PUBLIC MEETING
BETWEEN U.S. NUCLEAR REGULATORY COMMISSION O350 PANEL
AND FIRST ENERGY NUCLEAR OPERATING COMPANY
OAK HARBOR, OHIO

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Meeting held on Wednesday, September 18, 2002, at 9:00 a.m. at the Davis-Besse Administration Building, Oak Harbor, Ohio, taken by me Marie B. Fresch, Registered Merit Reporter, and Notary Public in and for the State of Ohio.

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PANEL MEMBERS PRESENT:

U. S. NUCLEAR REGULATORY COMMISSION

Mr. John Grobe, Chairman, MC 0350 Panel
William Dean, Vice Chairman, MC 0350 Panel
Anthony Mendiola,
Section Chief PDIII-2, NRR
Christine Lipa, Projects Branch Chief
Douglas Simpkins, NRC Resident Inspector
Scott Thomas, Senior Resident Inspector
at Davis-Besse
Geoff Wright, Region 3 Lead Inspector

FIRST ENERGY NUCLEAR OPERATING COMPANY

Lew Myers, FENOC Chief Operating Officer
Robert W. Schrauder,
Director - Support Services
L. William Pearce
Vice President - FENOC Oversight
David T. Gudger
Manager - Performance Improvement
Corrective Action Process Owner
Steve Loehlein
Manager - Quality Assessment
David Eshelman
Director - Life Cycle Management

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MS. LIPA: Good morning.

Hi. I'm Christine Lipa with the NRC, and welcome to our public meeting today. I'm a Branch Chief in NRC's Region 3 Office near Chicago, and I have overall responsibility for the inspection program here at Davis-Besse.

Over on the right here, you'll see we have an agenda today. There was also a stack of them on the table before you came in the room.

The purpose of today's meeting is to discuss FirstEnergy's Corrective Action Plan to address the Root Cause Evaluation of the nontechnical issues that resulted in the severe degradation of reactor pressure vessel at Davis-Besse. We'll go through the rest of the introductions in a few moments.

That Root Cause Evaluation was performed by FirstEnergy and was presented to us, the NRC, at public meeting on August 15th. And as background for that meeting, the transcript is available on our website and the Licensee's handout from that meeting is available on our website.

Also, the Licensee has submitted their Root Cause Evaluation, and that Root Cause Analysis is available in ADAMS and on our website. And the slides that are being used today by the Licensee are available on our website, so that folks that are on the phonelines will be able to

follow along.

This meeting is open to the public and the public will have an opportunity before the end of the meeting to ask questions of the NRC. This is considered a Category One Meeting in accordance with NRC's policy in conducting meetings. We have arranged for a hundred phonelines for participants to call in and listen to the meeting. Before the meeting is adjourned, there will be opportunities for members of the public here in the meeting room and on the phonelines to ask questions.

And then to assure that people participate, participating by phone can hear our conversations, it's important that all speakers use the microphone when talking, like I am.

We're also having this meeting transcribed today to maintain a record of the meeting. And we've got Marie Fresch here; and this transcription will be available on our web page in about three weeks.

For today's meetings, there is agendas and handouts available on the table outside the room. And also on NRC's website. And, we also have feedback forms on the table outside the room that you can use to provide feedback to us on how this meeting goes. We're trying to improve these meetings as we do them and make sure we're meeting the needs of the public.

Also, we're planning on handing out a monthly newsletter, which is not here yet. When it arrives, we'll hand that out in the room.

Okay. Next, we'll go on to the rest of the introductions. We'll introduce the folks here at the table. I'll start to my far left is Scott Thomas. He's the Senior Resident Inspector here at Davis-Besse.

Next to him is Tony Mendiola, and he's the Section Chief at NRR for projects.

Next to him is Bill Dean, and he's the Vice Chairman of the panel.

Next to him is Jack Grobe, and Jack Grobe is the Chairman of this Oversight Panel.

And then to my right is Geoff Wright, and he's a Lead Inspector in the Region, and he'll be doing a very important inspection that Geoff will talk about in a few moments.

I also wanted to introduce Marie Fresch, our transcriber.

And, do we have any representatives of public officials in the room? I saw at least one.

MR. KOEBEL: Carl Koebel, Ottawa County Commissioner.

MR. ARNDT: Steve Arndt, County Commissioner.

MR. PAPCUN: John Papcun, Ottawa County Commissioner.

MR. WITT: Jere Witt, County Administrator.

MS. LIPA: Great. Thank you.

Okay, I would like to turn over to Lew to introduce your staff, and then I have a few more comments.

MR. MYERS: Good. Thank you. Okay?

Okay. To our left, we have Dave Eshelman. Dave is an, is an employee of the Davis-Besse Plant. He's, he's now the, one of our corporate employees and along with me now as my staff assistant, helping us with Management/Human Performance Plans that we're going to be talking about today. So, Dave is going to be a major speaker here today on some of the actions we're going to take.

Beside him is Steve Loehlein. Steve Loehlein, for the audience, is from our Beaver Valley Plant. Is a long term employee there. Was the person that was my staff assistant at Beaver Valley before I left, and was the person that came here to head up the Technical Root Cause Team. Is very involved in that.

And he was also the, the lead for the Management/Human Performance Root Cause that we did,

independent team there, and was the lead for that. So, he did such a good job, we brought him over here and made him our Quality Manager. So, it's hard getting him out of Pennsylvania. He's now an Ohio native.

Over on the far right is Dave Gudger. Dave was a previous employee of our, was a previous employee of our Perry Plant. Dave's been a long-term employee there, involved with our licensing organization, corrective actions at our other plant. He has now joined our team here and is the Manager of Corrective Actions. So, we'll be talking a lot about our Corrective Action Program today.

The reason that's so important is, you know, one of the mainstay of a nuclear plant is the Corrective Action Program, in finding and fixing problems. It's one of the basic management tools. And to make sure that program is working properly, will be a key part in terms of service.

Next to him is Bill Pearce. Bill Pearce has a broad background, as NRC knows. Worked at power plant, Excelon; was a Manager of Beaver Valley Plant. He's now the VP of Oversight. And so, Bill has an extremely strong background in operations and management. What he's going to talk about is the safety culture of the plant.

And I'm Lew Myers. I'm the site VP and also the Chief Operating Officer of FirstEnergy Nuclear Operating

Company.

MS. LIPA: Okay, thank you, Lew.

I would also like to introduce a few other NRC folks that are in the room. Jan Strasma is our Public Affairs Officer. Jan is out in the hall. There is Jan.

Then we have Rolland Lickus. He is responsible for state and governmental affairs.

And we have Nancy Keller, she is the secretary at the site here.

And Doug Simpkins is the Resident Inspector.

Also the, we just handed out the monthly newsletter, and in the back there is phone numbers that you can reach NRC folks, if you have more questions.

The next item on the agenda --

MR. MYERS: Christine, we also have some people with us, I would like to introduce them, behind us here.

MS. LIPA: Go ahead.

MR. MYERS: Lynn Cavalier is our Vice President of Human Resources at your corporate office. She has been very involved in some of the management, helping us with our management action plans. So, she's here with us today.

Mike Ross, I've introduced before. Mike is the

previous Plant Manager of GPU Plants. And, Mike, as a proven manager, brought him over to help us out in the operations area. And so, as we return the plant to service operations and those things, will be a key ingredient; Mike is here to help us in that area. And they'll help field some questions today, as we go forward. Okay.

MS. LIPA: Okay, thank you.

The next item on the agenda, is a brief discussion of the August 15th meeting. And that meeting was held in our Region 3 Office near Chicago. And that was where FirstEnergy came in and presented the results of their Root Cause. And that Root Cause is on the web page and the transcript of that meeting is on the web page.

Let me just summarize, the Licensee presented to us that the root causes were in four specific areas and I'll briefly describe those.

The first one was Management Oversight, and they described that as a less than adequate nuclear safety focus, and a production focus combined with minimum actions to meet regulatory requirements.

The second area was an inadequate implementation of their Corrective Action Program. Lew just described to you why the Corrective Action Program is so important, and they found that they had inadequately implemented that over some period of time.

Third area was Technical Rigor, described as a failure to integrate and apply key industry information and site knowledge to compare that new information to the knowledge that the engineers here at the site already had.

And then the fourth area was Program Compliance. There was some steps and especially the Boric Acid Control Program there were not followed.

So, these were the four areas that we focused on in Root Cause discussion. Today, we're hoping to hear what they're planning to do about these areas.

That concludes my summary of the August 15th meeting, and I'll turn it over to you.

The next thing we're going to do is have Geoff describe the inspection he's doing.

MR. WRIGHT: As Christine indicated, I am Geoff Wright. I am the team lead for a group of individuals comprising of regional technical staff, headquarters experts in human factors and inspection, and a consultant who is an expert in root cause analysis. We have been tasked to look into the analysis that the Licensee has performed in the Management and Human Performance area.

We have taken this and broken it into three pieces. I call them three phases, if you like. The first is looking at the technique that they use to develop their

root causes. That inspection is ongoing. It started at the beginning of this month and will end October 4th. The second two phases are the implementation and the final phase then is the effectiveness review. The last two phases have not been scheduled at this time.

Christine.

MS. LIPA: Okay, thank you. We'll turn it over to you then.

MR. MYERS: Thank you. We're here today to discuss the Management/Human Performance Improvement Plan. That's our desired outcome. And explain to you how we came up with that plan.

We want to discuss our plan for improving the implementation of our Corrective Action Program. Once again, that program is the management program that we use to identify and fix and track our problems with, before they become safety, safety concerns.

And then, finally, we'll talk to you about the safety conscious work environment at our site, and our plan, our plans to improve that environment, if you will.

Just a quick summary, to talk a little about, I did that last night, I talked a little about FirstEnergy Nuclear Operating Company; its vision, mission and goals, if you will, values.

The vision of FirstEnergy Nuclear Operating Company

is operational excellence. And this event, and I said that last night, it did not help us in that area. Operational excellence is something that we should, that you never reach, is something we should be striving to improve the plant's performance and the personnel performance all the time.

And to do that and the only two assets we have, is one the plant itself, and two is the people that work for us. And our mission is people providing safe, reliable and cost effective nuclear generation.

Now, you do that through a process of incorporating your values and your standards. And, if you go look at our root cause, our root cause talks about safety focus. Our first value is safety. And it's having the right safety conscious at your plant; consciousness safety culture, asking the hard questions, understanding the material condition of your plant.

And then you, in order to get there, you're going to have your other asset, the work force. The work force has to be technically competent; you have to have good management skills, good leadership skills. We do that through our training programs, and our leadership and action program for our managers and supervisors.

