MR. POWERS: No.
MR. GROBE: Okay.
MR. MYERS: No, not at all.
MR. POWERS: Okay. Next topic I wanted to brief on is the Safety Features Actuation System Relays. These are relays in a system that were changed out very early in the refueling outage last year. They were part of the planned projects for the refueling.

We changed to a different type of relay. It was intended to be installed to replace the original relays that were supplied with the plant. Over time as we've been replacing those relays, we ran into a problem with obsolescence; that is, the supplier stopped manufacturing the replacements for us. So, we needed to come up with an alternative replacement.

The replacement that was developed, we found from our testing, is not really suitable for the application. So, we've taken those out. And, we're in the process of evaluating and returning the original relays to service, while we regroup and review and develop a replacement for them.

Some of the things we've done in this technical evaluation, we've looked at the predominant reasons for replacement of the relays and we found out there is -- replacements are usually due to coil problems. And, we

found out with perspective coils and replacements, they're random with respect to age.

We've tested the original relays. We've developed a bench test criteria looking at coil resistance and contact resistance and insulation performance of them, and gone through and screened out a small population that did not meet our acceptance criteria and we took those out of the population.

We believe that the remaining relays that, of this original group, will have improved reliability as a result. And we've developed an action plan to go through, based on our problem-solving decision-making process, to go through this testing and evaluation process. MPR Associates is our lead technical support team as we go through this evaluation.

Because we screened out a number of ~~outlayers~~ outliers that didn't meet our acceptance criteria, we obtained replacements from another utility for the ones we could not reinstall in our plant. And we have those on site now and we're going to run those through our bench test as well to be sure that those are demonstrating appropriate performance before we install them in our plant.

On the next slide, we see our Technical Evaluation is in process. Talked a little about the industry experts, MPR assisting us with this.

Our average replacement, we found from a historical review, has been about two percent per year for the past twenty years. We have had a low level of replacement activity ongoing.

We looked at temperature effects relative to aging. Does not appear to be an issue, but we're going to take several relays apart to confirm it, and look at their material condition to confirm that and to confirm their functionality for another fuel cycle. And we're also going to perform an independent review of this technical work that we've done.

We're going to prepare an Operability Evaluation to confirm operability in this case. The original relays that we had installed were operable. We had an obsolescence issue with them. We're reinstalling them. We'll document the technical basis for that for Operations to review. And expect to confirm that those relays were acceptable for operation through the next operating cycle.

And I should point out, one of the major other activities that's included in this effort is procurement of a new generation of relay that's specifically engineered for the application of panels, and that's ongoing now with the initial specification stages as well.

MR. THOMAS: What's been done to strengthen your procurement process, specifically in the

area of equivalency evaluations, to ensure you're getting the components that you need to go into your safety related equipment?

MR. POWERS: We have a Significant Root Cause Condition Report that was written on this issue, and that was assigned to our Procurement Engineering Group to investigate, evaluate this issue, and how those replacement relays at the beginning of the refuel outage were specified, and what problems led to the issue of their application.

So, they own that Condition Report. We have an individual that's investigating it, feeding back what he sees as potential causes. I have met with the Supervisor of Procurement Engineering personally, and with the CR Investigator, to go over some of the considerations when we seek to get replacement parts for the plant, the level of detail that we go into in scrutinizing the application of the parts, and the application that they're in.

So, we've had that dialogue, Scott, to assure that that's well understood, the issue here, its relationship to procurement process.

MR. GROBE: Just one more relay question. If the failure rate has been fairly consistent, two percent per year, does that indicate that there hasn't been -- it was my understanding that the

initiating action here was a perceived higher failure rate combined with a difficulty getting replacement parts, which caused you to replace these relays.

MR. POWERS: Right. What we're finding when we say perceived high failure rate. We find from historical records that there was a relatively steady low level failure rate. When you have a failure in IC, Maintenance needs to do a change-out. That activity was ongoing.

But, where it really became a critical issue is when the manufacturer stopped providing that style relay. It became an obsolescence issue that needed to have changed.

MR. MYERS: We're working with three other utilities.

MR. GROBE: Sorry?

MR. MYERS: We're working with three other utilities that also have this same relay in their systems. In fact, we went out and got them to give us their relays, so we would have enough for this cycle. I think it was like 256 relays.

But support knows this is a reliability issue. These relays, when they do fail, they fail in a safe state. They fail on trip mode. So, what you wind up with is a reliability issue.

MR. GROBE: So, these relays

won't be treated any differently under the maintenance rule then? They're in fine condition from a maintenance reliability perspective?

MR. MYERS: I think that's correct, yes.

MS. LIPA: Okay. Anybody else, questions for Jim?

This would be a good time for a 10 minute break. Your next session is about to start, right?

Okay, so 10 minutes.

(Off the record.)

MS. LIPA: Okay, Bob, you can go ahead.

MR. SCHRAUDER: Thank you.

I'm going to talk about two issues today; the high pressure injection pump modification we're pursuing, and also give you an update where we're at with the Corrective Action Program. I'll start with the high pressure injection pump.

Before I get started on that, I would like to recognize John O'Neill, who is in the audience. He is our Site Project Manager and coordinates all the activities involved with the high pressure injection pump. And, he's going a really good job for us on the site. I appreciate the support we have with him.

High pressure injection pump modification. The last time we got together, we talked about the potential for modifying the existing pumps in lieu of replacing with the pumps that we had purchased. Since that time, we have looked at this option in more detail, and have decided that this will be our primary success path.

We have confirmed for ourselves that this modification will work. With the modification installed, the pumps will perform all of their required activities. And we continue to work very closely with MPR Associates on this activity.

And the issue with the high pressure injection pumps is, we found even with the new screens that we put on our sump, that very fine debris that can get through the sump screen could impact the existing internal pump clearances and had the potential to cause the pump not to be able to perform appropriately.

Again, we had looked at replacing or modifying these pumps. Since our last meeting, we have not abandoned the replacement activity, but we put that on hold right now and are not proceeding with that option. We have very high confidence levels in the modification approach, as it's far less complex, touches fewer of the plant systems, and that type of piping modification and support modifications that would have been involved in the replacement option.

What we will do is modify our existing pumps with an internal strainer that will strain the water that goes to the hydrostatic bearing.

I'm going to talk a little about the project milestones, the strainer design and its testing, what we're doing to validate the pump performance for potential clearance opening as a result of pumping the debris water; and then talk a little bit about what it's going to take to implement this modification in the field. I would say that that field implementation represents the biggest challenge certainly from the perspective of the schedule.

So, on the next slide, I'll talk about the strainer design and the testing. The strainer will allow water to pass through and supply the hydrostatic bearing and the seal. It's what I call a self-flushing strainer. That would determine analytically that the transiental flow and the velocity of the water will maintain the screen clear of debris and allow water to get through, but will not allow the debris to get through there.

If you go to the next slide for a second, we'll talk about a little bit different design approach than we talked about last time. Right in here are the screens that we talk about. And right here is the take-off that feeds the hydrostatic bearing. This represents the volute in the fourth stage of the pump.

The last time we had talked, this screen, the port that goes over the bearing was located, is currently located right there. And the screen would have gone, can't see it real well, but this is a curved surface in here. And we have changed that location to the one that's shown in this configuration.

And we did that, because we found that by relocating those ports, the water that supplies the hydrostatic bearing has a higher flow velocity achieved to the screen itself over a wider range of the pump flows, which will assure that the screen stays clean, particularly at the, near the shut-off head of this pump or in the minimum recirculation mode, the velocity we would have gotten pretty low at the screen, and would have increased the probability of plugging the screen.

So, this new location also allows the pressure to be higher and to be more constant. That in turn maintains a more constant flow to the bearing, which will make the bearing stiffness more constant over a wider range of the pump operation. That's one design change that we had since the last meeting.

We have also discovered since the last meeting in this design, that the French actually have this type of pump, not the exact same model, but a similar pump in service in some of the French plants. And they have

actually done this modification; not the screen modification, but they've moved that port, we found, for very much the same reasons, which we kind of discovered after we come up with this design, that another group of engineers had actually found this also, that they get better performance out of the pump by just moving that port to the hydrostatic bearing to a different location there.

MPR Associates again is performing the design work for us. They're going to mockup and test this strainer design at Wyle Labs.

One of the things we discussed last time, we depicted a picture of what the mockup would look like. Since that time, we've obtained a pump, again similar to our pump design, not the same design, it's a single stage pump, but it has the same type of approach that this volute, that we can test more accurately, let's say, than we did the mockup. We'll actually be doing the strainer testing in a pump in the environment we need to have it with the debris in the water.

MR. GROBE: Bob.

MR. SCHRAUDER: Yes?

MR. GROBE: Just quickly, did you indicate that these pumps, this same design problem exists on pumps that are used in nuclear plants in France?

