What I wanted to talk about too was some strengths and weaknesses that we have in the program and I brought some observations along too, to read some of them to you.

The biggest weakness that I see right now in the observations is the housekeeping in containment. And I have a couple examples of some observations from people that went into containment. I was going to tell you what they found and what they did about it.

The first example I have is a shift manager went out and conducted a paired observation with a couple of other people in Ops. And they found that the conditions were unacceptable. And they added the containment sump and the 565 level inspections back on to the Mode 6 restraint list.

Another example is a superintendent in Ops was out doing a safety and PPE usage in containment observation. He found debris, such as tie wraps, loops plastic, tape, et cetera, and they were removed from the 565 level. So, what he did about it was he contacted the project manager, and they drafted up a paper; it was a position paper; on what conditions are acceptable.

And he wrote this position paper and it describes, like I said, the acceptable conditions and it also has a handout to it. They gave this handout at turnover and they gave it to all the containment managers. So, this is a

sheet of paper that they are using. It's a summary of what is acceptable and what is not acceptable.

MR. THOMAS: Kathy, you're discussing housekeeping issues and lower level of containment. Maybe someone could describe why that's important, based on your present plant conditions. I don't know if that's clear why those are important issues.

MR. POWERS: Housekeeping is important down there, Scott, because we've got our containment emergency sump construction complete to the point where the upper portions of the sump is available to the systems, and we utilize that sump as part of our defense in depth for shutdown risk.

It's a piece of the equipment of the plant that we want to make sure is available to us, should we need it from a shutdown risk perspective. So, we keep the areas clean, so that the sump remains available and wouldn't be clogged by any potential construction debris.

MR. THOMAS: Thank you.

MS. FEHR: Another one of the observations that I brought along was, a manager was out in containment and they were surprised that the lack of supervision around the RRA area. So, what I did was scheduled observations and I had people sit out there for, I think it was, I think I scheduled five observations that

week for that.

And one of the people did an observation. He went out there for six days and sat at the entrance of the RRA. And he sent in an observation with his statistics on what he found.

He said he saw 34 people entering the RRA and 53 exit. And the bottom line was, two persons were turned back to their supervisors due to inadequate understanding of work scope.

So, the weaknesses are being found out in the plant and there is on the spot correction of the problems.

Some of the strengths that I found is a lot of teamwork going on. This is, this is what I see of the observers writing about the observees. They see a lot of teamwork going on in the plant. I have a few observations here to give you examples of when they were, I think this was maintenance, they were lifting some barriers, and they wrote in their observation; they stopped and they went to get engineering assistance, so they could ask what size pipe to use.

I have an example of another person who was told that they needed to get engineering involved in the walkdown, along with RP, so they all agreed on how the situation would be done to begin with, at the beginning of the, at the beginning of the project.

I have another observation, and the activity was unplugged drain lines in the collection box. This observer mentioned notifying chemistry, RP was notified to take readings, and they stopped and they contacted Ops to make sure the flow was reestablished. And the strengths that this person did identify was teamwork and support from other groups. So, the groups are working together out there. We're seeing that in the observations.

Another example of teamwork was a core support assembly, when it was moved from the deep end of the refueling canal to the reactor vessel, this observer noticed great teamwork by FTI, and, which is Framatone and RP.

The other strength that I find in this program is, I can see a lot of what the observers, which is what management is doing out there within the field, and how they're reacting to what they're finding. The things I find is they're doing follow-up observations with what they're finding. They're going out there correcting on the spot. They're writing CRs. And, I have a couple of them just from this past month where they would go out a couple days later and they would find out if the situation was still occurring.

I have that, some examples of a superintendent of Ops that did that. He was out watching fuel handling in

containment in the spent fuel pool. He noticed the self-checking for the containment side operator of the transfer mechanism; they didn't stop; they didn't pause before their peer check.

So, this observer went out and he went over and he checked both sides of the spent fuel pool and the other operators out there to see if this was common; if they all knew this was just a problem. He found out it was just a problem with the one operator. What he did was he discussed it, discussed it from becoming complaisant and standards for self-check. That's what he discussed with them.

Then I noticed a couple days -- it was the following day, he went out and did an observation on self-checks just to make sure it was satisfactory.

So, I have some more examples of the follow-up that the managers are doing. Here's one from a person. I love these.

He was doing an observation of a prejob brief. And, what he did was -- I'll read it to you. The prejob brief form was completed and the work order package. The prejob brief form was not signed by both technicians on the job; however, both technicians stated that they attended the prejob brief. So, this observer questioned the technicians to determine if they were properly briefed; and he

determined that they were, but he questioned them for follow-up.

So, in conclusion, I think the Management Observation Program has had some positive, positive effects on what we're finding in the people at Davis-Besse. I do believe there is room for improvement with the situation with housekeeping in containment. That's why we do the scheduled observations.

Did you want to add anything to it, Lew?

MR. MYERS: I think, I just think it's, in September at these meetings you kept asking us, you know, what are you seeing; what are you getting out of the program. It was new and we had a little trouble, difficulty answering that. But I think today our data base is much improved, and we can tell you what we're finding, and I think we demonstrated that. So, that was the intent here.

MR. GROBE: Okay. Questions?

MR. DEAN: I have a couple questions. One is, you know, in your slide where you have the observation percentage by title. You have varying levels within the organization that are out there doing observations.

How do you assure that there is some consistency in the way these managers look at what it is they're looking

at in the field? Is there something to find that they can refer to for expectations in particular, work activity that they're looking at, or are they just out there kind of winging it in terms of...

MS. FEHR: We have set questions on the cards in which they answer. They all read the field observation card or the Ops observation card or the training observation card.

MR. DEAN: So, you've got several categories, so that gives you kind of a checklist approach.