And if you go look right now and you ask what really failed throughout this event, you know that's a key

ingredient, I think, of the failure.

Next area is accountability and ownership of your programs, your processes and mature condition of your facility. And you also have to be focused on that. And that's when you really get into the asset of the plant itself. And you accomplish goals and objectives to keep that plant in very good material condition, and constantly upgrading it. And that creates reliable generation, which is value creation for the company.

So, if you go around that circle, that's the way we sort of see our values at FirstEnergy Nuclear Operating Company; and, how it all fits together.

If you look at our Root Cause here, we would say that there is, the two first Building Blocks did not meet our expectations.

One of the things, I don't have a slide for, that you see on our, you see on our walls now, right in the meeting room; is that we went back as Senior Management Team of this site, and we expect every group to do that, and rebaseline our standards.

So as a Senior Management Team of this site, what do we have to be about? And that changes from time to time.

Now, we've posted these standards on our wall, and we're sharing standards with the NRC and sharing standards with the public. Now, we're expecting our employees to

hold us accountable as Senior Management Team, to these standards.

We expect them to go to us if we fail; we expect them to go to Bill and his oversite group, to go to my boss; and if necessary, go to the regulator. We have set down and we rebaseline the standards and we're meeting with our employees every day now, large groups. Posted the standards on the wall. This is what we need to be about as a senior team when we start the plant back up.

That's committing ourselves to the FENOC mission, vision and values. We're going to live those every day.

We're going to demonstrate our commitment to safety. Demonstrate our leadership courage by making hard decisions when we have to, to either shut the plant down, reduce power or go fix problems.

We will recognize the value of our asset of our people. And, we dropped some of our training programs to develop managers at this site over the years, and as a reflection of that, what you see us doing is bringing managers in from the outside. That tells you something is broken.

We pledge to uphold the leadership and action principles. That's a group of principles that's also on the wall; how we're supposed to work with our employees. And then we'll earn the right to lead this site through our

behaviors. Those are the basic standards we've asked our employees to hold us to.

Several months ago, when we first set out on this mission of returning the plant to service, we developed a plan called the Restart Action Plan; consisting of seven Building Blocks, if you will.

The first is recover the head. We made a lot of decisions, a lot of technical decisions of repair or replace. We decided to take a hard step and ensure our standards right then, and go rather than repair the head, go replace the head. That was hard decision, but it set us the right standards. And, it was not the cheapest decision.

We, we built this plan, if you would, not for a short-term action, but sort of like a 350 process, that we're into now. The 350 process does not change or go away after we start the plant up.

To make the changes that we need to make, we have to have sustained performance. We've got to build products that ensure sustained performance.

So, we've created two Building Blocks; one, the Program Compliance Plan and the System Health Plan. Those two plans have us do, have us perform systematic evaluations of our programs on a routine basis, and systematic walkdowns of our systems.

Those programs don't go away after restart. They need to be ingrained in our culture every day. And if they had been in place here, we probably would not be sitting here today.

The Containment Health Plan. We started off, and that plan has changed somewhat, with a plan to just address the boric acid, but as we looked at the containment a little harder, we expanded -- another example of setting standards, we decided to expand that plan into a Containment Health Plan.

Last night, we talked about a lot of upgrades. Millions of dollars of upgrades that we're spending on this plant today to improve the material condition and quality of the asset. And that's through the Containment Health Plan.

We're installing new, we're improving the quality of our containment sump. We're improving the quality of a pit called the decay heat pit. It's been a long term, nagging maintenance issue at this plant. And we're also installing a permanent cavity reactor seal around our reactor vessel. If that had been installed, more honestly the questions we've been asking about these technical evaluations about Boron that's running down the side of the vessel, it wouldn't be there. It wouldn't be there.

And that's a several million dollar commitment that

we've made to ensure that we're setting the right standards of the material condition, the asset of the plant.

The next building block would be the Restart Test Plan. As we start up and return the plant to service, we're going to find problems. I mean, this is not -- when you have equipment, you have problems. When you have people, you have problems. It's how we solve those problems in our decision-making to support them.

So, as we start this plant up, we've got to have not only a good start up integrated plan that we discussed last night, but compensatory measures to stop and address our problems as we find them and fix them. And necessary to come back down to the startup; make sure our systems and materials and the people and procedures are working properly.

And then finally is the Management and Human Performance Plan. That plan was designed not to be just the root cause that we gave to the NRC of this event. If you go to look, we gained a lot of knowledge, if you will, just by all the Building Blocks and all the system walkdowns and program reviews that were done. So, there is additional information that comes out of that.

So, we had the root cause that we presented to the NRC, we had the plan itself that we've been finding and fixing problems with. And then we had the oversight. And

Bill Pearce today will talk about the oversight process.

There is two organizations here; our quality organization and what we call CNRB, which is our Company Nuclear Review Board. And that's a safety review board that failed us. And we need to understand how that failed us, how we can improve it in the future, why we didn't find the Boron on the head with those reviews also.

So, we've studied all that, we've done root causes here on those areas too, and what we've done then is we've put together a plan that we'll talk about today, Dave Eshelman will talk about, that's called the Management/Human Performance Excellence Plan.

It would be very easy for us each one of us to take our root causes, run out and do things, but that would probably not be constructive. We have to have a consistent plan that we're addressing specific issues and have the building blocks to address those issues, a tool bag, if you will, for each and every issue.

So, today, we've actually broken that area down I think into five areas, and we'll discuss those areas today, and the actions. We're talking about people. So, you know, it's hard to measure people. So, we'll be talking about the actions that we're taking, like our standards and our values and goals, and departmental meetings and everything that we're going to do to improve the safety

culture of the plant, to address the root cause issues, all the reports and improve the oversight programs and make sure that we're not only ready for restart; for the long term, we put a culture, people in place and training programs into place, that ensure sustained performance for the long term.

With that, I'll turn it over to Steve Loehlein. He'll discuss the root cause somewhat. Thank you.

MR. LOEHLEIN: Thank you, Lew. I'll see how this microphone -- maybe it's better if I put it on the left. Maybe it doesn't work that way. I think we have it taped down.

What we want to do here is just briefly provide some context as to how the root cause investigations developed into supplying information to the Management and Human Performance Improvement Plan that Dave will be talking about.

So, the first slide that I have here is a flow chart on the process that developed over time. And as you look at this, we'll be starting in the upper left hand corner.

Clearly, when the damage to the head was first found in early March, the first permanent question was, how did this happen from a technical prospective, because potential implications to other operating plants was a big issue right away to have something new or important to be

concerned about at the other plants in the country.

So, from that original root cause investigation that was done and issued in April, there were two things that came out of that root cause that clearly were open question areas. One was the management was being called management and human performance aspects. The initial root cause issue in April really pointed at several key areas of management issues, if you want to term them that. One was questions about management involvement, particularly in the field; issues surrounding technical standards; oversight of the plant activities, and they also pointed at programming implementation problems with the ISI, Boric Acid Programs.

Also, the technical root cause, which is how we termed that report for clarity now, also identified five particular condition reports that represented opportunities for the plant to have recognized conditions that properly resolved that the root cause team felt would have allowed the identification of the damage to the head at an earlier time.

What happened next as we move across there, is quality assessment at that time assigned a team to investigate the particular five condition reports that were identified, I think on page 46 of the Root Cause Report; and they went off and did a detailed investigation, including additional interviews and so forth.

They came out with some conclusions along with some, they also added some investigative work they had done on pressurized spray valve that happened in 1988 and 1989; and they concluded that there were issues in terms of lack of involvement by operations in helping to prevent the event, and a lack of effectiveness of the Quality Assessment Organization.

So, while that was going on, senior management was also seeking input on the management issues side from industry executives, from IMPO, and a number of experts; and what they got was a lot of input, both from the technical root cause and from these experts, at issues in many attributes, is how I termed them. These are the things like ownership, accountability, attention to detail. The kinds of phrases you hear describing how good operating plants, the kind of attributes they have. That all went into the Management/Human Performance Plan at the time.

It was at that time that it became clear to senior management at the site that a rigorous root cause investigation of management and human performance was in order. That's when Lew convened a separate Root Cause Team, and the specific goal of that team was to -- make sure I read this here, so I don't get any words missing.

The goal was really to understand why over a period

of years the organization failed to identify the degradation of RPV head. That was the mission of the Nontechnical Root Cause Group.

And the NRC mentioned earlier what root causes we determined out of that investigation. They appear on the next slide.

The less than adequate nuclear safety focus, which was mentioned as the production focus with an approach to minimal compliance of meeting standards. That was the overarching concern or reason that we found for what happened at the plant.

The breakdown of these other root causes, the less than adequate implementation of the Corrective Action Program; there were five sub areas. What we did when we investigated that, we broke the process down into its key elements, because it has natural steps in identification, prioritization and resolution. Then you go through the steps of doing a cause analysis and so forth.

So, the subheadings under there are, that the plant was addressing symptoms rather than causes. The categorization of the conditions tend to be low, which meant the process was being handled at lower levels of management by and large, and was not required to have rigor in the analysis. This resulted in relatively weak cause determinations, and then that of course would allow for

inadequate corrective actions.

The inadequate training is identified there, is particularly related to equipment trending weaknesses. The process doesn't really do a good job at all of evaluating equipment trending issues.

The other two that were mentioned earlier were failure to integrate and apply key industry information. Again, for clarity what that refers to, is the organization, individuals, and so forth, had the information necessary to have handled this situation correctly; however, it was not properly integrated into the programs and processes, so that when the time came to use that information correctly, it wasn't, it didn't happen.

And finally then, the noncompliance with the Boric Acid Corrosion Control Procedure and Inservice Inspection Programs. This is, the actual key thing there, is the processes required for removal of the boric acid from the head in order to, to be certain of what the source of the boric acid was and that step was never completely successful because Boron was allowed to be left on the top of the head where it was so difficult to get off.

One other point of clarity for, just for root cause. As we did the nontechnical root cause, and I mentioned early that the Quality Assessment Group had found issues with QA effectiveness and lack of operation

involvement. There were three areas in the nontechnical root cause that we were able to obtain information that allow us to make observations within the root cause report; that was the Company Nuclear Review Board, the operation's lack of involvement and the quality assessment. Each of those, we did not have the information in our report to draw firm root cause conclusions.

How each of those was handled is, Bill Pearce early on, we talked about it and we decided that the best way to handle the Quality Assessment portion was to do a separate independent root cause investigation and they have issued their own report.

The quality, or the Company Nuclear Review Board, Bill Pearce had a separate review done and we have been discussing preliminarily results with Geoff Wright's team last week. I don't know if that was actually issued yet; is it?