MR. SCHRAUDER: That is my

understanding right now. I checked yesterday to see if the French had these in their nuclear facilities, and was told that they do.

We are attempting to get the reports on this, modifications that they've made, from the French, and we're expecting to get those in the next couple of days, so we can look in detail at that.

MR. GROBE: I have the other interest; you indicated that they don't have these types of screens installed in the other pumps?

MR. SCHRAUDER: No, they don't. They found by simply moving the port, it was acceptable. We looked at that and decided that the added assurance of the screen provides us a level of protection that we want; and we're going to continue with the screen modification.

MR. GROBE: Okay, thanks.

MR. THOMAS: Bob, did you say you were doing both; you are going to move the -- is that the location?

MR. SCHRAUDER: Currently, right here is where the existing pumps take-off would be, okay.

MR. THOMAS: Okay. I see. Thank you.

MR. SCHRAUDER: They were over here. And it's a down, and then into the port. So, it

changes, it's not a direct take-off of that anymore.

Okay. The next subject I'll talk about is the validation pump performance, validation. We actually did perform the first test on this with the pump clearances as they actually exist in the pump. Our rotodynamics analysis has predicted satisfactory pump operations.

What we'll do, is we're going to do two periods of this. The first one is called the baseline test. It helped us confirm the model that we created and took some baseline readings on vibrations for the pump, found where the critical speed of the pump was. We were able to find that. We did find in this test that the vibration was very steady on the pump throughout its flow regime that we exercised it through.

The next test that we'll do is, we have opened up the clearances, and we'll performed what we call the 2X Test, where the clearance are twice what they are normally in the pump. And we'll run the test again, and validate it with that isolated opening of the clearances due to debris impacting on the clearance, that the pump would continue to perform in a satisfactory manner.

The 2X was chosen, it's a maximum estimate that we currently have of what the tolerances and clearances would open up to. We're going to do a mockup test also on similar material to our pump to identify how much clearance

you would actually get, but we expect that the 2X clearance or twice the clearance will easily encompass the maximum amount of degradation we would see for the commission time of this pump.

Then after the, after the modifications are made and the pumps are resembled, we'll of course have post modification testing on the pumps before returning them to service.

Field implementation. Again, the biggest challenge, particularly in Pump Room Number 2. Pump Room Number 1, which is the pump that we're using to perform the tests on, is relatively easy; as easy goes to disassemble a 6,000 pound pump; but it's a fairly straightforward, pull the internals out of the pump, plenty of clearance there, then we move the pump to a plug in the floor where it can be lifted out and transported to the facility that's going to do the modifications on it.

The number two pump, on the other hand, has a lot more interferences by way of other pumps, other motors in the area, and it presents the biggest challenge to us to getting this pump out and maneuvered out of the building into the facility to modify and then to reinstall it.

So, there is about a month's work of activity between disassembly and reassembly of that pump in the schedule. And we have not had this pump apart in this

manner to take it out like this before, so we really don't know exactly how long it's going to take us to get it in and out.

There is a fair amount of rigging that's involved in there, and verification that our rigging points will take the six thousand pound load. There are conduit clearance that have to be made, taken out and reput in when we get back. So, there is a lot of field implementation challenge in pump number two.

We have a team resolving all those issues, laying out the travel path for the pump, and how it will come out and be maneuvered up and through the room; and they're progressing with that.

We've actually gone and, the next picture shows a mockup, a full-size mockup of the internals of that pump that we built, so we can actually take it through the travel path and know exactly all the way through the plant that it will clear all the areas that we need to clear it to get it out of the Plant and then back in again.

The next picture just shows what I was talking about, some of the congestion in the pump room itself. In the wall back here, relatively close, the pump will come out the back. It has to go out 32 inches this way and then tilt up and level this way and then brought forward and maneuvered around the corner. So, it is, you can kind of

sense the congestion within that room. So, it's a delicate piece of rigging and a lot of attention is being paid to that.

So, that's where we're at with the high pressure injection pump modification. In summary, implementation of this mod will resolve in our mind a debris issue. We'll demonstrate by combination of testing in laboratory and in the plant, that the pump will perform under all of its required conditions. And that the schedule for doing this modification supports being able to do the normal operating pressure and normal operating test in mid to late July.

I gave Christine a schedule of the activities down at the lab where they're going to do the mockup, so that the inspectors can come down and see that in progress, as well as we'll be down there observing that also.

Any questions on the pump?

MR. GROBE: Yeah, I apologize. We have a conference call I think we're trying to schedule for next week to do some preliminary discussions with the technical staff on this modification; then a meeting on the 19th.

MR. SCHRAUDER: Right.

MR. GROBE: You mentioned earlier today or yesterday that there might be some testing that will be going on before that 19th meeting?

MR. SCHRAUDER: Right, that's the schedule that I gave to Christine. It actually starts I believe on, around the 15th or 17th of June. I wanted to make sure that we had that schedule so you could get down.

MR. GROBE: We'll have to make sure we discuss that during conference call.

MS. LIPA: Right.

MR. GROBE: Okay, thanks.

MR. SCHRAUDER: Then, the next topic that I want to talk about is the Corrective Action Program. And kind of where we're at there, what we're seeing in the Corrective Action Program, what you're seeing, and some of the inspections that you're doing. And, Steve is going to talk a little bit too what the Quality Assurance Organization is doing.

This is an important topic for us. As we recall, the Corrective Action Program effectiveness was found to be a significant contributor to the events surrounding the reactor vessel head degradation; and its vitality and its viability are key for our future success, that we avoid any such problems in the future.

We strengthened both the procedure and the implementation of this program. I would not say it's perfect. We still have work to do in anchoring the program to the standards for all of the people involved in this

program.

We have seen some problems or shortcomings in some of the new implementation and the new procedure we put in. And I'll address some of those as we go forward.

In the meantime, we have I believe implemented some compensatory actions and oversight in the program to ensure ourselves that we're getting the adequacy out of the program we need to move forward.

At the same time that we're trying to anchor this program, due to, you know, the extensive reviews we're doing in the plant, design world, and across the site, really, we've generated over 12,000 Condition Reports last year and so far this year. So, we're trying to rebuild the program. At the same time we're moving a lot of Condition Reports, more than you would typically see in a given period for this amount of time to the process. So, that itself presents some challenges on oversight and assurance of quality of that program.

The first thing, I picked three topics that involve really the, the strength of the program. And the last one is one that's come up several times, is the rollover issue of Condition Reports, and I'll talk about that.

When you talk about the strength of a Corrective Action Program, you want to make sure that the Condition Reports that you're writing and evaluating, ~~A~~ and, that you

have the proper level of threshold that people will write a Condition Report. But once its written, you want to make sure it's appropriately categorized so it gets the appropriate amount of investigation into the condition and the corrective actions associated with it.

So, we look at categorization. We look at the quality of the Corrective Actions and the investigation that's going in; and then you also look at the timeliness of responding to the Condition Reports, once they're initiated. So, those are the three topics that I'll talk about, and then discuss a little bit the rollover process.

First one in categorization. Again, the new process became effective for us in March of this year. And it was issued as a FENOC Nuclear Operating Procedure. The major difference I would say, big change in that process is, it went from several different types of cause analysis. We have an apparent cause analysis, we had a basic cause analysis, and we had a significant root cause analysis.

The new process has eliminated the basic cause out of it. That is more consistent with industry standards.

Now, in addition to eliminating the basic cause, what we did, we upgraded the requirements for doing an apparent cause. So, the requirements there are stricter. There has to be a specified simple analysis method performed. And, we also required on apparent cause

analysis now, generic implications and extent of condition statements within the Condition Report Evaluation.

Some of the ones that in the previous system were called apparent causes would now be fixes. And some of them would remain just upgraded apparent causes. We did benchmark the process and believe that it is very consistent with some of the better corrective action programs within the industry.

Categorization is one of the things that we would measure, is how well the supervisor that does the initial review on the Condition Report when it's being initiated, how well they meet the categorization as specified in the procedure. And that is done by the Management Review Board, which is a collection of managers and senior managers at the site.

We have seen actually fairly good categorization. We've made what might be considered a number of changes, category changes, for instance; and we had a Condition Report written by an individual at the site that said, it seems like you are getting an awful lot of changes that the Management Review Board hasn't changed. They lumped together in that the significance level and the cause evaluation level. And we're looking at that.

What we found is, in the category changes, what we track very closely is where the Management Review Board has

felt they needed to upgrade from what the supervisor identified; no, this evaluation needs to be of a higher level than what you identified.

So, category upgrades, we would consider identification of a condition that's not a condition adverse to quality, where the Management Review Board says, well, yeah, for these reasons it is a condition adverse to quality. And then also a Condition Report that's identified as a condition adverse to quality, but the Management Review Board believes that it is a significant condition adverse to quality.