MS. FEHR: Correct. We go from prejob -- there is probably two hundred questions on each one of the cards, and they go from prejob briefs to housekeeping to safety to FME. There is a lot of questions on those.

MR. DEAN: Second question I have is, obviously, a program like this sets itself up for collecting all sorts of data, you talk about percentages of this, coached, uncoached, so on and so forth.

Have you set some goals or expectations of the program itself that you would consider to be valuable measures? Like, for example, you talked about 90 percent were done as scheduled. I mean, do you have some goals that you have for yourself in terms of things like that?

MS. FEHR: We do have goals for the scheduled observations, which is 90 percent or better. We also have a goal for coaching within FENOC; and we go with ten percent or better is what we're looking for with coaching. And that's all interaction with the field.

MR. DEAN: And then the last question is really one maybe more for Bill, is obviously, you talk about generating CRs out of this, which is good. You want to see these types of things, feed them to the Corrective Action System.

Bill, in the observations of your organization, do you see some sort of congruence here in the types of observations that you have had from your people in terms of in-field observations and the types of things that are coming out of this program?

MR. PEARCE: Yes, we do and I'll go through some of these in just a moment when I talk.

MR. DEAN: Good, thank you.

MR. SCHRAUDER: I think the challenge for us going forward, we are doing observations. We are doing better, but a lot of us aren't as trained. That's not been our forte of doing focused observations. Organizations like ~~IMPO~~ INPO, the NRC, their inspectors or their observers seem to have their skills honed much better than

we do. So, we're looking at methods to hone our skills in the art, if you will, of observation.

Some of the things will jump out at you. Like a guy standing on a CAC, it's not too difficult to figure out that's probably not the right thing to do, but there are some other subtle types of things that can come out of field observations and stuff; and that's where we have to hone our skills a little bit better.

MR. GROBE: Feed them raw meat. (laughter)

A couple of questions, you sort of by percentage have who is doing the observations. Do you also have the capability to sort by departments or functions or work groups?

MS. FEHR: Yeah, we have that, that's a candid report. Some of the reports that are in the program right now are available by anybody who uses this program. And they can just, any time, at any time and place, they can get these reports of the departments.

MR. GROBE: And can you do that both on the who is doing the observing as well as what the outcomes are?

MS. FEHR: Correct, we can check the observee and we can have the departments check on what people are finding about their departments.

MR. GROBE: Do you produce a a periodic report of some nature that you provide?

MS. FEHR: I don't currently right now. What I do, is the managers go over it weekly or monthly with their people and their departments, and they discuss their findings. I know maintenance and I know operations go over weekly and they go over them.

MR. GROBE: If you could just pull together a set of the various standard reports that you have, pages, I would like to see those at some time.

MS. FEHR: Okay.

MR. GROBE: Thanks.

I think it's one of the observations that you highlighted, the individual used the word complacency, and I think that's real important. I hope folks aren't taking these numbers and trying to say, you know, 2.8 unsatisfactory coached is not good, and 2.7 is good, because I think that's, that's kind of silly. As soon as you stop looking to improve, that's when you start declining in performance. And it's very important to have coaching in the field.

So, we've just got to be a little careful with some of these numbers, I want to make sure we don't inappropriately use them.

Any other questions?

MR. THOMAS: I have one more question. The discussion about the CACs, I was looking through the program and I didn't see a better place to ask it, so I'm going to ask it here.

Specifically, with the service water tree installation, and with a lot of your other projects that are ongoing, you've used the at risk change process, significantly, ~~due~~ to a large extent. You used it liberally, I guess. Specifically, with the CAC service water tree installation work, and you can expand to other projects if you like in your answer, have you seen that that's, the use of that process has caused any challenges?

MR. POWERS: I would say, what we're talking about, what Scott is alluding to on the at risk change; it's an engineering work release to the field that is, it's like a preliminary engineering design. We haven't completed all the details of the full package yet, but it's been worked enough that we feel comfortable that we can release work and begin working in the field, and if we find any changes that need to be made as we finish up the formal package, then we have to suffer the cost of rework, but there is no nuclear safety or industrial safety risks associated with it. If there is a risk, commercial risk is what we're talking about.

But, yes, the CAC service water distribution trees

have been the most significant issue that we've had with our process for work release to the field. The expedited process under the at risk has not had the level of interaction with the installers, the field craft and supervision, as well as what we found recently in evaluating this, the plant engineers and operators or others that we need to engage in this process.

And so, we found some good lessons learned with that process with the CAC trees, but we haven't seen that level of issue in many other projects that we've had. This one has given us an opportunity to improve in those areas.

MR. MYERS: Let me answer that question too. The answer is yes.

MR. GROBE: That's a very interesting question. I appreciate that, Scott. Let me take it a little further, if I could.

You had a number of observations in the containment air cooler design issues that might have to do with interface between design and system engineering, interface between design and maintenance, interface between design and operations. Was that process less effective because you were using the at risk modification approach, or did those reviews occur before the installation began?

MR. POWERS: In the case of the CAC trees, the process was less effective with the at risk

change. So, the answer again is yes, there was some issues there that needed process.

MR. GROBE: I need a little more of an answer there. When you do an at risk mod, you're doing at risk because you don't have all the design work done, but has op -- are you doing that modification before you've integrated the insights from Operations, Maintenance and Plant Engineering?

MR. POWERS: In some cases, yes, Jack.

MR. GROBE: So, you really have some substantial financial commitment before Ops, Maintenance and Plant Engineering get involved.

MR. POWERS: That's right. And in cases such as the emergency sump or the decay valve tank, now that we've lined, it's a static structural component and there is not a lot of input in terms of Operations and Plant Engineering and such.