MR. PEARCE: No, it's not.

MR. LOEHLEIN: And the third one was in the operations area; and in that case also, Operations Management and we agree in Root Cause Team that they would conduct their own separate root cause investigation into their lack of presence in helping to resolve or being involved in preventing the damage to the head.

So, all those things in terms of root cause basically feed into the Management and Human Performance Improvement Plan.

The only slide we have left is a photo of the team. I don't think we need to -- I think we've seen this before.

MR. GROBE: Steve, before you go on. Lew and other managers have indicated -- can you folks hear me? Is that better?

Lew and other senior managers at the site have indicated that supervisors and managers weren't getting out into the field to observe actual conditions and observe work in progress, to have confidence that things were going correctly and have direct observation of activities.

So, the only opportunity that the folks like Corrective Action Review Board and the management had to understand the outcomes of activities in the plant were the normal review of records. And, in the case of the Corrective Action Program and work orders associated with the head, the cleaning of the boric acid, the inspection of the head, many of those records contained inaccurate information, indicating that boric acid had been removed, the head had been completely inspected.

What role did the fact that there was inaccurate information documented by your staff and internal records

play in decision-making processes and awareness of the management team at Davis-Besse? What role did the inaccurate records have and contribution to the root cause?

MR. LOEHLEIN: Well, the records themselves -- I'm trying to make sure I understand the question correctly. I think what you're saying is right, Mr. Grobe. These Corrective Action Review Boards and so forth, yes, they would see these things and even the Company Nuclear Review Board got some review opportunities on some of the issues, but they were quite after the fact. They weren't really in process. They weren't valuable at all in terms of any process decision-making it appears. The Root Cause Team basically found that as well.

What we really found by tracking the condition reports, the progress of the condition reports, involved in all these events was that they, being at low level categories and being at, what I would call, really symptom-based cause analysis, meant that they, they just progressed through the system without any management cognizance of any level to where you would expect to see collective significance questioned.

So, as far as in process goes, that was really the issue. Not just management involved in the field, the other problem that happened was that because of the low categorization and the way that the process handles it,

there was a tendency for these things to get fewer opportunities for management to have in-process review. There were a lot of these things were handled at a supervisor level only; and, so that, in terms of in process, that really was the problem.

The other problem for the review boards is that many of the indicators were set up to look at things based on what was coded as significant, high level significance, which meant that even the review boards only saw a few of the issues, because very few of them were coded at the level that they would have seen. So, they had few opportunities as well as a review board to have certainly very few to ascertain any kind of collective significance in those venues.

MR. PEARCE: However, the issues were used to develop the root cause, right?

MR. LOEHLEIN: Oh, yeah.

MR. GROBE: During the first response to the agency after this was identified in early March, was to charter a special inspection, we call the Augmented Inspection Team. That was a fact-finding inspection.

And, during the course of that inspection, the inspectors spoke with operators. For example, through the years 2000 and 2001, there was a concern about the level of

unidentified leakage, and operators were touring containment and trying to identify where this leakage was coming from.

And, in speaking with the operators, the team identified that, that they had no concern about the head, because they had spoken with system engineers that were involved in the head inspections, and reviewed the work orders and corrective action documents, and they were told and read the records, that the head was cleaned, inspected and there was no leakage.

So, how can that not be a significant contributor to the root cause; the fact that your records, your internal records were inaccurate. I understand your comments regarding in-process activities, but after the fact reviews were impacted by that.

MR. LOEHLEIN: I think the answer to that really is, the standards had gotten to the point where Boron was left on the head. In other words, cleaning the head, meant to many people that it was cleaned as best it could be done. That was really the standard. And, at each outage, the boric acid had been left on the head.

Now, there seems to be at 12 RFO, which is the 2000 time frame. This is when the plant made a significant attempt to clean the head as best it could. There was about one I think 1800 milligram, expended 280 staff hours

involved in cleaning.

And that was declared a success in terms of cleaning, but even though that was so declared by many people that were involved, the standard was such that that boric acid left at the very center and top of the head didn't come up in any of the, in any of the things we can see as; oh, we cleaned it except for. That was never stated. It was so much better than had ever been done before, that was the standard of, yeah, it's clean.

That's what we were able to determine with the folks that we talked to and so forth. I don't have a good explanation for why that standard would exist, other than the standards had become low and that's clearly in the root cause.

It's not just in the area of the head. What we found is in explaining the operations reviews, operations reviews of the condition reports as they came through as related to these boric acid issues tended to not recognize their potential significance, even on the initiation and, as well. So, there was a question of those standards there of not being what we would want them to be.

MR. MYERS: If you go, go look, you know, the B & W plants, there is flanges up on top of control rod drives above the head. And, when we first built the plants, there was some, the gasket type had

some minor leakage over an operator site. We're talking about little drops over time. But those drops through a cycle would build up. And, and we didn't take what I think was aggressive action to go find and fix those leaks.

What that did was left a standard in place that having Boron on the head was acceptable, as long as it was dry, and it was coming from, it was coming from the flanges. So, even after we fixed the flanges over the years, and we went to a new type gasket, and very few flange leaks, we were still attributing the Boron on the head to the flanges that were no longer leaking.

It's like you're going down this path and that's the solution. It may have been the solution years ago, but now after you fix these leaks, it's not the case anymore, but we're still attributing that Boron to the flange leakage. It became the standard to have Boron on the head.

MR. LOEHLEIN: I might clarify in summary; in one of the particular containment entries that was made in more recent times between the 12th refueling and 13th refueling, there was some elevated contamination levels found near the exhaust area of the ventilation system that comes off the head region. And there was an erroneous conclusion made that if, if elevated, if the contamination levels were elevated there, that was proof that there might be a flange leaking or it would be a

flange leaking, because nozzle leakage would not result in contamination at that location, because the thing that was erroneous about it was that the air being drawn across the head would not come through that pathway.

And that turned out to not be true. That's not correct. That's not a correct conclusion. But it was one that the people involved in that particular entry and the follow-up discussions, we thought that was the conclusion they had, that they concluded they must have a flange leaking and would have to fix it coming on the 13th refueling outage.

MR. PEARCE: Did we answer your question, Jack? I'm not sure if we got to your question.

MR. GROBE: Not yet. For example, at the conclusion of the '96 outage; and, through the conclusion of the 2000 outage, engineers that documented that the head was cleaned, penetrations were inspected, and there was no leakage, yet there was substantial amounts of boric acid left on the head.

It's not physically possible to conclude that there is not leakage from the penetrations if there is boric acid surrounding the penetration. How could that documentation that the head was inspected and there is no leakage, how could that have not influenced the organization in its conclusions going forward?

MR. PEARCE: I think I can answer your question; is that the Corrective Action Program, although there was some information that was disinformation, misinformation, however you would like to categorize it, there was other information that should have been adequate for us to understand what was going on.

There was condition reports written on the fact that there was boric acid on the containment coolers. You know all the ones as well as I, that there was iron in the filters for the radiation monitors; those type of things. There was other fairly obvious information that we should have been able, if we had correctly used the Corrective Action Program to come to that conclusion.

And that's the real linkage and the root cause in my mind, is that there was some misinformation, but there was plenty of other evidence, had we used the Corrective Action Program properly, to have lead us to the right conclusion. And the second root cause is what really I think gets at the issue that you're asking there.

MR. GROBE: Okay. Bill, let me ask; you weren't in this position at the time, but the quality organization after the 2000 outage, did an audit of the effectiveness of the engineering organization during the outage. And in that audit report, there is glowing conclusions regarding the high level of quality of the

engineering organization and a laudatory, very laudatory comments about the efforts to clean and inspect the head; yet there was substantial boric acid left on the head and the inspections could not have been effective.

How did that come to be? What were they depending upon to make those conclusions?

MR. PEARCE: It's as you imply, Jack, it was the evidence of time spent, of effort expended, and the thought that this is the best it's ever been. And that was the, and the conclusion, as you stated earlier, that there was some evidence based on what was written in the reports, if you just looked at the written information, that the head was clean.

So, the Quality Assurance Organization concluded that this was a great effort that had been made. Finally, we had gone to enough effort to get the head clean. They had not gone and looked at the physical plant to come to an independent conclusion, but rather took the information they were given that the head was clean, and came to the conclusion that you described there.

So, misinformation did lead them to come to the wrong conclusion; however, as I said, there was plenty of other evidence and physical evidence, if we had just gone and looked at it. And that's some of the symptomatic issues that Lew described about the need for management

folks, for quality assurance folks, for all of us to be out in the plant, coming to our own conclusions and not trusting only what we hear second or third hand or even firsthand information back.

MR. MYERS: We have a document that we use to troubleshoot the problem-solving from a management standpoint. At Beaver Valley and at Perry, we recently turned that into a nuclear operating procedure; and just applied the principles as a management team, that's in that document, you would have concluded that the points didn't add up. The points just don't add up.

And the first thing you sit down and do is, a systematic approach, what all do we know. With all the facts that you know now; leakage rate again higher and never coming back to normal, with the containment air coolers, I'm going to say CACs, containment air coolers having to be cleaned as often as they were. For the past twenty years, they weren't being cleaned like this. The radiation monitors clogging up. What's changed? What do you know? Even with the misleading information, you would have still came up with, with something is not right.

MR. GROBE: You could have, but Geoff's team is going to take a look at the root cause and I think that's one of the areas we're going to be

focusing on, whether or not this misinformation, plant records was a contributor to decisions that were made.

Steve, you brought up the containment spray valve issue in the '99 time frame.

MR. LOEHLEIN: Right.

MR. GROBE: In that situation, there was boric acid corrosion on the upper components of that valve because of leakage. And, the NRC took what we call Escalated Enforcement Action, civil penalty to the company, and you folks took fairly extensive corrective actions, including a broad training program on what boric acid corrosion looks like and what are the indicators of corrosion.

It's my understanding that the engineers that were involved in examining the head attended that training. How did it come to be that the clear indicators of boric acid corrosion on the head following that training in an outage, within a year following that training, was not identified as corrosion?

MR. LOEHLEIN: Clearly we concluded -- here's really on kind of an upper level we concluded. We would have expected from an event like that, that the corrective actions taken would have been effective, exactly as you described it. Come the year 2000, and this boric acid coming off the head, people

involved would have recognized it. And that's why we were very concerned when we did the root cause, to understand, well, why wasn't that effective. Because it was handled at a level of root cause that you normally would.

So, we had issues with knowledge and provided some training. What we found is that this overarching root cause, which is this, you might -- we talk about the idea that issues are not problems, they're perceived to not be problems until proven so; that there is an alternate, alternate explanation for an issue that is more favorable, that is a tendency to accept that.