So, in the, not a condition adverse to quality upgraded by the Management Review Board to a condition adverse to quality, we've seen 125 upgrades since the March revision went in place. And since we put the revision in place, we've had about 2,500 Condition Reports initiated. So, 125 of them, we upgraded from what we call an NCAQ to a condition adverse to quality, and eight of them from a condition adverse to quality to a significant condition adverse to quality.

Where we've seen the biggest, what I'll call, delta between the management review and the supervisor's review is in the type of analysis that's required for the Condition Report. And the biggest one of that is, where the apparent cause versus the fix; where the old

process, they would all have been apparent causes, now some of them would be upgraded to apparent and some of them are saying, these are fixed and trend.

What we found is that the supervisors are more apt to put it into the apparent cause evaluation, then the procedure specifies it would be a fix and trend. We've had in the order of 250 of those, where the supervisor had said it's an apparent cause, and Management Review Board says, no, it's a fix and trend.

We've had some others. The next biggest one is 57, where the supervisor said, we've ~~taking~~ taken the action sufficient, we'll close this Condition Report. And Management Review Board said, no, you have a couple other actions, therefore, it's a fixed. So, that would be a category process change there.

Then, the rest of them are all, a lot fewer, and those are by far the two biggest hitters that we've seen in the recategorization.

So, we have not completed yet our review on the Condition Report that was written. We have looked closely at the datum and those are the kinds of things we found.

One of the other things I'll say we did find in that Condition Report was an expression by several people, I guess, this person was taking input from. What I'll -- the frustration over the feedback mechanism. That is, the

Management Review Board is changing these categories, and they're sending back information to us that says they've changed it, but you haven't given us enough details to why you changed it or what is the category, so we can learn from that process, rather than have you continue to feedback that we changed the category.

So, we're looking at better feedback mechanism to explain more completely why we changed the category or evaluation process.

What we have found is several of those that we sent back and said, no, we think it's this, they've come back to the Management Review Board and said, here's where I categorized it that way, this was my perspective of why it should be in this category. And in several of those cases, we have agreed with the initiator or the supervisor and said, yeah, we can see that, and it may well be more appropriate to be in that categorization. So, we've changed some of them back to the original identified one.

The next, the graph just shows what I've been discussing. This measures what, again what we watch very carefully is those Condition Report categories, significant or condition adverse to quality, that we've had to change and upgrade the performance of it.

We would like to get this into the 90 percent range, and we're doing reasonably well on meeting that goal right

now. It's, fewer than ten percent of the Condition Reports are upgraded as a result of management review.

MS. LIPA: Bob, how long have you been tracking this indicator, have you been tracking it for years?

MR. SCHRAUDER: No, we're tracking this -- well, I think they did track before, before the new process went into place also. The statistics that I've been looking at are since we've changed the process specifically, and that trend has also been improving on which ones we had to change also. And initially, it was like 29 percent the first month, and then 23 percent the next month, and 14 percent. This is all changes, not just the upgrades, but the evaluation process ones too.

So, we are seeing an improvement, as people become more acclimated to the new process. We're also looking at additional training, site-wide training, and we provided training to the Condition Reporting analysts, but we're looking at more training across the site on that process also.

Any questions on categorization?

The next thing I want to talk about is quality of the Condition Reports.

What we really, right now the measure that we have for quality is at the Corrective Action Review Board; and,

how often we have to reject an evaluation that comes to the Corrective Action Review Board.

One of the things I'll say is, this first slide shows the Corrective Action Review Board, by charter, by procedure right now, is not charted to look at apparent causes, but as an interim measure we've decided that they probably will look at the apparent cause analysis too, because of this change in the procedure, to make sure that people understand that.

That's where we've seen the biggest, I guess, delta between the procedure and what's actually coming to the Corrective Action Review Board. You can see right now we're running at about a 60 percent acceptance rate on those, and rejecting them for one reason or another.

We're looking at a hundred percent of them right now. Our intention is to look at all of them until we have confidence that they're being evaluated and dispositioned appropriately.

Recent changes we've made to help enhance the feedback is that the responsible manager of the section that's presenting the Condition Report to us, is present at the meetings, so that he can sense firsthand why, the kind of discussions we have and why we are rejecting some of these, and then we'll have communication back into the group. And when necessary, we see a specific area that's

struggling, we'll give one-on-one communication with that manager.

MR. GROBE: It took me awhile, but I think I understood the chart.

MR. SCHRAUDER: Yeah, well -- I'm sorry.

MR. GROBE: If I could, the height of the bar there is the indicator of the number of items processed, but you don't have a trend line indicating acceptance rate.

MR. SCHRAUDER: That's right. Actually, the legend is, yeah, the total height is the ones we've looked at, and the red are the numbers that we've rejected. It's going to have a trend line. It is a twelve month rolling average that will trend. We just now got the twelfth week for a couple days, so we haven't done it, twelve month rolling average on it right now.

MR. GROBE: Got it.

MR. SCHRAUDER: But the current rejection rate is right around 62 percent on here.

Scott, do you have something?

MR. THOMAS: Yeah, you said that items were rejected for one reason or another. Have you identified any specific reasons why some of these things have been rejected?

MR. SCHRAUDER: That's the next thing I'm going to get to.

MR. THOMAS: I'm sorry. I'll wait then.

MR. SCHRAUDER: Some of the reasons why we've rejected it. Some of the reasons are, the evaluations just have not been in the CARB's mind thorough enough, we would reject it.

If it doesn't meet the new format. The new process has a specific format that apparent cause needs to follow. If it's not in that format, we'll just reject it, have them get it into the format and bring it back to us.

The thing to keep in mind is, many of these apparent causes were actually, because we had this large number, they were generated prior to the change in the procedure. Some of them still have to go through the new procedure process.

If, for instance, they had been generated as a basic, or went through a process when we put the new process in place, some of the basics became apparents and some of them may have gone to root cause. So, they still have to meet the new format, even though they were generated early in the process, and some of them were not meeting that new format. So, that would be a reason for rejection.

The Corrective Action identified was either not specific enough, in our mind, or measurable enough or clearly written or was not timely enough in the Corrective Action Review Board's mind; or the experience review required or the generic implications and extent of conditions may not have been performed, that would be reason for rejection.

And a lot of them, I sit in on a lot of CARB's and a lot of them have been rejected because they simply did not specify the analysis method that they used. May have been apparent in reading it what type of analysis they went through, but they didn't specify, and the procedure requires that you specify the simple analysis that you're using.

Again the interim compensatory measure for this is the CARB itself. Again, we're continuing to review the apparent causes, all of them right now, until such time as we see, we'll start relaxing on that when we see particular sections meeting the standards.

Some of them are doing very well. For instance, we have noted that the Design Engineering Section, which does a very good job at meeting all of the requirements on the apparent causes. And apparent causes come in pretty well. And we've had only one rejection I believe out of design, and that was as a result of just not specifying an analysis

technique.

So, we haven't yet, but we will move toward design in the direction of doing a sampling of their reviews, rather than a hundred percent of their analysis.

And we are looking at, we'll develop additional training for the -- we've trained the analysts, if the sections use them effectively, the analyst can help them make sure their Condition Reports are in, in the proper format and the like.

We've seen the organizations that effectively use their analysts do a much better job at getting these things in, but we'll provide additional training there.

We did generate a Condition Report on this issue itself, that we had a high rejection rate from the CARB, so that Condition Report is in the process now.

Scott, do you have a question?

MR. THOMAS: Do you have specific training for the folks that do the cause analysis, or apparent cause?

MR. SCHRAUDER: We have a specific training module, as you know, for root cause analysis. We are developing the training module for the, specifically, the apparent cause analysis.

The techniques, you can either use a root cause technique, or simple analysis techniques can be things like

brain storming, interviewing, methods of collecting the data and assessing the data. So, we have not had the training module put together on that yet, but that's one of the things we've discovered in this that we probably need to do some additional training on some of these simple analysis methods; where you think it might be reasonably clear and in some cases it's not. So, that's under development.

MR. THOMAS: How many of your folks have actual root cause training? I'm not asking for a specific number, just --

MR. SCHRAUDER: Hundreds, I would say. I don't know the exact number, but we did a lot of training in root cause analysis techniques.

MR. THOMAS: Okay.

MR. SCHRAUDER: I can get the number for you.

MR. THOMAS: That's not important.

MR. SCHRAUDER: It's a large number of people, it's not just one or two.

When these Condition Reports come to the CARB, we have a check-off sheet that we go through. It's not just, you know, our collective wisdom that judges the acceptability of them. There is a check-off sheet that

asks specific questions. You know, does the information present any significant doubt as to the cause of the events? Is the evaluation package, does it lack clarity or conciseness or relevance?