For the CAC tree, it was a rather special case in terms of the long term inspectability in taking those CAC trees off. And what we found was, it was really found in the field once the craft began working with the ~~fellows~~ bellows trying to maintain alignment and control the welding distortion, welding up the stainless steel work piping connections. That began to become apparent that

disassembling that and controlling that alignment would be, would have some difficulty. So, that's what arose on that particular issue.

MR. MYERS: If you go back and you look at the entire outage, you know, typically, outage you would build your modifications months and months and months before you come down, order all your parts, do your feasibility reviews up front, all your walkdowns and everything else. We're doing a lot of discovery and we're building the ice while we're here. So, that's driving some of the at risk changes.

But, even early on, if you think back, you know, we're cutting the containment. We had some issues with some modifications. We had some issues, installation of the head. Had the crane issues, you know. That was an at risk mod. You know, it is not a, this is not a typical outage. This is not a situation that I think is the best way to do modifications. That's where we're at.

MR. GROBE: Sure. It's important to understand that. That this outage is not a normal outage, and these modification approaches are not what you would normally expect to occur, but it's, you still have quite a few modifications out there, that you're installing under this at risk program. Have you gone back to look at those, as to whether or not there might have

been some, there might be some additional benefit with respect to Operations and Maintenance in particular, Plant Engineering?

MR. POWERS: We'll be doing that. The issue on the CAC has really come up over the past several weeks, I would characterize it. This interface has become evident we need to do it. So, yes, there is cases we need to go and look and see if there is better interface needs to occur up front.

MR. GROBE: Okay, good. Thank you.

MR. PASSEHL: Okay. I think we'll, if it's okay, have one more presenter, Bill Pearce, and then we'll take a short break. So, go ahead, Bill.

MR. PEARCE: Okay. I want to talk about three subjects today. First one I want to talk about is Safety Culture Survey. And, as you remember, this is an independent assessment that's being coordinated by Fred Giese out of our Human Resources Organization in Akron. So, what I'm going to read is his statement where we are on this assessment.

Doctor Sonja Haber and her team have completed the on-site portion of the Davis-Besse Culture Assessment. And the activities that are completed are they interviewed approximately 90 FENOC employees. These included Senior

Management Team, FirstEnergy corporate executives, all Davis-Besse site managers, and representatives from various job titles and organizational elements throughout the plant.

The second part of that was they observed, her team observed a number of normal plant activities, including morning and evening meetings, control room turnovers, manager meetings, prejob briefs, planning meetings and restart readiness meeting.

In addition, they conducted a pencil and paper survey, which included approximately 80 percent of the site employees, the permanent employees. That's approximately 661 of 830 employees that actually filled out the survey.

Doctor Haber and her team are currently analyzing the information they gathered in those activities. And, as you remember, they do a process they call Convergent Validity. That's where they bring all those elements together and come to conclusions how they may relate to the culture, the safety culture aspects of the plant.

So, that's what they're in the process of now doing; and we expect that we'll get some initial results in the next several weeks. And, that's really the status of just to give you, because I know everyone has a lot of interest, as we do, to get that back.

The next subject --

MR. GROBE: Bill, before you go on, just a couple of questions in that area.

Lew, I know that this assessment that's being done by Doctor Haber is very important, but it's important to keep it in context. And, prior to entering Mode 6, you folks did your own assessment of where you were, using your model, and I think that was the first time you tried to use it. And, you presented that last month, I believe.

MR. MYERS: Correct.

MR. GROBE: Lew, I know that you sent out the first formal procedure for going through that process, and you're going to use it again next week. Then, I think, I understand that after that, you're going to revise the procedure appropriately after running it through its paces and then submit it on the docket; is that correct?

MR. MYERS: That's correct.

MR. GROBE: Okay, good.

And Doctor Haber's work is somewhat of an independent check, not, it's important to make sure that folks understand, it's not a go-no go. It's not a light switch, yes or no. That it's going to provide insights and inputs to further enhance the broader assessment tool that you're going to be using on a regular basis going forward.

That being said, it's also very important though

that Doctor Haber's work be completely independent so that her observations have validity and haven't been influenced by your processes and activities.

Could you talk a little about the process and how she's going to, how there is going to be independence maintained through the process. I don't know if that's a fair question for you, Bill?

MR. MYERS: I can't talk about it, because I don't know.

MR. PEARCE: We can say some things about it. I think what you may be referring to, is when we do get the initial report back, the NRC and site management will view that report simultaneously, even the initial report. The first time we see it, the NRC will be involved. We've made that agreement, so that we make sure that it is done independently, and it doesn't get, we don't have undue influence on it. I think that's probably what you're asking for.

MR. GROBE: Yeah, that's good. I appreciate that, Bill.

MR. MYERS: Let me add. We went out and developed our process. We think it's a good model. We shared that with you. It gives some framework. But the last thing, from my perspective, you know, the reason we put it up for the human employee development

organization, was because from a leadership in action standpoint, that's how we use our training program, to develop our managers, supervisors, that's where it's owned at; they're doing the core sponsors for that.

So, the last thing from my perspective anyway, sitting here, I can tell you I've been interviewed. Other than that, I have had no contact with Doctor Haber since she left the site. Other than being interviewed and taking the, looking at the survey that we did, that's, it's completely independent. And, it will stay that way.

MR. GROBE: Okay, good.

Bill, you mentioned something that's important. Doctor Haber is going to provide you a written draft. And myself and Christine and probably ~~Jeff~~ Geoff Wright, our team leader for that inspection will be there to hear her presentation.

Do you know if, have you considered whether that written draft report will be an attachment to the final report, so that if there is any changes in the interpretation or conclusions that that can be clearly understood?

MR. PEARCE: Jack, we don't know. We haven't seen it. We need to see it and understand, when we've got it, we can talk about that at the time.

MR. GROBE: Maybe you can mention that to Fred and he can give me a call.