So, couple that tendency along with history on the head, which it had rust-colored boric acid years before on the head that really was generated by the flange leakage that had run along the structural steel of the, you know, of the insulation. And so they had some rust-colored boric acid in their history before. Couple that historical issue, the continuation of flange leakage, the willingness, or you might say tendency to blame all boric acid on the head on these flanges.

The old knowledge base of, that must be old boric acid, seemed to creep right back into the consciousness of the people making the decisions, and the training did not take. Because what really didn't happen in '98 and '99, was there was not a recognition that the way problems are

approached for resolution was really what went wrong in '98 and '99 on the pressurizer spray valve, was not recognized as the underlying root cause, which at that time was approached at somewhat higher level.

We have issue with knowledge. We have issues with specific areas, and a significant number of corrective actions were entered at that level. And that's why we are really careful in this root cause to ask, well, why wasn't that effective when it should have been.

MR. GROBE: Other questions before we go on?

MR. PEARCE: I would like to make one point before we go on, about the root cause, and how we went about doing it.

We had a lot of discussion about how to do the root cause. I think it's important for the audience to hear our thought process in that regard.

What we intended to do, to do the root cause, was to use a known methodology, an accepted methodology, not only in our industry, but used across a lot of different types of investigations of events. And, we brought in what we perceived to be the, the best system approach that there is available to us. And, with that, we brought not only the team that we assigned, which was a team purposely lead by someone outside of Davis-Besse, and not because any problem

with the people at Davis-Besse, but so that they could have a more objective look at it.

We assembled a team of people that, that we thought would be objective and look at the issues that were there, using a system that gets known results through the industry, and we even brought the two people that invented the system in to make sure that we had used it properly. We were very, very careful to keep any management influence out of it, because it's important to us, for us to be able to stand behind this root cause. And for, for the root cause to be correct, and not to have some influence on it that would lead it to being influenced by some, some intention other than getting to exactly the root cause.

So, I think it's important for all of you to understand that we tried to use the very best system, to bring the people that knew how to use the system the best, to leave it alone from a management perspective, to let the team work and get to the root cause.

And these are the conclusions that the team came to, and I personally believe that they are, they are the right conclusions, and that we can stand behind them without, without thinking that they've had some influence that they should not have had.

MR. MYERS: Bill made two points, and I think that's important too. You know, it

takes management courage that you have to demonstrate, to bring a team of independent people, industry experts in, and really make them independent to tell you what you're doing wrong.

I mean, that's difficult to do. It's difficult for our corporate organization. It's difficult for FENOC organizations. It's difficult for the management team to do. But if you're going to really understand how you can improve, that's what you have to do. You have to demonstrate that management courage.

So, Bob Saunders sponsored this team and I guess I'm the owner. I mean, we really worked hard in bringing that qualified team in and then leaving them alone without our influence or any other management influence to show us what we thought the root cause was, and the actions we could take to improve the overall safety culture of our plant and the decision-making.

Our excellence plan is going to share some of that stuff with you, how we go forward. And, but you know, I think any one on that team, I'd tell the regulators or anyone else to talk to the people on that team; they were independent. Okay.

MR. GROBE: Christine?

MS. LIPA: The question that I had, we talked earlier about the difficulties over the

years in cleaning the head. Did your team look at the basis for deferral of that modification that would have installed the improved access ports to facilitate the cleaning of the head and how that would fit into one of these root causes?

MR. LOEHLEIN: Yes. We did look into the modification deferral, but that really was found in the early root cause and showed up as a contributing cause of the first report.

And really, what we were able to gain in the way of further understanding in the Management/Human Performance area when we looked at that, was the evidence suggests what happened in the early days when it was flange leakage, the boric acid being loose, had a tendency to run down the head, and was easier to clean off.

So, we had concluded that most likely, we were having a fair amount of success getting it, the boric acid from the flange leaks at that time. And that was part of the reason why in the early 90's, people felt that they didn't need the mod.

Soon thereafter, only about a year later, people concluded again that maybe we do need the mod to get to the center of the head. So, we weren't able to get to the real specifics, but clearly when the boric acid was running down the head, it was kind of like, you know, small clumps that

can come, can develop like that. And that's what would be indicative of small leaks from above, just drips on the head.

When that changed in the mid 90's, that's when the deferral of the head became an important thing, and really wasn't recognized how important that was to be able to get better access. The standards changed in the late 90's, to where leaving boric acid on the head was accepted.

And so, but there, I'll just say that that's really what we learned from it, why wasn't the mod deferred. It was always a consideration given us, what will be gained from it, and it was looked at a standards perspective later that it wasn't really necessary.

Then I think in the last days what we got was, going to replace the head shortly anyway; maybe the mod isn't the sensible thing to do. I think that was in forming the 13 mod, I think, was the thinking that it maybe wasn't going to be a cost-effective thing to do because it had to be replaced.

So, it has a history of coming up and being deferred again. I don't remember all the details, but they do appear better in the report that was issued in April, with revision of that information at least, and it gives a history of that, I just don't completely recall now all of it.

MS. LIPA: Okay, thank you.

MR. MYERS: As we go forward right now, you know, I was saying that some of the major mods that we're putting in containment is sort of unique right now. I was talking this morning that the mods and things we are going to do here, we have like 109 modifications that we're addressing right now. So, you know, that's, that's the standards that we need to get mods done.

You know, if we would just spend a little more time trying to implement that mod than we did trying to figure out why we didn't need it, we'd probably be better off today, probably be more cost effective too.

MR. PEARCE: A little bit.

MR. MYERS: Are you ready to move on to talk about the next part of the plan?

MR. GROBE: Yep.

MR. ESHELMAN: Go on to the next slide. It gives another visual of the plant.

Steve talked about the Root Causes, how that was developed, some of the inputs to it from the Technical Root Cause, identifying several areas of further review, getting into the Business Plan, the Building Block Plan, Excellence Plan, the Nontechnical or Management Performance Root Cause and how that factored into the Management/Human Performance

Plan, as well as he mentioned some of the other information that came in.

And this shows two things. First of all, it shows some of that other information; the input into the Management/Human Performance Improvement Plan.

At the top left and top right is the Root Causes that Steve talked about. The Technical Root cause on the left and the Management Failure to Detect Degradation on the right. We already talked about those and how they fit into that. But as he also mentioned, there was a spin-off condition report, that's Root Cause for Quality Assessment Effectiveness. Again, that spun off from this root cause. It wasn't contained in the technical or nontechnical root cause. That was a separate item. And what we're doing is feeding that back into the Management/Human Performance Improvement Plan.

On the right, there is other Management/Human Performance issues. There is other root causes. There is other investigations going on right now that are identifying some management issues. We talked about the Company Nuclear Review Board. Bill Pearce has a look at that. He's developed a plan and there is some initiatives we need to take from that.

As mentioned, the one on top is Operations Role in Safety Focus. From the quality assessment review of those

five condition reports, the leadership of operations and their role is questioned. That drove a condition report, the root cause, that's being factored into it.

Some of the other areas we're looking at; the modification process. We're looking at the implementation of that process. Dave Gudger has a couple condition reports, couple root causes on the root cause implementation and program, and the implementation is going to find some other Management/Human Performance issues.

So, what we're doing is essentially using various sources, not just the initial technical root cause and nontechnical. We're using all these sources to make sure we have our arms around the proper actions. Each one of these sources are going to be driving actions, creating actions to fix the problems identified.

The second thing this shows, is that we're also looking at the root causes. We've identified, as Steve said, four primary root causes from the Management/Human Performance Root Cause. We're also looking at each of the other condition reports, looking at those root causes and looking to see whether there is similarities or differences in there, because it is important, as Steve mentioned, he looks specifically at that head degradation, the effect of management on the head degradation, but there is other issues out there that are also leading into management

issues. We want to make sure we have our arms around the causes, so we have a good aggregate look at causes and corrective actions.

So, that also is going on. The information is coming in, various root causes are still in progress, but when it gets issued or when it gets communicated, we start looking at those causes to see if we can find some similarities; and the good news is we are. That, I think, leads credence to the Root Cause Report, Nontechnical Root Cause Report, because we are finding the same issues in the other areas.

From this Management/Human Performance Plan, we had, as I mentioned, a whole lot of actions, activities, causes. And we took a look at it and decided to put it in manageable bins. So, these are the five areas we decided we are going to pursue and what makes up, I guess, the foundation of the improvement plan.

The first is Nuclear Safety Culture. We talked about the primary root cause was the lack of nuclear safety focus. Well, that's one item in there we're going after, as well as the safety conscious work environment. Bill Pearce will you be talking on that later.

To the right, Management Personal Development. What we're looking here, we have the right leaders, the right behaviors, good evaluation tools, monitoring of management

out in the field, understanding, looking, seeing what's going on; and then feedback and coaching; something very vital.

Standards and Decision-making. We're looking at the leadership standards, as Lew mentioned. Senior Management Team came up with standards, something the whole site can hold the leadership accountable to. So that's a start. It starts at the top and it works its way down.

The technical standards; our rigor, our questioning attitudes, our decision-making.

Departmental standards. How operations is going to behalf, how maintenance is going to behave at departmental level.

Plant and equipment standards. This is important. We're doing a lot of activities right now that really don't need to be done. We're showing, demonstrating visually, which is the easiest way to show improvements in the asset of the plant. We're doing painting. We're doing cleaning. Conditions that were for years accepted and tolerated, we're fixing them; and we're showing our people that we mean business, and there is a demonstration of our increasing standards.

Then we talk about the safety focus and decision-making. That part of the decision-making process; how we go where we are. Making sure we use the right

rigor, understand all the information and move in an engineering logical fashion through that.

Programs/Corrective Action/Procedure Compliance. Corrective Action is a program that was called out in Root Cause fairly significantly, so we let that be a stand alone. So, we're talking about program improvements overall on all our programs. We're doing various reviews, another building block is taking care of that, the Program Review Building Block.

Implementation Improvements, and that's important. That fits into this plan. We could have great, great program, great plan, but if it's not implemented properly, you're not going to get the good results out of it. So, we need to identify the area that lead to poor implementation of some of our programs.

The Corrective Action Process, Dave is doing a pretty much top to bottom check on that and that's going to be a significant undertaking to revise that.

And Procedure Adherence is the other area we've identified. In a lot of cases the programs procedures we had were determined to be adequate. Not necessary the best, but adequate. Such that they were implemented properly, followed properly, we would not have had the results we had. So, procedure adherence is another key; not just having a procedure in hand, going step-by-step,

but for administrative program procedures, making sure there is a complete understanding and follow through for those actions.