And we answer these questions yes or no, and then make a judgment as to whether we ought to accept the Condition Report and making comments back to the evaluators, or whether it ought to be rejected and redone and resubmitted to the CARB. So, it's a formal kind of check-off process that we go through.

One of the things that we're learning as we go forward in quality measurements of the Condition Reports is that some facilities actually have a specific grade that they'll assign to the Condition Report.

We have a new program owner for the, FENOC program owner for this program. And he's in the process of benchmarking and developing some FENOC-wide performance indicators, and quality is one of the ones we want some additional ability to measure some of the quality.

The next slide shows these root cause evaluations that come in. These are typically the more significant issues. What we have found, this is probably a measure of the degree of training that you're given in root cause analysis, but we found a much higher acceptance rate and a much higher quality in the root cause analysis. Our goal

there is a 90 percent acceptance rate. We are currently meeting, meeting that; and the root cause has continued to be pretty good for the most part.

Things that we would reject a root cause for are really the same kinds of things. We don't see as many format-type problems with root causes, because they pretty much have a cookbook that they can fit their analysis and their evaluation into.

But sometimes if the root cause, maybe in the minds of the CARB they present the process, doesn't look like they maybe got to the root cause by way of not appropriately considering some pieces of data. So, if we felt that they may have missed some ingredient factor, we would reject it.

Again, if the Corrective Action is not clear enough, or we didn't believe it would have the potential to fix the problem, we would reject it. And a significant condition adverse to quality is different than apparent, in that the corrective action is expected that it would, would not occur again.

An apparent cause, you look at the apparent reason, and you do your best attempt at getting it, but you expect some percentage of those may recur. A root cause analysis is different in that you expect that you will get to the root cause and you will not have that condition repeat

itself. So, Corrective Actions need to be more stringent, more clear, more specific, and very clearly expected to prevent the action from occurring.

We would also reject a root cause if we believe that the extent of condition was too shallow, didn't, you know, look too narrowly for your extent of condition. So, that would be a cause for rejection for a root cause analysis also.

So, that's kind of where we stand in our look at the quality of what's coming in.

The next issue is timeliness. And this is another issue that I'll say is exacerbated by the volume of Condition Reports that we're getting in.

What we found, frankly, was that we had a lot of Condition Reports. The procedure requires a specific period of time, a default time, if you will, that an Evaluation and Corrective Actions are expected to be implemented within. And sometimes you extend those, depending on the circumstances and when the, you know, schedule in an outage, for instance, to get it done. But there is nothing in the procedure that allows for a Condition Report to just go overdue. So, we had a large number of, based on our volume of ones that were just overdue, were not being extended, and not getting done.

In response to that, we put together a high level

management review team that meets daily on the status of evaluations and corrective actions looking at what's coming up in the next three days, what's currently overdue, what's the reason for it overdue.

We can extend due dates in that meeting, but we have found that to be very effective. And that the overdue rate now is, is substantially lower, and is meeting a goal of less than five percent. For the last several weeks, it's been down hovering near zero of overdue. So, people are appropriately extending or getting their evaluations in and their corrective actions done.

MR. THOMAS: So, this chart doesn't take into account a corrective action that's been extended four or five times?

MR. SCHRAUDER: Does not measure extensions. We believe that extensions are granted at the varying levels of the organization, and extensions are approved with management oversight of them.

So that, now, that was the thing I was going to mention at the end of this, is that timeliness is another issue. I'm used to seeing more performance indicators. It wouldn't be as meaningful for us right now, based on, you know, several of these have been extended outs of post restart. So, the average age is one thing that you would typically look like, the average age of your Condition

Reports, Corrective Actions that haven't been completed yet. The average age to close a Condition Report is another one that you track.

We're not, we don't have those in place right now, because they wouldn't, wouldn't tell us much. As we move forward, we'll put together more timeliness of things too.

Go ahead, Jack.

MR. GROBE: What, what percentage in rough terms do you find -- you're involved in this group that meets daily, right?

MR. SCHRAUDER: No, I'm not. Mark is the chair of that meeting.

MR. GROBE: What percentage do you find that get extended?

MR. SCHRAUDER: I'd have to look at that.

MR. GROBE: Not precisely.

MR. SCHRAUDER: A lot right now.

MR. BEZILLA: It's stacks about this thick, and I'll say, it's probably about like five percent or less of that.

What we did was, about a month ago, we told the folks to lay out their work, match to their resource, and give us their due dates, and then they had to meet their due dates or hold them accountable to that; and if they had

trouble meeting their due dates, they need to come in and tell us ahead of time that they're having trouble, and we'll either help them meet their due date or we'll give them some relief on their due date.

And since we've done that in the last few weeks, we've had a lot less overdue items. In fact, we had a couple ~~day~~ days in row with like no overdue items. That's been very positive, I think.

MR. SCHRAUDER: In that though, if you look at the database, let's say, a lot of them would have had an extension somewhere along the line. That's what I was referring to. A lot of them in this process have been extended through the outage period. A lot of them are tied to plant conditions, where you're going to get. So, if the schedule moves, the due date moves out.

The process actually allows us to move those types, you know, where they're outage related and they're schedule, schedule driven, that an extension is not required to go through the same process, to move it with the schedule, so long as that, at the outage end date they are completed.

And that's part of our Restart Readiness Review, is that all the Corrective Actions, Condition Reports that were required to be completed for the outage are completed.

MR. GROBE: I think I agree with you, that this timeliness information doesn't tell the whole story. It seems like three items. Sorry.

This item is good, which is open corrective actions which are overdue, but you have two other indicators, one is number of extensions granted and the other is average age.

MR. SCHRAUDER: Right.

MR. GROBE: Extensions or indicator at a different level of organization management level.

MR. SCHRAUDER: That's correct, and we typically do in the processes that I've been involved with over at our other facility, we do track a number of extensions. And we do, we have a number of extensions on the Condition Reports, but it's a measure right now in the process that we're kind of in, that's not as meaningful, that once we get through this, this outage --

MR. GROBE: I understand.

MR. SCHRAUDER: -- and get them going. So, we will be adding those into our portfolio of Condition Reports that we use to look at the health of this program.

The next one is the same type of graph, and it

deals with the evaluations. It's the evaluations that we've done by its due date, the same type of information. The first one was the corrective actions that come out of it. This one is actually hitting the situation, evaluate it to determine what you need to do to fix it.

The other timeliness measures that we look at, shown on the next one, is the supervisor review. It's expected that the supervisor, once an individual has initiated a Condition Report, it goes to supervisor review that categorizes it, makes sure it's appropriately categorized and clearly identifies the problem.

We expect that to be done within one day. And again, we expect that at least 90 percent of them to get done within one day or less. And we're hovering right around 90 percent right now on that. So, I think that's 89 the last time we printed that out.

Again, that can be a condition of volume also, but the supervisors are doing a pretty good job right now getting through the Condition Reports on the day that they're initiated.

Then, the next review we looked at, is once the supervisor reviews it and moves it along, it's important that the shift supervisor and the SRO review it.

Now, it's not to say, if it's a significant condition impacting plant equipment, it's initiated, it's

typically walked to the control room, and control room is notified of, you know, potential immediate impact on the systems. But the process is, it's expected that the SRO would review the Condition Report within one day also of the supervisor's concurrence with, or not concurrence, but forwarding of the review.

We expect that to be 95 percent of the time, the SRO would get their review done within one day. Right now, we're seeing that it's right around 86 percent completed within one day. An overwhelming percentage of them are done within two days, so between 86 and 100 percent, nearly all of those are done within two days.

MR. GROBE: I'm not sure I understand this. Maybe I don't understand your process.

What review are you talking about here for the SRO review?

MR. SCHRAUDER: Well, every Condition Report that impacts plant equipment, that has any asset number in it that's a piece of plant equipment, goes to the control room for their review. They look at it for operability. They look at it for reportability. They look at it to understand what, you know, where the plant is at.

That's why, I mean, a lot of these Condition Reports are walked up to the control room when they're written for those very reasons. That if it's an immediate impact on

the equipment, the control room needs to know that right away.

That's what the SRO's review. Every Condition Report that is addressed to a piece of plant equipment or a configuration of the plant is reviewed by the SRO.

MR. GROBE: Does the CR first have to go through a supervisory review?

MR. SCHRAUDER: Yes, it does. Well, by the CREST software, before it progresses to the SRO, it needs to be progressed through the supervisor review.

MR. GROBE: And the SRO review timeliness, that does not include the amount of time that the supervisor took it?

MR. SCHRAUDER: That's correct. This is within 24 hours of the time that they get it, they have to have it reviewed in CREST.

MS. LIPA: Is this actually tracked in hours or days?

MR. GROBE: Days.

MR. SCHRAUDER: Days.

MS. LIPA: One day or two days or three days?

MR. SCHRAUDER: 24 increment is what is expected to occur in.

