree with him totally.

Next is me, and I've always believed that there's only one kind of nuclear program, and that's one that strives for excellence. In the short time I've been here, our vision has been excellence. That's our nuclear vision. And excellence, the gateway to it is safety. If you don't have safety, you can't get through the gate. We know that. That's why we are committed to safety.

Next is the FENOC organization. And prior to March of 2002, I had three site vice presidents and myself, and it was only I that reported to the board of directors. The events following March showed us that this organization just was not acceptable. So since then we have made Lew our chief operating officer and we have made Bill Pearce our vice president of oversight and we have added Gary ~~Lidick~~ Leidich to our ranks from the Institute of Nuclear Power Operations as an executive over engineering. This represents a substantial amount of experience and successful, many successful years of

nuclear operation. I think it's a very strong team, and a team that's definitely committed to safe operations.

Bill reports directly to me in his oversight role, and he also reports directly to the board of directors. And that's a nuance that we believe you won't find, I guess, in many other utilities, but it is with us; and he does so on a regular basis, and we think that's very helpful, and the board also likes it as well.

A couple other comments. Pete and I have been to all three sites and we have met with all employees. The message we delivered was safety first and the corporation never wants to sacrifice for production, never.

Lastly I'd like to comment on our key performance indicators. Now, these are the indicators that are used to determine what our bonuses are going to be, and we have done a great deal of restructuring of those in response to the criticism we put on ourselves in our root cause evaluation. And Todd, would you hand those to Jim,

please? This is a draft of the percentages of the bonuses, and you'll see that 50 percent of them are to safety, and we think that's a significant change, we're pretty daggone proud of it. That's been reviewed and approved by the compensation committee of the board, and I think once again just underscores our total commitment to a safe operation of the facilities.

And with that, I'd like to turn it over to Lew.

MR. MYERS: Thank you, Bob.

MR. DYER: Bob, before you go any further now, we're going to make copies of this. Is this any kind of propriety information --

MR. SAUNDERS: No, sir. Happy to share it with you and the public, whatever.

MR. DYER: Okay. We'll make it part of the meeting minutes then.

MR. MYERS: It's also the same thing that our employees get, right?

MR. SAUNDERS: Yes.

MR. MYERS: Thank you, Bob. First I'd like to

take a few moments and talk about somewhat about the background, just refresh us on the background of FirstEnergy and FirstEnergy Nuclear Operating Company. FirstEnergy was formed, FirstEnergy Company itself, November 1997. And at that time it brought together the ownership of several nuclear power plants. In April of 1999, we commenced the transition to take over the operations of the Beaver Valley plant and completed that December 3rd of 1999. And somewhere in between we actually formed the FENOC Nuclear Operating Company that's responsible for operating our plants.

Root cause report for the reactor pressure vessel heads that we had in our Davis-Besse plant found that management had less than adequate nuclear safety focus. Management team had less than adequate nuclear safety focus. Now, it also found some other things out. First, production focus, combined with minimal actions to meet regulatory requirements, resulted in acceptance of degraded conditions. What does that mean? It means when you talk to the team there, they're always talking about

minimal regulatory requirements rather than industry standards. And in the case of reactor vessel heads and the boric acid programs, we went below that.

Davis-Besse, until that time, as well as several other plants, was operated basically as a stand-alone plant. It wasn't until Bob Saunders came on staff as president of FENOC in 2000, that he immediately improved the focus on common processes to try to improve consistency at our plants. It was Bob's first focus area. I know that well. Up until that point, we were basically stand-alone units. FirstEnergy formed, FENOC formed, Bob took over.

In February, with degraded head conditions, we identified that Davis-Besse still did not have the same visions, goals and processes as the other two FENOC plants. Stand-alone once again, isolationism. Conditions were identified throughout this reactor head event, though, at a very low level. We went back and looked at our condition reporting system, and we found out that our employees, they're readily identifying CRs. In fact, we've been reviewed by the industry, by the NRC, and

our self-assessments, and our threshold for identification of issues by our employees is relatively low, pretty good. What we found, on the other hand, is the management team was not using the same corrective action process as the rest of us for classifying CRs, the methodology for classifying CRs and then the review and -- the review and root cause analysis were not getting done at the right threshold because of that. So the corrective actions were not proper.

From a quality assurance standpoint, we also noted that the quality findings were mixed. You know, quality is sort of reported up through the plant, not independently. The operations group was not in an active role in the plant from an improving material conditions standpoint. They really weren't taking the lead on material. You could see that, had sort of been taken out of the loop somehow.

After that, we put into place after the event, our building block plan that we submitted to you in August -- I'm sorry, in June. That building block plan was designed to return the plant

to service, No. 1; and No. 2, ensure sustained operations. That's what it says right in the front. It wasn't designed to be a short-term checkoff and walk away, return to plant service. It focused on all the things we thought we had to focus on to repair the reactor vessel head. First thing we did is we decided to replace it.

System performance, we brought our systems down, found tons of problems. We probably have the best benchmark right now of any plant in the country on the status of our systems. You walk outside my office, I've got two bookcases of reports, independent reports on every system -- not every system. On risk significant systems.

From a containment health standpoint, we knew that we had boric acid in the containment, but when you walked around our plant inside the containment, the containment was -- it was in good condition when you walked around. It wasn't just falling apart. We did find boric acid in a lot of ventilation systems, but you didn't find boric acid lying around our floors or on our equipment or

anything like that, you know? So we were replacing it, the containment coolers and a lot of the ventilation systems. We took the opportunity to go back and do some painting and do -- fix some long-term problems that we had in the plant. For example, the containment ~~dump~~ sump, that's -- spending a lot of money there, but it has nothing to do with boric acid. The containment ~~dump~~ sump has nothing to do with boric acid. And cooler repairs, nothing to do with boric acid. So the containment health plan was designed to improve the material condition of the containment, period.

We developed a restart test plan to test our equipment. And our intention is to heat the plant up shortly, come up, coolant hasn't been operating a year or so; we're going to find some problems, you know. We're going to find some problems with some of the workmanship. But we're going to test our equipment and prove the plant is in good material condition. Then we're going to shut back down and fix anything we need to fix, cool back down, before we start back up.

Our program performance, we sent you a list of all the important programs and we've permatized that process in our self-assessment process now. It's not something that's going to go away. So we will be not only looking at self-assessment from a group standpoint, but from a program and systems standpoint in the future.

And then after we did our management root cause -- I mean, our technical root cause, in early May we started -- we put an independent panel together, brought in experts, and had open testimony of that panel -- independent they were -- and put on the table what I think was a very comprehensive root cause that myself and Bob sponsored.

Once again, the restart building blocks were not put in place to get the plant started up and walk away.

I'd like to talk some about how we're anchoring the changes that we're looking at in our business. Not just at Davis-Besse, but at our other plants also. One of the things that we really focused on that's opened our eyes during this event,

if you will, over the last several months our executives have worked on improving safety focus at our plants, not just Davis-Besse. We have revisited our business ~~plant~~ plan, spent an entire day on that -- I have it with me today -- to ensure that we're providing the right message to our employees. We have the FENOC policy on command and control to ensure that you have managers in charge. That's not a policy for Davis-Besse. It's a policy for all three of our plants. That ensures the proper operational message.

We developed a policy and a model on safety culture. You know, if you walked around and asked somebody not long ago what safety culture was, when this event started, you would probably get three different definitions. I'm going to share our definition with you today. But we didn't start doing that last week or last month. These are things we have been working on for months. And the policy and a model of safety conscious work environment that we've taken all three of these documents and we've approved them. We've now trained each and every

person at all three of our plants and in our corporate offices on these documents.

I would like to take a few moments to share these definitions. These are FENOC definitions, similar to what you see elsewhere in the industry, but not quite the same. Safety culture, that assembly of characteristics that you find in the organization characteristics and attitudes in the organization that Bob talked about, and in individuals as a result, which establishes an overriding priority towards nuclear safety. And that this ensures that issues receive the attention warranted by their significance, by their safety and reliability significance.

And then safety conscious work environment, Bill will share with you later on. But I'll give you the definition. It's that part of the safety culture addressing the employee's willingness to raise issues and management's response to these issues. That's pretty clear and concise. You know, what I've seen in the past is people seem to throw these things all together, and we've sort of

separated out. Really safety conscious work environment is a subset, you know. So that's what we'll be talking about.

The next area that I'd like to talk about is the model that we're using in FENOC. As you see, our safety culture model that I shared with you -- Bill's going to do the safety conscious work environment -- consists of three basic safety culture areas, if you will; commitment areas we call them. Inside those commitment areas are competencies. That's the word we're using. Commitment competencies. You should notice that the model consists of these three areas, and I'd like to talk about the first one, policy.

The first area has to do with our corporate organization. It ensures that oversight and self-assessment is monitoring the performance of our work on a day-to-day basis. It's not just stand-alone or isolationism, minimum regulatory requirement. That resources are applied. Resources don't mean people. It means time; it means people; it means the equipment to do the job right.

Management values structures is in the business planning process. It provides our vision, our values, statement of policy is clear and acknowledgment of safety as a core value. We've revisited that. I think, you know, I'm really proud of what we've done with our business plan now. I think we've improved it greatly.

The second area is the plant management committee area, if you will. How are the plant managers focusing on the business that we want to achieve? When we look at that, we're talking about the following commitments: An emphasis on safety is our priority system that ensures that issues get addressed. Typically, the way we address issues through our corrective action program or employee concerns program. But issues are getting addressed.

Some of the problems we found in the root cause area. Acceptance of responsibility. What does that mean? That means that we're taking actions to fix plant problems; not to justify them away, but to fix plant problems.

Qualifications in training. We're not talking about just technical training there. We're talking about the supervisory training, training their supervisor on our Leadership in Action principles; management training, trains our managers and creates the environment in the organization that we want; and finally, leadership training so that we as leaders are looking forward at our fleet and making sure that our fleet has been managed and operated properly.

High organizational commitment. What we're talking about there is the people; people's willingness to identify with the organization. You know, you don't want a plant where everybody is walking around saying, you know, "who do you work for?" "Well, I work at the Davis-Besse plant" or "I work over ~~thre~~ there at one of the plants" -- but they're proud to work at our plant. What's more important is they're proud to be part of the organization. They understand our vision and can talk about our vision. They understand our vision and they've internalized our values. At our other plants we found our values

were well displayed. When I got to the Davis-Besse plant, I couldn't find our values or our vision. That's not the same today.

The third area then you get to the individual himself --

MR. GROBE: Lew, before you go on to the third area, just a quick question. To help me understand the difference between high organizational commitment, which I think I understand you to say is the alignment of the people in clear responsibilities and cohesiveness, could you help me understand that?

MR. MYERS: Well, one of the things you look at there is things like teamwork between groups. Some of the things we found is, you know -- and the willingness to sit down and get stuff done. We found situations at Davis-Besse where there were backlogs because there wasn't clear alignment of responsibilities and no one was making sure those responsibilities got taken care of, so consequently, backlogs with just closing out some of the paperwork. So that's what we mean there.

MR. GROBE: I understand. Thank you.

MR. MYERS: The third area deals with the individual himself. Drive for excellence. Those are nice words, but our employees know that we want them to do the job right the first time. If they need to stop, it's okay to stop. We're going to schedule the benchmark the best we can, but if something is wrong, we want you to stop. We seriously believe that the best way to have good productivity, good reliability, everything else, is to prevent errors. Just stop and do it right the first time.

Rigorous work control process. That's performing our activities in a quality manner. That's not really just work control. That's our engineering rigor is there. When we do 5059 reviews, safety evaluations, changes in design basis information, it's also our work control process. It's also our corrective action process.

The next area is open communications. What does that mean? We all sit around and talk? No. What it really means is that it's a blame-free environment, that we focus -- we hold people accountable when they need to be held accountable,

but we focus on the situation and we strive to make people nuclear professionals. And that's defined as understanding the safety issues and other issues with the work activity that you're involved with and understanding how to respond.

What do you expect to get? You understand that at the prejob briefing, one of your termination criterias, how do you terminate? Very important.

Let me spend some time talking about the first area, policy level commitment.

MR. GROBE: Lew, before you go onward, the rigorous work controls and prudent action, does that include necessary actions to comply with regulations and follow procedures?

MR. MYERS: Absolutely.

MR. GROBE: So procedural adherence would be in there?

MR. MYERS: Absolutely.

MR. DYER: Lew, just a question to reiterate. But I see safety in the policy level commitment, I see safety in the managers' commitment, and I don't

see safety in the individual's commitment. Not overtly. Is there any reason why, or can you explain?

MR. MYERS: Well, you know, I think as the individuals do their work every time, they need to understand -- that's in the professionalism area -- the safety significance of what you're dealing with and how to respond to that. And that's where that's at. What are you getting ready to do? "I'm getting ready to work on the reactor" or "I'm getting ready to work on the RPS," with the safety significance here. We do these things every day and we're doing calibrations, we're doing tests, operating our systems as a nuclear professional, understanding what you're dealing with and the risk associated with that and the termination criteria, prejob briefing. That's what we're looking at.

The first commitment area I'd like to share with you some of the things that we have completed. Policy level commitment. Corporate. This area involves the corporate policies, the management values, the resources, self-assessment,

quality oversight. Several of the actions that we have taken were shared by Bob in this area would have prevented, that would have prevented the root cause of the Davis-Besse issue.

Let me tell you what -- the strong actions we've taken to date. We've staffed and implement a strong corporate organization to ensure good quality and ownership of our programs. We used to have programs shared at our plants from an ownership standpoint, and what we found is things that we thought were being -- programs that were identical were not identical. So now we've elevated those programs to a corporate group, owned by the corporate group, and we will be assessing the ownership and that they meet industry standards, not just the minimum plant standard.

We've stengthened our self-assessment program. We have a strong corporate group that I will probably use to schedule self-assessment at all of our plants, not only to focus on the way we used to do self-assessments across the board, general area, group self-assessments, but we've built in to

focus on risk significance systems, and programs now versus industry standards. So as we bring teams in and schedule our self-assessments each and every year, we will be focusing on the systems and the program implementation.

These actions were supported by our board through the board resolution. Once again, our CEO is very involved. Not only has he been to the plant several times, but he's been to the restart oversight panel board, met with them. Very involved with restart of our plant.

We have reviewed our business plan to focus on safety, people and reliability and aligned our values to ensure that the message is safety first. If you look at our new model that's hanging on our wall, we used to have always things in bullet form. Now there's a pictorial form of that, so it's very obvious that safety is our cornerstone.

The board and CEO have revisited our incentive program tied to safety. You have a copy of that.

MR. GROBE: Lew, before you go on, I was looking

at this document that you had provided us, Bob. It's got a number of acronyms on it, and we will probably be attaching this to the minutes for this meeting. Could I make sure -- would it be okay if I annotated this?

MR. SAUNDERS: Sure.

MR. GROBE: Okay. The KPI is key performance indicators?

MR. SAUNDERS: That's correct

MR. GROBE: And then EPS?

MR. SAUNDERS: Earnings per share.

MR. GROBE: SVA?

MR. SAUNDERS: Shareholder value added.

MR. GROBE: And MPR?

MR. SAUNDERS: That stands for monthly performance indicators. And you're going to see that modified, Jack. It's going to become the nuclear performance indices, NPI. But that's where it comes from is our monthly performance indicators.

MR. GROBE: Is MPR monthly performance report, maybe?

MR. SAUNDERS: Yes.

MR. GROBE: Okay, got it. Okay. I think that's it. Thank you.

MR. SAUNDERS: You're welcome. I wanted to just interject a comment that struck me as Lew was going through. We do have our restart oversight panel that has been meeting monthly, usually the day before the chapter meetings. And Jack, you have been in attendance for those; a couple of them, I know.

I want to point out that three of those outside members have met once with the nuclear committee, the board of directors, totally independent from us, and are scheduled to meet with them again this coming month. Once again, totally independent from us. And the three that meet are Joe Kallan, I think who most of you know, Chris ~~Balton~~ Baken, the site VP from DC Cook, and then Jerre Witt, who is with us here today. But I think that's a nice touch that they can go directly to the board and report on how they view this entire Davis-Besse thing.

Sorry Lew.

MR. MYERS: That's okay. We've broken the tie between the site staff and the quality organization.

Quality assessment now reports to a VP, he reports to our board of directors. That alone would have been a significant change. And we've strengthened our employee concerns program from a program which is an ombudsman sitting in a room waiting for somebody to come visit him, to have an employee concerns program where we're out looking for -- being proactive looking for issues. We've got independent investigators now to ensure confidentiality. And we strengthened the people in that group and we're going to put a permanent person there later on before restart.

The next area is the management area. What that has to do with, once again, is with the management team of the plant. We've improved the -- we think we've greatly improved the management technical competence at the plant. In fact, if you go look -- put up the slide with the organization on it. If you go to look, there's a total of 24 managers that are at our site. There's a total of 24 managers at our site. Nineteen of our managers now have technical engineering degrees or other technical

degrees. There's a couple managers, like the manager of human resources, we probably don't think that he needs to have a technical degree, or document control. So 19 of our 24 managers are either degreed engineers, have a degree in chemistry or things like that.

The senior management team alone has over 160 years of successful nuclear power operations. There are 15 new managers to the Davis-Besse organization. All but one are new in their position. So if you look at that chart, all but one are in new positions. Now, when we say new in their position, let me be real clear. We're using the 18-month criteria, which includes Randy, so you know. Twenty managers have previously SRO licenses or certifications. So out of the 24 -- we really don't think the guy in charge of human resources needs an SRO. So if you really look like it, it's like 22, and most of them are SROs or SRO certifications. Thirteen of the SRO certifications or SROs are on PWR. We think we've greatly improved the management technical competence of our staff.

MR. DYER: Lew, question in that area. What was it before?

MR. MYERS: I didn't bring those numbers with me, but it was considerably less. The number of SROs? We've probably doubled it. Not much operational experience in some of the engineering areas and stuff like that. Corrective action person wasn't an SRO; is now, SRO cert.

MR. DYER: Okay, thank you.

MR. MYERS: We've stengthened our corrective action program. If you look at our corrective action program, employees who write a CR now get an e-mail back on how we dispositioned that CR. They should know that. Not just it goes to management, some subcommittee team gets evaluated, put in a drawer. Now the charter for the corrective action review board has been changed, and we've strengthened that. It's not a subcommittee any more for doing the CRs. It's the plant manager. He is the manager of our corrective action review board. So Randy chairs that board. He's got the operations manager in there with him and the design engineering manager. So

management is very involved with classification and evaluation of the CRs generated.

We monitor the accuracy and classification and the board ensures proper classification. First thing is the supervisory. He classifies them. But then we look to make sure that they're properly classified. We have trained root cause evaluators and we are monitoring the quality of these reviews. So all of the root causes are being monitored. And we've actually changed our process so that if it's a root cause, the senior management -- if we're putting a team together to do a root cause, the senior management team now reviews that root cause as a team. They bring it in, present it to us. Additionally, as chief operating officer, I select root causes from all of our plants and present them to the nuclear group council. So we can look at similar things across our fleet.

We are scheduling management observations on safety-related activities. It's not a little card any more. We're trying to make sure that managers are looking at the important issues, so

if we're out working on a piece of equipment, burned-out valves, ~~decayed~~ decay heat pump, something like that, we schedule management observations.

We revised the competence in our appraisal process. As you'll hear Fred talk about, we now have two new competencies that we've added to our Leadership in Action, and the appraisal process we use every year is called Ownership For Excellence, and we have -- the two new conferences are Nuclear Professionalism and Nuclear Safety Conscious in the Work Environment. So those are the two new conferences we've added.

The Leadership in Action training on these competencies is being given to our supervisors and managers. We're complete with that. We've assigned new owners and new expectations for engineers for all of our programs. We have established a strong management observation program. We've improved the management observation program, brought it over from the other two plants, so they learn how to use the computerized field observation program at Davis-Besse we had at our other two

stations. And the person that can testify to that the best is Randy. He loves the thing. And we've established a high organizational commitment. We're out benchmarking other plants. Randy will talk to you about that.

And the design modifications have been installed to send the right message to our employees. Many longstanding equipment problems will be fixed during this outage. For example, it is not our intent to start back up with any maintenance rule systems that are not in the monitor mode. We will address our reactor and cooling pumps, and since fixed the equipment. We've improved our problem solving and decision-making procedure and new operating procedure. That's being used consistently at all of our sites. We've made a nuclear operating procedure so it's consistent. We're implementing that procedure at our sites. When we find a problem, we expect to bring the best and brightest in, look at our options, and figure out how to go forward and how to write approval through the new improved process. We used that for our test this past weekend, and we

use it every day now.

The restart review meetings are being implemented for changes in modes. And that's something that at our other two plants we've always done, and it's new for Davis-Besse. But basically, we work real hard every day to get ready to change modes and move the plant to a different condition. Prior to doing that we sat down after we worked so hard, and said why should we go forward? And now with the restart we created like 180 actions that we put in place. And then we brought in Lincoln Consulting Group to help to us with activities to increase leadership, teamwork and alignment.

MS. LINCOLN: Okay. I'll start now. Actually, Christine, do you mind if I turn up the lights? I'm a little blinder than Lew is, and I don't know if everybody can see.

MR. GROBE: I resonate with that, Connie. But before we go on, I have a couple of questions, Lew.

I was at a meeting recently where we presented the results of a routine ~~resin~~ residnet inspection and asked some questions regarding the status of the

field observation program that you've implemented where you get managers out in the field observing work performance.

Could you give me a sense of your characterization of the implementation of that program and how engaged your managers are in the field observations and the coaching of staff?

MR. MYERS: Yes. We have -- Randy, do you want to take this one?

MR. FAST: I actually have a report, and we did a breakdown in several different areas. I don't know if I'll be answering specific questions. I don't know what specific information you need, but if I provide some of this, maybe we'll open some dialogue, Jack.

One of the things we did, we wanted to find out who at what level were writing condition reports as part of our observation program, and we looked at it at the director and vice president level, six percent came from there. Manager or shift manager, 25 percent of our condition reports were written by that group. Superintendents 18 percent;

supervisors, 33 percent; and they have the technician level 18 percent. And we looked at the observations that were done by title. Three percent of those observations were done by director or vice president; 13 percent were done by the manager or shift manager; superintendent at nine percent; but most importantly, supervisors, where they really are out in the field monitoring, 53 percent of the observations were done by first-line supervisors. As well through our peer program, technicians did 22 percent of those. We actually have achieved 81 percent overall in 2002 as we implemented this new program. 81 percent of the scheduled observations were completed in accordance with what we laid out.

Let me identify some of the areas of observation that really were part of our management and human performance. Safety focus, as we looked at the observations of whether they were saffed (phonetic), that's no action taken, or there was some coaching that took place. Eighty-nine percent were saffed; 11 percent required some coaching.

Improvements in standards and decision making was the

same, 89 percent saffed, and 11 percent resulted in some coaching. We looked at prejob briefs and we -- of the numbers of observations that we did, we had 24 percent of all of our field observations focused on prejob briefs. That's our preparation for the work that we perform.

Let me just identify in broad terms some of the things that we identified as strengths, and as well identify some of the areas we identified as weaknesses. Procedure usage, teamwork, ownership, questioning attitude, communications, self and peer check, and the use of as low as reasonably achievable process work observed as strengths and noted on these observations. Weaknesses that were identified were housekeeping, use of personal protective equipment, tool control, ladder usage, lifting and rigging. And we focused most -- a lot of work on our deep drain work. We did 75, I think -- 74, 75 valves, first-off valves from the reactor coolant system, and we wanted to make sure that we looked at all of those. And we, as part of that, we had scheduled awareness, job preparation and tool availability as a

common denominator amongst these deep drain observations.

So I wanted to provide at least a capsule of some of the things that we're doing in that arena.

MR. GROBE: You obviously anticipated my question and have overachieved.

MR. FAST: Let me tell you, Jack, I believe in this program. I honestly think that it is a fundamental key to improving our overall effectiveness. And even if we have to drive our managers into the field so that we can find out what the workers are dealing with and how to address the issues that they deal with, then that's the behavior that we expect. And this program gives us very definitive information about who's monitoring and what are the actions that are being taken.

MR. GROBE: Okay, good. Thank you. I believe -- I apologize for not remembering all of the names of the folks that you introduced, Bob, but I think there's a senior reactor operator in the gallery, right?

MR. SAUNDERS: Yes, there is.

MR. GROBE: Could we get that microphone to work over there.

Could you introduce yourself first?

MR. PATRICK: I'm Randy Patrick. I'm an SRO on operating crew No. 5.

MR. GROBE: Thank you. How long have you been at Davis-Besse?

MR. PATRICK: I've been at Davis-Besse since June of 1980.

MR. GROBE: June of 1980. How were you selected to come here today?

MR. PATRICK: My manager asked me. He said a group of people of Davis-Besse people are going up to Chicago. He asked if I wanted to come along. That was on Monday.