MR. PEARCE: Okay.

MR. GROBE: Credibility on this is very important.

MR. PEARCE: Absolutely, we agree with that.

MR. GROBE: You folks lost some credibility over the last few years and so has the NRC.

MR. PEARCE: Yeah, and you know, one of the things that's really important to us, I think, is the congruence between what she comes up with and how we've evaluated ourselves. We really are anxious to see that, to see where that congruence is; not so much to try to change it, but to understand are we looking at ourselves properly in using the tool that we're using. That's what we want to try to validate. That's what's really important, I think.

MR. GROBE: Yep, I agree. If you could mention that to Fred then.

MR. PEARCE: I certainly will, I'll be glad to do that.

Okay, the next subject I would like to talk about is Safety Conscious Work Environment Survey. We've talked

about this on several occasions. I know, Jack, you had some interest in when we were going to do the next survey. As I told you in previous meetings, we intended to do the survey after we did the heat up and cool down. That's moved out some now, and it's gone further than we thought it was going to go a couple of months ago.

So, we've decided to go ahead and do one now, because we want to get one periodically and have the opportunity to do yet another maybe sometime near the time we restart.

So, you know, our Safety Conscious Work Environment Action Plan provides for periodic surveys and the next one, as I said, is going to be on March 24th. The survey will consist of 30 questions. The majority of the questions will be the same as the August of 2002, and the January 2000, and November of 1999 surveys.

Another point about the survey we're going to do, is all the 21 questions that are in the standard industry document will be included in that survey. So, it will have all the standard questions. And, in addition, we're going to add some questions, nine more questions to that survey, surround, that surround some specific issues that we seem to try to get some more insight into the Safety Conscious Work Environment.

The rating scale will be the same as the previous

survey. And it's to be a pen and pencil, or pencil and paper method. The same as the survey that was just done on the Safety Culture. In fact, we're going to use a similar methodology, because we got a lot of good participation in the Safety Culture survey. So, we would like to use that same methodology, how to set up people that they can take it, that kind of thing, is what we're going to do on the 24th.

Of course, it will be anonymous. It's voluntary, but we do encourage all, all our site employees to participate.

You got any questions about that? We're going out of that subject now.

MR. GROBE: No. Great.

MR. PEARCE: Okay. The next thing I want to talk about is Quality Assurance. And, as you know, we committed to do a Quality Assurance Program Review, I think it was last October. And so, we started doing that review, and it started on November 1st of 2002. And, we brought a team of people, expert in this area, and we wanted to look at our program, and determine, you know, what are the, make sure we had everything in it that the best programs in the country have.

So, we found some improvements we could make in the area of implementation of commitments, audit checklists,

use of operating experience and auditing, training, qualification of auditors, escalation of inadequate actions to audit findings, and interference interface issues with American Society of Mechanical Engineers QA Program were areas that we found we could do some improvement with.

It was initially completed and went before the Program Review Board on February 10. When we got it before the Program Review Board, they thought we, that we hadn't focused enough on the ASME, or the American Society of Mechanical Engineers QA Audit Program. We didn't have enough focus in that issue.

We went back and revisited that area again. We completed that re-review. And it went to the board again yesterday. And of course, I haven't got the update in here, but I'll tell you the update. The update is, it went successfully through the board yesterday. Not saying it didn't have any comments. It did have some comments to it. And Thursday, it is expected that we'll get the final review of that Thursday morning. That's the status of that.

Lastly, I would like to talk about a few things that Quality Assurance has seen, what we've looked at. We've done oversight of the new reactor head. And you asked about the, in fact, you led in quite nicely with the At Risk Program. Of course, it all has to come together at

the end with a modification package, so it doesn't miss any of the steps.

We've been reviewing that with the new reactor head. What we found as the package was put back together, there were some, we did have some issues of process. They were, they were fairly minor in my opinion. I looked at them.

There is a small amount of work remaining, which is installing the seismic plates on the top of the drive for the control rods, and post insulation testing, which is part of the pressure tests of the reactor vessel that we'll be doing later on. So, that remains to be done.

Restart Station Review Board Oversight. We believe that conservative decisions are being made during that board, and good safety culture discussions are being done in our observations. No major issues. We do see a few minor things, which we gave feedback on or wrote CRs as appropriate.

Another area I would like to talk about is fuel handling. Lew talked earlier about a, about the fuel handling that was being done. And, in fact, we loaded the core. And I would like to talk about that a minute.

As you know, we had a stop work on fuel handling, and it was about what Lew talked about, about some of the design issues and we'd done some minor damage to some of

the fuel in the past. And we lifted that. And we lifted that stop work before we loaded fuel.

What we lifted it on was these four issues. We reindexed the spent fuel racks to have more precise indexing to make sure that we didn't have any interaction between the fuel grids and these fuel racks.

Fuel assemblies were required to be moved in slow speed in the refueling equipment throughout. That was a change to the process.

The core reload sequence was designed to maximize open water moves and minimize potential for unnecessary fuel assembly interaction. So, consciously, we're trying to make sure we didn't have those interactions that we did have one of.

And most fuel assemblies would be loaded with a, into the core with what's called an open water move, but we have a device where we can actually move it around, and make sure that it moves exactly in the right spot and is not subject to interaction between the grid.

So, those were the corrective actions that were put in place, as a result of our stop work. And we lifted the stop work. And then I think we had a fairly successful core load.

One of the things I would like to say on the positive side, is Lew talked about the fact that the core

support assembly was removed from the reactor. We oversaw that activity, trying to clean, make sure that the reactor vessel, the entire internal of the reactor vessel were clean.