MR. GROBE: Are these calendar days or business days?

MR. SCHRAUDER: Doesn't matter.

MS. LIPA: Calendar days?

MR. SCHRAUDER: Right, 24 hours.

MR. GROBE: So, my statistics are a bit rough, but if you're 89 percent of the time the supervisors are taking more than a day, and 86 percent of the SROs are taking more than a day, sounds like less than 75 percent of your CRs aren't getting an operability review in two days.

MR. SCHRAUDER: That could be, but again, I'd say, when it impacts operability, it's walked to the control room quickly.

MR. GROBE: Who is making that decision, an operator?

MR. SCHRAUDER: The initiator and reviewer are tasked with the responsibility of recognizing whether something can impact operability or not.

And those statistics, Jack, if you recall, that's the entire population of Condition Reports. I would say probably, and this is a guess, 50 percent or less of them involve plant equipment that needs to get to the control room.

MR. GROBE: All right.

MR. SCHRAUDER: So, it's not quite what you say. But you're right; I mean, with a delay by the supervisor and the delay by the control room, you could have issues there.

We think we're doing reasonably well in getting operability issues to the control room rapidly, even if it hasn't progressed through the software system.

MR. GROBE: Well, I can't tell that from these indicators. And, I think I need to look a little bit more into this.

MR. SCHRAUDER: I understand your, your insight on that.

MR. GROBE: Okay.

MR. SCHRAUDER: Any other questions on the timeliness review?

The next issue is a, is the rollover process. And the rollover has been identified both by our Performance Improvement Unit, some of the inspectors that have come in, I'll say confusing and a cumbersome process.

What a rollover is, it's a method of transferring the evaluation, whether the complete evaluation or partial evaluation of one issue identified in a Condition Report to be addressed in the another Condition Report that's looking at essentially the same thing.

We have found, and your inspectors have found, that

it is a difficult trail to follow sometimes. There have been cases where there have been multiple rolls; where it rolls from one Condition Report to another, and then that rolls up to another and you wind up doing about sometimes seven or eight of these all in one Condition Report.

Again, is exacerbated by the large number of these being processed. One area we have particularly seen this in is Containment Health, you know, where we had a lot of the walkdown type of CRs being documented and the like. So, that's why I say, it's generally been concentrated in a few specific areas.

We've actually found very few cases where we believe that the case, that the issue has not actually been effectively resolved. It's just a very cumbersome process at times to track them from, to which CR, to which CR did it go to and which one finally answered it. But we have typically found that if you persevere through that process, you will find the answer.

Now, Steve Loehlein is heading up a review team, because we got enough comments and saw enough concerns I'll say in this area that we wanted to really take a look at. So, I believe Steve is looking at all the restart or the 0350 Condition Reports that had rollovers or rollintos in them; given us some more insight on that. Out of his -- that's the independent assessment.

One of the other things I wanted to mention is that many of these rollovers occurred before we revised the procedure. And the new procedure has more clarity on the process for rolling over and what you're allowed to roll to another Condition Report; and more specifics on the process and documentation of a rollover.

So, to enhance that, we don't believe it's a bad idea necessarily to roll, roll over Condition Reports when the receiving one is evaluating virtually the same kind of circumstance. It has to be well documented and an easy trail. But it does appropriately align resources. I think if you just try to evaluate each one individually, you wind up using resources over and over again to look at the same thing. So, if properly administered, I'll say, and documented, it's not a bad process, but it needs to be rigorously applied.

We've seen problems with, the procedure right now requires that if you're rolling to another one, the receiving Condition Report has a corrective action in it that says, hey, I got this one, so that the reviewer knows that he's got to evaluate this other condition in it also. We've seen some problems in that area.

So, like I said, we have revised the procedure, tried to provide more clear guidance. Steve is going to give us some more insight into it and we'll further

strengthen the rollover criteria or, you know, if his evaluation and assessment so indicates, we will consider whether we want to continue the rollover process or not; and we'll strengthen that process if we keep it and feed it into the FENOC procedure.

Questions on the rollovers?

MS. LIPA: Thanks for that discussion, Bob. I know our Corrective Action Team Inspection will continue to look at corrective actions, and through that, I'm sure we'll look at some of these rollover.

MR. SCHRAUDER: Right.

MS. LIPA: Any other questions for Bob?

MR. SCHRAUDER: With that, I'll turn it over to Steve.

MR. GROBE: Steve, before you get started.

(Microphone adjustments.)

MR. GROBE: When you're thinking about this rollover situation, think about it also in the context of your performance indicators, and how you treat rollovers in the performance indicators. I don't think you want to discuss it here, because I'm not sure I've given you a chance to think about it.

MR. SCHRAUDER: It is addressed in the procedure, Jack. If you roll it, it maintains its current due date. You can't roll it and get an automatic extension on it. So, it has to meet the original CR's due date or it has to be appropriately extended for that.

MR. GROBE: Okay.

MR. MYERS: Jack, one of the things, you know, we have a lot of experience at other plants. There has been a large number of CRs here. We don't roll, you know, at Beaver Valley we don't roll but a couple a week. It's not like the rollover process causes a lot of grief because we're not rolling over that many. It might be different at Perry, but at Beaver Valley I don't remember rolling over. Do you?

MR. BEZILLA: That's correct. Just a handful a week at the most, is what I remember.

MR. GROBE: Okay.

MR. LOEHLEIN: Okay. Thanks, Bob.

I have two things to talk about today. One has been mentioned several times, and that is the status of the Independent Review of Condition Reports; and the other is an update on Quality Assessments of recent oversight activities.

In the Independent Review of Condition Reports, we

talked about this, or Bob mentioned the rollover issue, but we also decided, and Lew Myers and I talked about this; we heard enough reports about people having some difficulty tracking through all the volumes of Condition Reports and issues. And based on what Quality Assessment had been seeing in its oversight, we agreed that doing an independent review of the Condition Reports for the 350 Restart would be a good thing to do.

So, Mark Pavlik, who is an auditor in the QA section, is the team lead for us on this. We have team members from other departments on site and from other plants.

Now, who we really targeted most often is people on this team, is either people from the Quality Organization or these Condition Reports analysts that in the process are advisors to the managers, are the people that we're trying to put on this team on a rotational basis, so they will carry back with them to their organizations the Lessons Learned from how to improve on the work that's done on the Condition Report.

So, the scope does include all of these 350 Restart Condition Reports and Corrective Actions.

Next slide, please.

The objectives are simple in this review. It's to confirm that the initially identified condition has been

evaluated.

The other objective is to track and confirm the issues that were rolled to another Condition Report were not lost. In any cases that we find problems in that area, then we use the Corrective Action Program to document the problems that we would find.

Next slide, please.

Now, as of last Tuesday, I think that's what May 27 was. In the system, there are identified 1,783 0350 Restart Condition Reports. They have associated with them about 7,700 Corrective Actions. Not all of those are restart related; about half of them are. But we're looking at quite a few nonrestart corrective actions, as long as they were associated with the 350 Restart Condition Reports. And the population of Associated Rollovers was identified in our system as 510. As we go through the reviews, these numbers can move around a little bit.

Next slide, please.

As of last Tuesday, we had reviewed 5,057 of the Corrective Actions of those 7,700; and that includes the Rollover Corrective Actions. In 87 percent of those cases, we were able to track the, how the Corrective Action relates back to the initially identified condition.

Approximately 13 percent of those cases were still in review, because that trail is not clear to us yet. So,

we're having to do additional reviews. And this is, we believe this percentage represents the difficulty that people are experiencing. When I get to some of the causes or some of the problems we've identified so far, we're starting to hone in on why that is.

MR. GROBE: Steve, just a quick question. Are the 510 on the prior slide, the 510 rollovers, those are Rollover Corrective Actions, not CRs?

MR. LOEHLEIN: Well, actually, they can be either one. When a rollover occurs, it can either be a Corrective Action that's rolled over and then becomes a Corrective Action in the Condition Report that it's now in, which is the process that Bob Schrauder described. The receiving Condition Report gets a Corrective Action to identify it has received that issue.

So, it can be a CR, it can be a Condition Report that's rolled, or it can be a Corrective Action that's rolled. We treated everything from the Corrective Action standpoint from the back end of the process and count them all there. That way we have them all, whether they were a Corrective Action that was rolled or a Condition Report that was rolled.

MR. GROBE: Okay.

MR. LOEHLEIN: Of that 510, you'll notice here, as may have been suspected, the number

of percentage we're having difficulty tracking from front to back, is higher in those that involve rollover than the general population of the ones we've looked at.

On the next slide, what we've got so far is identified concerns, is overall, what's being seen as a general weakness in some cases, documenting the resolution and the identified concern.

There are cases, for example, where the closure statement says that appropriate actions were taken to correct the condition, as an example. You can't tell from a statement like that whether or not an appropriate action actually was taken. You can't confirm it. So, for anybody trying to review that on the back end, that's difficult.