MR. GROBE: Do you have any idea why he asked you?

MR. PATRICK: I assumed it was for waiting in the wings in case a question came up.

MR. GROBE: One did, by the way.

MR. PATRICK: Possibly it's just to, questions

asked, just tell the truth and tell what I feel about what's been going on concerning safety conscious work environment.

MR. MYERS: Let me answer that question. Randy and I are the ones who decided to bring some people with us. You know, the real thing that drove that is one thing is we might want to ask some questions. But the thing that drove it more than anything else is our people should be here with us hearing what we're telling the regulators and the world. And it's unfair, so we decided to bring a few with us. And they were sort of -- I didn't really know who was coming until the day I left.

MR. GROBE: Very good. Have you noticed a change in the operational focus at the plant? Specifically, I'm interested in Lew had articulated that one of the changes in the technical competencies in his management team is that there's much more operational training and experience.

What's your reaction to that? What positives and negatives have you seen in the management cognizance of operational performance?

MR. PATRICK: I've seen a big improvement. It makes a difference with myself. I can go to management and I can talk how a senior reactor operator talks. I can explain things the way I'm used to explaining things. I can say here's what's happening in the plant, and he understands. I don't have to go through and I don't have to say, "well, here's how this works and that goes over here," and it makes it a lot clearer communications between myself and that manager. And they understand if I have a concern. "Here's what my concern is. And here's why it's my concern." They say, "Yeah, that's right. I was an SRO too. I know what you're talking about," and they have a better feel for what it is that we have to do to correct it.

Does that answer your question?

MR. GROBE: Yeah, it does. Thank you very much. I think we have a mechanic here too, right?

MR. SAUNDERS: Two mechanics.

MR. GROBE: Could you introduce yourself, sir?

MR. BRINDLEY: I'm Dan Brindley, master mechanic at Davis-Besse. I specialize in safety valves,

anything in the piping system.

MR. GROBE: Okay, great. How long have you been at Davis-Besse?

MR. BRINDLEY: Twenty-six years May 2nd.

MR. GROBE: As a master mechanic involved in valves, I suspect you were involved in the deep drain work?

MR. BRINDLEY: Yes, sir.

MR. GROBE: Very good. Did you have the opportunity to do any of the peer observations that Randy was talking about a few minutes ago?

MR. BRINDLEY: I was one getting the evaluation sometimes.

MR. GROBE: What's your reaction to that program?

MR. BRINDLEY: I think it's beneficial. It brings any weaknesses I have within my job and my -- how I present things to the tooling and rigging and stuff like that. I think it's beneficial. It can't do anything but help.

MR. GROBE: Okay, okay. How does it work? I'm particularly curious about this peer observation

program. How does that work?

MR. BRINDLEY: When I was down in the -- when I was in containment, I noticed Mr. Fast was standing behind me unexpectedly, and he was taking a few notes here and there. And some of his friends that were with him, they went around to the different jobs that was going on. They witnessed, I think there was about four to five jobs going at the bottom of the deep rig at that particular time, and they came through and checked us all out, made sure everything was going smooth, and basically, if we needed something to perform our duties better.

MR. GROBE: Okay. Very good. Thank you very much.

MR. FAST: Jack, let me mention on the peer program, as part of our overall safety program, we have a program called SCORE, which is -- that's where individuals -- and Dan, I don't know if you want to talk, mention anything about our SCORE program. But that's where just a very simple card that identifies some key attributes of working in the field, and that is really used principally by the work force in

identification of good practice or problems that we have. So that's a peer driven -- it's overseen by our plant safety committee, and we do a monthly rack-up of what was provided. We have an award program for good suggestions that are developed by the work force. So that's a subset, we'll say, of our overall observation program.

MR. BRINDLEY: The SCORE program is a very good program because somebody could just walk up and see how this rig, for instance, or procedures, adherence and stuff like that. That's what it's usually used for. Other times you can come up and maybe I forgot to put the ~~FNB~~ FME cover on it. They bring that up also. The coat that I wore in here today, I earned that as a SCORE card winner for the month. I brought up the way the industrial safety manual in FENOC, for instance, had us setting regulators was not the proper way to do it, and I questioned it, I brought it up to management; and consequently, the whole manual had to be revised or rewritten. So in that aspect, it worked great.

MR. GROBE: Okay. Very good. Thanks, Dan.

Unless anybody else has questions.

MR. DYER: I have one for Mr. Myers. Lew, you know, I'm still stuck back in the background on slide seven when you talk about the root cause and the production focus combined with taking minimum actions to meet regulatory requirements, and then you highlighted it in the case of the vessel head you weren't meeting the regulatory requirements. And the part that concerns me -- and it's an overall theme -- is that you've talked earlier about your complacency had slipped in since the event in '85 and a lot of the recovery activities that you've done, and you've gotten to this point.

And I guess the concern I still have is, you know, the combined with taking minimum actions to meet regulatory requirements. And the regulatory requirements would get you there, would maintain safety. The concern I have is how are you determining whether or not you were meeting regulatory requirements? Was it set by whether or not the NRC caught you and issued you violations, or did you have some other threshold within the

organization?

MR. MYERS: What you heard, what that means is we would talk to our management team and they would talk about the regulatory requirements, "we can meet the regulatory requirements." In the case of the boric acid program, that actually got to the point where they justified not meeting the minimum regulatory requirements. But most of the programs we've looked at, they meet the regulatory requirements. That would keep you safe. But for example, we should be benchmarking it against the best industry practices which, you know, I think it's sometimes over and above that. You know, for example, there's a group of motor-operated valves that you need to test to meet the minimum regulatory requirements. What you find out is that's a pretty good way of testing valves, period. And AOV is the same way, that improves the reliability. So you know, there's a difference -- different mind-set in just meeting regulatory requirements and improving the value of the asset. And the other two value assets you have are people and the plant.

If you go talk to our people, what I hear in the 4C meetings is we were willing, and they saw themselves, if you look at over a cycle basis, for instance, was the material condition of the plant improving or degrading? Were the qualifications of the people improving or degrading? And if you look back from the 19 -- started about 1990, we saw a degrading trend, and a degrading trend in the managers that left and technical skills of the managers that we replaced them with, the degrading trend on some of the willingness to let material condition of some equipment operate in degraded conditions, as long as it didn't affect productivity. That's -- for instance, the diesel air system has been a long-standing issue. And what we did is add some dryers on that air system and just change the carbon steel to stainless steel. So we're going to do that. But that's been around since early '90s, and it's not been addressed yet. But at our other two plants, we have dryers already.

MR. SAUNDERS: I think it's important to acknowledge, Jim, that we did not meet regulatory

requirements as concerning boric acid inspection programs. And if we had, we probably wouldn't be sitting here today.

MR. DYER: But our own lessons learned reviews and that identified that that was an area that we chose basically not to inspect to, particularly concerned with the vessel head and that, and the question I have is this is the case where if the NRC -- if your motivation for your safety culture and that is to avoid the pain of an NRC inspection or violation in that, that's one level as opposed to, you know, meeting the regulations in all areas or above the regulations in all areas --

MR. SAUNDERS: Our motivation is to be well above minimum requirements. And like I told you, our vision is operational excellence. We want to be in the top decile for performance, and we can only get there by very strong safety focus.

MR. MYERS: You should be regaining margin. One of the things that we assessed is every cycle, are we gaining margin on our equipment, on our core? Another time we're back, did some new analysis that

gave us a ton of margin because of new technology that we have today.

What you see is at Davis-Besse was an isolationism. How much benchmarking were we doing in justifying not meeting industry standards? Some of the things -- cavity seals is a good example. We've got cavity seals already. Why didn't we go get one -- if you've ever put one in, you would go back from the cavity seal, you know. Fortunately, I put a few of these in, so now we have a permanent cavity seal. That's going to be a lot better on us in the future.

MR. DYER: Thank you.

MR. GROBE: Okay, Connie. Thank you.

MS. LIPA: For the people that are on the phone, if you could refer to the page that you're on so they can get caught up.

MS. LINCOLN: We're on page 15. My name is Connie Lincoln, and I'm with the Lincoln Consulting Group. I have been with FirstEnergy, the nuclear plants, since '97, and I was also involved with efforts at Millstone. So that's sort of my background.

Today what I want to talk about is the strategy and activities to increase leadership and teamwork alignment at Davis-Besse. I can say that in May, when Lew came over from our Beaver Valley plant, we sat down and said, "what are the key leverage areas that we need to focus in on at Davis-Besse to make a difference in teamwork and alignment? And how do we go about doing that?"

So in sitting down with Lew and talking through that, we determined there are four key leverage or focus areas that we needed to focus in on. One is the senior management team. As you saw in the slides before, the organization has a whole new leadership team at the top.

Second area was the management team. Again, it was a team that there were players going in and out, being moved around. So we had to bring cohesiveness to that layer in the organization, which is the management team.

The third area of leverage was our communications. And we have a very good organization within Davis-Besse that takes care of the formal

kinds of communications, but we also need to take a look at what are some of the infrastructures and some of the cross-functional kinds of communications that were happening, and what can we put in place so to sustain having those communications still be there.

And fourthly, or the fourth leverage area, was looking at the production organization; and I call that operations, engineering, work management, and RP and chemistry. We need to do a couple things for that to get those organizations working cross-functionally as a team. But we also needed to bring alignment in the organization vertically as we had new players all along, and those were some areas of concern that we needed to do some work in. So that's in working with Lew how we came up with our four leverage areas of what is our strategy in working with teamwork and alignment at Davis-Besse.

Let me start with the end in mind here. We're on a journey. You saw that it's a new team. So any time you have a new team, you go through these stages where they're forming, they're

storming, norming and performing. So where we are today I would say is typical of what you would see with a new management team.

But let me say something else. I've worked with Lew at Beaver Valley, I've worked with Lew at Perry. Christine can attest to this. So it's not the consultant that comes in and makes the team. It's the leadership team, it's the senior management team, their commitment to teamwork and alignment that is going to drive that. I mean, I can help along the way. We help to set up some of those structures. But it's got to be the commitment from the top team. And I think you can see if you take a look at Perry -- and Christine was there with us -- is that Lew is a proven performer in driving that teamwork and alignment at that organization. The senior management team works well together. The management team is the strongest in our system, and you can see the way they run outages, how cross-functional teamwork happens at the Perry plant is very, very good in comparison to what I've seen in the industry, as well as in other organizations. I think that's our

finest ~~plan~~ plant. And the thing about Lew is when he leaves, you leave those infrastructures so it is sustained and it continues.

Same happened at Beaver Valley, is that -- I mean, we're still working with the management team there, but it's to a person at Beaver Valley, if you go back out and talk with a mechanic, anyone in that organization and you talk about is the senior management team aligned at Beaver Valley, consistently you would have the answer yes. And I can attest to that because I was out in the trenches talking with people, talking with managers, talking to supervisors. So my point to that is I am confident in this team's leadership ability to drive teamwork and alignment at Davis-Besse. They're committed. What they did is bring us in to help set up some of those structures, help them along with that, in their busyness of the days doing everything else, to make sure that we are institutionalizing some of the things in the system.

So with that in mind, let me just walk through some of the actual activities that we have

been involved with since May, some of those structures that we've put in place to help ensure we have continued teamwork and alignment at Davis-Besse.

The senior management team, we meet with them. Strategy sessions -- that's done weekly -- and one of the results of that is you'll see them walk around Davis-Besse; you'll see they have their senior management team standards and their expectations. They didn't expect the rest of the organization to set what their standards are and expectations until they did it first. So we spent some long hard hours creating that as the senior management team on what's important to us and what can every employee expect to see out of us?

We spent some time on that and we do meet weekly and there's been some times where they haven't met, but we are much more strategic, take a look at the big picture, sit back and not get involved in the day-to-day operations, but look at the big picture. Where are we trying to go, and how do we need to get there? So that's what we spend our

time on with the senior management team strategy sessions.

Also we spend time developing them as a team. Because again, although Lew and each of the team members have worked with one another at different plants, it's a new dynamic when you bring them together in this situation. So we spent some time in working with them around group dynamics and getting their relationships built. Davis-Besse is certainly an organization that will sit back -- and many do -- and say "I'll believe it when I see it." When I see the senior team working well together, when I see the management team working well together, I'll know you're serious about this. I think, and experience will show, that that hadn't been happening in the past.

We have manager team alignment meetings. Those are held twice a week. Just recently we've moved those to once a week, and that's a time when the managers get together, they create their own agenda, and they deal with what are the tough issues cross-functionally that we need to make

decisions about? It's not that the senior management team is off making all the decisions. They empower the management team to do that, and they take the ball and they run with it. And I have to give Mike Roder, who is our ops manager, a lot of credit for driving this. Again, it's not the consultant who comes in and makes those things happen. It's having the right players in the right place who can drive those efforts. So Mike Roder, as the ops manager, has stepped up and is doing an excellent job in driving this and working through the agenda items.

We do coaching with directors and managers. If you ever talked to Lew, he will tell you that I'm his conscience in the organization. You know what kind of shoes that is to fill. But Lew is very open to feedback and actively seeks mine. You know, at the end of a meeting he'll pull me over, "how did I do? How else can I say it differently?" He talks to me beforehand in going to a meeting, "how can I present this well so I'm understood," because sometimes people are misunderstood when they're sending a message. So we try to help Lew with that,

as well as with the rest of the directors and managers.

We have sitewide supervisors and above alignment meetings. Those happen monthly. And each month it's a little different focus. Sometimes it's information sharing. Sometimes it's a dialogue. Sometimes it's actual training where we've done Leadership in Action training or Safety Conscious Work Environment. But we do bring that whole team together, and it's all supervisors and above that attend those sessions.

We've conducted transition meetings with all of our managers. As you saw, there are new managers in every position. So one of the things we do to try to quickly integrate them into the system is we do something called a transition meeting, where what we do as the consultant is we go in ahead of time, we interview the incoming manager and then do focus groups and interviews with a cross-section of employees in that area, find out what are the key issues, what are the challenges, what do you want to know about this new manager, what are your hopes and

fears? And then we hold a four-hour team session with the manager and every one of his direct reports. The first part of the meeting is sort of an up front and personal kind of interview, where I conduct that with the manager and ask every question you can think of that you would want to know about a new manager but are afraid to ask. So you can quickly get to know who that manager is, what are their expectations, how do they communicate, do they prefer things in e-mail, how do they want you to dress, what's the best way of talking with them, what's their vision for the new department? And then we also have the opportunity for the two-way dialogue where the employees also share, here's my hopes for you, here's what I'd like you to do, here's some of our concerns that we want you to deal with right upfront. So it sets the stage for two-way dialogue with the manager and his direct reports right from the very beginning. We do that usually within the first six weeks of a new manager taking over a position. We've consistently done that with new managers taking over.

We've created management team meetings to drive restart work forward. It was a couple-day meeting that we had with the managers and the directors in creating our transformational and our transactional organization to get the restart moving. That happened in early fall. We realized that we weren't organized in the way we needed to be and that we needed to share resources, we needed to be clear about our roles and responsibilities in doing the work as well as getting all of the 350 items and other things done. And what we saw is the organizations weren't necessarily talking with one another. So we pulled together some sessions where we had that dialogue, we created clear roles and responsibilities, chains of communication, and so that was something that was initiated, again, by the managers and team management team.

Being involved in restart readiness meetings. Jack, I know you've sat in on those, you and Christine. Those aren't always easy meetings, but I think you see how they have been really going deep and looking at what are the issues confronting

one another, bringing up the tough issues, asking the tough questions, and that consistently happens in those meetings. We have had RHR assessment. RHR is the name of a consulting firm that -- I don't know if you're aware of; I'm sure you were -- that were brought in to do an assessment of all supervisors and above on their competencies, are they the right people in the right place? And if so, from that what we do is we create developmental plans for each of those people. Now, what we're here to do is to help make sure we provide one-on-one coaching to help them with their development plans, internalizing those, looking for some consistencies around the site, and then dealing with those as a management team within the organization.

We're also involved with transitioning from the common process to standardization across the fleet. And that's happening in the total organization. Lew talked about engineering and how we've done our common processes in the past haven't been as effective as we would hope they would be. Say we have a common process and there are some

differences between the sites, now going to be driven from the corporate staff. And we're involved with helping to create that changed management plan so those activities are smoothly disseminated within the organization. So that's really your round leverage point one and two around the senior management team and management team.

Next slide, which is page 16. Move to our employee communication and alignment. Again, as I said, we have a very good communication organization within Davis-Besse who does a good job of disseminating information in a big picture on what's happening. But also we wanted to put some other structures in place so employees at any time would have the opportunity to ask questions, get information on a real-time basis; not only from their supervisor and their manager, but also the leadership team onsite. So we have weekly town hall meetings; those are run twice, once in the plant and once out in the building, where it's about a 40-minute presentation on here's what's new, here's what's happened in the last week, here's what's upcoming in

the coming weeks where we have that vision of where we're going, and then also it's a what's on your mind, what do you want to know, what questions do you have, what rumors have you heard, ask anything you want. Sometimes we'll just throw out some questions because we've heard that those are rumors out on the site, and let me tell you what I've heard. So it's an opportunity for two-way dialogue within the organization.

Lew has talked with you about these 4C meetings, which are compliments, concerns, changes and communications. That happens on a weekly basis. That information is compiled, it's looked at; when appropriate, changes are immediately made based on recommendations from them. And that is something now that is run through our communications department. We have monthly all-site meetings, which are sometimes they're mandatory, sometimes not. Again, it's a picture of what's coming up, what's been happening, to give people the vision of where we're heading to and what's the important critical activities that are coming up.

We had the reactor head case study training, which, as you know, we took a whole day, stopped all work, and each department in their vertical departments sat down for at least four hours and went through how did we get to where we are? What kind of standards and expectations do we as a team need to put in place so this doesn't happen again, and what do we as a team need to do to move forward so we continue these dialogues and don't get back here.

We have our restart overview panel sensing sessions. There's been a couple of those that have happened where Jerre Witt and Buzz Carnes -- Jerre and Buzz, where they requested a random selection of employees from supervisors on down, cross-sectional groups, where they would hold like five or six sessions of employees, have an open dialogue on tell me what's on your mind, what's going on, what about our safety culture here, what about safety conscious work environment, are you afraid to go to your boss, and compiled that information, fed it up to the senior management team and the

management team and then actions were taken as part of that. Another effort of communications and to keep people informed and pulsing the organization what's going on.

Other site-driven activities, we have staff meetings. Those weren't necessarily happening before with the manager and with the supervisors. We have safety conscious work environment meetings and training that's occurred. We have our daily focus, which any employee can go on on-line and take a look at what's happened in the last 24 hours, what's critical path for the next 24 hours, and what are key accomplishments that we've done on site? We have our on-line newsletter which comes out monthly, as well as we have the restart Web page that anyone can click on and find real-time information.

So our intent in setting up some of these structures -- and again, in each department they do it differently. In engineering they have some breakfast meetings, they have lunch meetings. Those happen every other week with a random group of people who want to come and ask questions and see

face-to-face the director. So we've tried to set up several different structures for the opportunity to have dialogue and two-way communication within the organization.

On to the next page, which is really our fourth area of leverage, which was that production team that I talked about, and paying attention to these four organizations needing to cross-functionally communicate and understand what's going on in each area and problem solve together, versus inner silence, as well as create vertical alignment in each of those organizations because we had new managers at the top of those, as well as a new director who was responsible for those areas. So we needed to bring about the alignment in the organization. And we did that overarching with our management and human performance root cause.

You'll find -- as an addendum in that, you'll find organizational and leadership plans that were specifically developed for each of those areas. And how those were developed were with the director, with the manager and a cross-section of employees in

that vertical department who came together and said what's going well, what's not going well, and what do we need to do differently? And how we collected that data is we did focus groups and interview in those areas on what are the key issues, we fed it back to this team, and then that team created specific action plans for their department on what we need to do to move forward. And those are being looked at, those are being worked. We have consultants who are assigned to each of those areas who are working with the managers and directors.

And again, just some of the other things on there, just talking about some of the other interventions that are under those leadership plans that we've done. We consistently sense and pulse organizations. You won't find us at a desk at a computer. You'll find us out in the site talking with people all the time, what's up, what's going on, what's happening. And oftentimes we are just involved in the crisis of the moment or the stress of the moment as you can imagine, when the organization is going through the amount of change that we are and

the stress and the work hours that people are on, we're going to help deal with that in any way that we can.

Okay. So I get done with all that and what I say, and what I would expect you to say as well, is "well, so what? That's nice. You've talked about what you've done, put some things in place, but what's some evidence that you can show us on this soft issue of teamwork and alignment that we're making some progress and that we're -- that what you've done and what the senior leadership team has put in place is making a difference?"

Let me go through a couple examples. We have active involvement in plant work activities. You've heard about our management observation, I've told you about the meetings that we've had. The managers and the directors are out in the plant with their work team. Now, I can say -- and you'll find this, what we've found consistently in our 4C meetings and in the ROP meetings, "I never see my manager." And that in some ways is true. They are in a lot of meetings because they are trying to

develop their cohesiveness this way, and we're working really hard on that in getting them out in the field, out with the work group. But that's an area that we still need to be working on.

We have cross-functional problem solving and decision-making teams that have had a proven track record. You look at your RSRB. We have two teams that meet daily. Tell me they don't work with some tough issues on the table every day. What's in restart, what's out, what's the best way to approach this? And they have to look at it not only from wearing their own hat as the design engineering manager, but they have to look at it on what's best for the site? So those are some proven activities where you see clear teamwork and alignment, and it's happening horizontally in the organization.

We have our restart readiness meetings. Those were pretty painful, but I can tell you it wasn't a bad pain. It was a good pain because we got the tough issues on the table. Lew said there's 180 actions. And people had to come and look eyeball to eyeball and say why am I ready to

restart? And it wasn't always comfortable to hear that you're not ready or you need to do this or that, but I can tell you -- and Jack sat in on those -- there was some healthy debate. And that debate was expected in that team, and we certainly got it.

We've had mode restraint meetings, and that was an effort that was led up by Mike Roder, where we had that production team, the cross-functional team who sat down and looked at all the mode restraints and said what do we need to do to get to mode six? So it was that cross-functional team who initiated that moving first and looking at that before we got to our restart readiness meetings. Again, I just can't emphasize enough the role that Mike Roder has stepped up in really leading the management team at Davis-Besse.

They had to do -- and just when I put contractor reduction, that's just another example of one of the outcomes that the management team had to wrestle with is how do we, to meet budget and look -- how do we reduce some of our contracts? We need to move that work over to our employees who are there

all the time. How do we go about doing that? And again, they had to wear the hat of the manager on site and the leader on site, versus their individual area in taking a look at where do we need to reduce, who may need to shuffle some players because we need more help in the outer organization than we need here. So it was tough meetings, but the team came together and made those decisions.

I think RHR assessment reinforced the caliber of our leadership. We've made any changes that we needed to make, but the players who were in their position are the players who will be in their position. They're competent and proven and with developmental plans and actions that will set forth as moving forward, you'll see that those are the right people in the right place who have the capability of aligning and developing teamwork within their organization and working cross-functionally.

Lastly, I just want to end with employee testimonies. As I said, we're out in the plant. We talk with people all the time. We are in these meetings, so sometimes unsolicited, sometimes

solicited, we say, "well, okay. So what's different here at Davis-Besse? Give us some examples of what you see different." You get your mixed reviews, but I can tell you that people say that it's a different leadership team. "We see the difference. It feels different here. I don't have any hesitancy in bringing up issues," and that you hear that from our managers, if you talk with them, as we constantly do about how are you functioning as a team? It's different than it was before. You know, as I said, we're on a journey. They're working well together now. Same with supervisors and same with our front line staff. Any questions?

MR. MYERS: I was listening to Connie talking. This is not a question I've shared with her, but it sort of came up. If you look at working -- you worked with Bill ~~Canda~~ Kanda at our -- and the senior management of Perry plant, also at our Beaver Valley station, was there a -- you had the opportunity and worked some over here at Davis-Besse prior to the event. Was the relation -- did you see a difference in the way you were utilized at the --

MS. LINCOLN: Yes. And there was clearly, I would always say, there was clearly a difference in the management team's ability to work together. As I said earlier, I thought Perry was the strongest management team. Then actually I would go to Beaver Valley. That's because they had a strong aligned senior management team there. The management team was coming along, but they were willing to talk about the tough issues dealing with those things.

Then we went to Davis-Besse. We did an assessment of just November of last, and took a look, and we had the managers. It was a culture survey that we did with the managers and senior management on how well are we functioning together? And the concrete data is we came out, and they weren't. And their desired organization on how they wanted to work together compared to how they saw themselves today was diametrically opposed with where they were and where they wanted to be. So they weren't a cohesive team.

MR. GROBE: I sometimes lose track of time. Was that November of '02 or November of '01?