The station spent a lot of effort trying to clean with a core support assembly in place, and, in fact, they did remove a lot of minor material from the reactor. And, I really believe that they could have evaluated the condition that it was in to be okay, and justified that it was all right to go on. That's what I want to give. I give a lot of negative, I want to give a positive. They actually stopped and took a five day hit in the schedule in order to make sure that the, that the reactor internals and the reactor itself was absolutely clean before we went forward.

So, I saw that as a good thing. I'll go down through a few more issues. The In-Service Inspection, see some implementation issues and Condition Reports we've issued in that area.

And the Quality Control area. We previously rated the Quality Control Department as marginal for the previous quarter, and the issue was lack of use of Corrective Action Program. That just wasn't enough activity, we didn't believe, to, for where it should have been for the type of things we're seeing in the plant. And, since that time, we

saw a marked improvement.

Contractor Control. We still saw issues with Contractor Control. We'll talk about that more in a minute. I think that's been an issue we've had ongoing, and we continue to have, and we're trying to provide a lot of oversight in that area.

We did a, an assessment of Safety Culture, an independent assessment that we did ourselves in QA. And, we didn't -- and I think we talked about it, I don't remember if we talked about it at the last meeting or the last public meeting, but we assessed about ten percent of the site population, and we looked at Safety Conscious Work Environment and Safety Culture. And we believe from the assessments we've done previously to this one, that we're seeing an improving trend in what we're getting.

These were all face-to-face interviews and a specific set of questions that were asked, and we think that we're seeing an improving trend in that area.

Corrective Action Program implementation, we're still noting problems with clear and concise corrective actions, and incorporating appropriate level of detail. Traceability, you can look at the condition report always, and we're seeing a lot of them, and there is a few of these that, where we'll see the condition report and the issue identified as the corrective action. Actually go back and

fix the problem clearly without having to find out a lot more story besides what's written down. That's one of the major issues.

Last summer, you may be familiar with, we identified a compliance issue in the fabrication code for the feedwater flow modification that needed to be radiographed. Well, the radiograph was performed and identified that three welds needed to be repaired, and that's ongoing as we speak.

And the last thing I wanted to talk about, and this is probably one of the most significant things that I'm concerned with; is we're concerned with the quality of work being performed on mechanical equipment. You said something about several instances of that. What we witnessed is inconsistent results on equipment. And sometimes it comes out pretty good, and other times it doesn't.

We have an issue with that; talked to Lew in depth about that. One of the options we're considering, I'm just telling you we're considering it; one of the things about moving the Quality Control Department back under the Quality Assessment, so we can get more field observation time. We're a limited size group, and to combine those two we get more time in the field in not only the Management Observation Program, but in addition, the Independent

Program to see if we can see what we need to do to improve the quality in that area.

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

MR. HOPKINS: I have a quick question. You mentioned the feedwater flow modification. Is that connected to a power upgrade request at all, Jim?

MR. POWERS: That is the caldon, excuse me, Jon, that is the caldon, the install power ~~upgrade~~ uprate request, it's related to that. And these were field weld installations and the MBE interpretation on whether radiography was required on those.

MR. HOPKINS: So, radiography was done on that?

MR. POWERS: Yes.

MR. PEARCE: And the weld that remained, trying to get the radiography rescheduled now after the repair.

MR. HOPKINS: Just, just so you know, we essentially have suspended review of power ~~upgrade~~ uprate at this time. I mean that's coming later, if it happens.

MR. POWERS: Very good. As well with us, that's not our first order of affairs either. So, we'll be in contact when we want to reactivate that.

MR. HOPKINS: Okay.
MR. GROBE: Other questions?
MR. PASSEHL: Okay, let's take a --
MR. GROBE: I was asking for questions from you guys. I have a couple other questions.
MR. PASSEHL: Oh, okay.
MR. GROBE: Bill, on the Quality Audit Program Review, was that a review of both the program and the implementation of the program?
MR. PEARCE: Just a review of the program. It puts the program together in place. Now, we're putting all the actions that came out of that in place is what we're doing now.
MR. GROBE: Okay. Good.
I was looking through a little booklet that you folks have for your Operations Organization. I can't remember what it's called. It's got a yellow cover on it. It has all the procedures and standards and expectations in it. In the org chart in there, I notice that Mike Ross' name was in the Ops Organization. Is he back in the Ops Organization now? I ~~now~~ know that you took him out for awhile.
MR. MYERS: No, he's not back in yet.
MR. GROBE: Okay.

MR. MYERS: But Jack, he's still providing coaching.

MR. GROBE: That really gets to my question. There is a couple of areas that I would appreciate some independent observation from your folks on, thoughts on how you're doing, maybe at our next meeting. One is the area of operations ownership and leadership, and the second is operability evaluations.

And, I thought if Mike was back in Ops, maybe he could provide some input. And Bill, I would put that to you to provide some input, but those are areas where I don't have a good read on how things are going and there has been some issues coming up, and I would like to get a better, we'll be focusing a little bit more in that area, and I would like to get a better sense from you folks in what you think.

MR. PEARCE: We'll try to give you some insight on the next meeting, Jack.

MR. GROBE: Okay, thanks. Thank you, Dave.

MR. PASSEHL: Let's take about -- everyone be back by 4. Thank you.

(Off the record.)

MR. MYERS: We have a couple new players here. Lynn Harder is here to talk about

Containment, and Clark Price will go through our performance indicators later on, so we've done some rotation of people.

MR. PASSEHL: Bob, are you going to talk System Health progress?

MR. SCHRAUDER: Yes.

MR. PASSEHL: Okay. Go ahead.

MR. SCHRAUDER: Thank you.

System Health Progress. We continue to make good progress on answering the questions, the Condition Reports that were generated during the System Health Readiness Reviews, the Latent Issue Reviews, the NRC Inspections and the Safety Function Validation Project.