In the cases that we're examining, we're finding that there is evidence that correct actions were taken, but they're not taken credit for in the process. That clearly is a lessons learned for people using this process, that to document accurately what actually settled the issue is the practice and the standard you want to have for the Condition Reports.

So, that's been identified on the Condition Report as a generic concern with a number of these.

Another identified concern has been, with cases where the evaluation did not address the full scope of the identified issue. Now, here, the most common type we found

here is in the Condition Reports involving valves. Most commonly, if there was a valve that was expected to require a repack of the stuffing ~~blocks~~ box. In a number of these cases, the condition -- initial Condition Report had additional recommended actions on it. It might be to verify fasteners or to replace them.

In the resolution of the Condition Report, the packing issue is either addressed as repacking or may provide a basis for why repacking wasn't necessary, but the issue about the fasteners doesn't appear in the explanation as to whether it was or was not addressed. So that, we have written up on a Condition Report as a generic issue to make sure that has not been missed.

And in these cases, we're finding when we spend the time to track down the people that did them, in most cases, we're finding there is an explanation, but once again, the documentation of the actions taken being sufficient is what, is what people are having difficulty with in reviewing the Condition Reports.

In these ones we've reviewed so far, we have two examples so far of incorrect actions. One example in which there had been an error made closing a Corrective Action to a work order number. That was an incorrect work order number. The work order number associated with, did exist, but it was not complete yet. So, that was a mistake. We

identified that on a Condition Report.

And, we had another one we found in which a procedure improvement had been recommended and was not picked up in a Corrective Action. Those are two specific examples we found so far.

MR. GROBE: Before you go on, the definition of acceptable. If this Condition Report involved a design engineering issue, does that acceptable include a review of the adequacy of the design work, or does the acceptable mean that you can track through and identify the specific actions that were taken and they appear to be relevant to the question?

MR. LOEHLEIN: I think if I understand your question, Jack, you're asking about whether we're looking at or this team was looking at, say, the adequacy of the cause evaluation associated with the Condition Report; is that what you're asking?

MR. GROBE: Right, or the acceptability of the corrective actions to address that cause evaluation.

MR. LOEHLEIN: Right. I would say, what you just described there is what we're going to be taking on and are doing right now in Quality Assessment as part of a focused assessment. I'll talk about that in a couple minutes here.

This is strictly a review here. I'm not doing it as an audit-type function. So, it is a bit more superficial in the sense that it's really looking, when you can track the end result from the initial condition; and so I would say that the level of intrusiveness is not there. It's really a review, and that's why we termed it that.

But what you're talking about is questions that we are looking at in the Quality Assessment area under a focused assessment. I'll talk about that in a minute.

MR. GROBE: Okay, thank you.

MR. LOEHLEIN: So, that's a good lead in to the next slide, which talks about some of the recent key activities that we've been observing in Quality Assessment.

First thing I would like to comment on is the, are the two tests that the other members have spoken about recently; the 50 pound per square inch and the 250 pound per square inch Reactor Coolant System Leakage Walkdowns. In both of these cases, Quality Assessment Assessors accompanied walkdown teams in Containment to directly observe how this was being conducted.

The 50 pound test in particular was, we thought, an excellent decision made by the organization, because it is not required by the process in place to demonstrate return to service, but it really was used by the line organization

to do a couple things that are going to pay off. That is, that set a baseline, and also everybody involved in these walkdowns had an opportunity, while the system was at a very low challenge, to locate the components and make sure they knew where they were. So, that was a very positive thing we in QA thought.

The next bullet I have up there is Emergency Preparedness. This is an area that's always important, the emergency preparedness be in good shape. And certainly with the plant focused the way it is right now, it's an opportunity for QA to evaluate whether the organization is properly focused on this important area as well.

We watched and observed the activities in the last few drills and exercise, and did note that the weaknesses that were identified in the April drills and so forth, in large part were corrected in the May exercise. So, we continue to observe the activities in there, but the weaknesses that did come up were being addressed by the organization.

In the area of Observations of Technical Issues Resolution, there we're seeing some good decision-making being made, especially in the area of the plant support center and in senior management involvement. We saw a real turnaround.

This is something I get to see firsthand, because I

watch a lot of management decision-making. And the priorities are being established and emphasis on the effective resolution of the technical issues. And this focusing within this plant support center of these issues seems to have had a real strong influence on getting the issues focused on for resolution and clarity of the plans and the challenges to success are discussed well there.

On the other side of the technical issues resolution thing, we have continued to look at the contractor oversight part of this. Right now, a lot of the action in terms of contractor oversight is now in the technical resolution area.

Some months back we talked about what QA was observing in Maintenance. And early on, the contractor oversight activity is really more in the engineering end. And we have identified some concerns on the owners acceptance process that's been used, and identified that on a Condition Report. We felt too heavy reliance on using contractors as part of the owners acceptance process, and that's been shared with Engineering.

We've identified some issues in the control of purchase orders revisions, and discussed that, we briefed that with the Engineering organization as well.

And we continue in the System Health Condition Reports area also. We're watching those real carefully,

because of the same issues that Bob Schrauder mentioned about the Corrective Action Program. This is an area, Jack, where we're watching real carefully that the Condition Reports have in them a cause analysis that clearly substantiates the basis for the conclusions in the cause analysis.

And this is an area where if the evaluator is too cryptic or too brief in his description of how the solution is properly resolved, it will make it unclear for posterity as to why it was the right solution. So, that is an area we continue to watch and we think there is still room for improvement there.

MR. HOPKINS: Let me ask a question here, Steve. The last bullet about oversight vendor activities.

MR. LOEHLEIN: Right.

MR. HOPKINS: Are you just referring to on-site vendor activities or also off-site vendor activities?

MR. LOEHLEIN: The reason I added that bullet and hadn't spoken to it yet is we are reabsorbing quality control function back into the quality assessment, quality assurance umbrella. So, I thought I would add a bullet here on the type of off-site vendor activities we recently been involved in; like going to,

going out to Oklahoma to take a look at the radiographs that were done on the cyclone separator for decay heat pumps is one example.

Recently, just this past week, have been involved at a vendor shop in Utah to take a look at the troubleshooting that's being done on the service water valves for the containment air coolers.

We also were recently involved down in Cincinnati with Makeup Valve 3 looking at the certification of the AOP parts associated with that.

And so, we're looking now that they're part of the Quality Assurance Organization as to how we can be more effective in some of the vendor oversight, some of the off-site vendor oversight activities, because throughout the industry there have been some issues and we've had some issues with vendor supplied equipment.

MR. HOPKINS: Okay.

MR. LOEHLEIN: So, we're getting more active there. But I put that there, because they're a recent addition to Quality Assurance.

MS. LIPA: Steve, before you go on, you mentioned emergency preparedness, and that's an important area to us too. I neglected to mention earlier, we have a baseline inspection next week that is looking at your evaluated emergency preparedness exercise. They will

be here the full week, but they'll be focusing on that exercise the one day.

MR. LOEHLEIN: Right. Thank you.

MR. GROBE: I apologize for going backwards.

MR. LOEHLEIN: That's okay.

MR. GROBE: But you've keyed me into a thought. At the end of every outage, you're required to do an American Society Mechanical Engineer Leakage Test on the Reactor Coolant System, a pressurized test to look for pressure leakage. Is that normally done hot?

MR. LOEHLEIN: I believe that's done in Mode 3.

MR. GROBE: I'm still pondering the DH 11 and 12 valves and why they were leaking. So, normally, those are tested hot. So, you may have not seen leakage if in fact it's a temperature driven issue. Okay. Thanks.

MR. MYERS: If it's very minor --

MR. GROBE: It's minor at 50 pounds, but 250 pounds...

MR. MYERS: Let me finish. If

it's minor and it stays dry, which you find more on that, and it stays that way on up, then those valves that were in it, was close.

MR. GROBE: Right. So, you may not have seen it.

MR. MYERS: That's correct.

MR. GROBE: All right.

MR. LOEHLEIN: Okay, next slide, please.

Under some of the current activities, an important one is this Focused Assessment, Jack, that we talked about, or I mentioned just a few minutes ago, a Focused Assessment on Corrective Action Program. That's because we know that the organization made some stiff changes to the process on March 1st.

The early data we had did not show improvement in a couple key areas on implementation; specifically in the, we didn't see improvements yet in the numbers on the quality of the cause analyses and some other important parts of the process.

And the CARB data that you saw, Corrective Action Review Board data, showing their rejection rate also, we have a lot of indicators that this was an area deserving of a Focused Assessment.

What we do in a case like this, it's more like the,

the older common, done commonly years ago, used to call an audit, a checklist type, where we have a number of things we'll be looking at. We'll be interviewing people that are involved in the process, that includes both managers and lower level interviews. We'll continue to review the Corrective Action Review Boards, what they're doing.