MS. LINCOLN: November of '01.

MR. MYERS: Okay. Thank you, Connie. Any questions?

MR. PASSEHL: Yes, I have a question. You talked a little about your management observation program, field and training observations. How do you integrate that with your formal corrective action program? If they identify an issue in the field do you write a condition report, or is that something separate?

MR. MYERS: We actually -- if you need a condition report, and you're a manager in the field, you write a condition report. So if you find a condition, you write a condition report. You don't write a -- so as part of the management observation, if you find a condition, you write a CR. But a lot of times we find things where, coaching, you know, prejob briefs, things like that, where we saw they weren't doing, we'd write a CR. But if coaching is involved, we're not, you know. But it could result in a CR.

MR. FAST: It's incorporated in the observation

program, so you have to ask -- you have to actually ask that question is this something that then requires a condition report because it requires some action or follow-up? So if it's a coaching in the field for a behavior, it doesn't require a condition report. However, if we found a process problem that needs to be documented and then formally corrected, we could use a correction report.

MR. PASSEHL: Thank you.

MS. LIPA: Just to follow up a little bit more on Dave's question, would the results of your management observation, do you trend those, and does that trend then become entered into the corrective action program?

MR. MYERS: We would enter into collective significance. We might enter into corrective action if we saw a negative trend. In other words, we would do that, but look for those trends.

MS. LIPA: Have you done any of that?

MR. FAST: I don't believe so.

MR. GROBE: Bill, do your folks look at the results of the observation program?

MR. PEARCE: That is one of the things that we are looking at overall. But the observation program is, in my belief, is starting to take hold now, and we'll be digging more into that. And truly as we start moving towards core load and some of those things, it's going to give us more of an opportunity to oversee and try to make some tie between behavior, look at why the behavior is like it is. We'll probably look at the observation program and see if it was trying to correct that.

MR. WRIGHT: One question here. Oftentimes -- I think it leads a little bit to what you're saying. Oftentimes when a manager is out in the field, if you're with an individual and the manager identifies an issue, sometimes you could end up with two separate pieces. One is the physical condition that the person identified; the second being why didn't the individual I was with identify what I saw? Is that captured in both places? Do you write or put together two documents, one is "I need to fix the piece of equipment that was deficient or the condition that was -- as well as look into why didn't

the individual identify that?"

MR. MYERS: Right.

MR. WRIGHT: Is that done that way, or how is that handled?

MR. MYERS: As part of your management observation, if you found a material condition problem and you identified it you'd note it in the -- either write a CR or work request on top of that, whichever document you needed to generate;

MR. PEARCE: But Geoff's question, you'd also coach the individual. That's really what it's all about is management out there interacting with employees, setting standards, coaching behaviors. What's significance -- supposed to be significant about the trend program that we've had asked, I think it's an important point, is then you go look for trend and say across the organization do we see -- are we having to coach a lot of people that they're not wearing their protective equipment, and those types of issues, and then take some corrective action across the board of that issue.

MR. WRIGHT: Thank you.

MR. MYERS: We would mark that as a coach, why didn't the employee do that?

MR. DYER: Lew, a question for Connie, a clarification. You referred to the senior management team, the managers, the supervisors and that. Just referring back to the organization chart, on the senior management team, what group of individuals is that?

MS. LINCOLN: That's Lew, that's Randy, Bob ~~Shrouder~~ Shrauder, Mike Stevens, Jim Powers. Those are directors and Lew.

MR. DYER: And the senior management review team is? That's them?

MS. LINCOLN: That's the senior management team.

MR. DYER: Then the managers are below them?

MS. LINCOLN: Right. Those are the heads of the departments.

MR. DYER: What involvement would, say, Bill Pearce's organization, the quality oversight, and Gary ~~Lidick's~~ Leidich's organization of nuclear engineering and support, how do they integrate into these reviews?

MS. LINCOLN: Well, one is Jim Powers is a

member of the senior management team, so he is the person who is responsible for the engineering organization. So he's directly involved. He is a member of that senior management team. And actually, Bill does attend the sessions with the senior management team, and I can tell you, he brings great value and a different perspective and asking sometimes the tough questions of the conscience of that team. So Bill has been involved to date with the senior management team when we have sessions with that team.

MR. SAUNDERS: He's independent. Bill reports to me and to the board.

MS. LINCOLN: But we think he adds value so we appreciate his input.

MR. MYERS: Okay. So we talked about a lot of things. What you heard, I hope, is that a lot of activities that we have been doing, some of them first part of last year. So we've been taking a lot of actions.

And the next area that I'd like to talk about is the final building block that we're

working on, the management committee areas, the individuals themselves. You know, going into this, I've heard a lot of discussion about us compared to other stations and 350 station [other IMC0350 stations]. I feel, from a management standpoint right now, you know, I'm not -- I think our strength will be and it will be measured by the relationship between our employees and the managers and the senior management team. I feel pretty good; I'm a pretty seasoned manager. And Connie was talking about our directors. Our directors are all seasoned. They're all seasoned managers, seasoned leaders. There's some basic differences that I feel -- I'm not afraid to walk into the shops and I'm not afraid to bring our employees down or you down or anyone down. That's not to say everything is perfect, but we feel good about some of the communications with our employees. That being said, let me go into the employee commitment area.

The employee commitment area, first thing that we've done there is we've evaluated our supervisors. We don't have a supervisor in place we

don't believe in. That's not to say that we don't have supervisors that we have developmental plans for, because we do. And the developmental plan is something that we have for all of our supervisors all the time. Some people want us to get SRO licenses, some want us to get other things. We have one guy at the Perry plant working to get his degree. So anyway, so we work on those developmental plans for our supervisors and our managers all the time.

We've completed the case study with all of our employees. That's not, "well, we do a case study." That's not what we did. We went over this event in great details and spent half the morning with each and every person assigned. And then we went over the standards in the department, and we also looked at how each and every group -- and we did it on a group level -- could have contributed to this Davis-Besse head issue, how they could have prevented it, what could you have done? And at the end of the day, to make sure that we had a clear understanding, we had a test for understanding for each and every employee. So that's the basis

there.

We provided the supervisors with refresher training in Leadership in Action. Not only just the supervisors; we've done it for managers and senior managers also. We provided the supervisors training on safety conscious work environment for all of our managers. That's been done. We've strengthened our individual ownership and commitment.

Our engineering rigor is not something we started on yesterday. We had an engineering review board in place at our other two plants for a long time. And that's the purpose of that board, is to make sure that the -- it's a quality check to make sure that the quality of the second check, peer check, as you call it, to make sure that the quality of the engineering information that we're putting out is good. We didn't have that at Davis-Besse. We've had that since we created the building blocks.

Operability decision making, that's training we've done with our operators and our engineers to ensure that we knew how -- we were teaching operability issues correctly. That's

complete. We trained over 200 people in that area.

Operator license responsibility training. That's complete, right, Randy?

MR. FAST: Yes -- or the last crew may be done this week, actually.

MR. MYERS: I think it is this week. So that's complete with all our operators. Shift manager command and control responsibilities. We've now sat down with all of our employees at all of our plants and at corporate and made sure that everyone understood shift manager's responsibilities.

The town hall meetings, the 4C meetings. There were 500 people there. there is an independent person that comes in and meets with the team before I do so if they're afraid to bring an issue up to me, they can bring it up and present their issues as a group. It's not an individual's issues. What's really surprising to me now and a very big change from what I saw when I first got there, is I would come in with this list of questions and go through them. And it was amazing the types of questions, first of all, how they've changed now.

But what's more amazing is people stand up and say, "well, that was my question." I did hear that. Just about every question, you go monitor it in the room, somebody will say, "oh, that was my question." I consider that an important step.

Participation in monthly all-hands meetings. We have tried that. We got a lot of feedback, came out of the 4C and town hall meetings. People were getting things out of the newspaper, so what we try to do is when we have a meeting of this type or a public meeting, we're trying to make sure that we communicate it to the employees first. For example, I think the day before we came here, our employees were receiving some information about this meeting.

We stengthened our questioning attitude. If you go look at our restart readiness review board meetings, that's something that's normal at our other two sites, but wasn't normal at Davis-Besse. It is now.

We have a standard format for prejob briefings that's in place all through our sites now.

And then we've made our decision-making nuclear operating procedure a nuclear operating procedure for the entire sites. And we're using that every day. In my mind, that process, you know, I was here -- that process got started at Perry when I was here for an enforcement conference, and it was a systematic way to go through troubleshooting and decision making at our plants when we run into issues. Get a plan, type it up, so it's handed off well, we understand it.

The other night we had one where we were looking at an issue we had, and Randy led the team. They came in, 4:30 in the morning they called all of us, the entire senior management team, on the phone, they went through the options. We chose the option. One of options was to do nothing, but that wasn't a good option. We said, "no, not going to do that. It's going to take us two or three days, but we're going to go fix this problem. And here's the most likely candidates," and we went through that. And when we walked away from that 4:30 in the morning telephone call, we had a consistent message on how we

were going to go forward. Decision making is important.

Implement our operator leadership plan. That's well on the way, and Randy can talk about that later.

Requalification of all root cause evaluators. We took every root cause evaluator and we did qualifications. We've now trained over a hundred people -- retrained. So we have a good core of competent root cause people.

With that, I'd like to turn it over to Bill Pearce to talk about our safety conscious work environment.

MR. PEARCE: Thank you, Lew.

MR. GROBE: Bill, before you get started, it's -- we're about a third of the way through the slides and nearly 50 percent of the way through the time we allotted for this meeting. That's not a hard-and-fast time that we're going to end, but -- we can certainly extend it if that's what's desired, but we do need to take a lunch break. I was just looking over your presentation. It looks to me like you're

going to cover about eight or nine slides. Is that something that you want to do --

MR. PEARCE: I think I can do it, Jack -- and in fact, that's what I was going to tell you is I've covered this in a couple public meetings. This is just to refresh everyone today so that we can go over some of the monitoring areas later on in the presentation, so I'm going to keep it at a high level.

MR. GROBE: Good. Okay.

MR. PEARCE: Thank you. What I want to describe is the safety conscious work environment and how we're dealing with those at Davis-Besse and how we're looking at them, and we've put together this picture. And what it depicts is four columns and -- that support the safety conscious work environment. And it's founded in the basic principles, and of course, those principles are anchored in the Leadership in Action. All supervisors get the training on the basic principles before they can become supervisors. So we know that we've got that in place and it will stay in place.

The four pillars, I'll describe them just one at a time, and then we'll go through and tell you the actions that we're taking.

The first pillar is management support and worker confidence, and then the second pillar is the corrective action program or the normal problem resolution process. The third pillar is the alternate problem resolution process or the employees concern program. And the fourth pillar is the methods to detect and prevent retaliation, or the forward-looking issue about safety conscious work environment, and we call it the safety conscious work environment review team. It's a team we put together to deal with that issue. Next slide, please.

And the management support and worker confidence column, we've issued a FENOC policy -- we talked earlier about that -- from Bob on safety conscious work environment, what our expectations are. All employees were taught at all three stations on that policy, were trained in the policy. Lew just talked about his -- this is the 4C meetings I'm talking about here. The site vice president met with

400 employees -- and he said it's over 500 now, but I know that it's over 400 -- in groups of 15 or so, to reinforce management support.

Now, what's important about this concept is Lew's a busy guy. I guarantee you, he's a busy guy. He works a tremendous amount of hours. He's spending four or five hours a week meeting with a group of 15 employees to get a message across to them. And it's primarily aimed at this: Making sure that the employees can see that Lew is a person, that what he cares about, what he values -- and one of the things he always goes over at that meeting is safety conscious work environment and that he wants to have issues brought forward if they can't be resolved, bring them to him. Those are the messages that he transmits in that meeting. It's a highly important thing we're doing. He spends a lot of effort getting it done, and it's about this column in the safety conscious work environment.

We've trained all managers and supervisors on safety conscious work environment. We brought in some experts in that area to do case study

training with our managers and supervisors. It was good training. Everyone went through it. I attended it, Lew attended it. We have all been through it. We also started training all the operators -- not just the supervisors, but all the operators on safety conscious work environment. And we're in the middle -- in the midst of doing that. I think we're in the last session of that. And so that's where we are in that first column.

The second column is the corrective action process. I'm not going to talk about this a lot either since we've talked about this at multiple public meetings, where we are, the actions that we're going to take, and a lot of that's done now. We're in the implementation. We've done the study, we figured out what we want to do, we're now implementing, we're getting a new process in place. We've got to do good change management as we implement the new changes. Although they're not huge, there are some new ones. As we'll implement that, we have to do good change management to make sure our employees well understand how to do use the

process and it still fits their needs and takes a little feedback. But I believe that the new process will be good. It's going to serve our needs. It's as good as any in the industry, from our research.

The third part is employee concern program, the third column. The program became effective in December of 2002, the new program. There was a program in place before. We've strengthened it. The new program went in place last December. We benchmarked other plants, looked at what they were doing. Millstone, Diablo Canyon, San Onofre and the NMC; some of the NMC plants were looked at to understand how they were doing it. And our model is around that. It reports directly to me, and -- which means it's outside the line management at the plant, and so that was a way to strengthen it.

Protection of confidentiality. We've got a process in place now to ensure that the confidentiality is maintained when it's requested or required. Sometimes employees have reasons to want the process to be confidential, and so we've got that in place. We brought in four independent

investigators, and they're professional investigators. And that's important to try to strengthen the types of investigations, the independence of the investigators. In the past we used management folks to do that, but -- and it gave our employees a feeling of doubt about whether things were really being investigated to the depth and get to the real issues and that type of thing. And I've gotten quite a bit of feedback, mostly to the positive -- by far, I would say to the positive, that they appreciate the independence of the investigators, they think good investigations are being done.

And the fourth column is --

MR. GROBE: Before you go on to the fourth pillar, the employee concerns program, I know that you were beginning to monitor a number of different performance indicators and benchmarking those performance indicators. Where do you stand on that? Do you have a set of performance indicators for the ECP?

MR. PEARCE: Yes, I do, Jack, and this afternoon

we'll talk about that. That's what we're going to talk about.

MR. PASSEHL: Just another question. How do you advertise your employee concerns program?

MR. PEARCE: Marketing is a big facet of it, and one of the ways that we're doing it -- of course, we trained everybody on safety conscious work environment, and that was a marketing tool in that regard for the employee concerns program. Also, the employee concerns program manager goes out and attends -- we have morning tailboard sessions and working line organizations, and he picks a couple of those a week and attends them and talks in the meetings about our program, what it's about, you know, takes feedback; and he actually records some of that data, as well as his monitoring points.

MR. PASSEHL: And where is their office located on site?

MR. PEARCE: It's located in the training building.

MR. PASSEHL: Okay.

MR. PEARCE: And the fourth column is the

methods to detect and prevent retaliation. And this is a review team and it's a concept, was kind of what we started with, but we got it in place. And we charged this team to look forward at pending actions dealing with people. And that's where we're getting a lot of the -- if we get issues with harassment, intimidation, retaliation or discrimination, we get those kind of issues, that's generally how they come about, is we're dealing with our folks over some type of discipline issues or something like that. So that's where we put this team to look at. Any time anyone is going to do any level of discipline at the plant or we're going to make some changes, we run those changes through this team. And it's made up of top level managers. The directors are on the team -- Randy is on the team; and also, the legal department is on the team; HR people, Fred attends a lot of them. And so we review. And the purpose that we're reviewing for is to make sure there's no harassment, intimidation, retaliation or discrimination. Are we being fair? Are we doing the right thing? Why are we doing this discipline? Might the person be

involved in some type of protected activity that we need to look at to make sure it's not going on. So that's why we've got the people on the team that we do.

I'll give you an example of the next one. It's the example I've been using about the contractor reduction effort. We had this team look at that before we got -- we were going to reduce contractors toward the end of last year. Before we did that, we had the team look through the contracts of our vendors. You know, the people -- we'll hire some company to work for us, and they bring in people and then we say okay, we need to cut so many people. Well, we had this team go look at their contracts with us to determine what methodology were they going to use in the force reduction. Was it, for instance, last in, first out? That's a type of reduction policy that's nondiscriminatory. If you're the last guy to be hired, you're the first one out. That's a seniority-based system. And there's several methods that are utilized. So the team looked at the methods that the contractors were going to use to make sure

that we weren't going to use any types or any systems to reduce force that might be perceived as discriminatory for some reason. They reviewed the results. We did exit interviews -- and that was a recommendation. We did exit interviews for each employee that was reduced, and they were asked in that did they have any concerns? And of course, the team reviewed the results of that. So I think it's a good thing.

We're trying to understand and get better at looking forward, staying on the front side of it, rather than having to react to when someone has had something that they believe is some type of discrimination or harassment happen to them. We're trying to get in front of those issues. And I believe that we've had some success already with the team. Like I said, they look at every time we discipline anyone, the manager takes it to the team and goes over with the team what he intends to do and why and what the issues are around it. So I think it's a good thing and I think it's going to give us some payback.

And that's my presentation, unless you have any questions.

MR. GROBE: I had a question. I believe it's probably over a month ago I read the charter for the safety conscious work environment review team, and the charter was a bit broader than what you just described. It also included kind of continual assessment, benchmarking and advice regarding the safety conscious work environment. Is that still part of --

MR. PEARCE: That's still part of the ~~chart~~ charter.

MR. GROBE: Okay. Other questions?

MS. LIPA: This will probably be a good time to take our break then, unless it disrupts the flow. So what we should do is be back at five minutes to one so we can get started promptly at one o'clock.

MR. DEAN: Before you break, I have one question.

MS. LIPA: Go ahead, Bill.

MR. DEAN: Bill, on your slide regarding management support and worker confidence, you indicated that you're in the process of training the

operators, including training operators on safety conscious work environment. I assume that was just the operations staff. What about the rest of the organization? Are there plans to get to the maintenance and engineeering organizations as well?

MR. PEARCE: We trained -- we have been training everyone on safety conscious work environment. In fact, a case study had a piece on it. But we wanted to give the operation group the same level of training that we gave the managers and supervisors, with the case studies, and so we've given -- we've chosen the operators to give a more higher level of training than we did the general population of the plant. But we have trained everyone in safety conscious work environment. We've discussed it. We've discussed it in a lot of forums, too. In fact, you heard us talk about that several times during this meeting today where, if you look at, you know, they talk about training of something and then all of a sudden you see safety conscious work environment. And we've taken every opportunity that we could to add it on to different things that we've done to keep

reinforcing the concept that it's important to us, it's important for us -- for them to know that we value it, and we just continue to try to market it and give information on it.

MR. MYERS: I went to a couple hours of training the other day in one of our engineering areas on the safety conscious work environment policy, on the safety culture policy and the command and control policy we put out. And the meeting that I attended and sat through was in the engineering area. But we've done that for all three plants and our corporate office also. So that's been done consistently; that training has been done consistently with all of sites.

MR. DEAN: The only other question I had related to the employee concerns program, and maybe it's a little too early to tell since it's really a new program that only became effective the end of the year. Has there been any observations regarding through put or the amount of activity that the employee concerns program has generated as opposed to the previous ombudsman approach?

MR. PEARCE: Yes. I've got that data, and I'll present that this afternoon as part of the monitoring part of --

MR. DEAN: Thanks, Bill. That's all I've got.

MS. LIPA: Okay. Thank you. So we'll resume again at 1:00.

(Whereupon, a recess was had.)

MS. LIPA: We'll go ahead and begin the session. We plan to go from one to three with FirstEnergy's presentation and questions, and then done by three with that part of it, and then we'll start the public question-and-answer period. We'll take a short break at three and then start the public participation a little bit after three. So that's the plan. Go ahead.

MR. FAST: Thank you, Christine. Good afternoon. My name is Randy Fast, and I'm the Davis-Besse plant manager.

What I'm here today to talk about is anchoring the changes in safety culture for operations, and I'm just going to mention a couple of

things. One, I know we want to get through a lot of information here so I'm just going to provide a high-level view, but I wanted to identify that there's direct linkage from a root cause that we did at operations back to our overall root cause, and a lot of the things that we're doing are a subset of really what came out of our overall root cause. But there is that direct linkage.

One of the things we want to establish is very clearly site-wide commitment to safe plant operation. Bob and Lew both talked about our overall commitment for safe operation. We really believe that operations, the best of the best overall are operationally focused and led by a strong operations team. As part of our operations leadership team and our overall plan for improvement, we have a continuous improvement culture that's really always looking at the way we're doing business and the things that we're doing to improve the way we do business, and that is part of our operations leadership plan. And I think it's a mantra that will serve us well in operations and being complacent or

never being satisfied. We're always moving forward.

Part of what you have to do is really drive things through a training process, and we do have two license classes that are in the pipeline. We have several of our senior reactor operators in rotation of assignment. Operations took a leadership role in the development of the 9118 [Generic Letter 91-18] training that we've provided to all of our senior reactor operators, but as well as our engineering folks, so that we understand clearly operability concerns for our equipment.

We talked about operations having all of our folks have safety conscious work environment because they are out at the plant seven days a week, 24 hours a day all the time, and they're there in the presence of the work force.

One of the things we talked about was the nuclear operating procedure for decision making, and we have been using that most recently. In fact, I brought some examples, ones I can share with you later. But those are, I think, improvements overall in our operations focus.

Leadership in Action, operations has taken a key role in developing operations leadership. And I'll give you some specific examples. The shift manager, which is the senior licensed person at the station, and as Lew had talked about, the identification of his roles and responsibilities had a lot of administrative burden, and we examined that burden, reduced that burden, carved out an actual office for the individual that provided a place where the plant staff could go and talk through any issues. But our expectations -- and I believe they're very clear -- is that the shift manager be visible in the work force and in the workplace, out reinforcing standards, adding value. And I have some specific examples where our shift managers have improved processes by being out.

We had some discussion of the observation program, the deep drain work. One of our shift managers was monitoring a job, the unpacking of a valve and being able to examine the physical condition within the stuffing box. He saw that the lighting was fairly poor, the guys were using

flashlights. He said, "Hey, I think we can get some fiber optic equipment that will actually be able to do a lot better examination, as well as some additional tooling," and we went -- he actually went and bought the stuff. And within about 24 hours we were able to implement a process improvement that really helped mechanical maintenance. So I think our staff are appreciating the contribution that our operations leadership are providing.

We have instituted a benchmarking program, and all of our crews have been out to benchmark, most notably Progress Energy, Entergy, and Exelon, in looking at the way that they have focused operationally.

The next item I was going to talk about were measures to prevent recurrence. And as we talked about, we're anchoring or institutionlizing our expectations and our safety culture supporting policies, programs and procedures. One of the things we have seen really a lot of improvement in the quality of oversight and the intrusiveness of quality coming and questioning the operation staff about what

we're doing, how we're doing it, why we're doing it. And we appreciate that, and I believe it's adding value.

And then we'll continue to monitor our safety culture. It's -- I feel pretty good about where we are. I feel that Ops understands where they are, and I think our overall plan will continue to mature to establish the standards at the shift manager level.

Lastly, our FirstEnergy chief executive officer, Pete ~~Burke~~ Burg, has a personal commitment that each shift manager meet with him prior to restart one-on-one so that Pete can have that open and honest dialogue to ensure that his expectations are satisfied and that the role and the responsibilities of the shift manager is clear. I think that's a tremendous commitment by Pete, and I know that it will be value added for our shift managers.

That's really all I had to prepare. If there's no questions, I'll turn it over next to Fred Giese. He's our manager of FirstEnergy Nuclear

Operating Company human resources.

MR. GIESE: Thank you, Randy. I'm speaking to page 28 in your slides. As Randy said, I am the -- and Bob Saunders earlier said -- I am the manager of human resources for FENOC, and I am new at the position. Not only am I new at the position, it's a newly created position, and it was created with a desire to have somebody in place, a senior HR kind of guy, who helped with the three HR sites -- three HR departments in the various sites, to develop some consistency across the fleet and also act as a coordinator between the corporation and the FENOC organization.

I am the owner of the leadership development process, and we talked a lot about that in lots of different ways. Underneath the umbrella of that process is the Leadership in Action courses, the Ownership For Excellence, which is a performance review process.

Let's talk about some of the things that we've done to -- some of the actions we've taken, some of the improvements we've made. As a

part of the Ownership for Excellence and the Leadership in Action, we have added two new competencies which Lew and others spoke to earlier on, which is nuclear safety consciousness and nuclear professionalism. We have anchored those competencies in our performance review program or Ownership For Excellence, and they are not only being defined as part of the competencies that we look for all employees, but they are being measured as part of the performance review process. And that will be done this year as a part of an element of the reviews for the prior year.