A lot of the analysis for the operability and functionality of those systems are starting to come back, and looks like we're going to be able to demonstrate for the most part that the systems will and could have performed their intended function.

Not all of the analysis is back and not all of the systems are as far along as others. One notable one that we're, I would say behind schedule on is the Electrical Distribution System, and the calculations for that; they're similar to the water flow calculations with the flow electrons. And so, we're behind on the electrical distribution, but we have some corrective actions in place.

We'll try to get that more organized and completed.

We have scheduled a meeting, I think the meeting is scheduled now. I'm not sure of the date, but I know we're working on scheduling a meeting to go over in more detail all of the design issues that we've identified. But today's meeting topic I want to concentrate on are the topical issue reviews we've done. I would say in adjunct to the Safety Validation Project.

There were five of those topical issues that we had identified. Four of them are through the review process and are ready for Lew's signature. In fact, I believe he signed one of them. The final one, Appendix R - Safe Shutdown Analysis is in what I'm calling the final stages of review, and I expect that will be ready here very soon also.

Just real briefly again, the Collective Significant Reviews, how they came about, we had done the System Health Assurance Plan Reviews and they had identified some potential cross-cutting issues. The initial Collective Significance Review identified five topical areas that warranted further evaluations. They were Seismic Qualification, Station Flooding, High Energy Line Break, Environmental Qualification and Appendix R Safe Shutdown Analysis.

I went over this last meeting very briefly, but we

did institute a NOP, Nuclear Operating Business Practice, for collective significance reviews and had the process we used to evaluate these topical areas. The process was to look at all the Condition Reports, that had been identified, ~~been~~ "bin" in common areas; evaluate each and determine its significance to the program, and then conduct ~~extended~~ extent of condition evaluations where warranted.

We didn't just look at the Condition Reports that were generated as a result of those System Health Readiness Reviews and Latent Issue Reviews, each of the program owners actually went into the ~~CRS~~ CREST Database and searched that database and pulled out and identified Condition Reports that went back to, I believe it was, January of 2001 is what's the ~~CRS~~ CREST Database. So, we went back an additional year and pulled those issues out, and also reviewed those in the Collective Significance Process.

I forgot to ~~mentioned~~ mention as we finished those, I don't know if we forwarded them yet, but we had told Marty Farber that we would send those reports to him as part of his inspection plan on the System Health Building Block.

I'll go through each of these five topical areas. And, again, I want to remind you that when I talk about Appendix R, that that will be preliminary information, but I don't expect it to change significantly in the review process.

What I have done is broken down each one of these categories into actions that we found that we need to take to support restart, and then what I call enhancement items to go forward. I'll talk about how we get out to those actions, what we found, and why that's an action.

So, under the first program or topical area I talked about is the Seismic. Reactions to support that, I would say, evaluate impact of Cooling Tower Makeup Pump not in accordance with the USAR. We found some seismic category one issues on that, where that, the documentation, if you will, the USAR and PID identified that that ~~typing~~ piping, which is in the proximity of the service water pumps, it was supposed to be seismic category one. The Condition Reports said it wasn't; it wasn't installed seismic category one.

So, we did, first of all, we evaluated that Condition Report, applied SQUG methodology and found it would withstand the appropriate response spec for the earthquake.

We did find some improvements that there was a higher than expected stress at the mounting bolts in that pump; that we'll be changing the bolting configuration on that. But as a result of that issue, we did an ~~extended~~ extent of condition review ~~seeing~~ screening, looking at other potential impacts of ~~doable~~ two over one criteria, particularly impacting multiple trains or multiple systems. We did that review and found

no additional problems in that area.

The next one is ~~revolving~~ resolving boundary conflicts between Seismic and Quality classification. That came as a result of a couple Condition Reports that identified what I'll call conflicts that was introduced into the database system where a Q boundary ends, quality boundary ends, but seismic category needs to extend down stream further to an instrument.

We looked at that once before and addressed it pretty well for pressure gauge, but hadn't addressed it I'll say thoroughly enough for other interests. It also may need to perform a pressure retention for seismic readings.

We went through that, looked at ~~extended~~ extent of condition on that one also, identified where those Q boundaries were and what down stream instruments might need to be assessed. We have about two hundred instruments that we have to go back and look at to make sure that the seismic properties and the pressure retained properties of those instruments are appropriate. That activity is in progress.

The next one that was another example we did. HFA relays, that's an issue where very early in the life of the plant, General Electric had sent out a service information letter on these relays identifying that they need to be calibrated.

We didn't get the information from the vendors because we had purchase ours through a third party. That third party did not forward the information to us. We're looking at the process to make sure we plugged that gap, so we get all that information.

We did an ~~extended~~ extent of condition on those HFA relays. Identified there were in fact six of them that we had to calibrate to make sure, these were chattering in the relays, and whether it could prohibit actuation of a safety function that the relay needed to do. We hadn't had any problems with those, but some of those did need calibration that were identified in that service information.

Then, the other ~~extended~~ extent of condition, which is actually part of the Containment Health Walkdown was impact of boric acid on the side supports. We did that and found that was not a problem for us. Each of those had some activity in the containment to work on.

Other improvements we're going to make in seismic going forward is, we'll fix this confusion on the database, Q boundary, and seismic boundary.

Procedural requirements of control of temporary equipment, we found this begin is two of one type of issue; work in progress, we weren't being as diligent as we should have been retaining that two over one criteria. So, we're beefing up procedures in that area, and also for storage of

breakers and the like and their impact on seismic qualification equipment.

And then we're going to pull together all the seismic information programs, procedure to get through that information. And we'll be looking at using the SQUG methodology for new and replacement equipment. So, that's kind of what we found in the seismic area.

There is a lot more details and stuff in the report. We'll give that to you, go over that, and assess the impact of that.