We're going to also do a lot of random selection of Condition Reports from various categories, and we'll sample rollovers as well, to see that they have actually been completed through the process and all the steps the way they should have been, and take a look at what that data tells us. And we'll also verify compliance with the program itself. So, that is something we're doing right now in this quarter.

We'll continue in the next few months over the next, during the summer, continuing to do drills in the emergency preparedness area, we'll continue to observe those.

Then I put the last bullet down. It's just sort of a general kind of things that we do all the time and incorporate into our daily oversight activities, as the oversight of Management Decision-Making, Safety Culture, Radiation Protection and there is a lot of activity right now on the regulation changes for our Security Program.

MR. HOPKINS: Just mentioning a Security Plan, I would think a lot of those changes would

be generic to the other FENOC plants also.

MR. LOEHLEIN: That's correct.

MR. HOPKINS: So, you're in contact then with the other FENOC QA Organizations?

MR. MYERS: Absolutely.

MR. LOEHLEIN: Well, I know that, we talk every day, but I can't, you know, security being safeguard, we don't talk openly about a lot of things, but yeah, we do communicate with our, we communicate daily with QA from the other two sites, and one of the topics that is appropriate is the security part of that.

MR. MYERS: We also have a lead person, our corporate office for security issues.

MR. HOPKINS: I was just concerned that, you know, that I figured a lot of the changes would be the same from plant to plant; and I wanted to make sure the QA Organizationss are --

MR. LOEHLEIN: That is true, and that kind of conversation goes on, Jon, every time there is a projected change in security level as well.

MR. HOPKINS: Okay.

MS. LIPA: Just to give a time check, we have about 15 minutes for the next two sections.

MR. MYERS: Okay.

MR. LOEHLEIN: Mike Ross is going to take over.

MR. ROSS: Thank you, Steve.

Good afternoon. Our Davis-Besse Plant Support Center is in full operation. The following items have been completed. We developed an issues list and it currently has about 84 items on it. These issues are being reviewed in detail against the standard checklist to identify restart issues and obtain our agreement that the resolution is a quality and lasting type fix.

An Action Item Database has been created with owners and due dates. And the issues identified as needing decisions or extra assistance are being brought to the management team in a timely manner.

As clarity is brought to new issues, fragnets and part needs are developed and owners assigned, they are transferred to the Outage Control Organization for field implementation.

To ensure quick resolution to supply issues, the Corporate Director Supply Chain has been stationed on site and is part of the support center.

Listing of modifications has been developed with field implementation dates and is being tracked and prepared for field execution.

The Condition Report Database has been reviewed to

identify those issues not yet through with the evaluation process that may be restart. This will assure no hidden restart issue resides in that Corrective Action Database.

We do believe we know the issues that need to be resolved.

Next slide.

Our focus is on early identification of new issues and proper resolution of existing issues. This includes delivery of a quality resolution to the field organization.

Several issues are receiving extra focus. These are High Pressure Injection Pump Modification, that's already been discussed by Bob Schrauder. The Electrical Transient Analysis and the Safety Feature Actuation System Relays. Both have been addressed by Jim Powers.

Other issues that are receiving extra focus; the Air-Operated Valve Program. We have identified some emergent work in this area, with identification of three new work items. This is the addition of air reservoirs for service water valves 1428, 1429, and 1434. It appears this will revolve without significant impact.

The Plant Block Walls Seismic and Tornado Loading issues. As a minimum, we will need a procedure change to resolve one issue dealing with the tornado differential pressure, and additionally a modification to the boric acid

tank room door to address the seismic ability of a wall during a postulated line break in the area.

The Thermal Overload Bypass for Safety-Related Motors issues. It appears we will have some field work for that item and a full understanding of and resolution for its being developed.

Additionally, we identified two modifications. They are designated, that are designated for restart. The Containment Spray Pump Cyclone Separator addition. This is the addition of a separator to ensure postulated sump debris does not affect the containment spray pump seals. A Boron Precipitation modification has been identified. This is an enhanced method of ensuring the backup capability to provide Boron precipitation flow after a postulated accident.

It should be noted, both of these items add significant safety margin to our plant. These items do not impact our overall schedule.

In conclusion, we believe we have scrubbed through the present issues and have a good understanding of what needs to be done. We continue to believe all issues are in fact resolvable.

MR. HOPKINS: Let me ask, Mike, the Boron Precipitation Modification, is that considered a restart issue?

MR. ROSS: It's a Mode 2 issue.

MR. HOPKINS: Okay, thank you.

MR. GROBE: Just one quick question. I've heard these two issues discussed; the Cyclone Separator Containment Spray and Boron Precipitation. For quite awhile now they've been on the engineering issues list. What causes something to get added to the modification list?

MR. ROSS: We go through our checklist to verify that it has an issue. We bring it to senior management. We get a firm decision early. And we put it through the process and get it started. That's the value we bring to the organization.

MR. GROBE: Okay, and you indicated that you also reviewed other CRs, and I assume that covers everything that's on Jim's Engineering Issues list?

MR. POWERS: That's correct.

MR. GROBE: And identified other key issues that could be risk items.

MR. ROSS: That's correct. We probably started with Jim's Engineering Issues.

MR. GROBE: Okay, good.

MR. ROSS: If there is no

more questions, I would like to turn it over to Mike Stevens for Schedule Milestones.

MR. MYERS: Why don't we skip over that one. Let's go to the Performance Indicators. I think we're running out of time, correct?

MR. GROBE: Okay. I mean, Clark's gotten skipped on multiple other occasions.

MR. PRICE: Okay, thank you, Mike.

Good afternoon. Can you hear me?

I would like to conclude our presentation today with an overview of our progress on the O350 Restart Checklist that Christine presented at the beginning of the meeting. Then take a quick look at a couple of our charts to show our overall restart progress on our restart required actions.

The next three charts provide a summary of our status on the 0350 Panel's Restart Checklist Items. These charts are colored to show where we are in the discovery and implementation actions.

You'll see, and also if you have trouble reading, I apologize on your handout, I know black and white is very difficult to discern between the colors. There is a chart over on your righthand side on the wall that also lays this out.

You'll see on each chart that we are complete with our discovery plans for each of the Checklist Items. So, I'll mainly focus my discussions on progress on our implementation plans.

On Checklist Item 1A and 1B. They both address our technical and nontechnical root causes and other root causes we've done in the Management/Human Performance area. We completed all our 0350 Restart Actions under these two items.

Checklist Item Number 2, A and B, address the reactor vessel head replacement and our restoration of the containment vessel. 2A is colored in light blue. Basically, it's on hold waiting for our Mode 3 full pressure test. And 2B is essentially complete, waiting on plant conditions to allow completion of a few local leak rate tests that we have remaining.

In the 2C area, that deals with restoration of our containment systems, structures, and components. And as Mark Bezilla discussed at the beginning of our presentation, we're closing in on final containment closure and turnover of the building and systems to Operations.

Mark addressed some closure packages that we still have that are being worked on in the discovery area; and we'll have those done hopefully by the end of this week.

On Checklist Item 2C-1, that's in our Containment

Emergency Sump, which we've completed. We discussed that project several times, and in the meetings. And all work on that, and the inspection activity is complete. We have a couple follow-up items that we're working on as a result of the inspection, and should have those to the inspector this week.

Our corrective actions for Checklist Item 2D, which looks at systems containing boric acid outside of containment building are also nearing completion.

If there is no questions on that slide, I'll move to the next one.

The next slide lists ten of our safety significant programs that are on the O350 Checklist. As you can see, we have completed and identified, the identified corrective actions in each of the implementation plans for the first eight programs. Those are either inspection complete or continuing with ongoing NRC inspection activity.

The Radiation Protection Program actions are 97 percent complete, and which is the 3H line item. They will be totally complete the first of July, which will support an NRC inspection that will be starting on July 14.

Then, our final and most recent Checklist Item, which is 3I, which is underway, is the Corrective Action Plan to address Checklist Item that deals with completeness and accuracy of NRC records and submittals. And we are

currently working on that action plan, which essentially includes procedures for the validation of NRC correspondence.

Training for our site employees; we have our training program developed for that and now we need to deliver that to our employees.

And extent of condition review to determine what we may have submitted on any previous correspondence in the past that may not have been totally complete and accurate. That is just a starting and we're putting that plan together.

Next slide, please.

Okay. In Item 4A-B, those contain Corrective Actions that were identified through Management/Human Performance Improvement Plan. We continue to make good progress in this area, and as Lew discussed earlier we have more work do to, but we have that plan scheduled and should be getting through that in the next month or so.