Lew spoke to refresher training in these two areas. Let's talk about the impact. These were six-hour courses where we sat down with all the folks that were trained and spent six hours talking about these two characteristics, these two competencies. So it was not a brief conversation kind of thing. It was an intensive amount of time, and very completely discussed. We also brought in our HR industrial psychologist to help assess the capabilities of our supervisors -- the supervisors,

managers and above, including the senior FENOC management team. All of us have gone through this process. And Connie talked to some of that. And both Lew and Connie said that -- and I absolutely concur that we feel that we now have the right people in the right places. And we are doing the things we need to do to support those folks, where needed, with individual development plans. And the individual development plans will be in place for all of our supervisors and above at Davis-Besse within the next couple weeks. The target date is February 15th.

We have, as I said a couple moments ago, we have anchored these competencies of nuclear professionalism and nuclear safety culture in our performance review program, and we've reinforced that a number of ways, as we've talked about it today, and what we're trying to do, and get people's attention and what the focus of this business is, as Lew has said, and Bill and others. I'm not going to spend a lot more time.

What I'd like to do is introduce Sonja Haber, who is an expert that we brought in to help us

evaluate the safety culture at Davis-Besse. And if you have no further -- if you don't have any questions, I'll turn it over to Sonja.

MR. DYER: Fred, I have one question, and that is how are you proposing to measure these two new attributes?

MR. GIESE: It's going to be part of the Ownership for Excellence, which is the review process, the performance review process. And I'm going to look for Randy and some others to give me a little help here --

MR. DYER: They seem rather subjective, from my perspective.

MR. FAST: There are some very specific attributes that, as we developed these competencies, we looked at what were the enablers for those? An enabler for safety consciousness will be training. There's an element there. We focused on getting our folks qualified and trained for the work that they do. So we have rating sheets. In fact, there are two rating sheets for each competency, so probably somewheres around 10 to 12 specific attributes, and

in one of three categories: it does not meet expectations, meets expectations, or exceeds expectations. So there's, as you go through each one of the attributes, an individual is rated on those. I performed that assessment for the folks that work for me and --

MR. DYER: So you set expectations for these?

MR. FAST: Absolutely.

MR. MYERS: Absolutely.

MR. DYER: Okay.

DR. HABER: Good afternoon. Thanks, Fred. I'm Sonja Haber. As was mentioned, we were asked to come in and do an independent evaluation of safety culture at Davis-Besse.

What I'd like to do today is to present to you a little bit of background on the development of the methodology that we're using, the premise and the characteristics of safety culture that we're looking at, what we will review with Davis-Besse, how we will review it and, of course, what the outcomes of the methodology will be.

I'll tell you a little bit about the

background. We don't have to review here the human performance issues that have occurred across the nuclear industry, not only in the United States, but across the world. As a consequence of those back in the late 1980s, the United States Nuclear Regulatory ~~Agency~~ Commission actually implemented a very large research project, at that time looking at the influence of organization and management factors on safety performance. And I was integrally involved with that project for many years. And the project basically attempted to develop a methodology to assess those influences, look at methods that could measure them, and then look at the resulting outcomes with respect perhaps to a regulatory framework.

A lot of the work that was done during that project is documented within the USNRC documentation. In the mid-1990s, the USNRC basically stopped the research, or it came to an end before it really ever implemented it in a regulatory framework. We had conducted some pilot work in U.S. plants and some other organizations. At that time the Canadian Nuclear Safety Commission, which is the

equivalent of the USNRC for the licensees in Canada, decided that they were interested in the methodology and decided to pursue it. And we were asked to review the methodology, see if it needed to be modified or adapted for the Canadian facility and then we actually conducted over the next few years the methodology of benchmarking their licensees using this particular application. And that ~~projet~~ project just recently ended.

During this time of this development from the start of the USNRC work through the Canadian work, the methodology has had some modification, not a great deal. As you'll see as I describe, a lot of the methods are not that unusual. But we also had an opportunity to be working in countries of the former Soviet Union with Soviet-designed reactors, and we had an opportunity through some of our visits there to implement aspects of the methodology in those plants as well.

And finally, we've been involved with the International Atomic Energy Agency in some of their recent work in safety culture. In particular,

I've been involved in implementing and developing guidelines for the assessment of safety culture, as well as on some evaluations of safety culture at different nuclear installations around the world.

So the method that I'm going to talk about today really has been through an iterative process. It's been through a lot of peer review. It's been used in different countries, different cultures, different types of facilities. And I think it brings to the table a lot of what people agree on as to what's important with safety culture.

The premise of the methodology is that safety culture exists in an organizational context. And what I mean by that is you can look at culture in many different mediums or contexts; and here we're looking at the organization. You can look at culture in a societal context; you can look at it in an individual context. We're looking at it with respect to the organization of interest.

If you do that, it's helpful to think about Edgar Schein's model of culture. And I bring it up. It's one that the International Atomic Energy

Agency is using as a frame of reference because it's helpful in understanding what you can assess when you talk about culture. Schein basically argues that there are three components to culture, and I'll just take a minute to explain them.

The first is the artifact level. Artifacts are the observables of culture that we can see. For example, a plant has a mission statement, it has vision statement, it has a policy statement. And basically, you walk through a plant, you may see posters on the wall that talk about "safety first" or "stop, think, act and review." Those are artifacts of safety culture. You can observe them.

Claimed values are exactly what they say. It's what the organization espouses as its values, in this case with respect to safety culture. So you will hear things that "safety is first" or that "management says that safety is a priority." Those are claimed values. I think everybody would agree that these first two levels are fairly easy or easier to observe and measure.

But it's the third level that Schein

argues is probably really the most important, and that is the basic assumption level. And what we're talking here is about what are the beliefs and the attitudes that people bring into a situation with them? In particular, I give you the example if you believe that people are inherently good, then you will behave towards people in a certain way, as opposed to if you believe they're inherently bad or that you're highly suspicious of people. By bringing that basic assumption into your work environment or into your life, you will change, or your behavior is a function of that belief. So if you believe that everybody can contribute to safety, and that's an assumption or basic assumption in the organization, then people in the organization will believe that they can make that contribution to safety in the plant.

So those are the three levels. And the third level, as you might imagine, because it concerns beliefs and attitudes, is often the most difficult to assess. But we will talk about how we will address that.

In addition, the IAEA talks about stages of culture development, and I think that's very important too. First is the compliance stage, when an organization basically is trying to follow the rules, regulations that have been put into place, in this case, by the regulator. And they just try to meet, as we talked about, perhaps minimum requirements. Then you would like to think that as the organization is trying to promote a safety culture, it moves into a performance-based stage. And there the organization starts to develop measures and actually tracks and trends those measures for safety culture. Finally, the ultimate goal, which I think is where we would all like to see organizations, not just nuclear organizations is in the process stage, where you believe that safety is really a continuously improving process, that you're not happy with a stagnant or a status quo, that you've never really achieved the ultimate safety. You're always learning and willing to work towards a better safety culture. So I think we need to keep those in mind as we talk about the

methodology.

On the next graph -- I'm on Page 32 -- basically, I just want to point out very quickly that a lot of people confuse the management of safety with safety culture. And they really are two different things, and we would probably argue that the management of safety is part of safety culture. But the management of safety really focuses on the processes and the outcomes of those processes. And we're pretty good in the nuclear industry in trying to assess those processes and look at the outcomes of those. But when we're talking about safety culture, we're talking about the culture or the driving force that really influences those processes and outcomes.

Mr. Myers gave you a definition of safety culture that they've worked with here at Davis-Besse. I'm just going to reframe it a little bit into words that will make perhaps more sense as I describe the methodology that we're going to use and the material that I just provided to you with the IAEA.

Safety culture refers to the

characteristics of the work environment, such as the values, rules and common understandings. Let me take a minute. You can replace those with the three levels that Edgar Schein refers to as culture. We're talking about basically the values are the claimed values, the rules may be the artifacts, and the common understandings would be the basic assumptions. And it's those things that influence employees' perceptions and attitudes about the importance that the organization places on safety.

I want to take a moment and just draw your attention to the word perception. Having applied this methodology in many organizations, the one comment that we always get by many individuals is that this is really a lot about perceptions and people's perceptions and attitudes and what they think about the situation. That's correct. And if you think about it as most psychologists will tell you, perception is reality. If you really believe something is true, then that's how you will behave, even if in fact that is not the case.

What are the safety culture

characterstics that we're going to look at? They're aggregated here into two groups. One is called generic and one is called specific. And let me just spend a minute because I think it's very important to understand the framework in which we're conducting this evaluation. These generic characteristics have been identified in the literature by Robert Zambea (phonetic) -- I can give anybody the reference if they'd like -- that helped to define what constitutes a highly reliable organization. And that's an organization that must minimize failure because of the consequence if it occurs, to public health and safety in particular, if you're familiar with their work. And over the years, they have amassed a great amount of data, not just in nuclear facilities, although they have worked there as well, but in other highly reliable organizations, and they have come to the conclusion that there are three things that a highly reliable organization has. And in fact, if you're thinking about promoting a positive safety culture, you can use the same type of framework.

The first is that the organization

aggressively seeks to know what it doesn't know. And what do I mean by that? You're always trying to be one step ahead of the situation. How do you do that? Well, you train people to respond to all types of anomolies. You also spend resources on redundancy, and you also try to be one step ahead in terms of the programs and processes that you have.

The second is that you design -- the organization designs a reward and incentive environment to recognize the cost of failure, as well as the benefit of reliability. But an environment in which the respect for people is very high. What are we saying here? What gets measured gets managed. People will basically do what they think they are rewarded to do, and so if safety is a high value and rewarded in an organization, then people will behave in that fashion. And you need to design a system that realizes the benefit of short-term safety, as well as long-term reliability.

And finally, in a highly reliable organization, there's consistent communication about the big picture. What is the mission? What is the

vision? What are the values of the organization? And not only communicating it and getting people to understand it, but getting people to talk about it with each other. Not just in formal meetings, but in informal situations, in anecdote, perhaps in a lunch room, over a coffee break, getting people to really buy into the mission and vision of the organization. And this can be done also by the organization spending resources for effective communication processes. And of course, the one that we've heard about is that management will encourage a culture of open communication for this to occur. So these are what we call the generic characteristics, because now I'm going to tell you about the specific characteristics. And in fact, they can be aggregated up to these generic ones.

These characteristics you'll see shortly in a document that the IAEA is in the process of finalizing with respect to how to assess safety culture, and they have been aggregated up from many, many bullets that contribute to each of these. These are not the only things that you look

at. Of course, they include many other facets. What I'd like to do is I'll give you some idea of the kinds of things under each of these, but we don't have time to discuss each of them today.

The first is that safety is a clearly recognized value in the organization. How can you see this? You can see this through documentation that describes the importance of safety. You need to see it through the transmittal and understanding of safety throughout the organization. You need to see it through decision making that reflects safety as a value. And you need to see it in the allocation of resources. How is the time, money, and people placed with respect to things that are important to safety? All of these bullets that I mentioned are artifacts and claimed values in Schein's model.

If we really want to understand that safety is a clearly recognized value, we need to think about what would be the basic assumption. And the basic assumption for this particular characteristic would be something like safety conscious behavior, both formally and informally, is

socially accepted and supported in the organization. And what I mean by that is not just that management says that safety conscious behavior should be encouraged, but that people in the organization, peers, cohorts, coworkers, actually support that in a social framework. I think we all agree that that's most important, because even if management supports it, if your work group or your peers don't support it, then you won't perform in that fashion. So that would be a basic assumption, that people would come into the organization and believe that safety conscious behavior was accepted both socially and technically in the organization.

The second is accountability for safety is clear. Roles and responsibilities are clearly defined and understood, most importantly; that there is compliance with regulations and procedures; that there is a delegation of responsibility but with the appropriate authority. Often we delegate responsibility for safety, we don't provide the individuals with the authority to actually implement it; and that there is a major

commitment to safety at all levels of management in the organization.

Again, those are artifacts and claimed values. What might be the basic assumption here might be that ownership of safety is recognized at all levels in the organization. So that everybody really believes they have ownership of safety and that they can take hold of that and help resolve safety in the organization.

The third point is that safety is integrated into all activities in the organization. And here you would look at things like good material condition, good working conditions, the quality of documentation, perhaps more important, the quality of processes, from planning through implementation and through feedback. You would see a set of performance indicators that are tracked and trended, but most importantly also evaluated and used. And you would see the use of self-assessments in the organization. Again, artifacts and claimed values. What might be the basic assumption is that everybody in the organization can contribute to safety, that there's

no individual in the organization who can't make some contribution to that.

The fourth bullet is that a safety leadership process exists. Here you want to see the visibility and involvement of management in safety-related activity. You want to see individuals that are motivated in their job to perform in a safe fashion. You want to look at the ability of management to resolve conflicts and make decisions with respect to safety as a value. And you want to recognize, perhaps very importantly, the informal leaders of safety in your organization. I think we all recognize that there are formal leaders and former leadership processes for safety. But often the informal leaders are very influential in the organization.

Those again are artifacts and claimed values. A basic assumption here might be that everybody in the organization is working towards the common goal of safety.

And finally, that safety culture is learning driven in the organization. Here you would

look for an open reporting culture without blame for reporting unsafe acts or conditions; that you would use internal and external assessments; that there would be the use of organizational and operating experience, both from within the organization and outside; and that while there are processes to identify problems, there's also the development and implementation of a very comprehensive and integrated corrective action program; and of course, that a questioning attitude would exist at all levels in the organization. Here again, claimed values and artifacts. The basic assumption here is that safety can always be improved and, therefore, demonstrating the willingness to learn.

If we think about those characteristics, what are the types of behaviors that we might want to see when we are conducting the review or using the methodology? I've identified some of them here. I'm really not going to go through all of them right now, but they really revolve around a lot of the same words that we have just been talking about through the characteristics,

constructive values or working together, teamwork, drive for perfection, working so hard not to avoid mistakes, the questioning attitude, minimal avoidance behavior. We want people not to be afraid to take responsibility because they're afraid of reprisal. You don't want them to avoid responsibility. You want them to accept responsibility.

High organizational commitment, work with cohesiveness, job satisfaction, open and effective communication and, of course, a heavy emphasis on safety.

The methodology that we will use and have used in other organizations is to look at the following organizational behaviors. And they're all related to what we've been discussing. These are a comprehensive list of behaviors that were identified through the processes that I mentioned earlier in the background portion of the presentation through peer review workshops, through multiple groups, through academia, through the industry, from the private sector, from universities that work together to come up with this list. And behind each of these

behaviors, of course, are attributes and, more importantly, the tools that we're going to use to measure them.

What I've done here is put together a graphic to show you the relationship really between the generic safety culture characterstics that we addressed, three that I mentioned first, the aggressively seeking to know, designing a rewards system and consistently communicating were some examples of some of the specific things that you might see, and they're identified in the left-hand column. And in the right-hand column are the behaviors which we utilize in the methodology to actually assess and measure those types of behaviors and characteristics. Perhaps if we have questions, we could come back to that later.

So now that we understand a little bit about the characteristics and the behaviors that we're going to use to assess the status or the existence of those characteristics, what about the method? I think the strength of the methodology -- the methods are not new. You've seen them used in

various applications before. The strength of the methodology was really premised from the USNRC's work and the Canadians and the safety commission. That was that they must be capable of broad-based use across different types of facilities, by different types of people, that they should be as objective as possible. There's an issue about whether or not you wanted objective types of assessment. The methods have quantitative as well as qualitative results. They have withstood and can withstand high scrutiny and uses. Many of them come out of the open literature. They have been peer reviewed. They have been used across many different industries and organizations. And finally, the real strength is that they provide what we call convergent validity. What we mean by that is that when we go in to look at, for example, the behavior of communication, we will not just use one method to assess that. We will use multiple methods to assess communication so that when we come away with the data on behavior, we've acquired it from different types of tools and using different sources of information; and the results,

therefore, will have validity to be presented as representative of that behavior in the organization. And I'll explain the method.

Basically, the structured interviews and focus groups are identified that way because what we have amassed over the years, we have a data base in question about all of the behaviors that I showed you before. And we utilize that organization so that when we go in to ask questions about any of these behaviors, we can ask the same or similar questions to people at all levels of the organization. So we might ask the plant manager similar questions to the maintenance technician or maintenance mechanic. And that way we can understand any difference that might be with respect to those type of issues, or similarities. And that helps to understand, perhaps, where the barriers in the organization might be. Or perhaps, in some cases, maybe they're meant to be there for a reason.

So we call it a structured interview. Of course, it's not totally structured in the sense that other issues come up. But we do use a minimum

set of questions from our data base to ensure that we will get the same type of information at all levels of the organization and across all functional groups as well. And we do similar exercises with some focus groups. At the end of the interview we ask the interviewee to complete what the next item is, which is called a behavioral anchored rating scale, or BARS for short. And many of you may not be familiar with this, but it's another way for an individual to present their attitude or their perception or their understanding with respect to one of the behaviors we're looking at.

So if we stay with the example of communication, if we've just conducted an interview and asked somebody about communication in the organization, at the end of the interview we would hand them a rating scale that showed different behavioral examples of how an organization might communicate. And you might in fact have there an organization that would communicate very well, and you would describe all the behavioral attributes associated with that, right down to an organization

that didn't communicate very well, with some other examples in between. We ask the interviewee to put an X next to the behavioral example that best describes their organization, in this case Davis-Besse, with respect to that behavior -- communication -- at this point in time. If you think about the method that we use for the structured interview, now you can also compare the results on these behavioral anchored rating scales at different levels in the organization and across different functional groups in the organization. So it gives you another nice way also to validate perhaps the information that you received in the interview through the use of the rating scale.

The fourth bullet are behavioral observations, and here we go out and look at certain activities, whether they be planned or unplanned, a lot of shift turnovers, planning meetings. But the difference is that we have a checklist that we complete as the observer after the observation. So in addition to taking our notes, which provide qualitative data, we have quantitative data as well

that will help us during the meeting to look for certain attributes of the behavior.

Staying with my example of communication, if I'm sitting and observing a managers meeting and I'm interested in the communication process in that meeting, I'll take notes. But then I'll also, after the meeting, complete a checklist that identifies some of the attributes and whether or not they occurred in that particular activity that I observed. The checklists come about after hundreds of hours of observations, shadowing managers and supervisors around nuclear facilities. So they are based upon data collected within the environment in which they will be used.

And finally, there's the organization and safety culture survey. This is a paper-and-pencil questionnaire, and it consists of several different aspects to the behaviors that we have been talking about.

The first thing it looks at is organizational culture. Not safety culture, but organizational culture. And the reason we do that is

that the questionnaire really wants to understand what do people think is rewarded and valued in the organization. So when people complete that portion of the questionnaire, they do not complete it with what they do or what they think they should do, but rather what do they think is expected of them to succeed in the organization. And that way you're understanding what their perception is of the values in the organization that are rewarded. That's one part of the survey.

Additional parts of the survey look at communication, as you might expect, different aspects of communication: the accuracy, the desire for communication, the trust in communication. We also look at coordination of work, work with cohesiveness, job satisfaction, attention to safety, environment safety and health issues; and several scales, therefore, comprise the survey. And if you notice, they also tap into many of the behaviors that we've talked about. And I'll discuss in a minute how we intend to implement that at Davis-Besse. But those are basically the methods that we use. And as I

said, in presenting the results, we feel that we have convergent validity, based on data from several of the methods for any particular behavior.

This is just a prototype of how you might implement the methodology. This is not specific for Davis-Besse. But what it really shows is that you go across the organization, as identified by functional area, and you go down within any functional area through the organization. And what we've identified here are the five specific safety culture characteristics that we will look at throughout the organization, both laterally and vertically.

As I mentioned, the functional analysis is the documentation review and some preliminary and informal walk-throughs, talk-throughs and focus groups. I will discuss towards the end of the presentation on a schedule, but I can say that we are in the process of doing the functional analysis at this point in time, and we have received a great deal of documentation from Davis-Besse to conduct this portion of the evaluation.

The structured interviews and behavioral anchored rating scales, people will be interviewed from all organizational components and levels in the organization. Positions will be identified during the functional analysis, the individuals are chosen by the site. What I mean by that is at the conclusion of the functional analysis, we will submit to Davis-Besse a list of positions in the organization that we would like to interview, not individuals. So where there are multiple people in that position, the site will identify the individuals to be interviewed by us. Obviously, where there's only one individual in that position, that will be the person, and I think they will be self-identified. But we will allow the site to identify the individuals to be interviewed.

MR. HILLS: Quick question along those lines. If you're doing that, how are you ensuring you have an unbiased sample that the site --

DR. HABER: I'm sorry. Unbiased sample of --

MR. HILLS: Unbiased sample of the people you're actually going on and doing the behavorial anchored

rating scales you're talking about.

DR. HABER: You're talking about because the site is deciding who will --

MR. HILLS: Right. Who are the actual people who are going to be doing --

DR. HABER: We have identified to the site that we have the right to ask for any other individuals or ask for additional individuals if we feel in fact that's a problem.

MR. HILLS: Is there anything you're looking at, any criteria to decide if that's a problem or not?

DR. HABER: I think that if you've done interviews, I think at some point you understand when people are giving you at least the same picture and the same line in the same arena, I think we would just ask for another interview with a different person that we might name or we might find, after -- after we've been at a site for a while.

The interviews last about one hour. Occasionally we may do a follow-up if an issue comes up and we want to validate something. We might ask for a follow-up interview with a person or, as I

mentioned, some additional interviews with people who have not been proposed on our initial list.

As I mentioned, at the end of the interview, the BARS, the behavioral anchored rating scales, will be administered, and we do no more than four rating scales for any interviewee. We are not trying to be overly intrusive. But by doing the type of cross-section that we will across the organization and through the organization, we'll get more than enough behavioral anchored rating scales for the behaviors that we're looking at.

MR. GROBE: Sonja, any given work category, let's say the position of maintenance mechanic, how many people in an organization with a thousand employees would you interview? If there's, let's say 50, 30 maintenance --

DR. HABER: What we try to do is we usually try to do about ten percent of the organization total. I can tell you that right now in our starting to identify the list, we may exceed that a little bit in this case. It depends on the how the organization is structured. And if it's highly compartmentalized,

where you might have a lot of smaller sections, you might want to get a better cross-section and exceed that. But we probably try to do at least three to five mechanics if they have 50 mechanics, to answer your question. It would be ten percent stratified across the organization.

MR. GROBE: And is that the type of category? You said you identified types of positions.

DR. HABER: Yes, yes.

MR. GROBE: Lew, have you thought about how you plan on selecting the people to participate?

MR. MYERS: No. Pretty randomly. I would want to ask David a question, based on his question.

First of all, you know, what I've wondered, first of all, why would you stack the deck? Second of all, how would you stack the deck? I mean, I wouldn't know how to go out and find a bunch of people that -- I wouldn't know how to stack the deck, you know, that could answer -- I don't even know the questions. How could I stack the deck?

MR. HILLS: That's what I was kind of asking you.

MR. MYERS: Why would any manager want to do that? I mean, what you really want to do is take a good representative and send that -- we've sent that message to our population. She can talk to anyone she wants to. Because what you really want back is what you think is something you could use as a tool. There's no reason for any manager to ever want to stack the deck.

The next thing is, you know, I'm not a psychologist but I certainly wouldn't know how, you know, and I don't think we're that smart. You're giving us more credit than we deserve.

MR. HILLS: All right. Thank you.

MR. PASSEHL: I have a question on page 43, your last bullet there. Can you explain a little bit more clearly what you mean by no more than four rating scales are completed by an interviewee?

DR. HABER: Sure. At the end of the functional analysis, we will decide on some set of behaviors that we're going to focus on from that list of about 20 that I showed you. That's not to say that we're not looking at all of them, but we need to focus on

some, and they're not independent, and so therefore, by looking at one, we're also capturing others. At the end of an interview, we have behavioral anchored rating scales for each of those 20 behaviors. We couldn't possibly ask each interviewee to fill out 20 ratings scales.

MR. PASSEHL: Okay.

DR. HABER: So we'll do a sampling to ensure that we get data from each level and each component in the organization.

MR. PASSEHL: Thank you.

MR. GROBE: Sonja, it would help me understand, as we go through the methodology, the answer to this question. Is this an analysis methodology that would give you a point estimate at any given time that you can compare against a scale?

DR. HABER: Yes.

MR. GROBE: Or is it a methodology that you use to measure trends, and its greatest value is trending?

DR. HABER: Well, I'm going to talk about that in terms of the deliverables a little bit. But it

does give you a snapshot right now. And as I will mention, we have gone back into organizations using this, the first one as a base line, and then having gone in later to look at whether or not interventions have been effective. But we also believe that we will attempt to do some trending, maybe not in the quantitative sense, but in the qualitative sense. I'll talk about that in a minute.

On the behavioral observations, as I mentioned, activities -- and this is just a subset of what we might ask to look at -- scheduled meetings, routine activities, unscheduled, work processes, when applicable. We have in some organizations done minicase studies. If it happens that something comes up during our first couple days onsite, something we might want to follow through during the period of time that we're at the site, that might provide us a very nice case study of a lot of the different behaviors that we're looking at.