Next area, I have is station flooding. I put that one next, because it really is very closely related to the seismic issue. In fact, you see the very first issue is the same issue I talked about on the Cooling Tower Makeup Pump, which is because the impact is, if that breaks, then you flood the service water, so the same issue becomes a flooding issue also. So, I've already talked about that. I won't go over that again.

There was another Condition Report that questioned the flooding in the service water tunnel. Now, user identified service water tunnel under certain conditions floods. And equipment was evaluated in there. This, originator of this Condition Report questioned two specific valves that were, let's see, I forget what valves they are, but isolation valves for other buildings.

We had to go out and evaluate those specific valves and make sure that they were adequately assessed and that they could perform their function prior to any flooding occurred. And no problems were found in that or any of the other equipment in the service water tunnel that we've already identified that that condition can occur.

And the final thing in there, we did an ~~extended~~ extent of condition on functionality of critical floor drains. We had an issue that came up, identified by a condition report, that specifically addressed the diesel generator and the day tank drains in the room, as to whether a flooding issue occurs, whether the room will drain or not.

We looked at those, and in fact the diesel generator drains were plugged. They needed to be unplugged. Now, the day tank was fine, but we did additional ~~extended~~ extent of condition review ~~or condition~~ on that, particularly concentrating on essential rooms and the cooling water room was one we had to look at; ~~panic~~ mechanical penetration rooms were another.

We found no additional problems. We did water tests on those, and did not find any additional drains plugged. But in the improvements in that one, on the next one, we will implement, we are implementing improving the requirements throughout and will periodically check those floor drains in the process also.

MR. GROBE: That will be part

of your maintenance program?

MR. SCHRAUDER: Yes. That's what I would equate it to. I don't know if it would actually be with pm, but I expect it will be. But maybe some programmatic tie to go out and periodically check for those.

Other improvements; installing these flood seals and conduit penetrations. That issue involved, identifies there were certain conduits penetrating below the station's flood plan. And when they installed the work on the junction box and the like, rubber gasket and seals and stuff, they were found to be acceptable to maintain the water tight enclosure; however, once again, there were no pm's, I'll say, to go out and periodically check that barrier, if you will, which is a flood barrier. And, also that rubber starts aging, you could start getting some leakage.

So, what we decided to do, is to go in and install some flood seals in the conduit itself where you can actually seal where it comes in and not rely on the rubber gasket seal any longer.

Then, one of the other things that came up, we looked at was the, we have a formal inspection program for barriers in the fire protection program. You know, something everybody has you go out and you have a routine

inspection of your barriers. We don't have that formal program aspect of inspecting other barrier like flood barriers and the like. So, we're going to incorporate that as part of our barrier inspection program; where it will be the same type of inspection we do on our independent inspections.

Do you have a question?

MR. GROBE: Yeah, I was just thinking about what you were talking about, in the context of the reactor pressure vessel head. You were probably wondering what kind of activity there is here.

All of the things that you've talked about that you're putting preventative maintenance activities in place, are passive components; floor drains, seals, barriers. And one of the reasons we didn't focus on the reactor head as part of our inspection program is that you focused more on active components that have real significance.

Is there some learning here that there might be other important but passive components that aren't part of your preventative maintenance program? Kind of a wide open question. I don't expect an answer.

MR. SCHRAUDER: I haven't thought of any.

MR. GROBE: I was wondering

if that was something that may be we should take a look at?

MR. SCHRAUDER: Yeah.

MR. GROBE: Okay.

MR. SCHRAUDER: Again, most of these, as we talk about it, are not in the containment building itself, most of these are really in the other buildings; and most of these, there are seismic concerns, obviously, contained in other, these particular ones are not in the containment building itself.

The High Energy Line Break is another one in the Actions to Support Restart. Complete reanalysis of turbine building breaks. And this was, we had already started this in response to Information Notice 2000, 2000 Information Notice Number 1. And so, we need to complete that analysis, and in fact, determinability of analysis will demonstrate a crack or break in a location that we have to further analyze the impact on the feedwater pumps. So, we're looking at that.

The issue there, we have a high energy line, impacts on the environmental qualification of the equipment, whether it can take that. We'll complete that, and any impact on the environmental qualification or any new postulated crack or break in the building as a result of that. We'll get that done and complete prior to restart. Again, I consider that to be an ~~extended~~ extent of condition type of

evaluation.

The next issue on revise calculations effecting line breaks and cracks. We had an issue that came up that identified that we had misapplied a stress factor, revised stress factor. We applied a new stress factor to an old equation, and impacted the calculations. We did an ~~extended~~ extent of condition on that, where we had applied that stress factor. It did impact some calculations. Most of the calculations, it didn't change anything. I mean, it was wrong in the calculation, but it didn't change the outcome, because the old equation still postulated a break or crack in the same location. So, this would still have identified a crack.

But one calculation did show, when we applied the proper stress factor, that we could have a crack in an area that was not previously postulated for it. And it was in an area that we didn't, didn't feel like we, there was too much equipment in there to allow that to happen. The amount of qualification impact would have been pretty significant.

So, we moved where that stress would occur in the system, basically to soften the system a bit and move the stressers out into another location. And that required to replace some rigid supports with snubbers and also to move some other supports to move that stress into a more

palatable location.

Then the other one is in building free space, we found a high energy line barrier, happened to be an elevator door credited as a high energy line break barrier, and the analysis challenged that. We found it -- I forget what we found, whether it was acceptable or not. I believe it was not. It was not acceptable.

We did an ~~extended~~ extent of condition for the rest of the auxiliary building on that; found no other unacceptable barriers in that; but that did lead to another assessment of all the free space volumes and openings in the auxiliary building.

I was told before I did come up here, I did have one lifeline to go out to the audience for additional information. I almost had to use it there.