Our Checklist Item 5 covers our Readiness For Restart in both Systems and Operations Readiness. We've completed 91 percent of the Condition Report Evaluations and Corrective Actions that have been identified through our System Health and our Design Calculation Resolution Plan.

We also continue to enhance our Restart Readiness

Review Practice that we discussed earlier to ensure that we have comprehensive review of our readiness to make mode changes and ultimately for plant restart.

Then we have Checklist Item 5D, which is the test program which is 72 percent complete, which Mark Bezilla also addressed earlier, where we have completed so far our 50 pound and 250 pound test of the Reactor Coolant System.

Checklist Item 6 covers the licensing issues associated with the new reactor vessel head, and is complete, including the inspection activity, and closed out.

Then Item Number 7 contains our Confirmatory Action Letter; our responses, which are all progressing, and also in that area we cover our final Integrated Restart Report that we are currently working on.

If there are no further questions on that, I'll move on to the next final two slides.

Okay, these final two slides show at a high level our overall progress on our actions we've identified as required for restart. Many of these actions go well beyond the requirements of the O350 Checklist. As a matter of fact, approximately 60, we have approximately 60 percent of our total restart required Condition Reports and Corrective Actions, are actually over and above the 0350 identified Checklist Items.

The first slide shows the work-off of our Condition Report Evaluations for the Condition Reports that we have classified as restart during our entire restart effort. As you can see, we're closing in on nearing completion of those evaluations. They leveled off a little bit, but they're leveled off at a manageable level.

We continue our daily review classification of Condition Reports for restart by the Restart Station Review Board, which we discussed in previous meetings. Some of the recent additions that show up in the, these evaluations or Condition Reports are the results that were discussed earlier from our 50 pound and 250 pound test, and our walkdowns of the Reactor Coolant System that Mark Bezilla discussed at the beginning of the presentation.

And approximately 100 of the Condition Report Evaluations identified here out of roughly the 300 remaining to go, are to support the first mode change to Modes 4 and 3. As Mark Bezilla discussed earlier, those are all scheduled out now with due dates that support the milestones.

The final slide shows our work-off in our Corrective Actions that have been classified as restart from our, from the previous Condition Reports that I just talked about. Again, all the Corrective Actions have scheduled due dates.

We currently have, as you can see here, around 800 that are open. Out of those, 397 of those open Corrective Actions are scheduled to complete to support our first Mode 4, and changes to Mode 4 and 3. And so, we're working well, and have that, have that all laid out.

In conclusion, I would like to say that we are making good progress, and we have confidence that we will complete both our 0350 and the non0350 Restart Actions in support of our Restart Milestones.

Are there any questions?

MS. LIPA: Thank you. No.

MR. PRICE: Okay. If you don't have any, I'll turn it back over to Lew for closing comments.

MR. MYERS: The past month has been pretty significant. We've had, we started out last meeting with several organizational changes. We think those organizational changes have been very effective for us.

We changed our direction, which had a significant impact on our schedule. We focused on modification. We've already test ran the pump. Pulled the impeller on the one A pump. We're planning to pull the Number 2 pump now.

We continue to look forward to the, lots of activities in the Management/Human Performance area,

especially in the Safety Culture area in the next couple of months.

We were very pleased with the performance of our operators in the 250 pound test; and the overall, with the performance of the plant, even though there is some work for us to do there.

The modification of the HPI Test, we believe will be successful. And we'll be through that in July, early July, allowing us to, to be ready for Mode 4, and Mode 4 and Mode 3 pressure tests in the middle of July. And shortly after that, we'll be, from a plant standpoint, be ready to, look at restart of the unit, which right now we talk about the first part of August, from our perspective.

We demonstrated consistently that we're able to work off the corrective actions at about 140 a week. And consistently now, if you look at our back logs and all, it looks like the middle of July is easily done for Mode 4.

Checklists; Item Number 5 indicates we're about 91 percent complete with activities for Restart.

Once again, you know, I think we demonstrated today, we made good progress. We ran all four Reactor Coolant Pumps for a couple of hours. We drew a vacuum -- put a bubble in our pressurizer. Didn't draw a vacuum. And went through a 250 pound test that performed well.

We got, we really bounded the work. Now, I think

Mike Ross's group is going, did an excellent job of bounding the work, and laying the work out on the diesel air dryers. He got that lined out, assuring the parts are here. We know what the work is.

So, we really feel very solid right now about our ability to reach the schedule of activities at the first part of August.

So, with that being said, we continue to make progress, and we look forward to our next meeting. Thank you.

MS. LIPA: Thank you, Lew.

Well, that ends the business portion of our meeting today then. What we're going to do is take a ten minute break, and we'll go to public comments and questions.

MR. GROBE: Lew, I need to excuse myself. I have a meeting tomorrow morning which requires me to fly out tonight. Bill will continue chairing the meetings tomorrow afternoon and this evening.

(Off the record.)

MS. LIPA: Okay, we're ready to begin with the public comment/questioning period. We would like to open up the microphone for anybody who has a question for us or a comment to address for the NRC folks here.

Jack Grobe did have to leave, but Bill Ruland, the

Vice Chair, and the rest of us are still here.

What we would like to do is start with local members of the public first, and then we would like each person to limit their time to five minutes. And, at the podium we have a sign-in sheet. And, if you want us to follow-up with you, feel free to put your phone number, that way if there is anything that we didn't fully address, we can contact you later.

So, is there anybody who would like to come up and ask a question or give us a comment today?

Are there any members of the public that are not local that would like to come up?

MS. RYDER: Hi. My name is Amy Ryder. I'm with Ohio Citizen Action. I just have a few questions.

One is that, I might have missed this earlier in the meeting, because I was late, but if the Reactor Pressure Test does not identify conclusively where the additional rust is coming from, what happens next?

MS. LIPA: You talking about on the lower part of the vessel?

MS. RYDER: Right.

MS. LIPA: Well, right now, the NRC is evaluating Licensee's plans on how they're going to test that and how they're going to determine it. So, we

should know more before that test. And then once we get the results of that test, we'll be able to figure out what the information means. But I really can't tell you yet how we're going to process that information.

MS. RYDER: Will the source of that rust have to be identified before restart is completed conclusively?

MS. LIPA: The source of the rust. Well, I think what we'll be doing is making sure we understand the Licensee evaluation of it and what it means and whether that makes sense and whether there is an indication of a leak. That's my understanding right now where we're headed with that.

MS. RYDER: So, there is a possibility that it could restart not knowing where that rust came from?

MS. LIPA: Well, I don't really want to say that right now, but I think as we get closer to that test and after that test, we will be able to answer more fully your questions on that.

Do you have any comments on that, Bill?

MR. RULAND: The key criterion is that the reactor itself has no unidentified leakage, not that the rust stains have or have not been identified.

MS. RYDER: Okay.

MR. RULAND: So, theoretically, there could be some possibility they would not identify the rust stains, or excuse me, the Licensee will identify the rust stains. But if we were satisfied that the Licensee did a sufficient test to make sure there was no unidentified leakage --

MS. RYDER: Leakage.

MR. RULAND: -- we wouldn't have any problem with that.

MS. RYDER: Okay.

MS. LIPA: No, actually it's pressure volume leakage.

MR. RULAND: Right.

MS. LIPA: Pressure volume leakage is the criteria.

MS. RYDER: Okay. My second question is, whether or not the OI Investigation Report will be issued before restart is permitted.

MS. LIPA: I can't address that. That's all I can say.

MR. RULAND: The OI Report will be issued when the OI Report is ready.

MS. RYDER: Will you allow the plant to restart if that OI Report is not completed; I guess maybe is the more accurate?

MR. RULAND: That's all I can say; the OI Report is issued when it's issued.

MS. RYDER: Right. I understand you don't have control over when that's issued, but will the panel want to know what the report says before you allow FirstEnergy to restart Davis-Besse?

MS. LIPA: I think that's a question we'll have to address at a later time too, Amy.

MS. RYDER: Okay. Thanks.

MS. LIPA: Does anybody else have any questions for us?

Okay. Well, just a few things, then I'll check one more time if there is anybody else.

We will be returning tonight at 7 p.m. to give a summary to anybody who wasn't here; and if anybody wants to come back and ask questions, that's fine.

And then next month, July 9th, our public meeting will be at the Oak Harbor High School. And we're going to go for the same times with an afternoon meeting and evening meeting.

Then, we're also holding a meeting on June 19th in headquarters, but we'll have bridge lines for folks that want to call in and listen to that meeting. And the June 19th meeting we'll focus on the high pressure injection pump.

Was there anyone else that came up with a question while I was talking?

Okay. Well, then thank you for coming. Good day.

(Off the record.)

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CERTIFICATE

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Norwalk, Ohio, on this 13th day of June, 2003.

Marie B. Fresch, RMR

NOTARY PUBLIC, STATE OF OHIO
My Commission Expires 10-9-03.