We will conduct many observations of, for example, shift turnovers. We will not be reporting that data on just one or two. We'll often

do anywhere from 10 to 20, depending upon the time on site and also trying to get different shift crews.

The organization and safety culture survey; I'll make a couple of points about this. I think it's a very important, very strong piece of methodology. We administer it in large groups, and we're working with the site at this time to actually organize that. The surveys are conducted anonymously. And what I mean by that is we don't ask for any personal identification, any company ID numbers. The only thing that we will have is what we call a background sheet so that we can ask if people are -- in what work group they belong so we can look at differences between operations, between maintenance, between engineering. We'll also ask people to tell us what their job classification is so that we can then look at differences perhaps between managers and nonmanagers. We'll also ask people for how long have they been employed at Davis-Besse. Because as we all know there are a lot of changes that occur in an organization, and you can often capture subcultures, if you will, based on different

times in the organization or when people came into the organization. So we will have that category as well.

So all of the results by the survey will be analyzed by these demographic variables, not on any individual level. In fact, we tell people -- and we do not present results if any group is smaller than eight individuals so that we can retain the confidentiality and anonymity of those results.

We are planning actually right now to administer -- and I'll go over this again in the schedule, but we're planning to administer the surveys next week at the Davis-Besse site.

MR. GROBE: Sonja, your first bullet on page 45, that your goal is to administer the survey to as large a group as possible, what would be the expectation? Would you expect a hundred percent participation in the organization survey, 30 percent participation?

DR. HABER: We typically see, when we have good management support and good communication, we typically see 85 to 90 percent of the population. We

won't use anything less -- or close to 50 percent to 60 percent, because then it's not a representative sample if you're sampling the entire population.

MR. GROBE: Could you give us a sense of the magnitude of this survey? Is it ten questions, a hundred questions --

DR. HABER: It's about 190 questions. It takes 30 to 45 minutes for people to complete. We usually schedule about an hour because some people take longer, some people take shorter. But it's pretty self-explanatory, although we will provide, our people will provide instructions to the group so that in case there are any questions, we will be there to answer them.

MR. GROBE: I'm certainly not a survey expert, but I've taken a few. It seems to me that characteristic or effective surveys ask similar questions or get at similar topics in multiple different directions with different types of questions, and there's a validity process in the survey. Is that characteristic of your survey?

DR. HABER: Yes. In fact, part of -- the

organizational culture part is actually a copyrighted tool that has a great deal of reliability and validity. The other scales that I mentioned are in the literature, and plus we do additional reliability estimates. And we've also used this in different countries and translated it with very high reliability. So the scales are reliable and they're valid, and the validity has also been demonstrated in the literature as well as in our own work over the period of time. We also have in the survey -- I think it's important because this question does come up. Good surveys are designed so that sabotage is not possible or detectable, and so we do in fact have questions that are in the survey that would detect any type of pattern of answering.

MR. DYER: Sonja, could you explain, is this -- are the results of your surveys and that going to be correlatable to some of the information, say for instance, Bill Pearce brought forward in September 18th, there was a rather startling survey where he talked about the safety culture and where it was at various points, 1999, I think, to 2001, 2002, and

that. So as far as trending correlation, anything like that?

DR. HABER: We hope to be able to do some of that in kind of a retrospective analysis of what the site has done, rather than in terms of what we're doing right now. Since I'm still going through the functional analysis portion of this, I'm not familiar yet with all of the data that's available to us from the site's previous activities, but we will intend to try to make those correlations as much as possible. I'm not sure, you know. The survey is not the same survey, so we just want to be careful on how we make those comparisons.

MR. GROBE: Before you go on to the -- I looked ahead. I'm sorry. This is a lot of work. Could you give me a sense of how many people are involved in this activity?

DR. HABER: Sure. We will have -- actually, we have two people that will be coming to do the surveys because they can be done by a single person, and we hope to do two sessions currently so we can minimize the time of intrusiveness on the site. Then we will

have four people basically onsite for about two weeks, and we will work in teams of two so that we will do two-on-one interviews where possible, and if not, then we'll do one-on-ones. In certain positions, sometimes that's desirable. And the other person may be doing an observation. So we intend to complete this within doing the surveys next week and then two weeks after that. We have done larger organizations in that period of time, so it is doable from our perspective.

MR. GROBE: And the functional analysis is essentially prework?

DR. HABER: That's right. And we're doing that now, and we don't have to be at the site to do that.

MR. GROBE: Thank you.

DR. HABER: Okay. Just to tell you a little bit about where the method's been used so you understand some of the issues of credibility and reliability, we have fully implemented the method in 18 different organizations. Included in that are at least 12 nuclear plants, and the others are other types of nuclear facilities, and then partially implemented in

17 organizations, additional organizations. What I mean by partially is maybe we only did the survey in those, or maybe we only did some interviews and BARS in those. But in 18 of those we've actually done a full implementation of all the method.

We've implemented it across the industries that I've identified here, nuclear power, chemical reprocessing, mining, fossil fuel, health care and the research-type facilities.

As I alluded to you earlier, the methodology has been used effectively in five different countries, representing different cultures, in some cases different languages, and has worked rather effectively. And I think most important is that it discriminates between organizations, and that really is helpful. Not only does it allow you to look inside the organization and look for differences within the organization in terms of subcultures or differences that you see that might be useful for management in trying to make intervention, but also you can look across organizations and do some type of comparative analysis. And part of that is because

it's a systematic and standardized type of methodology, and the data you often collect is very structured.

MR. DYER: Sonja, did I understand you to say of the 18 fully implemented organizations, 12 are nuclear?

DR. HABER: Yes. But two of them are U.S. and others are not. And the U.S. Ones were done in conjunction with the USNRC research.

Deliverables. Okay, what can we get after we've done all of this? First thing is that there will be -- we believe, because the nature of this is important for discussion and I think verbal presentation, there will be a debriefing session at the site with management and with employees. It's very important that after you ask employees, of course, to take part in this, that you provide them with the feedback. So we typically do two briefings, one with management and then one with employees.

There will be a report provided, and this is what the report will include. It will include an overall conclusion on those generic safety

culture characteristics, the aggressively seeking to know, the consistently communicating and the design of a rewards and incentive system. Probably more useful will be the summary of the specific safety culture characteristics, the five bullets that I talked about, with a description of strengths and areas for improvement. So we will go through each of those, based on some of the sample bullets that I gave you, and identify areas of strengths and areas in need of improvement, based on all of the data collected. This is not just on the survey data, not just on the interview data, but it's an aggregation of that data rolled up into the characteristics to provide that convergent validity.

We will provide some conclusions on whether the safety culture characteristics are absent or present. We don't want to always focus on the quantitative. I think we'll all agree that it's important to know first if the safety culture characteristics exist, and then perhaps where are the strength and areas for improvement?

And finally, as you alluded to before,

we're going to try to identify trending in these safety culture characteristics, and that will depend largely on what we can get as a retrospective analysis from the functional analysis portion versus the data that we will collect from the evaluation itself. We would like to be able to say that these characteristics are improving or degrading if we have that data available to us. But obviously, we can only collect information at this point in time using our particular evaluation. If, of course, you did this again in another 18 months or two years, then you would be able to go back and look at the trends even in a quantitative sense; and we have done that in a couple of organizations where they've asked us to come back and readminister the method to look at whether or not their interventions were effective.

And finally, I think most important is we talk about continuous improvement, is that after the independent evaluation it's our intention to transfer this technology to Davis-Besse or to FirstEnergy so that we can work and perhaps train their people to use these tools so that they can

continuously monitor themselves on these types of characteristics in the future. I think that, from all of my experience, the best way really to ensure continuously improving safety culture is to get people to do self-assessments, to understand the need for these types of characteristics and how they can monitor them over time.

MR. WRIGHT: One question. I'm not sure where it fits in this presentation, so I waited toward the end. Where you're dealing with people's beliefs, how does the system, you know, if I really believe what I'm doing is right and we're doing things in the correct manner and the like, how does -- and let's say we're not, as in pre-2002 Davis-Besse, where people thought they were doing things right, they thought they had the right systems, they thought they had the right ways of doing business. How does this system get past that where they think they're right but they're not?

DR. HABER: Well, I think that we would acknowledge there's a body of literature and there's a body of experience that identifies what should be

going on with respect to the safety culture characteristics that I mentioned. And what we have to do through the methodology is to match those beliefs and attitudes and perceptions with the artifacts and the claimed values that are actually going on in the site, and so that's why I find that that three-level model is very useful because you can have one or the other, but you really need to have all three of those in synch with one another. I'm not ready to say yet because I'm really not familiar with all of the material, but I would suspect that there are probably ways to uncover, perhaps, what wasn't going right before by some of these types of methods. But you know, that's nice to say, but I can't go back in time and do that.

MS. LIPA: Question I have is on the survey, you talked earlier about that there's ways to prevent sabotage and check the validity of the answer. But it seems like there could be some external influences on people might be concerned about losing their job if the plant doesn't start up. And how does your survey guard against people wanting to present the

rosy picture?

DR. HABER: That's a good question. That's what we like about the multimethod approach, because then it would also have to come up through all the interviews, it would have to come up through the BARS, it would have to come up through the observation. And over the period of time that we're there -- and I would argue that we'll probably be there during a high tempo period -- it will be hard for all of those things to all line up so that those results were consistent in the fashion that you described.

It's been my experience in organizations that have gone through similar situations or perhaps newly transitioned organizations where people are uncertain about the future, that by and large, people are pretty open and honest, especially if they really believe that it will be anonymous and confidential. And that's really one of the main things that we have to ensure.

MS. LIPA: So you think that because of the

different approaches, that will help to prevent that bias in the results?

DR. HABER: Yes. If we only did the survey, then you're absolutely right. You might have that bias, and you'd have no way to check it against something else.

MS. LIPA: Thank you.

MR. HILLS: I had a quick question on the results. How are you going to evaluate the results of the interviews, the BARS, the safety culture survey? Is there preestablished criteria on how you're going to judge it? For instance, if a certain percentage of the people answer a certain way, does that predispose a certain conclusion, or do you kind of decide that after you review the data and then come to your conclusions based upon that?

DR. HABER: Probably a little bit of both at this point in time. But we have a lot of -- first of all, we have a lot of experience and a lot of data. But with respect to that, we integrated up into the behaviors and then the characteristics. And let me just explain that when we go through the interview

data, for example, we never take any individual interview data. If we don't hear something consistently, it will not be reported in the results. We're not out to just provide anecdotal information, so that if we're looking for communication behavior, just as an example, we need to hear the same story throughout the different functional areas, within the functional areas to report that as a result, or for us to integrate that result into our conclusion.

For the quantitative data, you can see profiling fairly easily to look for differences within the organization. So from a survey, where you may not have a criteria on a seven point scale of whether you want to accept a five or a four, we're more interested in the profile of that and if it's consistent in the organization or with discrepancies or flaws. So it's a combination of having the quantitative data to compare it against each other, as well as the aggregation. Did that address it?

MR. HILLS: Yes.

DR. HABER: The outcomes of the -- continue?

The outcomes of the methodology, just so we understand what the expectations are, is that we will be able to provide a status of those generic and specific safety culture characteristics. We will be able to provide anonymously, that is not identifying the organization, but some comparative results to other nuclear and nonnuclear organizations. I should point out that we have over 20,000 people in our data base that have taken the same methodology.

And finally, I think what's very important --

MR. GROBE: Did you say 25,000?

DR. HABER: 20,000. That's nuclear and nonnuclear.

MR. GROBE: You've been busy.

DR. HABER: Over a period of time.

MR. MYERS: One other thing is the nuclear plants that you have in the United States were predereguIation, right?

DR. HABER: Yes.

MR. MYERS: So there's a base line there that --

DR. HABER: A little bit out of context in terms of time.

MR. MYERS: That's good --

DR. HABER: Safety culture should have been there.

MR. MYERS: That's right. Shouldn't have changed.

DR. HABER: I think the last point is also important to mention, and that is that this is a safety culture review, independent evaluation, but it's really only one result which needs to be integrated in ongoing activities and, hopefully, will be viewed that way.

We talked a little bit about the schedule. We got notification, started putting a team together and some preparation early in January. We really started collecting some documentation right around the middle of January. As I mentioned, we will start the survey administration next week. We hope to actually get that completed between February 4th and February 6th. Of course, some of the shift crews will be doing those on shift. We will be

working with the shift managers to do that, and they will have to be collected over some period of time to get all the crews.

The observations will begin, to the extent that we have time, next week, when we're at the site, since we won't be doing survey administration all day. And the interviews and BARS will actually start on February 10th. That's when we'll have the full complement of four people on the site for approximately two weeks.

We also intend to identify a few people from the corporate part of the organization for interviews. We will begin analysis and evaluation of the data once we leave the site, which will be around the 21st of February, and then have a briefing and final report sometime probably towards the middle of March or end of March, in that time frame. We haven't fixed that date yet.

In summary then, the safety culture review methodology will provide an independent evaluation of the current status of the safety culture characteristics at Davis-Besse. We also

believe that the methodology will assist in the enhancement of safety culture by identifying ways in which the organization can continuously improve its safety culture through self-assessment and continuous monitoring; and just by going through the methodology and learning about it and asking those questions and thinking about those characteristics, you're already going through a learning experience.

And finally, the review will facilitate the progression of development of safety culture from the compliance to the performance based to the continuous improvement stages of development. Thank you.

MR. GROBE: Questions?

MR. DYER: Yeah, one question. This is not necessarily for Sonja, but to Bill Pearce. On the presentation you gave us back on September 18th, is there any ongoing -- does this supercede that, or are you still following up on the training and that which were done on your safety conscious work environment independent assessment?

MR. PEARCE: Yes. We intend to continue that.

And when I show the monitor, I'll show you how that -- and that's in addition to what the independent survey will accomplish.

MR. GROBE: I've got several questions, but Bill Dean, do you folks have questions at headquarters?

MR. DEAN: I have a question regarding how Dr. Haber intends or if she will intend to use any of the information that's been gathered in the past, some of the surveys the licensee has done, or are you basically starting with a clean slate in doing basically a moment in time to assess the status of the plant now?

DR. HABER: In terms of integrating the previous activities with what we find?

MR. DEAN: Correct.

DR. HABER: And your question is how are we going to do that?

MR. DEAN: Are you going to do that, or is your methodology really intended to be just a moment in time, taking a snapshot now where is the plant at, or is there an attempt to try and link it with -- they've done some surveys and some things in the past

that have indicated the status of the organization to some degree.

DR. HABER: Your point is well taken. The methodology strength is in taking a picture now and assessing the status of where the site is now. But as I mentioned, in the functional analysis we do acquire a lot of information that we've asked for about what the plant has done previous to this evaluation. And to the extent that we can integrate those in relevant areas, namely the safety culture characteristics, we will try to do that by pointing them out and perhaps, as I mentioned, even identifying trending of those characteristics as they relate to the safety culture characteristics that we're talking about. I really can't -- sorry?

MR. DEAN: I'm sorry, Doctor. I really -- really what I was kind of trying to get at is some of the surveys that they've done in the past had some indications that could relate to safety culture. I guess the point I was trying to get to is what you were going to be able to do, at least to provide some assessment of either improvement or lack of

improvement in some of those areas.

DR. HABER: We're going to try to do that, identify the trending bullet. We will try to use that information and compare it to the data that we collect at this point in time.

MR. DEAN: Okay. Thank you.

MR. GROBE: Any other questions?

MR. DEAN: Lisa had a question.

MS. LISA JARRIELE: This is Lisa. I'm the agency's allegation advisor. I had a question about the BARS. Can individuals request to be interviewed at the site? Is that part of the process?

DR. HABER: We have done that. If somebody would like to be interviewed, we'd be more than happy, within some boundaries, of course, because we have limited time at the site, but we have done that in other organizations. If that's something the site would like us to do, we would be happy to do that.

MS. LISA JARRIELE: And the second question I had involved your survey. Has the plant or your organization done anything to -- in preparation for educating the employees about the survey and how it's being done

and how they will be protected and what happens to it afterwards? Has there been some sort of an education to enhance their participation in it?

DR. HABER: My understanding is there has been a memo that was sent out to management. I'll let the site address that. But we will also provide instruction at the beginning of each survey administration that will state how we will use the results and the confidentiality and anonymity of the results. But I'll let the site address their preparation.

MR. GIESE: Do you want me to address that, Lew, or do you want to --

MR. MYERS: Either one. What I can tell you is that we're -- our management team is in full support. We've already sent out some memos, and it's our intention to, you know, to make sure that our -- all of our employees, through our normal communications process and all town hall meetings, 4C meetings and all this, to understand what we're doing here. So we would hope that we wouldn't find surprises there. So we're telling them every way we

know how.

MR. GIESE: It's been introduced in the employee communication document that goes out from our communications department. There have been in the various meetings that have been held it's been talked about. It's been in the media; although that's not our only internal communication, it's certainly been there. And there has been a letter sent to everyone onsite that was in advance of the stand-down meeting that was held a few days ago that spoke to the fact that this survey or this assessment would be going on, it would be independent, it is absolutely private, the folks conducting the surveys, the conversations are not from FirstEnergy or FENOC. They're external to our company. And I think we have dealt with that in a number of ways and we'll continue to do that as we move along.

MS. LISA: Thank you.

MR. DEAN: That's it for here, Jack. Thanks.

MR. GROBE: I've got a number of questions. I guess the first question is more focused on safety culture. Last August, I guess, FirstEnergy concluded

that that was a principal cause of what happened at Davis-Besse, that they had lost their eye on the ball, as it were, the safety ball, and that manifested itself in a number of performance issues throughout the organization which ultimately resulted in the organization not responding to problems properly and the degradation of the reactor pressure vessel proceeding. But what is the process, or what is the time frame, in your experience, that it takes to make adjustments to safety culture? Is that something that's like a switch, or is it something that takes two decades, or is it someplace in between?

DR. HABER: That's a good question, and it comes up quite a bit. I think that you can -- we have seen changes in some of the behaviors. They can occur perhaps more readily than changes in the overall culture. Culture, typically, in my experience, has been a three-to-five-year process. And it can -- that can change, depending upon the situation. I've been in organizations where new management comes in and there's really a culture of uncertainty for a

while. And that has to settle down before you know what the culture of the organization is going to become. So I think three to five years is usually what's considered to be a reasonable time frame to look for changes in values and attitudes.

MR. GROBE: Okay. Interesting. How often -- this is a very intrusive tool the way you've described it. I've not seen one of these before. But how often would it be beneficial to pulse the culture of the organization with this type of intrusive tool? And I know, Bill, you're going to get into some ongoing measurement, and I haven't looked ahead on those slides yet. But what kind of period would be appropriate for this kind of a tool?

DR. HABER: Well, as I mentioned before, you don't have to always use all of the methods at one point in time. So to do a comprehensive methodology such as we will be doing it at Davis-Besse, we wouldn't recommend doing it in less than two years. But in terms of looking at certain of the behaviors, where you might be able to just, let's say you do a communication intervention because you want to make

your communication process more effective. You could do structured interviews or mass communication, you could do BARS, you might do parts of the survey; you wouldn't have to do the whole thing. So you can use -- as I mentioned, we have done partial implementations, and that's what I'm referring to in different organizations.

MR. GROBE: I have a number of questions that focus in the area of independence and inspectability or scrutability. Let me start with the second area first.

The report, you described in general terms what type of report you provide. There must be a wealth of supporting data and analysis that backs that up. Is that also available?

DR. HABER: That will be provided to the site.

MR. GROBE: Okay. What -- we're in the inspection business and -- you noticed that, Lew? But there may be a situation where inspection of some of the aspects of this activity could be disruptive to the activity. Could you go in a little bit to the concept of what aspects of your activity might be

inspectable in process, in lieu -- or as contrasted with after the fact?

DR. HABER: Sure. I think that the one area that I feel most uncomfortable with inspection would be the interview. I think, for obvious reasons, because we do tell people it's confidential and anonymous. With respect to observing the observations, I think that that's -- you know, at the site the NRC does sit in on a lot of the meetings and types of things that we would look at, so I don't see that there would be any problem there. We're not asking -- that's really not an intrusive type of activity.

With respect to the survey administration, you know, depending upon who's there, you want to ensure anonymity and confidentiality. That might be an issue, but basically all you're doing is watch people fill out a paper-and-pencil questionnaire. That's what's done. So with respect to those methods, I think the interview presents perhaps the biggest obstacle.

MR. GROBE: The survey tool itself, is that

something we would have access to?

DR. HABER: I'm sure, yeah, we could provide that.

MR. GROBE: Let's talk a little bit about independence. We just touched on sampling, and a question was asked earlier about whether or not somebody could volunteer to be interviewed. And I think you described earlier that you don't report an outcome from the interviews unless it's something that appears systemic. You don't report individual anecdotal information. I guess I'm interested in FirstEnergy's view on the sampling and whether they're comfortable with the commitment that this may be a random sampling maybe from Fred's organization.

MR. MYERS: Yes.

MR. GIESE: Absolutely. In fact, not to demean this, we've just asked a clerical person to pick names, and we've not given directions as to what names, other than Sonja's organization has provided a list of titles or areas, and it is that random. So there is no particular direction given as to who. The question of somebody volunteering has not come

up. Unless there is a problem from Sonja's perspective, we certainly would not object to that.

MR. GROBE: I'd want to make sure that that was in addition to the random sample.

DR. HABER: I would agree with that. I think that would be an additional interview, not a replacement interview.

MR. GROBE: Your reporting process, you're going off to somewhere -- by the way, where is it that you go off to do your analysis and develop a report? Because we might want to visit you.

DR. HABER: We do it in our home offices.

MR. GROBE: Okay. What's the process that you use to develop the report and deliver it? Is there a draft report that's shared with the company?

DR. HABER: Typically, at the time that we come back to give the verbal briefing, we present a draft report. And we allow the organization to check for accuracies in anything that we may have presented -- not to change perceptions or beliefs, but if we use an example, we want to make sure we've represented it accurately.

MR. GROBE: Okay. There's -- this is obviously going to be a very important activity to the company, and it's very important that the results of this are clearly independent and demonstrably independent. Is there the possibility that that could be done in a public meeting, or would the company insist on having a draft report and debriefing first before any of this information is shared with the NRC?

MR. MYERS: You know, Jack, as we go through this, I think we're perfectly willing to come in and assess what we're doing any time. But we're not allowed to bring this to closure, you know. I'll talk some about what our responsibilities are next before, you know, we put it in a public meeting. Because there's other things we're looking at also. This is just one tool.

MR. GROBE: I understand that. It looks like a a good one, though. And I'm not sure you answered my question, and maybe we need to circle back on it later.

MR. MYERS: Okay.

MR. GROBE: Do you have an example, Sonja, of

what this report is going to look like? I'm not sure you necessarily want to share a report from some other organization, but it's difficult to appreciate what you've done. You've done a good job describing everything that you're going to do, but it's difficult to understand how it all comes together. If we can see it, maybe a format of the report --

DR. HABER: I can briefly describe to you what it would look like. The problem, of course, depending on the client and the purpose, whether you're doing it for the Nuclear Regulatory Agency as opposed to the organization itself. But typically, what we have will be an executive summary. We will have the 20- to 25-page content, text content, which will describe, as I mentioned, the deliverables, the characteristics, the areas of the strength and areas of the weakness. And then behind that would be the appendices of the report, which will contain the summary of all the data from the different methods. So it will an aggregation of the interview results; it will be an aggregation of the BARS; it will be an aggregation of the survey data. And actually, the

survey data will be presented -- it's an excellent management tool also, and so they will have a lot of data that they can look at that may go beyond what the results in the report will actually be in terms of what's on it. But basically it will be a text report along the lines of the safety culture characteristics with an executive summary and the accompanying appendices behind. Did that help?

MR. GROBE: Yes, I think so.

MR. MYERS: One of the things we committed to also in there, we're going to share the results with our people. That's pretty public right there. But I would want to share it with them before I share it with you.

MR. PEARCE: Have you had this kind of interaction with other people when you do your base line stuff? In other words, did the Canadian regulators, were they involved in the overview of you doing this base line information? And I'm asking that of pure interest because I don't know the system or the process, and I don't know if we --

DR. HABER: Remember that in that case the

client was the regulator.

MR. PEARCE: I understand that.

DR. HABER: In terms of their involvement in the methodology?

MR. PEARCE: Right.

DR. HABER: They were actually tying to train up their staff in the methodology, and so some of them would be along.

MR. GROBE: Are there publicly available documents where other regulators have evaluated your results? You indicated that you were working for the Canadian nuclear regulators. Are there publicly available documents where they assessed and reported on the results of your activities there?

DR. HABER: I'm not sure. The assessment of the assessment, if you will?