Then finally the Oversights and Assessments. And we're talking from independent external oversight, for instance, Company Nuclear Review Board. The FENOC level oversight, Bill Pearce's organization, internal oversight; this is Steve's organization now; quality assessment, management oversight. Now that all kind of feeds into the management personnel development, we are watching, monitoring, understanding what's going on; not just reading, but going out and looking.

Then, Review Board Oversight, examples would be Engineering Assessment Board, working on the standards and some of the company corrective action review boards to make sure there is proper oversight of the processes, how they're being implemented.

So, that in a nutshell is pretty much the plan.

Next slide, please.

MR. MYERS: Let's stop here for a second.

From a public standpoint, and I think it's important that what we do, is we start out with the root causes and then we built these tool boxes from all the various root causes, and the corrective actions that we're trying to

take as a management team focused in these toolbox, right?

MR. ESHELMAN: That's correct.

MR. MYERS: So, rather than each group going off, maybe because operations did a root cause, and they're going out to take actions, that may be a negative action to the whole. So, we're trying to focus everything through these toolboxes. And so, as we, as we go forward in our implementation plan, of correct safety culture or behaviors or standards, you know, it's important that we focus it through this process.

And you find that, for instance, our standards should be aligned from a senior management team level and their values, then below in the health physics area or the operations area, should be verbal alignment throughout the organization. So, we'll be looking for that.

Okay.

MR. ESHELMAN: Part of this review is also to take a step back from this nuclear safety culture, we have an owner for that. He's looking at all the causes, all the actions we're taking; and his job is to look at it and say, are we really getting what we want out of it or are we just doing a whole bunch of individual actions or really getting a benefit out of it. That's part of the review also, the aggregate look, to make sure we're resolving these issues.

As Lew mentioned earlier from the top, Senior Management Standards were created. Do you want to talk any more on that, Lew?

MR. MYERS: I mentioned those standards earlier. These are the standards that will be. If you look around this room, you know, we have a mission vision, the basic leadership strategies that we have under leadership action program for managers, how we're supposed to deal with people, and then management standards.

Our intention at this plant is to have these hanging on every wall in our major meeting rooms, and in our major buildings, so that we can look at them every day.

What we found was misalignment. What I personally have found is some policies in the ways of doing business in misalignment from the FENOC Organization to Davis-Besse. When you have that misalignment, you have confusion, because you're getting mixed messages.

What we've got to do is give a consistent message to our employees. And it's gets back to, for instance, is Boron okay on the head. It's that simple. It became culturally acceptable to have Boron on the head.

So, we can not be giving those mixed messages. It's a group of behaviors that's a reflection of us as a management team.

Okay. Go ahead.

MR. ESHELMAN: Next slide.

This plan really has a few objectives. First of all, we have at lot of actions. Geoff, you'll be looking at the actions, as well as the second one is verification of effectiveness; what are they doing, are they working for us.

The plan is a living document. As we speak, there is information coming in relative to human performance, management issues that are going to be factored into it. And essentially, we'll be having a leadership plan that takes us well past startup.

Next slide.

For safety culture, each of these we have an objective. And the safety culture, we're talking nuclear, radiological and personnel safety is always important to us, but understanding it needs to take precedence over other objectives. And from a safety conscious work environment, make sure there is no fear of retaliation and people will willingly bring up issues.

Some of the initiatives we're taking. First of all, FENOC Safety Policy. This again is starting at the top. From the very top, here is the standards, here's the expectations that we'll hold each other accountable for.

Safety Conscious Work Environment Improvement Plan; Bill will be talking on that later.

New management in the FENOC level; Lew, Bill, Gary Leidich, as far as their new positions in the FENOC Organization, as well as the leadership team at Davis-Besse. High standards have been brought in with that new management team.

Training on Safety Focus. That's going to continue for a long time. In the sense we have training for supervisors for our people, we're going to make sure it contains the right elements of the safety focus.

The People Team. What we're looking at is when issues come up, when people have issues, they can go to the, to the People Team and provide the issues. So, they will be anonymous, almost like an ombudsman, but a few more people out there will help resolve the issues and get quick action, so the people will recognize when issues are raised, they will be listened to and they will get actions from them.

And another issue came up just to make sure that the Business Plan, FENOC's Business Plan, or Davis-Besse's Business Plan, that incentives are aligned with the plan to make safety important. So we need to make sure that we incentivize safety.

Next slide.

MR. GROBE: Dave, I know that I've peeked ahead at some of your slides and you're

going to go into some of this in detail. Are you going into which of these initiatives are going to be complete prior to restart, and how you're going to measure the effectiveness of these initiatives?

MR. ESHELMAN: I can cover some of that. The plan itself will list specifically what's going to be complete before startup and we were going to go into some of the indicators, but we'll spend as much time as you want on that.

The safety policy, the management, the people team and business plan, they're some of the restart issues. The safety focus training will continue. There is a lot of initiatives that will start now and continue for many years, if not forever.

MR. MYERS: For example, you know, some of the key ingredients is, you know, we talked about the program reviews, system reviews, you know. Those, we've done a lot of those before we start the plant up. We've looked at all of our system phase one; about five systems, Latent Issues Reviews. We've got system reviews laid out for the next couple years now, you know, and we'll be doing a few a year. Same way with program reviews.

From a corrective action standpoint, we've brought some of the ways of doing business here with our Corrective

Action Review Board, been sponsored by our plant manager and we're grading those corrective actions as they come in. We've already been doing that at the plant.

Engineering Assessment Board. We have that up here. And we have that at Beaver Valley, so we're bringing that over here.

If that's in the Building Blocks, but it becomes part of the internalization of the organization for a long time. Those are management structures that we think should have been in place. Is that fair?

MR. ESHELMAN: That's fair.

Next slide.

Here's some more areas that we're also doing. Very importantly is the Employee Communication Opportunities. Whether it's Lew, some of the other directors or in Restart Overview Panel, essentially an independent panel; going out, talking to the people, understanding the issues, listening and then taking action. That's really important, it will help to spur more openness in the organization.

Case Study Training is a major contributor. This will go through how we got where we are, the errors involved, mistakes that were made. Then, that's going to spur the discussion of the standards; what are our standards, how are we going to behave in the future. That's going to be completed before startup, given to all

site employees, Davis-Besse employees.

MR. GROBE: Dave, could you explain what 4C's meeting are and what the ROP is?

MR. ESHELMAN: Okay. The ROP, that's the Restart Overview Panel. That's a panel made up of essentially very highly experienced individuals, as well as community leaders. Jere Witt, County Administrator is on it, Lou Storz is on it, Chris Bakken; some people that have involvement in plants, turning plants around. Buzz Galbraith is the Chair of that panel. And their job is to review all these Building Block activities and give us feedback; if not assess, give us feedback, let us know if we're not going where we need to go. So, they are essentially our critic.

MR. MYERS: Excuse me. They are also, we sponsored that group with having employee meetings. They're going to have to recommend restart before we come to you all. Okay. So, first, we as the management team have to have meetings to discuss, do we believe we're ready for restart. We go to the ROP, and they've got to make that recommendation. Then we will come to you guys. You know, so we've asked them to start meeting with our employees.

Jere is here today. Do you have anything you want to add? I know I'm putting you on the spot. Do you

know.

MR. WITT: Yes. Thank you. As part of the Restart Oversight Panel, we did meet with, I think, somewhere in the neighborhood of a hundred employees about a week and a half ago, and provided that feedback to management. Have been even part of some meetings since then with management and the employees, trying to make sure that all of the concerns of the employees are addressed in some manner, and that more importantly probably the communications between management and employees is a two-way street.

And I think, you know, that has started and it is something that the Restart Oversight Panel will continue to monitor, and be concerned with as we go down this path. It's not completed yet, but I think we have a good start in getting that done.

MR. GROBE: Could you also explain what the four Cs means?

MR. ESHELMAN: That's another meeting, initially it's facilitated by one of our organizational development folks. It's groups of employees, and the idea is to get all the issues on the table, what are we doing, what aren't we doing; what kind of issues are out there; compliments.

MR. MYERS: Complaints,

concerns and criticisms.

MR. ESHELMAN: Yeah, so. And, from this, you get results; a lot of information, good information. Since it's lead by an organizational development person and there is no leadership people or management folks in there, you get good open feedback.

That is tabulated and then Lew takes action on that. He goes back and addresses the team and talks about what we're doing, what we're doing to address these issues, what we're doing to go forward.

MR. MYERS: So, from objective evidence standpoint, you know, we keep records of the meetings and each meeting and the actions we've taken; and we would be able to provide those to you guys. And then, for example, I was just giving feedback here to some of the complaints that we had a few weeks ago and are now compliments.

So, from a safety culture standpoint, you know, the openness of our employees is very important. And this is designed to strengthen that, will they bring an issue forward, safety culture.

MR. ESHELMAN: So, besides the openness of employees, we also make sure management is doing our job; make sure we're out in the field, make sure we're observing, make sure we're doing great things, make

sure we're reinforcing proper behaviors. So, we have an observation scheduling, people will be scheduled for certain activities. We have a monitoring program, for making sure that people meet those expectations. So, essentially, it's going to make it into an indicator that we can see, make sure that we know whose doing their job and who is not.

Now, some of the measurements poles. The next slide, please.

Measuring Safety Culture is difficult. You mentioned behaviors. Some items, as far as Lew mentioned, shutting the plant down. Let's shut down and fix something. Some of the decisions, hard decisions that are made; that demonstrates behaviors.

So, you can look at behaviors, but we also have some self-identification of adverse action, of adverse conditions. Are our people willing to write condition reports rather than oversight organization or someone else. That gives you a sense or you feel that people feel free to identify conditions.

And when action is taken, that will promote, rather than if no action is taken, it will stop. So, that would be another indication for us.

Safety Conscious Work Environment. We'll be doing several assessments of that, measuring our improvement

throughout the years. And management observations, we'll be looking at specific attributes, making sure we're complying with procedures, making sure we are exhibiting the proper behaviors.

So, that's some of the areas that we'll be monitoring, as well as self assessments for each group. We'll also have indicators to demonstrate the health of whether it's programs or groups or processes.

MR. MYERS: Let me talk a moment about our Management Observation Program. We're getting ready to install our Computerized Management Observation Program at this station. And it's our intention between now and startup into the future to schedule management observations every week of key jobs.

If we had scheduled a management observation at the head containment, and if we had had, one of the things we're supposed to do is a good Prejob Agreement. And the Prejob Agreement has some very good information. It's not policies and procedures. Policies and procedures is important. It's understanding though what you're supposed to do, what you're supposed to see, and making sure that you know the compensatory measures you need to take if you don't get what you expect. It's all the right questions.