So, that's, that was what we did in response to high energy line break.

MR. THOMAS: Bob, before we move on, you addressed the Aux feed water pump room. I believe there is also issues of the component cooling water pump room. Are those, has that been resolved or will that be resolved prior to restart?

MR. SCHRAUDER: There is issues in the component cooling water room. I forget whether they were due to high energy line break or there was some --

MR. THOMAS: There were high energy line break issues.

MR. GROBE: The steam line break right outside the doors there. There is a block wall right behind.

MR. SCHRAUDER: We had high energy line breaks --

MR. BYRD: It was due to a pipe width in the steam line break outside the wall and it was resolved.

MR. GROBE: It was resolved?

MR. BYRD: Yes, was resolved.

MR. GROBE: Through analysis?

MR. BYRD: Through analysis, that's correct.

MR. SCHRAUDER: I remember that now. It was a pipe width judgment and it was found to be acceptable.

MR. GROBE: That's it. That was your lifeline.

MR. MYERS: That's your lifeline.

MR. SCHRAUDER: Future improvement for high energy line break. When we did that review of the

auxiliary building, we did found our model could be updated and made more user friendly in the auxiliary building. We're going to do that.

We are going to revise those calculations. I told you we reviewed the calculations and found certain of the calcs didn't impact a crack or break location, but they are in fact incorrect. We'll revise those calculations.

We had some USAR design criteria manual changes to make that need to be updated in there.

And, then one other issue that came out was a time critical operator actions and bases. There were eight condition reports that initiated, that were questioned or challenged whether we could get the operator action done or not. We ran those on the simulator and determined that we could in fact achieve those, net per time critical operator actions.

We're going to get the whole list of time critical operator actions to Operations to make sure they can periodically use those in their simulator training scenarios, and make sure that we're in good shape there.

We don't believe that there is any problems in meeting those times, but it's good to have a compiled list of all of them and the basis for those times for the operators, so they have better access to the information.

Environmental qualification is the next issue.

Again, this one is related to the high energy line break. Any time you do a reanalysis of where your high energy line breaks are, that can have an impact on your qualification of equipment. So, as we complete those analysis, we'll feed that information to the environmental qualification people to update their files and make sure we haven't impacted any of the environmental qualification for the equipment there.

Vendors license with EQ Splices on the Containment Limitorque Actuators. One of the things we did as part of the ~~extended~~ extent of conditions, we did a dedicated environmental qualification ~~extended~~ extent of condition in the containment building as a result of the boric acid dispersion in containment.

We opened up virtually all of the op, limitorque operators in the containment. One of the things we found in that ~~extended~~ extent of condition review was certain of these limitorque actuators, limitorque supplies when they're dual voltage actuators, they can not provide a qualified splice in there. And it's up to the user to upgrade that or to supply a qualified splice. We found I believe six limitorques that that splicing had not occurred in. We needed to replace those vendor splices or qualified splices.

This is probably a good time to mention, we haven't

completed this review though. Any of these actions or any of these issues I talked about where we found something not up to snuff with the, like EQ equations or equipment, or the high energy line break, we are reviewing those for past operability reportability concerns for those also.

MR. HOPKINS: Let me ask, Bob, in that regard. Are you going to be reviewing your IPEE ~~run Triple E~~ at all to see as to, if that's still correct or not?

MR. SCHRAUDER: Ken Byrd, of the individual plant external examination; how does that relate to that?

MR. BYRD: Yeah, actually, we're going to be, we have been doing quite a bit of work on that, both on our seismic and the fire part of it; in fact, we're putting those in the PRA. That should be complete rather shortly, so that is actually ongoing right now.

MR. HOPKINS: So, your PRA is then like a living document?

MR. BYRD: That is correct. And we'll include fire and seismic. We already have seismic completed. Fire should be completed by the end of year. That was already ongoing at the time this occurred.

MR. HOPKINS: All right, thank

you.

MR. SCHRAUDER: Okay, we also found in our reviewing containment four Raychem splices where the bend radius exceeded the bend radius and we need to correct those prior to restart.

And then we found one, the containment purge inlet isolation solenoid valve had accelerated aging. What we did is we looked, we discovered this solenoid valve and it appeared to be, have thermal discoloration I'll, call it on the thing, which was strange, because the environment that was shown in the picture or in the documentation showed it should be a certain level, the temperature should be at about 113 degrees. It looked like it had been exposed to temperatures higher than that.

What we found was that it was actually at a different elevation in the containment, and it was actually exposed to temperatures in the range of 150 to 170 degrees and it had caused the discoloration. And, what that did was decreased the thermal aging life of the piece of equipment. It was intended to be 40 year life component, and this prematurely aged it, I would say thermally. It's still functioning, but we figure we've used up its thermal aging life. We're replacing that, and changing the pm frequency or the EQ frequency for changeout of that piece of equipment.

We did do an ~~extended~~ extent of condition review on that also to see if we had properly identified those components that have a thermal aging aspect to their qualification life.

Future things we're doing in the world of environmental qualification. Revised the documents for installation of limitorque actuators, make sure we're getting qualified splices put in when we get the limitorque.

Provide drainage configurations for containment conduit. This is an issue that came out some years ago, actually in NRC information notice or some generic correspondence, on potential for accumulating condensation in unsealed conduits or conduits that don't have weep holes and the like.

Our containment ~~extended~~ extent of condition evaluations opened up all of these. We found no current evidence of any precipitation condensation in any of the conduits with the exception of one that we found, some rust around it; could be indicative of that, but we actually believe that was due to a cable pulled through there, is a high liquid content in the material that you put on the cable pulls.

But we are going to in the future go back and put these drainage configuration weep holes in there. We want to be able to take the time to, it can be a tricky thing to put weep holes into conduits that have live wire in them.