MR. GROBE: Right. Or the assessment itself, just to confuse it really -- seriously, the detailed plan assessments, as well as an evaluation of your assessment process.

DR. HABER: Well, the assessments, I think, would be available through their -- they have an

equivalent Freedom of Information Act. But I'm not sure exactly how they distribute that. I'm not aware of all of those details. I can provide a contact if you're interested in pursuing that.

MR. GROBE: Could you provide that to Geoff? That would be great. How about any of the work you've done in Europe, or is most of it --

DR. HABER: We did a couple of plants in Spain. I'm not sure that they were -- I believe those reports are for the site organization.

MR. GROBE: Okay. Any other questions?

MS. LIPA: Yeah. We talked earlier, Jack asked about inspectability. And it occurs to me that one potential opportunity would be this analysis and evaluation beginning on February 21, as far as when your team -- those are like your team's assessment of all the data that you've collected. Is that an opportunity, do you think, to have some inspection work on our part?

DR. HABER: Actually, at that point we would just be aggregating interview notes and submitting it to a centralized person -- me -- and the BARS and the

survey will be done. It's done through software, computer software statistical analysis, pretty straightforward. It's not anything unique in that sense. So when we leave the site, we'll have basically raw interview data notes, we will have surveys sent out to be scanned. The BARS will have to be done in terms of calculating means across the groups, and that won't start until after we leave. I'm not sure what they would be to look at at that point. The team will probably not get together again, or maybe once before we have the final draft. It will be circulated to the team members, but a lot of that process occurs individually with people doing their own aggregation and then centralizing it into one location.

MR. WRIGHT: Following up with that is the observers observing the observers, in that process. Would there be -- obviously, one of the checks is if I'm watching one of your people observe what would be some activity, I'm writing down or making my own notes of what I observed. The check there would be to have some cross-checks so I could have some access

to the notes from your individual, say, "did you see the same things I saw? Did you see more than I did or did you see only ten percent of what I saw?"

Is that -- would it be possible to get or have access to those types of notes?

MR. PEARCE: Let me say something there. For QA, right, I have some of the same concerns -- our folks have some of the same concerns about how are we going to do oversight. But a bigger concern on my part is that we don't skew the results. And if before they have not had a comparison of the data when they made their data base, as we go through these separate functions, what effect is having someone come in and compare what they're getting, going to do to the -- on the result now minus the result when the base line was taken? I have no idea and I don't know the process, but that's the thoughts that I had about the QA organization --

MR. WRIGHT: Let me step back one then. Let's go back. If it's just a question of when you look at the information, that's different than whether we can look at it at all. I mean, if it's after the

analysis has been done and it's put into the process and you've got a report, you've made your conclusion. Then is it possible to go in and take a look at what the information is at that point and say, "did we see the same things?" You've already used the information. Could we do it at a later time?

MR. MYERS: Absolutely.

MR. PEARCE: I agree with that.

MR. MYERS: And while you're there, if we're doing something, you're always -- if you're there the day I'm being debriefed, you can sit in, you know?

MR. WRIGHT: Okay.

MR. PEARCE: It's not that we're trying to -- you know --

MR. WRIGHT: I understood the point. If we come in and start discussing what your people saw versus what I saw, that can have a bad effect on the results. I would say if we can get in at some time to look --

MR. MYERS: We intend to be as open as we possibly can. We also intend to be as open with our

people as we can. That's the only way we can take this and use improvements -- turn them into improvements. Are you ready to move forward?

MR. GROBE: I think so. Bill, any other questions in headquarters?

MR. DEAN: No. We're good here. Thank you.

MR. GROBE: If I could just make a comment, Lew, before you move forward. The level and depth of questions we went into here, I don't want that to be interpreted as an overemphasis on this one tool as part of your overall structure. It's just something we haven't seen before, so we wanted to explore it a little bit more thoroughly. And I am particularly sensitive to the issue that you raised, Bill, that we want to make sure that we don't disturb the process in such a way that it would affect the veracity of the outcome, and we will be particularly sensitive to that.

So with that, why don't we go on.

MR. MYERS: Let me see if I can -- I'd like to think that Dr. Haber -- I'm really excited about this. This is not something I've ever done before,

and I would tell you, this is -- we had our methodology and what we're going to do is I'm going to present to you now, before we brought Dr. Haber in and as we finish this, we might go back and make some changes in things we're doing. So it's a pretty exciting process for me too just to look at it. It's a different way of doing business.

So once again, you know, as I told you in August of last year, Davis-Besse's safety culture was mixed. There were several areas of good performance. The plant material condition at Davis-Besse is probably the best of any of our plants, you know. And I've worked at all of them. But the plant material conditions here are good. There was good plant performance prior to then, with few plant trips and the number of personnel areas was quite low when compared to the industry. We were good at addressing several industry issues. In fact, in some cases we sort of were the leaders; for example, when I go back and look at the thermo-lag issues, we were really aggressive in getting the thermo-lag out at Davis-Besse. And in general, from

an industry standpoint and a regulatory standpoint, the performance appeared to be good.

FENOC's assessment in 2002 has shown weaknesses in the corrective action program, technical rigor, and the management team having minimum regulatory standards. However, if you go back and you look at the entire event, our people's willingness to write CRs at a very low threshold appears to be constant and consistent.

MR. GROBE: I think that's an important point. Every one of the head inspections that identified boric acid on the head was documented in a CR. There was a wealth of CRs --

MR. MYERS: Twenty-nine.

MR. GROBE: Obviously, the problems weren't properly addressed. But okay.

MR. MYERS: FENOC's goal is to verify the adequacy of our safety culture as it exists and take actions to address any weaknesses.

It is our management team's responsibility to ensure readiness of our facility. And one of the things that I've been doing recently

is trying to drive us back to a normal organization. And you're not a normal organization when you're in a stand-down. We put a strong management team together, seasoned veteran. Its responsibility for ensuring readiness to move to different modes, take the plant to different positions cannot be delegated. And that's one of the reasons that we bring our contractors in to try to help us do our job better. We have decided to assess our safety culture as we move forward, and I want to explain to you how we were approaching this.

First of all, we had planned on rating our commitment areas in a color code type system, similar to the way the industry typically monitors plants. For example, green, we would say a commitment -- that's this little blue box -- all major areas are acceptable with a few minor indicator deviations. So we would say that would be green.

MR. GROBE: When you say commitment areas, are you talking about page 10, in the blue boxes there?

MR. MYERS: The little blue boxes on the side, right. And then we will rate the overall area as a

management team. So the blue boxes, and based on what you see there, in the commitments, commitment areas. For example, management, management commitment.

MR. GROBE: I understand that. Are you going to go into how you get to these colors?

MR. MYERS: Yes. Somewhat. White would be all major areas are acceptable with a few indicators requiring immediate management attention. Yellow would be all major areas are acceptable with several indicators requiring immediate management attention. Red would be several major commitments -- that individual blue box, a couple of those -- in a particular area do not meet the standards and require immediate management attention. It's a collective judgment to that process.

Here's what we would expect to see. Ratings are based on what we call a convergent assessment. Performance indicators, management observations, demonstrated performance during critical plant evolutions, feedback from an independent safety culture review, and our nuclear

quality assurance assessments would be the areas that we would use to rate our overall safety culture. We've also added Dr. Haber in now to feed into that process, if you will.

For readiness for restart as a management team, the type of things we would look for is improving safety culture is a long-term activity. For restart we'd expect to see no red areas. However, we would not expect to assess ourself with all green areas. If we did that, I don't think that I would expect to see that at some of our good operating plants.

MR. GROBE: Lew, Sonja didn't expect to see it for five years.

MR. WRIGHT: Lew, on that one area, are there any areas that you would say would have to be green before you could proceed?

MR. MYERS: No. Here's what we would expect to see. FENOC expects to see some areas that may be white or yellow. The key for restart would be showing improved safety culture, remedial actions for any whites or yellows are in place, and the

management team's assessment that we are ready to move forward at our restart readiness review meetings. That's what we'd expect to see.

Now I'd like to talk a little bit about the various areas. Under policy level commitment, there's four commitment -- that area, there's four commitments. Statement of safety policy, management value of structure, resources, oversight self-regulation -- those are commitments.

Now, in the first area we would expect to see an establishment of a safety policy and emphasis on regular basis of that policy by management. We will continue to evaluate our message to our employees as we go forward and how they're receiving the message. We'll do that with ad hoc surveys of our employee awareness of the safety policy. We will -- oversight will evaluate the safety conscious work environment and safety performance as we move forward, and we will anchor this in our performance appraisal process, which will -- the first step was the RHR reviews we did for everyone and the new competencies; and then we'll

anchor that in February, when we do -- for the first time with these new competencies, we'll do the Ownership for Excellence evaluations for each one of our people.

And then assess the adequacy of resources during the restart reviews. So each and every time that we go to a different plateau in our restart readiness reviews, that we have the right resources and why do our teams and groups think that they're ready to go to the next plateau? So we'll do that in readiness restart review meetings.

The next area --

MR. GROBE: If we could stop here just for a minute and make sure I understand, because the same questions would apply to the next areas. By the way, they're already learning convergent assessment. That's interesting.

MR. MYERS: We picked that up last meeting.

MR. GROBE: Who's going to do this convergent assessment? Is that done by the senior management review team or --

MR. MYERS: The management team and senior

management review team.

MR. GROBE: What role does the restart oversight panel have?

MR. MYERS: They have a part of that too. We will present our conclusions to them and make sure it's in line. So the restart -- you have your restart readiness review meetings, and then we present our conclusions to them. Now, the restart oversight panel, from a management standpoint, they're out independently assessing our plan also. So we -- we wouldn't -- we would not go, change, start up without their authorization.

MR. GROBE: Just taking this policy level, you've got four areas, statement of policy, management value structure, resources, and oversight and self-regulation, and you were going to develop like a window system, a green, white, yellow, red window system for each of those four areas?

MR. MYERS: Right.

MR. GROBE: And that window system will have a number of feeding indicators or data sets?

MR. MYERS: Right.

MR. GROBE: Is this all described somewhere --

MR. MYERS: We're putting it in a business plan now, so that's what we're trying to do now. Now, some of this stuff in this management policy area, they're subjective.

MR. GROBE: I understand.

MR. MYERS: But wait until I get to the back part, and you'll see more.

Now, when you get to the manager level commitment area, the commitments are emphasis on safety, their responsibility, the acceptance of responsibility, qualification and training, and high organizational commitment. I covered those earlier. What would we be looking for in those areas? Well, implementation of the management observation program is effective, you know? That would be a tool.

Frequency of plant tours and questioning of observed conditions.

Nuclear safety emphasis to employees on a regular basis; can we prove that we're emphasizing safety every day of the week in the way we do business.

Completion of Leadership in Action training and safety conscious work environment training. This will be added to the continuing training for the future.

Encouragement of employees' questioning attitudes on safety. And we'll do that with some questions we're asking at the 4C meeting.

Recognition of employees who improve safety. Let me tell you what we're doing there. We have an employee of the month program. We're changing that program considerably to focus on the corrective action program and look for CRs that are written that improve safety. And then at the end of the month we'll look for the one that we think improved safety the most, and that's going to be our employee of the month. So that sends a strong message there, we think. So we're changing that program.

Application of our decision-making tool. Now, we find cases of management team were not using this tool. We found some cases. We have to push them into -- our expectation would be that we

would write a CR on that, okay?

Program ownership. Modifications to improve margins. Can we identify things like the containment emergency sump, long-term equipment problems so that we can assess that we're improving the overall material condition and margins in our plant. Degrading containment air coolers would be an example. We fixed those things for the long-term.

And then operator recertification program. That's one of the things we just -- Randy just went and assessed. We completed our operator recertification program with no failures this time. So we would look for performance problems in that area.

The next area is clear responsibilities and cohesiveness in management. The kind of things we look at there are personnel error rates, demonstration of clear ownership of the programs, ad hoc surveys to pulse the organization's understanding that nuclear safety is the highest priority, corrective action review board assessments of the ownership of CRs, engineering assessment board

evaluations of ownership -- how good are engineering products; we're already looking at that -- program ownerships for leak rate programs, boric acid programs, and reactivity management programs going forward. We may change those as we move into other areas, but right now those are the areas we want to focus on.

Now, the next area under management commitment would be acceptance of responsibility. And the kinds of things we look for there -- and remember what that means is are people going to be doing the things that they're supposed to be doing from our standards standpoint, doing their management observations appropriately, things like that. You see our managers taking on their issues, getting their backlogs down, following through with the actions they're supposed to get done, stuff like that. So what are we looking for there? We're looking for performance appraisals and development plans. Are they following through with the things that we put down under development plans?

Ad hoc surveys of willingness to

challenge employees, other managers, and supervisors regarding safety considerations. Do we see that? And does quality see that?

System assessments as a means to increase safety margins, such as flus leak monitoring system, the containment emergency sump, diesel air starting system. We've got right now probably one of the best base line of books with all the system issues that we possibly could ever have. There's a lot of information there, and it's outside my office. How do we use that going forward, and continue to assess our systems?

Nuclear quality assurance field assessments. We're looking at those.

And then finally, the number of management observations requiring coaching. Are we having to coach, how many do we see, and in what areas?

The next area under management is qualification and training. Now, remember, that's not just technical training. That's leadership training, supervisory skills training, and the

management skills training. So what are we looking for there? We're looking for performance benchmarking of organizational staffing. You know, we do surveys compared to everyone else. We have the right number of people to do the job.

We've completed restart required training already, and we've completed root cause training already. We've completed the operability determination training. A lot of this stuff is done, is what I'm showing you.

We've completed training on the legal responsibilities of licensed operators, and we've completed the safety conscious work environment training for 300 people, and completed the stand-down on January 27th for safety culture policy training, and completed training on the decision-making NOP-ER-3001. That was a major issue to get completed prior to fuel-up. So that -- that's the management-type things that we consider a success there.

Completed training on case study, completed training on standards and expectations, and

then continuing training identified by the curriculum review committee. So now that we're moving forward, what's the continuing training? And what we will do as we go to the next plateau, we'll be looking for more things, so that list.

MS. LIPA: Lew, you have two examples there under the completed training on the problem solving and decision making, decay heat pump and cavity seal. Are those good examples of where that kind of benefits you?

MR. MYERS: Yes. Where we see that tool used. There's some areas where we haven't seen it used, you know.

MR. DYER: Lew, on the -- you also have one, completed training in legal responsibilities of licensed operators. Is that their duties and responsibilities to --

MR. MYERS: Yes, it is. Yeah.

MR. FAST: And it really, Jim, coincides very well with the discussion you've had with our operations about those duties. So we talked about very specific legal requirements for our licensed

operators.

MR. DYER: Okay. I hoped that was what it was as opposed to what the legalistic requirements are. That's the wrong --

MR. MYERS: So if you went right now and said assess us for fuel load, these are the things we wanted to get done. Did we get them done? Okay.

MR. PASSEHL: One more question. Is your operability determination training part of your corrective action procedure, or is that --

MR. FAST: It is an outcome. So if there's a condition report that's written with a condition that needs to be evaluated, we use a 9118 process. It's flagged by the senior reactor operator and it goes through the process of operation -- operability evaluation.

MR. PASSEHL: But this process is in your procedure? If I looked at your procedure, I would see what's covered in this training in there?

MR. MYERS: Yes. It's embedded in the procedure. Now, it's impossible to train -- to write every possible condition, so what we deal with in

that training and those kinds of conditions, and we wanted to do that before we changed -- before we load the fuel. Because we're going to a different plateau, right? So that was something we could assess ourselves, did we get that done?

MR. PASSEHL: Thank you.

MR. MYERS: The next area is high organizational commitment; and the things we're looking at there are implementation and training of the employees on safety conscious work environment. That took a lot of time, but we wanted to get that done prior to fuel load.

Effective employee concerns program. Is it effective enough to move forward? Restart oversight panel assessment, licensed operator pipeline. Do we have the licensed operators in place that we need and for the future? Benchmarking programs against the industry standards, operation crew benchmarking, scheduled management observations program -- are we getting those observations done? And then goals for zero temporary modifications, zero control room deficiencies and zero operator

workarounds.

So those are the kinds of goals we're setting. Are we meeting those goals? And we would assess ourselves to this group of things to turn that panel, you know, red, yellow, white, whatever, you know?

Now, the next area is the individual. And when we talk about the individual, now we're getting into some things that are no longer as subjective, and I use a different term than -- if you look, it's called performance monitoring. In that area we have drive for excellence, questioning attitude, rigorous work control, open communications and nuclear professionalism as the commitments. Now -- and they would be the commitment area of individual commitment.

Now, from a performance monitoring standpoint, the things that we would look for for drive for excellence is the number of systems classified in the a(1) category, you know? When we start up this time, for instance, we had four or five systems that were in a(1). Our intention is to have

those in the monitoring mode of a(1) prior to start-up, so we call that a success if we can meet that goal. So for each one of these things we have goals.

Number of operator workarounds, number of temporary modifications, number of control room deficiencies, individual error rates, number of long-standing equipment problems, percent of self-identified condition reports. We have to write condition reports, so how much of those were self-identified? And then engineering assessment review board index, and that's where we grade the engineering product.

MR. GROBE: Lew, before you go on from that page, what is your expectation with the identification of conditions by the working level staff as contrasted with supervision or management? Do you have an expectation or monitor indicator that looks at how many of your front line folks are identifying condition reports as contrasted with supervisory and management folks?

MR. MYERS: What we do at our other plants --

two things. From a management standpoint, we look at -- we have a performance indicator that where we look across the board at the number of CRs written by group. And that was really a telling story at Beaver Valley. Now, that's from the management standpoint. And so if you see, you know, that all your condition reports have been written by your IC department and none by the mechanical, that's a problem, you know. So we do address those areas.

Now, in individual department performance indicators, what you'll see is the number of CRs written per person, you know. So if you've got people that haven't written a CR in two years, you probably have to ask them why. So -- and what you're seeing, we're going to install in our plants the same thing that you'll see at our Beaver Valley plant. Each department has group performance indicators that are in the department area like that, and they're in a shadow box and lit up and pretty much all of our people can tell you those kinds of things at that threshold. So we will have those installed in the next couple months, I think.

MR. PEARCE: We're trying to procure the boxes, and they're hard to get.

MR. MYERS: I think I finished drive for excellence.

MR. PEARCE: You wouldn't believe how hard they are to get.

MR. GROBE: I believe you. Is there some unique reason that you isolated number of engineering condition reports outstanding? Is that a resolution of old issues, or is there something else going on there? Second to the last dash on page 62.

MR. MYERS: Looking for old issues.

MR. GROBE: So that's essentially the workdown of the backlog of old design issues.

MR. MYERS: Old design issues.

MR. GROBE: Okay. I understand. I have not seen before the, quote, "number of longstanding equipment problems" as an indicator. How do you measure that?

MR. MYERS: What we do is we look at our equipment problems that are three, four, five years old, and we have a top ten list that goes in our

business plan at Perry and Beaver Valley, and we look at how well we're performing working those out.

MR. GROBE: Okay. I understand.

MR. MYERS: Questioning attitude. The things that we can look at there -- and once again, there are some things that you can actually go physically measure now is quality of prejob briefings as management observation. What's the quality of those things we're seeing? How many times do we have to do management intervention? So we can monitor that.

Number of condition reports, CRs, if you will, per person per group, once again. Number of programmatic CRs that are against our programs. The number of procedure problems and the number and type of operational events -- tagging errors, mispositioning, and things like that.

Now, under rigorous work control, you remember I indicated that was more than just the work control process. So we would look there at the employee event free clock error rate. We have a systematic process -- procedure, if you will, for resetting our event free clock common at all three of

our plants. So do we see trends there.

Industrial safety index. We can measure that.

Employee error rate. We can measure that.

Program process error rate, significant human performance errors resulting in plant transients, and backlog of procedure change requests. Once again, that's something other than just a work control process.

Quality control hold point/rework. When our quality people go out for their hold points, how many times do they have to stop the job and do something different because they find a problem, you know? And we think that's a good indicator.

Number of work orders in the backlog -- oh, yeah. Number of work orders scheduled to be completed each week versus what gets completed. That's a tool we use at our other two plants also.

The number of late PMs. One of our other plants used to have a number of late PMs.

Today they don't have but two or three at the most, and so number of late PMs is a good indicator.

Backlog of corrective maintenance, and once again, number of a(1) systems. Now, in the area of open communications, this gets a little hard. The -- you get back then into the willingness of people to identify problems. So we look at the number of condition reports per person per group, and that's that indicator that we use at our other plants. We look at does it seem reasonable? Is there one group out of line? And last year at our Beaver Valley plant we found several areas there we wanted to improve. So we think that's a good indicator.

The number of concerns going to employee concerns programs versus the NRC. So does it look like our employee concerns program is working well for us?

Once again, we'll do ad hoc surveys pulsing the organization about communications.

And then finally, feedback from our 4Cs meeting, that we ask some questions there that we ask everyone each meeting to provide an assessment of

the meeting. So we intend to trend that stuff.

And then finally, the SCORE program we talked about a while ago, the peer program. We'll use that to monitor.

Then the last area is nuclear professionalism. I defined that a while ago as understand what you're dealing with when you're working on something in the plant, whether it be a safety evaluation or working on a physical job.

And the things we would look at there is completion of Ownership For Excellence, you know. When you get in these jobs, you've got, I think it's a year to complete the Leadership in Action. So the completion of the Ownership for Excellence items, training attendance, rework, individual developmental plans, results of engineering assessment board assessments, the number of yellow windows in training. If you go look at the tool we use at our plants for -- that's been very, very successful, and we got that from the industry more than anywhere else and improved on it is that each one of the subcommittees grades their training effectiveness,

and then that feeds up to the training review board, which I chair, and we look at that routinely.

The absence of low-level radiation protection events in our plant, and then chemistry performance index. That's something we can monitor also. So if you go look right now at what we have in place, you have the first couple of areas that are somewhat -- what was the word I used? -- somewhat subjective, I would say. And then the last area that we can physically monitor how we do work and behave in the plant on an individual basis and what are those performance indicators that we have there that we can go look at? So those are the key areas that we're looking at right now as a management team.

MR. GROBE: How often do you expect to assess these?

MR. MYERS: You know, some of these things will be monthly and some of them will be probably quarterly, you know. But right now we would expect to assess these at each and every -- as we go forward, because we're changing conditions, at each and every readiness review board meeting when we

change modes or whatever. We probably would not do a restart readiness board before mode four to five, but we'll do one prior to fuel load, mode four, and then prior to breakout.

MR. GROBE: When will the guidance for doing this be completed?

MR. MYERS: Well, we have some of this already, like we already have all the business -- we've got a really good tool I'll show you. I think you may have seen it for the restart readiness review board meetings. Did you see that with all the --

MR. GROBE: Sure. I think so. The handout at the meeting?

MR. MYERS: Right. That's all done. And that's what we're using right now. Then we're building this business case that we'll be using in the future, and that will probably be done in the next month, anyway.

MR. GROBE: Okay. Before we go into -- I assume, Bill, you were going to talk about -- other questions on this part?

MS. LIPA: Yeah. We talked about that packet

that Jack saw at the restart readiness review board, but it seems like a lot of these factors are going to be like the number of yellow windows. Have you already defined your criteria for what makes that, the number of a(1) systems? Have you already defined how you're going to get green and white?

MR. MYERS: No.

MR. WRIGHT: Lew, just one other detail. On one of the items that I know you do track right now is looking at the coding of condition reports, the initial coding versus what the panel finally comes up with. I may have missed it when you were going through --

MR. PEARCE: It's in this.

MR. WRIGHT: Okay. Thank you.

MR. DEAN: Jack, I have a question here from headquarters.

Lew, with respect to the -- within the individual commitment areas, I notice there was some duplication of some of the measures as you move from blue box to blue box. Is that a sense that some of these give you indications in several different

areas, or does there need to be a little bit more of an emphasis on what truly contributes to each one of these boxes?

MR. MYERS: No. When we put these together, I looked at that, and I really think that as you're grading that particular commitment, individual commitment, that this is applicable to that. So there may be six things there, and any three of them may turn the thing yellow, you know. So to delete it would be deleting something that, even though it may be repetitive, but you need it for that box, you know? So no. To assess it there, I think is appropriate.

MR. DEAN: I thought that Geoff asked a good question earlier about, I would think that there would be some boxes here, you talk about they all don't have to be green. I think there's probably some here that you would want to have green before you even considered restart. You know, for example, manager's commitment on emphasis on safety, I would hope that you would think that would be a green box before you started up.

MR. MYERS: I would hope so. But you know, I think it's too early to tell right now, you know. One of the things we would do is we would go back and, what I said is, for instance, we've got our policies. Are we reinforcing those policies? And we may grade ourselves, yeah we're doing a pretty fair job, and make that white, you know. But we'd like to do better. We can identify three meetings where we really reinforce this standard that we think we can do better so -- before we grade ourselves white. So I wouldn't think that that would be the end of the world.