You know, I don't understand if you were going to do a head inspection, how a prejob briefing, a good thorough

job briefing, you know, what is the desire outcome; what are you trying to accomplish; what do you expect to see? You know, it would probably raise this concern at the management level. I just can't imagine them not having a good prejob approval. So, that's going to be an important part of that management observation of our process.

Go ahead, Christine.

MS. LIPA: I have a question about the self-identification rate for condition reports. You have a goal of 80 percent.

MR. ESHELMAN: We got feedback from Restart Oversight Panel; we're revisiting that.

MS. LIPA: Okay. Well, my question is, you're in a unique situation now where you're doing a lot of reviews and identifying a lot of issues and they are all being counted as self-identifying, so that could tend to skew that data and make it look like a higher percentage and not a valid indicator of safety conscious work environment.

MR. MYERS: We don't believe the data is correct now, but over the next five or six week period, as we get more into, out of discovery and into getting physical work done, that I think that's going to be a turning point, it's going to be harder to reach that goal.

My belief is having it skewed the way it is right now is going to make it, we're going to really have to try hard to keep it there.

MR. PEARCE: Well, another point is, you're going to have a lot of teams here that's going to tend to skew it back the other way if it doesn't go properly; right?

MS. LIPA: That's right.

MR. PEARCE: We should be seeing a balance there.

MR. GUDGER: Christine, we did in fact recognize that data was skewed and I am taking a look at it from a different point of view, making sure we're measuring things in a qualitative manner.

MS. LIPA: Thank you.

MR. MYERS: Okay. Next slide.

MR. GROBE: Excuse me. The self-identification PI can be a valuable performance indicator, if it's structured properly. And we'll make sure that we have confidence that it's structured properly.

Lew, you mentioned management observations. You talked in the context of work activities. Are they going to be management observations of human performance as

well?

MR. MYERS: That's one of the, I think it's another area in our observation program, I think Christine you're pretty familiar with the computerized data base that we use to track at Perry and Beaver Valley. With the correct tools, correct behavior, there is sections in there for good prejob briefings.

You know, what I did is, I went through that a couple weeks ago; the Management Observation Program. I picked the key parameters that I thought would be important for us to measure going forward to make sure we seek the performance in the fields that we expect.

I don't remember what those were right now, but I went through that whole observation program. We're going to be pulling performances out of those management observations to look for those type issues, human performance issues.

MR. GROBE: So, you'll have a performance indicator that comes out of management?

MR. MYERS: Absolutely.

MR. GROBE: That's not developed yet?

MR. MYERS: Yes, it is. I mean, we have it already at our other plants, so it's not hard.

MR. GROBE: But it's not in place here right now?

MR. MYERS: No. We put, that computer system, Computerized Management Observation System will be in place at the end of this month.

MR. GROBE: That will be part of the performance indicator package we get on a weekly basis?

MR. MYERS: Right. It will be something you can look at throughout your 350 process, even after restart.

MR. GROBE: You talk about, in the safety conscious work environment assessments area, you talk about periodic assessments. What does periodic mean? Is that annual?

MR. PEARCE: He haven't decided that yet, Jack. We know that we're going to do some more. We're trying to figure out what the right time of going forward with that is. For us to understand, what the training, what we're going to do with training, I'll talk about that later, some of the stuff we're going to do. And at what time we do another evaluation of where we are and expect to see some change as a result of what we've done.

MR. MYERS: It's certainly not annual, it's more like monthly and stuff like that.

MR. GROBE: Are those assessments going to be primarily interview basis?

MR. PEARCE: They're survey basis is what they are. And I'll show you, later on I'll show you the results of the survey that we've done so far.

MR. ESHELMAN: Any more questions on the culture?

Next is Management Leadership. So, we're talking about experience, high safety standards and they're directly involved, some of the key issues that we already mentioned.

Next slide.

First of all, New Management Team. Standards for Management. So, we have the team, we understand the standards, so now we can go implement.

Operations has the improvement of leadership plan. There are supervisory evaluations, we're using RHR Consultants to help us with some of the evaluations in personnel.

Leadership in Action Training and Foundations for Leadership is our Supervisory Development Plan. If you want to become a supervisor, you start off in the Foundations for Leadership. We're going to make sure that that training has the right focus, so we're looking back at the causes, looking at actions; and we're going to make

sure that those training programs have the right elements in them to get the right safety focus and train our folks the way they should be trained.

Ownership for Excellence is our performance monitor. That's the key. You set standards. You set expectations. You monitor to make sure the standards and expectations are the same. Then, this is the feedback part. If people are not meeting expectations, you need to tell them; otherwise they'll continue not to meet expectations. That's what the Ownership for Excellence Program is about.

As we mentioned before, Management Monitoring also gets us involved, directly involved with plant activities.

MR. GROBE: Dave, could you talk a little bit more about supervisory evaluations, what that means?

MR. ESHELMAN: Working with Human Resources in corporate, Lynn Cavalier as a matter of fact, we're developing, we're actually modifying competency; what we expect our people to be able to do, our supervisors, our managers, even individual contributors. What are the competencies we expect from them.

The evaluations are done to monitor against those competencies. Using the behavioral base, or experience base interview to understand how each individual fits or

doesn't fit those areas. So, we can identify areas for improvement; make sure there is a clear alignment between what we expect, the competence we put out and behaviors exhibited. Similar to what was used at Byron Station; they also used RHR.

MR. GROBE: Is there going to be baseline evaluation done and then a continuing evaluation in your Management Oversight Monitoring Process?

MR. ESHELMAN: Right, we do have baseline. It's going to be starting next week. And from that, we'll have further evaluations. Use that as a tool to make sure we're maintaining the proper focus and our people are not losing it. We haven't decided yet on the frequency of that, but that is going to be one of the long goal plans.

MR. GROBE: When will the baseline be done?

MR. MYERS: Before restart.

MR. ESHELMAN: Before restart for the key groups of supervisors identified.

MR. MENDIOLA: Quick question. Your leadership in Action Training, and I guess your Foundation for Leadership Training; how is that, or who is doing that, and how is it going to be done?

MR. ESHELMAN: We have

essentially a FENOC group that does the training. It's a FENOC wide program; and we have trainers, facilitators that are responsible for that. Right now it's being done in our training organization. One of the facilitators has the ownership of that. He's reviewing it, he's going to make changes. We will do refreshers as needed and incorporate it into the ongoing programs. So, that's in process right now.

MR. MENDIOLA: So, it's done in-house by your own folks?

MR. MYERS: We do use some contractors along the way. We use, some mods have been talked about using contractors in the past, and we may do that from time to time. Generally, it's our program, yes.

MR. MENDIOLA: You mentioned it was FENOC wide. I assume it has been in use at your other plants?

MR. MYERS: We think, let me give you my personal thoughts on this.

Leadership in Action is, I think, a building block for your supervisors and managers and your culture. In my mind, at our other two plants, we're using that program pretty effectively to develop our future supervisors and leaders, you know.

I think it sets the standard of our people, and you

see the, the basic leadership principles, the strategies being used in meetings and the way we do business. The decision-making models we use and everything consistently.

When we come over here and we look at D-B, you see a lot of people had been trained, but it was more like a checksheet mentality. We got it done, but we're not, you know, we were forced to get it done, we got it done, but we haven't internalized it.

Part of what we're trying to do, include leadership strategies and behaviors on the boards in our room and all, start demonstrating that we're really as a senior team support that program.

I don't sense that it got the leadership support that we thought it was, but it's not a new program, there is some enhance many times now that we'll go make, now that it's been, I really looked at it very closely, and there is some enhancements we'll make, and we have that being done.

We're going to go back and refresh every one on that program and really start utilizing it at this site.

MR. ESHELMAN: Next slide.

Some of the indicators, again, more matrix for management. The monitoring process is going to give us a lot of information. We've talked about that. We'll be able to access that and cut and slice it any way to get some good information. Just a few examples; quality of

briefs, safety practices, supervisory behaviors. We'll be able to assess those and focus on corrective actions in those places.

Individual Error Rate, Human Performance.

Condition Reports. The quality, initial quality of those.

Next slide.

Some of the assessments. We're going to be using the Institute of Nuclear Power Operation as part of our ongoing evaluation process, as well as some focus assist in this area. They have some people in the Management/Human Performance area that were involved initially. They gave us feedback and we're going to use them to kind of give us another measurement once we have been in process awhile.

And the Restart Overview Panel. They're our critic, and they're going to make sure we are effective before we go forward.

MS. LIPA: Dave.

MR. ESHELMAN: Yes.

MS. LIPA: Before we go on to the next section, we're going to take a break. So, we'll take a break for ten minutes; be back at 10:45 and start again. Thank you.

MR. MYERS: You're a lot better than Jack. He only gives us five.

(Off the record.)

MR. ESHELMAN: We'll get started. When we last left off, we were talking about some of the initiatives in monitoring. In sake of time, there is a lot more important issues. I'll try to go quickly through this. Knowing first of all, the information is in front of you. It will be on the NRC web page as well as Geoff Wright himself will be personally validating, verifying and giving us feedback on that.

Standards and Decision-making was the only other area. Go ahead, Linda.

And, Lew already talked about one of the primary elements was the Decision-Making Nuclear Operating Procedure. Essentially, that's going to be our road map to make sure we go through the technical process.

Go ahead, Linda. Wherever you stop, I'll start talking.

Again, a lot of the monitoring we're going to be doing again is in the management monitoring. We had that data base being built that will capture a lot of these areas. And we have external oversight also.

Programs, Corrective Action. Dave has a project for himself, that's the Corrective Action, but we've talking about improvements in the programs themselves, the procedures, et cetera, which is the program we use, but

also the implementation, and that factors into discipline; how well we're following our procedures, our demonstration of ownership, our understanding of it.

So, we have actions in that area to address the programs; and as well, some building block plans, reinforcing standards.

Go ahead.

Now, if you see a corrective action, there is a long list of items; from initial categorization to the root causes and actions. That's all in Dave's house, Dave Gudger has that activity we're working on.

We have Oversight Boards, Corrective Action Review Board, which again has the plant manager now as the Chairman in Oversight.

Go ahead, Linda.

MR. MYERS: I think it's important to say, that's another one of those areas that in my mind, that should have been the way we do business here all along. And it's something we've done in the Building Blocks, but it will become part of the normal way of doing business; performance indicators we have on the Corrective Action Review Board and having the plant manager chair that board, rather than some lower level subcommittee.

MR. ESHELMAN: And, again, we'll have various indicators, performance matrix set up for

them. What we did skip is the oversight, and as we mentioned earlier, we have some programs right now; the Program Review Process, the System Review Process; that will continue. These will be permanentized as you would say, institutionalized in our system so we'll continue to do that.