MR. DEAN: I think the important thing is that, you know, in the past -- and we may be quibbling over some details here, but the important thing here is at least this provides a basis for dialogue and discussion where we can have some appropriate assessment discussions about how are you doing in certain areas related to safety culture, which we were struggling with in the past. So at least this provides some sort of framework for doing that, so I think that's a real good benefit.

MR. MYERS: Yeah, I do too.

MR. GROBE: Other questions from headquarters, Bill?

MR. DEAN: No, Jack.

MR. GROBE: Okay. Anything else here?

Okay, Bill.

MR. PEARCE: What I'm going to show you again is the four pillars and very similar process. In fact, it's supposed to fit in with the way Lew is monitoring the safety culture issue.

So the first one is look at the management support, worker confidence area. And here's something you've been asking about is the results of a standards survey is going to be one of the things in it. And I put on here post core reload because that seems to me to be the right point to do this -- redo this same survey that we did previously, and because -- and the reason I picked that point is I'd like us to actually physically do something with the people and something towards normal operation and get -- just see how we do in performance and then do the survey and see how they're feeling about things,

because a survey is a lot of perception about how they're doing and how they're feeling about their own performance. So that's the point I think is the right point. And that, of course, is not going to be very long, hopefully, and we'll have another survey done. If things were to change in the schedule, I may change when that occurs too.

The next one is the NRC concerns or allegations versus the employee concerns program, the performance of those two. And I do in fact have a graph here. Jack, I can give it to you and Jim and let you look at it if you want to. And it's -- but I guess -- you can see from those results that what the graph shows is the number of employee concerns program contacts are going up at a steep rate since we've implemented the new program, and the allegations are building -- the NRC allegations are at a much slower rate. So it shows improvement when comparing one to the other. We're looking at that because that's going to be one of the things we use to monitor this area.

MR. DYER: What's the Y axis on this graph, the

number zero to 90? Is that allegations per month?

MR. PEARCE: No. That's cumulative since -- if you look at the bottom, it says since 1 January 2001 --

MR. GROBE: Two. 2002.

MR. PEARCE: You're right.

MR. DYER: So this says there were no NRC allegations from, according to you, from December through January?

MR. PEARCE: None that we've been told of. And then the next thing that we're going to use is quality assurance interviews. And in fact, we started the set of interviews this week, first set to look at safety culture and safety conscious work environment. And we intend that our process is going to have us do ten percent of the employees where we sit down face-to-face with the QA folks with the employees and we go through a set of questions and we write down the results of the questions, and then we do some cumulative assessment of what that's telling us. So that's the quality assurance assessment that we're doing, and that's ongoing presently. And we

will redo that a couple of times to get some feel for this area. You're going to see that come up in several of these pillars, but there's -- I forgot the number of questions. There's 12 questions. So some of the questions are relevant to different pieces of different things.

All right. The next pillar is the corrective action process, and here's going to be the things we're looking at there, is the status of the implementation of the corrective action program improvements. We expect those to complete this month.

The root cause evaluation quality, that's an output of the corrective action review board that Randy chairs, where they look at all the root causes and how many did they reject versus how many did they accept? So that will be a measure.

Condition report category accuracy. Geoff, this is a question you asked earlier, is how are we going to use that? And this is where we think it applies here. We look at what the supervisor classifies it versus what the management team

classifies it. That's what we're looking at.

Basic cause evaluation quality, this is more of a sampling. We'll go through about the performance improvement group, then go through and look at those basic causes and look at evaluation quality on those. And Randy, you all are looking at those also.

MR. FAST: Right.

MR. PEARCE: Condition report self-identification rate, another one we talked about earlier; that's the ratio of how many are identified by the line organization versus the oversight or NRC or who else. And results of the survey, again, post core reload, it's the standard survey that we previously performed.

And then of course, the quality assurance interview results. There's a couple questions around the CAP program in that interview.

The third pillar is the alternate --

MR. DYER: Bill, before you leave that one, your review, I understand your basic cause evaluation quality, that will be done by your organization?

MR. PEARCE: No. It's going to be done by the performance improvement with the CARB, actually that data form, and they put that together. But it's a corrective action review board. It's got Randy as the chairman. It has the design engineering manager, Ops manager, maintenance manager, systems engineering manager, chemistry and --

MR. DYER: So do I understand that all of these oversight activities are really done by line organizations, and you're just monitoring them?

MR. PEARCE: Yes. We sit in on the meetings. We come to independent assessment, what the line organization is doing. Is that what you're asking?

MR. DYER: Yes.

MR. PEARCE: And we do come to some conclusions.

MR. DYER: But no independent technical review on your part?

MR. PEARCE: In some areas we do choose to do some independent technical review, and we've got those reports to show that. In fact, when we are doing system health, we picked a couple systems

ourselves, independently went out and paralleled with the line organization and did some work, and then let the line organization do its, and then compared the results at the end to understand if we thought they collected everything and got -- at the right level, and came to our own conclusion with it. And that's how we intend to go ahead with the rest of these processes too.

MR. DYER: Where would that fit in this monitoring? Is that one of the --

MR. PEARCE: Well, this interview results, at the bottom, but we will issue a -- you know, how we're doing in the area of safety culture and safety conscious work environment. We'll come to an independent assessment of that. And this interview process that we're doing now is one piece of that. Is that what you're asking?

MR. DYER: No. I was -- the question, I guess, is -- and I'll use an example -- is are you going to independently sample condition reports away from the CARB and everything else and have your QA, independent QA, corporate QA staff review them soup

to nuts in an area that they have some technical expertise in and then make an independent assessment as to whether or not the line organization is functioning properly?

MR. PEARCE: Yes, that's correct, Jim.

MR. DYER: How does that fit in --

MR. PEARCE: It's not shown --

MR. DYER: It's not going to be in here?

MR. PEARCE: No. It won't be in here, but we will be giving that feedback.

MR. MYERS: We'll use that one way or the other, independent quality assessment we would use that.

MR. DYER: Okay.

MR. PEARCE: And that's the methodology we've used through this entire process thus far, and you have inspected that in the areas that we've already done. Okay?

MR. MYERS: What's sort of interesting, getting back to safety culture again, is back -- if you go back and read some of the quality assessment reports, for example, on the corrective action program a year or two ago, they're just really well-written

reports. When you read them, then you look at the overall conclusion they come to, there's a complete disconnect. They're really well written. So the independence that he has now with these reports coming to the right conclusions, I think, will help drive us along pretty well.

MR. PEARCE: Okay. And the third pillar is the employee concerns program, and of course, we use the use of employee concerns program by employees; that's a number of concerns they're collecting. This is one that we're working on. And in fact, we've got some data. I didn't bring it with me, but satisfaction of employees that have used it, employee concerns program, where we go back in our -- we've got a little process where we go back after a period of time and go back to the person who had the concern and get some feedback on the satisfaction that they have with the program after they utilized it as an indicator.

And then of, course, again, the number of issues directed to NRC versus the number in employee concerns program. I just showed you that.

And the last one is the safety conscious work environment review team, and here's what we reviewed. We looked at the number of times that we actually use the team to review issues and get some type of trend or number out of that. Then we're going to get the effectiveness of the safety conscious work environment review team in avoiding valid discrimination claims. So we'll -- we look at that as a negative indicator because they're supposed to be looking forward, and it should be causing those things not to happen, or at least be on some kind of decreasing trend.

And then all valid harassment, intimidation, retaliation, discrimination reports. So if we get something in the ECP or into the NRC and we find that we've had a valid HIRD issue, then that ought to be an indicator against this team looking forward about why didn't we get that into the program and do something ahead of time before we got there? And I think that will be alarming for us, and we should see those decreasing.

And the number of actions reviewed

versus the number of actions rejected. This is a little different indicator in that what happens at this team level is that the manager or supervisor that's got some issue or decides they're going to discipline someone in the organization, they bring in their recommendation, you know -- give background and then the recommendation of what they think ought to happen. If the team has to intervene to change the level of what is going to go on because of some issues, then we want to collect that to give feedback to the managers and see if we've got our managers properly attuned to be able to understand the level and the types of things that they -- how they should deal with issues.

And so that's the safety conscious environment review team indicators.

MR. GROBE: Questions?

MR. PEARCE: Okay. I think Mr. Saunders is going to give us closing remarks.

MR. SAUNDERS: Put the next slide up, please. This is the atmosphere that we are developing, and I'm not going to read you those attributes. You can

read them yourself.

What I'd like to do is go back to mid-2002, and recall that we commissioned a root cause, what I refer to as the management root cause, and it was published, I believe, in August of last year. I thought it was thorough, comprehensive, hard hitting, and I thought it was very clear and open about our shortcomings and who was responsible for them. And I think we did a very fine job of that. Actually, I'm very proud of that piece of work.

What it really determined is that management had a less-than-adequate nuclear safety focus. That's what it determined. Production focus. I think we presented you some material here today that shows you that we clearly understand it has to be a balanced approach, that if you do not have a safety focus, you don't even get to play in the game. We clearly understand that, so we do not have production focus over safety.

Davis-Besse was operated as a stand-alone plant. Well, I think if you look at the new management structure that we've put in place,

chief operating officer, another executive over the top of engineering, and our establishment of a corporate organization, it is not going to ever be a stand-alone plant again.

Conditions were identified as relative low threshold. I think that's very, very important. As Lew said, 29 condition reports were written on the reactor vessel head. The problem was recognition of the importance of those reports and then proper execution of what work should have been done in response to them. I think our new corrective action program, our new management team in place, will never let that happen again.

Quality assurance findings were of mixed quality. They were. We've got some fine people in that organization, and I think under Bill's stewardship, they have come a long way in a very short period of time. They have become a quality group. And a little simple example, we have a 0730 operation call every morning, and Bill, of course, is on that call, and we talk about the daily activities of the plants. And then Bill has an 11:30 call for

quality assurance, and he better hear all the same stuff out of his group or there's going to be something to pay. Just a little insight as to how that group is performing now.

Ops didn't have an active role in really making improvements in the plant. We have placed operations in a leadership role now. We have good leadership there, and we emphasize that every day. So we feel that we've got that well on its way. I just thought it was important to go back over that root cause and let you know that we think we have effectively addressed problems that we have identified. So FirstEnergy is definitely committed to nuclear safety, and that's from the board room to the control room. Thank you.

MR. GROBE: Okay. Questions? Bill, do you guys have any questions from headquarters?

MR. DEAN: I have one question and maybe a comment or two. My question is that you've established a framework now, a monitoring system. I guess what will be the first time that we will have the opportunity to see how you've graded yourselves

in those areas so that can form a basis for dialogue in our public meetings?

MR. MYERS: I think we're doing that. We have been having -- we start readiness review meetings now, we've had four days of those, and we're getting ready to have another one Monday morning of this week to determine why we should load fuel, you know? Why are we okay and why should we go load fuel? And what we're doing in those meetings is grading these things. And you know, we won't go load fuel until we're ready. And some of the things that's fallen out of that is, like I said, we had 180 items, which some of it was training and some of it was some policies we wanted to get in place, and other things were procedure changes. But a lot of it was equipment. For instance, we're really pushing hard to go ahead and complete the second decay heat pump prior to fuel load, you know? So we're trying to get that done.

So if you go look at that, I think that's the meetings I would invite you to come and sit in. And then the way I've thought about this,

anyway, you have these restart readiness review meetings, and they get you to the point now you're ready to go in sustained monitoring, and that's when we would start putting out like the monthly reports or whatever on the sustained performance, you know? So that's the way I've seen this, anyway.

MR. DEAN: I guess the issue I'm trying to get at, Lew, is that we and you have identified the safety culture as an issue that needs to have some definitive progress before consideration of restart.

MR. MYERS: Right.

MR. DEAN: Thus far, discussions publicly have been of an anecdotal nature, talking about insights you get from the 4Cs meeting, talking about how you've dealt with various equipment issues and doing things to improve margin and so on and so forth. But there really isn't anything out there that provides a face on the whole effort to look at safety culture at Davis-Besse. And what you've established now is a monitoring framework that can do that, which is green, white, yellow red windows. So what I'm getting at is I think that would serve as a very good

public display that then could form a basis for our dialogue at 0350 panel meetings where we can talk about okay, we've assessed this area as yellow, and here's why. Here's what we've kind of got to do about it. I think that that would help the public, as well as us, better understand how it is that you look at yourself from a safety culture assessment and what it is that you're doing about it.

MR. MYERS: For instance, we'll be ready to talk about how we assess ourselves and some basis for that at the next 350 meeting, public meeting, because by then, we will -- I hope we'll be loading fuel. We won't load fuel until we assess ourselves ready to load fuel, you know, and so -- then the next one will be mode four. We won't go to mode four until we assess ourselves ready to go to mode four, you know? So each one of those we'll be able to talk about how we assessed at those meetings.

MR. DEAN: Okay. My only comment is -- thanks, Lew. My only comment is that I greatly appreciate the fact that we now have this framework that we can more effectively monitor and discuss what's going on

in the safety culture world, and I think the inclusion of the independent assessment that Dr. Haber is doing will provide certainly some good validation of your efforts and your state of affairs in that regard. So I think what we've heard today, generally, has been pretty positive, from my perspective.

MR. MYERS: I'm really excited about, you know, I believe we'll get the -- we'll make this transition and then somewhere along the line we'll get this report back. And it's going to be interesting to see if that report matches up with our assessment. That may cause us to change it somewhat, okay? So we're looking forward to that. We think it's a healthy thing too.

MR. DEAN: That's all from here, Jack. Thank you.

MR. GROBE: Thank you. Just a couple of observations. I think this meeting has been extremely informative. It's pulled together a lot of issues, a lot of activities that have been ongoing for months. The NRC has been inspecting many of

those activities in process, from detailed things like attending 4Cs meetings and the safety conscious work environment review teams, SCWERT meetings, and various training activities have been ongoing. So we have been engaged in this, but we have not been able to articulate clearly how it all pulls together, and this has been quite helpful.

The morning session -- I just want to ask one question just as confirmation. You described a variety of corrective actions that you have ongoing for the safety culture area. Are all of those captured in your management performance building block?

MR. MYERS: You know, I don't want to answer the question wrong, but I think the question is probably yes.

MR. ESHELMAN: We've been developing these activities since these -- since we first got into this. And as we have been developing, part of my role is making sure that they're in the corrective action program. That's what we're using as a tracking mechanism, so each of those activities will

end up in the corrective action program which then will get into my plan. And in revision one, which we're working on after Sonja's assessment, will reflect those.

MR. MYERS: The problem is I'm always coming up with something else to do that I forget to tell him about.

MR. GROBE: So shortly the management human performance improvement plan will be capturing all of these activities?

MR. MYERS: Should, yes.

MR. GROBE: It's not often that the NRC moves into this area of assessing safety culture. It has occurred in the past. The commission has established a policy on safety conscious work environment, and that's been published since the late '90s -- I think it was '96. Clearly, there has been some visible areas where we've monitored safety conscious work environment and engaged in that area. One is most known, for example, but also, Bill, you might recall the Commonwealth Edison oversight panel in the early to mid '90s, where we gained some insight into these

areas also.

I can't remember recently a more comprehensive articulation of an assessment of safety culture. I guess I want to highlight that there are no standards, NRC standards on how to do this. What is important to us is that you have a set of indicators that appears suitable that can be tied to a logical process of monitoring the various activities and areas that you're trying to monitor, and that we understand the results of those indicators and how you're utilizing them. And I think we're headed in the right direction in that regard.

Some of our inspections in this area, the material that you presented most recently, the kind of inspection activities we are going to accomplish, I think we've done those before, and they're pretty straightforward. The inspection that you might consider for Dr. Haber's work is not clear to me at all -- you'll probably be discussing --

MR. MYERS: Nor us.

MR. GROBE: I think that's all the comments I

wanted to make.

Jim, do you have any comments before we move into the public session?

MR. DYER: No. Thank you, Jack. And I wanted to really echo what Bill Dean and Jack Grobe offered up. It's been a very helpful meeting in trying to get our arms around and understand the issues. And I was thinking more in the background area in getting ready for this meeting and the challenge -- the 0350 panel reports to me, and the challenge when we set this up, I know that I spoke to Lew and at least in a meeting one time when we set the panel up, was to understand the root cause and look at the corrective actions and level of involvement that the NRC would be involved with was really the diagnostic or as thorough a look and review of the root causes that we performed as a regulatory agency. And it will either be done by you all with our oversight; or if you didn't do it, then we would have to find a way to do it independently.

And I think this was one of the key outstanding areas that, when you looked at all the

root causes and some of the problems that you identified, that I think, as Jack said, we were struggling with understanding how were we going to deal with this issue? And looking back as, also as Jack said, the safety conscious work environment policy statement is really our only guidance in this area, and that talks to two aspects, safety conscious work environment as has been discussed: the discrimination and also the corrective actions aspect of it.

And I just want to read the operable paragraph as I went through this background document, was the problem, effective processes, the expectation for effective processes for problem identification and resolution, and it talks, "thus, the commission expects that each licensee will establish a safety conscious environment where employees are encouraged to raise concerns and where such concerns are promptly reviewed, given proper priority, based on their potential safety significance, and appropriately resolved with timely feedback to employees."

And I think, as Bob Saunders just said, in the case of the cavity formation and the boric acid corrosion on the head, that wasn't the case. And that's the key root cause on the 29 condition reports written throughout the history of Davis-Besse. And clearly, it isn't a discrimination issue, as it was looked at, at least not that we know of now; but certainly, it was a corrective action violation. It crossed over expectations, it was a corrective actions violation, and the challenge, the 0350 panel does, has to look at, is the diagnostic level of understanding and assuring that the corrective actions are effective.

And the other thing that -- and again, the 0350 panel still has to figure out how we're going to complete that. But the presentation today serves as a good foundation for them to work on.

The other challenge that I'm particularly interested in is right now you're in a restart mode. You've off-managed your organization and have a lot of additional oversight. We're in a manual chapter 0350 oversight role. Both of those

are what I would call anaerobic states on both sides of the organization, areas that we're not going to maintain. And what we have to look to is to the -- what is going to be left when -- if and when we exit these oversights, and what is the continuing emphasis that's going to be placed on this area, as well as all the root causes and that of the problem.

And I think you discussed at length the enhanced corporate oversight and the organizational increase in assets that you provided to the FENOC organization, and I'm particularly interested in the independent assessment, that it is truly independent. That's why my probing questions on the corrective actions. It can't be just a monitoring of line organization data. It's got to challenge the organization, not be a reporting-out organization.

You know, I think Dr. Haber's presentation, as I was looking back at the three components, artifacts, claimed values, and basic assumptions, and I'd echo my experience with Davis-Besse before is that the written reports and

the claimed values and trending and everything you'd see around the plant were pretty good. There were some innovative risk tracking initiatives and awards given and that, but the basic assumptions weren't there. And that's the challenging one, and that's the one that the corporate organization and the line organization has to make sure they get to, not only in the process of improving their standards to an acceptable level, but establish the programs that will be ongoing and continuing to make sure that there's no backsliding. And that's what I'm going to look to, the 0350 panel, to provide to me, you know, as part of our restart deliberations. So that's it.

MR. GROBE: Thanks, Jim. It's 20 minutes to four, central time. Let's take a five-minute break, and then we'll reconvene for questions and comments from members of the public, both here in Chicago and in Washington area and also on the phone.

(Whereupon, a recess was had.)

MR. GROBE: Thank you. At this time we'd like to move into the second part of the meeting, where members of the public can ask questions of the NRC

staff or make comments, if they so choose. This is kind of a complicated situation because we have at least three venues. We have folks that are here in the Region III office in the Chicago, Illinois area; it's possible we have some folks in headquarters, I'm not sure, in the Washington, D.C. area; and we also have, I think, somewhere on the order of 70 people on the phone.

What I'd like to do is first open it up to the folks here in the Region III office, then move to headquarters, and then to the MCI operator and allow her to moderate questions from the folks that are on the phone, and then repeat that just in case somebody came up with an additional question as others were speaking.

So why don't we start here in Region III with any members of the public that are here. Please approach the microphone that's on my left-hand side of the room, and state your name and ask your question or provide your comment.

MR. WITT: I'm Jerre Witt, county administrator for Iowa County, and also a member of the restart

overview panel. I just have a brief comment. It's been a long meeting. It's been, I think as Jim Dyer said, it's been a productive meeting in terms of learning what's going on here.

The only comment I would like to add, because we covered a lot of ground here today, is that I've seen, through many observations, and I think I counted up the other day just to see how many times I've been to meetings on this issue with Davis-Besse in the last year here, and it's somewhere over 60 meetings, and some of them all day long.

The most important meetings I was involved with was with the employees of Davis-Besse, and I think the first meetings were back in August or September and a successive meeting in December, and then in discussions I've been involved with over time with the employees. And I guess what I'd like to comment on is the fact of what I have observed with the employees and with the attitude change and the safety culture that I believe is there with the employees at this time. And I've seen many, many displays of changes in that culture, and I've also

observed issues brought forward by the employees. And I think that's important here because when it really comes down to where the rubber hits the road, it's really there with the employees. I think the management team has certainly ingrained that culture, and I think it's happening.

And the other one comment I would like to make is I know you've talked today about how certain individuals were picked for this trip as employees. And having observed the comments of some of these individuals in the meetings, I can assure you that they weren't picked because they were coming here to say the right things, because they challenged us in the meetings and I know they've challenged Lew and the management staff; and that's a good and healthy thing, and I'm glad that these individuals are here today to observe what goes on and to make their truthful from-the-heart comments. Thank you.

MR. GROBE: Thank you, Jerre. Other individuals here in the Region III office who are interested in asking questions or making a comment?

MR. WHITCOMB: Good afternoon. My name is

Howard Whitcomb, and I'm a resident of Ottawa County, northwest Ohio.

I had a number of prepared comments, but I would like to focus on a couple of impressions or perceptions -- that word was used this afternoon -- that I've seen this afternoon. First of all, I think FirstEnergy is about ready to embark or is embarking upon, perhaps, one of the most critical tests in its history, and that is the survey of its employees in determining whether or not there's a safety culture. What is disturbing is there is no test acceptance criteria. Right now we're going off, marching off and doing these surveys, but yet, we're not sure what constitutes an acceptable level of safety culture by which we can measure the results of the survey. That is -- presents a particular challenge, but yet that is the big picture that we cannot let pass by.

Second of all, I had been approached by several folks, FirstEnergy employees, and they would like me to relay the following. Consider that the current working environment at Davis-Besse

Nuclear plant remains hostile. Within the last two weeks at least two employees who raised concerns to their immediate supervisors or who stopped work for safety reasons received letters of reprimand, verbal threats of harm by coworkers, and/or experienced damage to their personal property while onsite. That is slashed tires. While both the NRC and FirstEnergy managements are aware of these incidents, neither organization has raised or discussed them this morning. Rather, FirstEnergy leadership emphasizes the development of unproven programmatic changes that they are trying to put in place. Any measurable indication of improvement with respect to the creation of the safety conscious working environment has yet to ~~begun~~ begin. Thank you.

MR. GROBE: Howard, a couple of observations. We went through what is very clearly a complex analysis that Dr. Haber is going to be leading. I believe she articulated that there are some measures by which she will be judging safety culture and making judgments on whether individual aspects of safety culture, using her tools, are present or need

improvement. I expect that in future public meetings we'll be getting into more detail on that assessment approach and the measurement technique that she's using.

In addition, Lew and Bill presented their ongoing assessment approach. We have not yet seen that in writing, other than these slides, and we'll be looking at that in more detail also. I appreciate your comments in that regard.

On the second issue that you raised, I'm very interested in additional details on the specific examples, of course privately, that you raised. We are unaware of the examples that you raised. You stated that both NRC and FirstEnergy is aware of that. That's not true. We are not aware of that, but we would appreciate any specific information that you would have on specific concerns of a lack of a safety conscious work environment at Davis-Besse.

MR. WHITCOMB: I believe two folks from Region III have already spoken to one of the individuals. I don't know what the results of that investigation are

at this point.

MR. GROBE: Well, we should do this privately. Actually, Brent, could you raise your hand? Brent Clayton is the person I'd like you to talk with, if you don't mind. Thank you.

Okay. Any other members of the public here in Region III that desire to make a comment or ask a question?

MR. DYER: I'd just like to comment on one of Howard's questions, and let me ask FirstEnergy too. The issue of acceptance criteria, again, I view this as -- we heard the framework and that. What is the -- I mean, you have benchmarking and comparisons and that. Is it your intent to have your evaluation criteria as you go in, or is this going to be a consulting report made by --

MR. MYERS: I don't know if I know the answer to that. Right now our process will have us ~~asssess~~ assess the areas that I told you about. We will not -- if we assess those areas as red, we would not do something before we change modes or restart it ourselves. Then we would look to our oversight panel, the restart

oversight panel, to provide us input. And if we had multiple areas that were all yellow, we would be very concerned about that too. So our intention is to assess ourselves. Some things are objective -- are subjective prior to each basic change in plant conditions, and we won't move forward until we're comfortable that we should move forward.

MR. DYER: What I was referring to is some of them are subjective, but some of them are objective. You had ratios and you talk about numbers and things like that; and I guess, in my mind, when Howard asked that question, the question I had is do you develop your acceptance criteria before or after you see the results?

MR. MYERS: No, no. Before. We've got goals on all those things.

MR. DYER: Okay. Because I didn't ask that --

MR. MYERS: You know, for corrective maintenance backlog, we have a goal right now, I think -- we came down, we were going around 250 corrective maintenance backlog ~~area~~ items. That's rough, you know, but we intend to be in that same range when we restart, you know,

from a corrective standpoint. So you know, not only have we done all the things that we're doing, we've maintained material condition at the plant. We have goals in those areas; rework goals, stuff like that. We have all that.

MR. DYER: Okay. So then you understand you're going to establish acceptance criteria before you get the results and you come up with your color scheme on your thresholds?

MR. MYERS: Right.

MR. DYER: Okay.

MR. GROBE: Okay. Thanks, Jim.

Any other questions or comments from members of the public that are here in Region III?

Bill Dean in headquarters, do you have any folks there that have questions or comments?

MR. DEAN: There are no members of the public in our meeting.

MR. GROBE: Okay, great. I'd like now to turn it over to the MCI operator and let her moderate any questions from folks that are on the phone.

MCI OPERATOR: Thank you, sir. For any

participants on the audio portion, if you would like to ask a question, you may press Star 1, and you will be announced prior to asking your question. If you withdraw your question, you may press Star 2. Once again, to ask a question, please press Star 1.

We do have a question from Paul Ridzon.

MR. RIDZON: Good afternoon. This is Paul Ridzon at McDonald Investments. I think this topic was touched on by some questions from headquarters, but it did not come through the phone lines very clearly. It appears as though FENOC has established some pretty comprehensive metrics. I'm wondering if that was basically the desired outcome of the meeting today or whether you wanted to see some quantification of those metrics or any actual discussion of trends in those metrics and whether that, getting those items, the quantifications or trends, is going to be paramount to actually have that information before you allow a restart?

MR. GROBE: Paul, could you spell your last name?

MR. RIDZON: R-I-D-Z-O-N.

MR. GROBE: R-I-D-Z-O-N. Thank you. First, the purpose of this meeting was not to specifically discuss performance indicators as much as it was to gain a comprehensive insight as to the activities, corrective actions that FirstEnergy has undertaken, as well as understand how they're going to be measuring safety culture and safety conscious work environment going forward. We did not receive today, I don't believe, any specific quantified performance indicators, so I don't have a response to that part of your question.

The second part of your question concerned restart. And maybe it would be helpful just to explain a little bit of the restart process. There's an oversight panel that is comprised of the people here in the region, NRC employees here in the regional office, in our headquarters offices and at the Davis-Besse facility, who are monitoring and assessing licensee performance.

At some point in time I anticipate FirstEnergy will believe that they're prepared to

restart the plant, at which time they will meet with the NRC in conformance and describe their basis or their belief that they're ready to restart the plant. The oversight panel will have been and continues to monitor FirstEnergy performance, and would provide its insights to Jim Dyer. The plant would not be -- the NRC would not approve restart of the plant until the oversight panel made a recommendation to Jim and he were to accept that recommendation; and he would do so in consultation with the offices of nuclear reactor regulation and headquarters and the executive director of operations in headquarters. So it's a process that moves forward.

One of the elements of the process -- it's guided, the process is guided by what we call a restart checklist, and one of the elements on the checklist is management and human performance. Within that aspect of the checklist is the topic that we were talking about today, and that is the safety conscious work environment at the facility and the safety culture. And Geoff Wright here with us today

led the first phase of inspection into that area, and we have additional inspections planned. We've also been regularly attending a variety of the corrective actions the FirstEnergy employees described in the first part of today's meeting. So we have a number of inspection insights to date that the panel has at its disposal for considering performance at FirstEnergy, and we will have a number of additional inspections before the panel would make a judgment on that specific aspect of the restart checklist, and that is the management and human performance aspect.

So I think I've answered your question. Do you have any other issues or questions with the information I've provided?

MR. RIDZON: No. Just a follow-up, though. You've got to close each meeting with a "we continue to see slow and continual progress." I mean, is that how you close this meeting?

MR. GROBE: Well, this was a different kind of meeting. I think what you're talking about is my normal meetings out in Oak Harbor area where we meet with the company monthly to receive performance

assessment. We didn't really receive a broad dissertation on progress that the licensee has made today, so I don't think, based on what we've heard today, I would make such a statement. But specifically in this one area, I think the information that they've shared with us today has been -- has met my expectations for what we wanted to accomplish today, and that is that we have a comprehensive description of the corrective actions that they're taking, as well as our first thorough discussion on how the company plans on measuring safety culture going forward. So we've seen progress in these areas, as far as articulating comprehensive and corrective actions and articulating in a cogent manner how they're going to be measuring safety culture. So that is progress, but I don't want you to infer that that's an assessment of overall plant performance.

MR. RIDZON: Thank you very much, Jack.

MCI OPERATOR: The next question comes from Billie Garde.

MS. GARDE: Hello?

MR. GROBE: Yes. Can you state your name and spell it, please.

MS. GARDE: This is Billie Garde, G-A-R-D-E.

MR. GROBE: Go ahead, Billie.

MS. GARDE: I have a couple of questions. First of all, I've reviewed the procedure on -- or the policy for maintaining safety conscious work environment issued by Mr. Saunders on November 21st, 2002, and the kind of companion statement by Lew Myers.

First of all, what we've heard today is certainly far beyond what was set forth in the November policy, and I assume there will be a revision of this policy issued that captures the commitments that were laid out today. I'm not sure of that, but I'm assuming that.

But one of the things that was not addressed today and I'm concerned that the NRC look into this, is the expression in both the policy statement and Mr. Myers' statement that workers can raise concerns or they prefer to raise them up the chain of command, and if not the chain of command, to

the NRC. That is maintained kind of throughout all of the documents, including a kind of disturbing statement in the policies, that 3.5.4, that says failure of a FENOC employee to comply with this policy may result in disciplinary action up to and including termination. As you know, the law provides the right of employees to contact anyone, if necessary, to resolve concerns, and I'm sure if the only choice a worker had last year regarding the corrosion would have been to go to the newspaper, that that would have been preferable to not at all. And so I'm concerned that that aspect of their policy be addressed directly by the agency.

MR. GROBE: Billie, I appreciate your comments. I think I heard two specific things that we need to move forward on, or at least I can comment on.

The first one had to do with whether or not the policy that FirstEnergy has issued needs revision following today's presentation, and I ask Lew to respond to that.

MR. MYERS: What I think she's reading is the policy on safety conscious work environment. There's

also another policy on safety culture that -- so there's two policies. And under safety conscious work environment, the intent there was, you know, our corrective action program is our main frame of finding and fixing problems, and that's the way we do probably 90 percent of our problems. If an employee is not happy with that, then there's other avenues up through the management train, to me or to our employee concerns program or quality programs; and if they're not happy with that, they're perfectly acceptable to go to the NRC, you know. And they can use any of those at any time. You know, assuming you're using one of those, you know, we certainly would not think that anyone would be disciplined, you know, in any way, but you know, in our mind, we think if you've got a safety concern, then use one of those -- using one of those avenues is definitely one of our requirements. So that's the way we think our policy is written.

Now, I'll go back and review it based on your comments, but you know, I read -- I've never read it quite the way you're reading it. It's

interesting. So we'll go back and take a look at it. Thank you for your comment, though.

MR. GROBE: And Billie, I hope that any employee at any of our nuclear plants would first raise a concern to the company, and if they don't have confidence in the company or the employee concerns program, that they would come to us. I would be disappointed if their first choice was to go to the media, simply because the media has no capability or responsibility or authority to ensure the safety of the nuclear plant. So I would hope that an employee would come forward to those folks that can fix the problem and have that responsibility first. But I understand your question, that it would not seem to be appropriate to eliminate all that use of bringing issues forward as a performance matter. So I appreciate your comment. Did you have any follow-up questions?

MS. GARDE: I do. I don't want to get into debate, but I really do recommend that you review the law that's available to protect employees for raising concerns and recognizes that the employee has the

right to go wherever they believe they need to go to have a concern addressed, because they can't possibly second-guess the circumstances that they find themselves in to raise that issue.

The second -- actually it's an observation on the presentation today, is there was a number of references to the employee concerns program, and I, just as a member of the interested public here, haven't seen anything that is available for public review about the current ECP program. I know that it has been under development, there's been a lot of things to it. There was reference today of using some independent people. But the last thing I ever saw, other than what I heard today, was that the ombudsman program at the site was -- had very little procedures, had very little structure to it, no formal policy on confidentiality, and wasn't tracked and trended in a way that most ECP programs are. The representations today are there have been those changes made, and I would hope that the NRC would review that or ask for a presentation specifically on the strength of their employee concerns program and

how it operates in a way that the public, certainly informed public could review to make some kind of determination on the strength of that program.

If the plan, as I assume it is, is to restart the plant before -- or at least to hope the NRC will approve restart of the plant before cultural changes have really been able to take hold and a lot of these changes are identified and worked out, the quality and the rigor of an employee concerns program as an alternative is critical. So I don't think it's kind of just one of the building blocks that we can get summary information on. I think it's critical for public confidence to have a lot better understanding of how that program works.

My final comment really is a combination of response to the doctor's identification of how she's going to deal with anecdotal issues that come up within the context of the interviews, and I guess from my perspective as a member of the Millstone review team, which did very similar work to what she is describing, although it's -- certainly we had a lot more than four people

over two weeks in terms of identifying issues. Setting that aside and assuming she can do a job consistent with her methodology that she's set out, I would be very concerned that anecdotal issues that she captures in employee structured interviews or surveys are captured in some manner to evaluate because I will tell you that the depth and breadth of what changed Millstone was responding to the specific anecdotal examples that were inconsistent with many of the kind of broad-based inclusions and objectives that management had. It is at that level. That is on the individual behavior level between managers and supervisors that you really test whether you've got a safety culture that's working in accordance with the goals and desires and visions that you've set out, and rejection of anecdotal evidence because they're one-time events and not -- I'm not saying they have to be included in a way different than other methodology, but they certainly can't be lost.

Those are my comments. There's a lot of material presented today. Unfortunately, I was not available to follow with the written material as

well as you on the phone to be able to study that. And other questions or comments I have I will put in writing.

MR. GROBE: Thanks, Billie. Let me, Bill, do you want to comment on the status of the formalization of the procedure for safety conscious work environment?

MR. PEARCE: Yes, I'll be glad to. We do have the process all written up. It is, as she describes, a formal process. It will formally protect confidentiality as the process, and that's all in there. I've already reviewed it. We're on the very last stages of getting the formal written process in place. I expect it's going to be out within the next week or so. And in fact, at the next public meeting we can report on the status of that, Jack.

MR. GROBE: Thank you. That would be great. I'd -- Billie keyed a question in my mind. I guess I'm a member of the public. I can ask questions.

MR. MYERS: Can I answer?

MR. GROBE: Sure.

MR. MYERS: I think I have the policy in front

of me here, and the way it reads is "FENOC is committed to maintaining a workplace with zero tolerance for harassment, intimidation, retaliation, or discrimination against individuals who raise safety concerns. It's our first mission to not cause or participate in any form of harassment, intimidation, retaliation or discrimination of any individual working at FENOC site. Failure of a FENOC employee to comply with this policy may result in disciplinary action up to and including termination." That's if you intimidate or harass someone, you know.

MR. GROBE: I appreciate your observation, Lew. I think the specific question that Billie raised had to do with if an individual lacks confidence in you folks, your employee concerns program, and somehow lacks confidence in the NRC, it could be construed as going to the media or the public or a lawyer as being a violation of your policy, which would be actionable and --

MR. MYERS: That's not what that's written for.

MR. GROBE: Right. I understand. But if it's

clear in your mind, that's fine. If it's ambiguous in some respects and warrants revision, that's fine too. I think the request was to take a look at it.

MR. PEARCE: We'll certainly go back and review it in that regard.

MR. GROBE: Thank you. And the second half of the question had to do with specific information that is received during the course of interviews. If there's a specific bit of information received in the interviews that would indicate a violation of requirements or a problem at the station, is the review that Dr. Haber is doing going to be plugged in somehow with your corrective action program?

MR. PEARCE: What we intend there -- what I intend; I'm speaking for QA now, not the line organization -- what I intend to do was to go review some of that material after she was done to look for that kind of thing. And because, I mean, there's a certain set of expertise that's required in some areas to understand some of the technical issue. But that's what my intention was.

Now, she raises a good point. Are we

going to collect all the anecdotal information? I don't know. We'll have to think about that and look at it, and I'll have some conversation with Dr. Haber afterwards and see if I can figure out how to do that.

MR. GROBE: I think it's important to not lose the information that's collected, and particularly important that if some of the information provided in response to a question indicates a problem at the plant, that that get into the corrective action program. So I don't know how those interfaces work, but I think those are important connections to make.

MR. PEARCE: Right. But it's going to take someone outside in our organization to understand what to put in and what not to.

MR. GROBE: I didn't say it was simple. I just said it was important.

MR. PEARCE: That's why I said we will review it afterwards and see what there is there.

MR. GROBE: Okay. Billie, did we answer all your questions?

MS. GARDE: You answered my questions. I'm

concerned about this anecdotal thing, capturing the information that, you know, if she's asking employees -- just two examples, are you aware of issues that should have been raised that aren't -- and I don't know if that's one of her questions -- and the answer to that question is yes, I think that has to be captured in a timely and effective manner and run to ground through some process.

I, of course, would not want her to have the credibility and integrity of independence over process compromised, but that really is the meat of her work or the possibility of her work outside of drawing kind of broad organizational conclusions. I mean, you could reject five specific examples and not include them, and they would blow a hole in the whole organizational conclusion if you don't capture them correctly and run them to ground correctly. So I'm going to be looking at, you know, when this whole thing comes to fruition, not just the broad organizational conclusions, what did people say about what their day-to-day work was? Or even, I guess since I don't know her questions, I don't even know

if the questions are going to provide an opportunity beyond, you know, multiple choice or single-word answers to give examples.

But her discussion of rejection of anecdotal issues concerns me because it just raises a whole host of other questions which I've highlightd on, and I'm sure you can pull the strings further, but you see what my concern is --

MR. GROBE: I appreciate your thoughts, Billie. I think they're very well taken. And during the course of our inspection of this activity, we'll make sure that we touch on those issues. Thank you very much.

MCI OPERATOR: Our next question comes from Paul Blanche.

MR. BLANCHE: Hi. This is Paul Blanche. Can you hear me?

MR. GROBE: Yes.

MR. BLANCHE: I know many of you people know me. I've spent 25 years at Millstone through the rise and fall and so on and so forth.

The first comment -- I have three or

four comments I'd like to make reinforcing what Billie said about the procedure for reporting safety concerns. In an ideal world we'd like to have all employees feel comfortable bringing their concerns through management. That's what we strived for and eventually achieved at Millstone. And if they are not comfortable going to management, we encourage them to go to other avenues, such as the employee concerns program, ombudsman program, Little Harbor -- which Billie worked for -- media, politicians, courts, lawyers, public interest groups, so on and so forth.

Let me just read from the root cause analysis report which was produced by Valerie Barnes -- and by the way, I think it was an excellent report. And I'll just quote here. It states, "The operations standards and expectations documents will address (audio cut out) in operations by including expectations for operational personnel to raise any operational concerns. It also contains the requirement for operations person (audio cut out) leadership and resolving concerns by continuing to

escalate them through their management chain, up to and including the president of FENOC until resolution is obtained. Davis-Besse and FENOC senior management expect operations personnel to inform the NRC of their concerns if management does not address the concerns to their satisfaction."

I agree with Billie 100 percent. That sends the wrong message, and in fact may even create its own chilling effect. I communicated that to Mr. Randy Huey with my thoughts on that already. That's a comment, and it just reinforces what Billie said.

Comment on the operations root cause analysis done by Valerie Barnes, I thought was excellent. It was candid and very well done. But reading that and knowing Millstone, I think you have symptoms of the safety conscious work environment that indicate to me it could be worse than Millstone was ever. For example, Davis-Besse has already in the year 2002 received 14 concerns related to discrimination, and over 40 concerns. These numbers are higher than Millstone from 1997 on. That's the only data I have from the NRC. Further, there are

still 23 open concerns with Davis-Besse.

Next comment is it appears as though Dr. Haber is measuring the safety culture. While that's an important measurement, I think what we're really concerned about is measuring the quality of the safety conscious work environment. I'm not sure how that is going to be done within Dr. Haber's work.

The other problem I have is -- was mentioned before. There is no benchmarking of the survey. I realize that Dr. Haber has done a lot of work in foreign utilities, but foreign utilities certainly have their own cultures. I don't know of any benchmarking that can be done versus other utilities such as Millstone and other utilities who have had similar problems. My only question is -- well, I'll make a statement first. At Millstone we have a vice president, Mike Brothers, that was appointed the point person to lead the safety conscious work environment. He did a great job. Does Davis-Besse have a designated overall officer for the safety conscious work environment? And from now on I'll just listen to the responses, if there

are any. Thank you.

MR. GROBE: Wow. I think the question is pretty easy to answer. The safety conscious work environment function reports to the vice president of oversight, Bill Pearce. So I think that's the answer to your question.

I hope encouraging employees to bring their concerns to plant management and to the NRC doesn't send the wrong message, but I completely recognize the observations that you and Billie have made from the perspective of coming from Millstone and other locations when there was a challenging environment, that it's not appropriate to send the message that if they go elsewhere, it would be a failure to follow company expectations and would be actionable as a personnel matter. So that's something that I think FirstEnergy has already taken on board and agreed to go back and look at.

I appreciate your comments, Paul, and we'll continue to look at this. And I do receive input from you on a fairly regular basis through e-mail, so I appreciate that too. Thank you.

Other questions or comments?

MCI OPERATOR: We do have a question from Daniel Horner.

MR. HORNER: Hi. I apologize if this question was covered already. I was off the phone for some brief periods during the course of the meeting. But Lew Myers sort of sketched out what the criteria are for when FENOC feels that it will be ready to go ahead with restart, but I don't have a clear idea of what NRC feels are the criteria in terms of safety conscious work environment for going ahead with restart. What sort of changes -- presumably submission of reports themselves are not sufficient. At least, that's what I gather. But how far along does the process have to be, and how are you going to measure that in order to reach a point where you can say yes, we've gotten to that point now and it's all right to go ahead to restart, at least in terms of this one category?

MR. GROBE: Dan, thanks for the question. That's Dan Horner, H-O-R-N-E-R. It's a good question.

The commission's policy very clearly articulates that each licensee is expected to have a safety -- an organizational focus that allows issues to be brought up and categorized and dealt with according to their safety significance. So the first answer to your question is when FirstEnergy demonstrates that that exists, that will be a benchmark. Beyond that, we will be performing inspections of their implementation of the corrective actions program, the safety conscious work environment program, and this assessment in the management human performance area, and we'll be reporting on those inspection results publicly and publishing them, and that will go into the assessment that the panel will make to determine whether or not the plant is ready to restart.

MR. HORNER: But do you have -- I mean, there was a question as of FENOC, if they have test acceptance criteria. Do you have criteria in mind now that they have to get up to such and such a level before you say go ahead?

MR. GROBE: I'm not aware of any specific

criteria in any of these areas. You speak of such and such a level. I'm not aware of any criteria of that nature. What we will do is, once FirstEnergy documents their process for measuring safety culture going forward, we'll evaluate that and follow their monitoring of it and evaluate their assessment in that area and make our own independent assessment and then make a judgment. There isn't an objective number, you know, when you get to four, it's okay. It doesn't work that way. There is subjectivity involved in this.

MR. HORNER: But the problem really -- isn't there sort of an inherent Catch-22, that you can't really know if they're adhering to this until you see how they're doing with a plant under normal operations? But in order to do that, you have to allow them to restart. How do you get around that?

MR. GROBE: The panel has to make a judgment that it believes that the activities have been adequately completed to address the issues in the restart checklist and that there's sufficient confidence going forward that the plant can be safely

restarted and operated. Part of that assessment is going to include a readiness for restart inspection that will address both the operations and other supporting organizations' readiness to operate the plant safely, and that inspection will include round-the-clock observation of operators in the control room, activities in the plant at a time when a significant amount of the equipment has been returned to service and the operating environment is challenging, probably more challenging than a normal operating plant would be. So it will be a good indicator of the operator's readiness to operate the plant. And those inspections will occur within a few weeks prior to the panel considering the question of whether the plant is ready to restart.

MR. HORNER: Several weeks -- that probably takes a few weeks, you said?

MR. GROBE: The inspection is likely to span a couple of weeks, and it will occur at a time when the plant has returned a significant amount of equipment to service. So that would be sometime around the second time the plant goes to Mode 4, operating Mode

4. That's not in the near future.

MR. HORNER: Thank you very much.

MCI OPERATOR: Our next question comes from Joe Carson.

MR. CARSON: Yes, sir. I'm Joe Carson. I work as a nuclear safety engineer for the Department of Energy. Can you hear me?

MR. GROBE: Yes.

MR. CARSON: Okay. I'm a licensed professional engineer, and I have been in -- I'm a whistle blower also in the Department of Energy. And I haven't heard today -- I've been listening, I think, to almost everything -- I haven't heard anything about the relevancy of engineering ethics and/or professional engineering licensure to the Davis-Besse situation. And I guess my question is if it's not relevant, then I question why there should be PE licensure; and if it is relevant, why it's not being identified as such.

MR. GROBE: It's a -- I appreciate the question. It's a very interesting question, and we've had some interaction with the State of Ohio on

this question. I don't believe there is anything at a nuclear plant that is dealing with nuclear safety that requires a professional engineering certification.

As you're well aware, professional engineering certifications are required for various engineering activities, but the NRC regulates the engineering quality at a nuclear power plant for those activities that affect nuclear safety. I don't want you to infer that ethical conduct is any less important because there is not a requirement for licensure by the state as a professional engineer, and we have very clear requirements on the responsibilities each individual, as well as the company, has to follow regulations. And those are issues that we would follow up on if they became apparent. So it's -- a professional engineer license is not required to express engineering judgments to approve engineering documents affecting --

MR. CARSON: I understand it's not required and it's not required because the State of Ohio has what's called an industrial exemption. It's really

not because of the NRC. It's because of the industrial exemption. But FirstEnergy could, on its own, say, "independent of the industrial exemption, we want our engineers to be licensed." If they were were licensed, they would be just as subject to the jurisdiction of the Ohio state board as any other engineer who needed to be licensed. So that's my -- if FirstEnergy seems to be saying, "we're doing everything we can with respect to safety," this seems to be something -- engineering licensure is all about public health and safety and creating an independent legal accountability for it and obligation for it. Could this also be a -- not required, I agree, but just an appropriate means to be evaluated? There's nothing that stops it. Let me put it that way.

MR. GROBE: I appreciate your comments, and FirstEnergy has heard them. We believe that the NRC has appropriate regulations and oversight of the behavior of people at nuclear power plants, but I appreciate your comments. Thank you very much.

MCI OPERATOR: At this time we show no further questions.

MR. GROBE: Okay. Are there any other questions here in Region III?

MS. LIPA: I'd like to make one comment. This was a person who comes to a lot of our public meetings who was not able to be here, so she sent some comments in, and her name is Donna Lueke. And her comments were in the areas of making public safety a part of every corporate document at FirstEnergy and then also taking safety culture lessons learned from Davis-Besse and applying those to other nuclear power plants. And we will be making her comments part of the minutes from this meeting.

MR. GROBE: Thank you, Christine. Could you also provide a copy of that to FirstEnergy so if there's something specific about Davis-Besse, they don't have to wait for several weeks to get the transcripts?

MS. LIPA: Yes, I will.

MR. GROBE: Thank you.

Operator, are there any additional questions or comments at this time?

MCI OPERATOR: We show no further questions.

MR. GROBE: Okay. Thank you very much.

With that, we'll adjourn the meeting. Thank you very much.

(Which were all the proceedings held in the above-entitled cause on this date.)

STATE OF ILLINOIS)
) SS:
COUNTY OF DU PAGE)

I, MARY N. LEAHY, C.S.R., Notary Public duly qualified and commissioned for the State of Illinois, County of DuPage, do hereby certify that I reported in shorthand the proceedings had and testimony taken at the hearing of the above-entitled cause, and that the foregoing transcript is a true, correct and complete excerpt report of the entire testimony so taken at the time and place hereinabove set forth.

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