Bill and his group are going to make sure we have right oversight, the right standards for the oversight, and at various levels. So, that was a part we skipped. And again, there is a lot of indicators of what we're using. A lot of them kind of inferred behaviors, and Geoff, you'll have the opportunity to look at some of those. I'm sure we'll get feedback from you. We appreciate that.

MR. MYERS: Let me stop here. I know we want to move. But for example, the Management Oversight Program and Weekend Duty Coverage. What we found here, is that it was not an expectation that the Weekend Duty Manager was in the plant. And at our other two plants, Weekend Duty Manager is in the plant working with shift supervisors, making sure we're monitoring weekend activities, that we're getting feedback from our operating crews; and then on Monday would go over what we saw on the weekends.

That wasn't in place here. So, we'll strengthen

that some. Once again, management involvement and management standards is a big part of this.

MR. ESHELMAN: I'll finish by saying that, in review of the various condition reports, not just head related, but pretty much all of them so far, there is two common threads. Has to do with understanding standards or clarification of standards and the other is management monitoring.

So, throughout this discussion, pretty much you heard a lot of repeat. First of all, set the expectation. Okay, make sure it is clearly communicated. So the expectation is what we communicate and we want to make sure it's in writing for all people to understand. The standard is what we accept. And if we accept a lower standard than our expectation, if that doesn't match, there is the confusion. That's why people don't understand the standard, because it's a moving target. A batter needs to know where the strike zone is.

So, it's important that we give our people the understanding of what's acceptable, and then more importantly as management we go out and monitor it. Because again, if you do nothing, it's slowly able to fade away. You need to be out there as management, need to be looking for behaviors, making sure you're reinforcing proper behaviors and correcting ones that aren't right.

Throughout this program, I say that is the key, and that's why we have the standards in new management and make sure we're clearly communicating; and then more importantly, we're out there reinforcing it and holding people to it.

That would end my presentation. If there is any questions. Otherwise, we'll head on to Dave Gudger, Corrective Action.

MS. LIPA: What page are you on?

MR. GUDGER: I'm on page 33, for my presentation.

MR. DEAN: Dave, I have one, kind of overarching question for you; and this really is for the whole management team. But, in going through this Management Improvement Plan, Human Performance, Organizational Effectiveness; you outlined a lot of different things that you're doing, lot of areas you're focusing on. I guess I would like to get a sense from you all as to what you believe are vertical elements here where you believe you need to see meaningful change, meaningful improvement before you think that restart is a viable evolution for this organization.

We've gone through a lot of stuff. I understand you can't have all that stuff in place at a certain level, but

there's got to be some things that you're really focusing on that you think provide the undercurrent for you to recognize that things are moving in the proper direction and safety culture is at the level you want before you move forward.

MR. MYERS: Let me answer that. I went back last week and we put in our 350 Building Blocks, we think, what that acceptance criteria is.

In general though, let me go through it. I think that we have to have our Engineering Review Board in place, and prove that engineering documentation got good rigor. I think that we have to have our Corrective Action Boards in place, and proving that we are properly classifying our products, and that in a Corrective Action Program, and that, that our root causes and basic causes are in good stead.

I think that we have to have our Management Observation Program showing that our managers are in the field finding and fixing problems. I think that we have to have a positive improvement, vertical alignment in safety culture of the station.

MR. GROBE: Along that same line, along that same line, I looked at page 41 and page 42, which are your overall performance indicators to measure improvement, pretty much summarizes a lot of

performance indicators that are through the first 40 slides.

You speak of vertical alignment. I think that's absolutely critical. And by vertical alignment, I think what you mean is that everybody throughout the organization vertically from the senior managers to the folks in the field doing the work have a common understanding of expectations and standards.

I don't see any of these performance indicators to measure improvement, including the assessment of that alignment. Most of it is counting issues.

MR. MYERS: I think the Safety Culture Work Environment Survey did that, Jack.

MR. GROBE: That's not on here. And your management observations is not on here.

MR. MYERS: Okay.

MR. ESHELMAN: I'll write that, thank you.

MR. MYERS: Certainly our intent.

MR. GROBE: Okay.

MR. GUDGER: Are we ready to move on? Okay.

For the benefit of the board here and the public, I'm Dave Gudger. Lew's introduction with my experience

goes further back than the Perry Plant. I spent 15 years at the H. B. Robinson Plant, at the Carolina Power and Light Company. I did receive a NSR certification at the Perry Plant and my background did involve bringing the Corrective Action Program off the ground at the H. B. Robinson Plant.

I come to this group as a new manager and my focus is the Corrective Action Process, and I am the owner. I accepted the position with the full understanding of how much lies ahead with correcting this program, as far as the problems that we have identified.

The purpose for what I'm trying to discuss today is to discuss the Corrective Action Program Improvement Plan that addresses the following items; Corrective Action Program Issue, as we understand it; the Interim and Compensatory Measures established for assurance of the program integrity as we move forward, and lastly, the Approach to the Long Term Improvement Plan, which I'm involved.

All our assessments show all program elements are in place. The issue lies within the implementation of the Corrective Action Program that was less than adequate as identified by the Nontechnical Root Cause.

I won't read through the bullets, but this is just a restatement of the cause as we know it. The process or

program elements have been determined to be adequate. We have two other nuclear facilities that use the present program and are successful and do not have the implementation problems that we have at the Davis-Besse Plant.

The first order of business for me when I came into position was to look at the staff and look at the organization to move forward. I have added the center leg to address the step Improvement Changes Necessary, under Tony Sillakoski.

I also took a look at the third leg to the right, under the Self-Evaluations Program, which I believe is the key to strengthening the implementation of our program.

I am presently looking for individuals that have the skills in change management and communications to strengthen the implementation. I am building a bridge. This bridge will encompass half the river, and I have to facilitate and support the other half of the bridge from the organization to take the ownership and accountability to meet me halfway.

The interim compensatory measures that I've completed so far, and I'm not finished, based on the first one; I performed a Barrier Analysis to look at the program and the flow, how the program works. I have identified areas that compensatory measures need to be added as well

as validating compensatory measures I've taken so far.

Some of these more important ones are Corrective Action Program Owners, which is my organization, are now directly involved with the management of categorization of condition reports, each and every day. I have director level support in this effort and we will continue until we strengthen the management team's approach to categorization.

The Standards Enhanced for Senior Reactor Operators. I work closely with the operations organization during their root cause effort to help in strengthening their standards and what's acceptable in their reviews; including timeliness.

Causal Analysis Review Group, which we refer to as the CARG for the acronym, has been established. It's a springboard from what Lew mentioned that was previously established at the other two sites. This is a very key action that we're taking to strengthen the implementation of the organization. I'll speak more to this in the following slide.

The Corrective Action Review Board is now chaired by the Plant Manager, which you've already heard. The Corrective Action Expert Facilitation has been established. We have an outside industry expert that is helping with the CARG and the Corrective Action Review

Board as well as myself in the mentoring.

And lastly, the Corrective Action Program Closure Review is another place where I've injected my staff to be an in-line review for closure of condition reports to ensure quality exists. So, I've injected myself on the front end and on the back end of the program.

MS. LIPA: I have a question for you, Dave.

MR. GUDGER: Yes.

MS. LIPA: The question I have, are these compensatory measures being proceduralized?

MR. GUDGER: Not at this time. As I get further in my presentation, I'm going to show you how my improvement plan will pull all this together.

MS. LIPA: Thank you.

MR. GUDGER: What I want to discuss a little bit, because it is what I think is a key comp measure, and more importantly it will be here to stay, is the new Cause Analysis Review Group, as I refer to as the CARG.

Review of basic cause evaluations and selected conditions adverse to quality is their charter. Ensuring cause quality and programmitic requirements are being adhered to. Provide peer review feedback to the evaluator

and approve long term quality behaviors is key.

They use it as Corrective Action Program users group. And lastly, more importantly, is the development of individual department corrective action improvement plans will be a responsibility of each member.

I can put together an improvement plan in a generic sense for the site; however, it's more important that each of these coordinators look to themselves for their specific needs. I think this will strengthen the overall implementation improvements of my efforts.

MR. THOMAS: What are the, what's the background training and evaluation techniques for this group?

MR. GUDGER: 12 out of 14 have received Root Cause Training, and the two remaining are scheduled to receive the new Root Cause Training to occur next month, the middle of next month. We also performed familiar, refamiliarization training with our expert industry leader, Tony Sillakoski.

MR. GROBE: It might be helpful for those on the phone, if you would just indicate what slide number you're on.

MR. GUDGER: Okay, I'm on slide 49.

What I would like to talk to which has been the

subject of interest this morning is our new Corrective Action Program, Performance Indicators.

The purpose of the indicators is to monitor transition, to improve the quality and ownership. Establishing performance category measures for each program attribute is to be in place by September 30th. It will measure productivity, timeliness, efficiency, quality and effectiveness. And more importantly, I am focusing on some of the qualitative aspects of what we believe a healthy implementated Corrective Action Program is.

MR. MYERS: Let me stop you there.

One of the things that's key is we talked about a performance indicators to improve the quality and ownership, I guess. You know, I'm familiar with our Corrective Action Program. I'm not used to a tremendous amount of performance indicators. Typically, at our Beaver Valley Plant and when I was at Perry, we looked every week at all the corrective actions that were coming up, and made sure we didn't have any late ones. There was not an expectation that we have latent corrective action.

We looked at our backlogs and we didn't have significant backlogs. And we looked at our implementation and our Corrective Action Review Boards. I personally approved every, every root cause that we did at our sites.

I really didn't need a lot of performance indicators.

At my staff meetings, after we approved a root cause, which is a significant issue, we routinely brought it back in, made sure we're following through on the corrective actions. But for where we're at now, and the numbers and what we're going through, we're going to need these performance indicators to help drive the culture that I'm talking about.

I think for that to work for us at the startup, it needs to get to where we meet those kind of criteria in the future; that Corrective Action Program.

I'm just, we throw a lot of CRs now, you know, that we're shut down. We probably need this. In the future, I will expect that backlog to go down and us not to have, our corrective action to be timely, more timely than that. Okay.

MR. GUDGER: And I'll expand on the performance indicators with regard to the qualitative statement I made. A couple of examples, I'm looking at the CARG membership and assessing each individual member of the CARG and report back to their management. Additionally, I am looking at the management's miscategorization of condition reports each morning. This is just a couple examples of how I'm trying to look at our behaviors and whether we're meeting the ownership and accountability

expectation, as Lew discussed in our mission and vision statement.

Next slide.

MR. GROBE: Dave, are those performance indicators going to be included in your weekly report?

MR. GUDGER: Yes. They are, Jack.

So, how am I going about my long term improvement plan? This is a graphic depiction of what all I have to consider in order to create a plan.

The first block there is CR, a condition report, 02-891. This is the Nontechnical Root Cause and 16 corrective actions I've received. The Open Corrective Action Program Condition Reports, which came from various areas of the organization. And lastly, the Program Compliance Review, which includes significant condition reports.

I've established two Root Cause Teams. And, I also want to stress their focus self-assessment. The first time is Human Performance and Implementation Team, which is the larger of the two groups. And the second one is the Infrastructure or the Program Team. These teams are comprised of outside experts in each of the three facilities program owners.

The output of this effort will be a Restart Action Plan for items to be performed prior to restart, items of significance that will be performed post-restart, and thirdly, a three-year business plan outlook.

In conclusion, we believe we understand what the Corrective Action Program issues are. We have interim measures to address them, and we're developing a long-term improvement plan to ensure continuous improvement and sustained performance.

I am the owner of the Corrective Action Program, and I will set the example and the leadership role for accountability and ownership for the site.

MR. DEAN: Dave, can you give us a sense as to when you expect to have your Restart Action Plan available?

MR. GUDGER: Yes, by the end of October.

No other questions?

I'll start on slide 52. I'll turn it over to Bill Pearce.

MR. PEARCE: Good morning.

MR. MYERS: Let's go back to that. The end of October is very close to startup. We already got a lot of our correction actions in place.

The problems that we had were not write -- we were

writing CR's, it was classification of CR's; and I think we can measure now that our CR's are being properly classified today. So, I think that's in place.

The other thing was timeliness of corrective actions. I think we're going to have that in place too, because we want to have all of our CR's as we speak right now, system reviews and program reviews, and we have -- what's that CR review board?

MR. GUDGER: CARG?

MR. MYERS: No, the ones where we go through each CR for startup.

MR. GUDGER: Restart Station Review Board.

MR. MYERS: So, Bob Schrauder leads that board and he's going through every CR, has gone back and gone through every CR since the shutdown.

So, a lot of our corrective actions for startup are in place. We've got to validate that we properly classified and taking actions on the CR's important to this plant prior to startup. Our Building Blocks take us there. Okay.

MR. GUDGER: Not withstanding, we're working through the condition reports.

MR. DEAN: Then what would be the expected use of the output of the Restart Action Plan?

MR. GUDGER: My Restart Action Plan, it is to formulate a program that will increase performance in a sustained way beyond restart.

MR. DEAN: So, that sounds like something you would want to have in place as a framework before you did restart?

MR. MYERS: Oh, yes.

MR. GUDGER: Yes.

MR. PEARCE: Absolutely.

MR. MYERS: Absolutely. But we're not waiting until October to take actions.

MR. DEAN: All right.

MR. GROBE: I guess I'm not clear then. Could you explain once again, what's the difference between a Restart Action Plan and a Post-Restart Action Plan?

MR. GUDGER: Our process and our procedures, I'm required to make up an Implementation Plan in response to this Program Compliance Review, and all the RSRV decisions for the condition reports that they coded.

In addition to that, I want to bring to your attention was, I'm pulling this all together. There are management discretion items that need to be done after restart, in addition to a long range three-year business

plan. That's the sustained performance aspect of my planning actions. Does that answer your question, Jack?

MR. GROBE: I think so.

MR. PEARCE: Okay.

Good morning. I'm Bill Pearce. I'm Vice President of Oversight for FENOC. What I'm going to talk about this morning is Safety Conscious Work Environment, and I'll try to explain that.

First of all, I'm going through the assessment structure and methodology that we use, and then I'm going to give you the survey results and then the actions to address assessment findings and finally of course the conclusion.

All right. First, under structures and methodology, we used a team. We had Ken Woessner from Beaver Valley; we used Stewart Ebneter, an independent consultant; and we use Morgan Lewis, some of the attorneys from Morgan Lewis to help us do that, as they had experience in this area.

It is really based on the NRC policy statement on freedom of employees in the nuclear industry to raise concerns without fear of retaliation. That's the actual basis for this. And this survey instrument that we used is a widely used instrument for the most part of it. We did add some special areas to it, but we wanted, since we had some baseline, used this survey previously, we wanted to

see how it had changed with the event that we had.

So, I'll go through this. I'll go through the results.

The Structure and Methodology. We did a survey and we surveyed essentially all the Davis-Besse personnel on site. Only about one third responded. The survey consists of 26 questions, which the workers were asked to respond whether they strongly agree, they agree, they are uncertain, they disagree or they strongly disagree with statements. So, that's kind of what you're going to see the result of.

The performance indicator, indicators that I'm going to show you, are the number of condition reports initiated, the number of NRC referred allegations, and the number of concerns brought to the ombudsman.

Under personnel interviewed, we interviewed the Ombudsman, the HR Manager, Regulatory Affairs Personnel and the Safe Conscious Work Environment Leads from three primary Davis-Besse contractors. That's Sergeant and Bechtel and MPS.

Then we did an diagnostic quiz. We provided that to 20 Davis-Besse supervisors, managers and directors. So, we did a diagnostic of the supervisor level up. And, you'll see the results of that.

Now, the survey results. The first part of it is,

is willingness of workers to raise concerns. What we have here, if you look at the three columns, we have 1999 survey that was completed with these same questions; and then we had a survey that, helpfully enough, we did just prior to knowing we had this issue in the first part of 2002; we did the same survey, and now we've redone it in August of 2002. And so, you'll see the issues.

First one is ability to challenge nonconservative decision by management. You can see actually that issue has improved since 1999. Every one of these, you're going to see a pattern, most of them you'll see a pattern.

In 1999, the survey results were, I would say poor compared to the industry for the most part. In the first part of 2002, they were actually real good, greatly improved result. And then in August, after we had the event, then they have degraded to some degree again. So, that's what we see here.

70 percent is the number that agree or strongly agree with these issues in the first bullet.

Feel free to approach management with nuclear quality concerns. 80 percent agreed that they could do that.

The willingness to raise nuclear quality concerns without fear of retaliation. You can see in '99 it was 73; and the first part of the year it was 89 percent and now

after the event, it's back to where it was in 1999.

Under one of the performance indicators, was condition reports initiated, and you can see that in '99, the number; 2000, and then 2001, and this year we have so far, a much larger number, and a lot of that is driven by the event we've had and the issues coming up and what we've done to document those issues.

The next one is management wants concerns reported. You can see that there is more doubt now about that issue than there was in 2000, the first part of this year. Management is willing to listen to problems. That has degraded since the first of the year, although it's improved from '99.

Constructive criticism is encouraged. Again, it's improved, but since '99, but degraded since the first of the year.

Management cares more about identification and resolution of nuclear quality concerns than cost and schedule. Now, we didn't ask this question before, so we don't have the previous history; however, only 39 percent agreed with that.

Now, I didn't realize that, this, when we wrote this survey. When we were going through the survey, we were still, I think doing the management root cause at the time. But that is the management root cause, is, remember

the balance between cost and schedule, and safety was what the issue was. And only 40 percent of the respondents agreed that we cared more about the resolution of nuclear quality concerns than cost and schedule. So, I think in reality, it took me awhile to come to this conclusion, I think this really validates from the employees view the root cause that we did.

Next one is the Employee Concern Program. In this particular plant, we call that the Ombudsman Program. This is, when employees have concerns, they go through their management. They have some issues they don't want to take to their management, or they've already taken to their management, haven't gotten it resolved or maybe it's about their management, but they need someone else to help them with it. This is how they feel about that program.

I can use an employee concern program without fear of reprisal. 85 percent felt they could at the first of the year. And then after we had the event, only 70 percent felt they can do that presently.

That the ombudsman will maintain confidentiality; and only 66 percent or two thirds believe that the ombudsman will maintain confidentiality.

Upper management supports the Employee Concern Program. Only 60 percent agree that upper management supports that program.

And I'll tell you, that the, I think this is an important program in a nuclear power plant. It gives employees a way to bring forward safety concerns, and get those issues elevated. When they try the normal system and it doesn't work, it gives another path or method to elevate those issues and ensure that they get resolved.

You can see the strength of that is indicated by the survey is certainly not where we want it to be, and at the end I'll go through some things we're doing to correct that.

In fact, Dave referred to that, you could see that through our management plan, a lot of the things we are doing is aimed at that issue.

Then performance indicator at the bottom is about the ombudsman contacts. And you can see, although there is a lot more this year and lot more investigations, with the amount of issues going through as a plant, I see that as a consequence of the amount of issues that are being brought forward at this plant, and not having a healthy environment or feeling that the management will resolve the issues when they're brought forward. So, that's kind of how I see that.

Effectiveness in resolving issues using normal processes. Again, I want to tell you that I look at these questions; I think they validate what Dave just told you

that he and his team have found by looking at the Corrective Action Program; that this is the employees view of the Corrective Action Program.

The Corrective Action Program is effected to identify potential and nuclear safety quality issues. Only 57 percent agree with that.

Free to report concerns using Corrective Action Program without fear of reprisal. 71 percent agree with that, which I think that is pretty good.

Issues in Corrective Action Program are prioritized appropriately, investigated thoroughly and timely resolved. Only 41 percent agree with that. And that, in fact, I think validates the issues Dave says are problems in the Corrective Action Program and what we need to get resolved.

MR. MYERS: Stop there a second. In the four C's meetings, we hear over and over again, we write a CR in our process and our job is done, you know. If we write a CR, our job is done. We're not giving good feedback, and we created that culture that once we write the CR, the job is done.

The message that we keep saying is, when we have a safety concern, you wrote a CR. There is no job done and there is no organizational structure. You need to continue to drive that to the highest level of our organization

including PO, ombudsman, or you guys.

So, we're getting some of the same things, and I would say validates it in the 4 C's meeting and group meetings also. We've got to fix that.

MR. PEARCE: I wrote these other two, Corrective Action Program is effective to timely resolve conditions adverse to quality, was 42 percent agree with that.

Corrective Action Program is effective to address root causes and broader implications of nuclear safety quality issues, 45 percent.

The performance indicator in this area is NRC allegations. These are issues that the employees have, that they feel the need to not use either the management or the Employee Concern Program, but rather the need to go to the NRC to ensure that the issues get resolved.

And you can see so far this year, we've had 25. I'll tell you, based on the industry experience, that's a fairly large number so far this year. And I guess I would say, that there is a lot going on at the plant and some elevated numbers normally associated with a plant that's going through some type of event.

So, I'm not trying, I hope I'm not trying to rationalize that it's okay for that to happen, but rather tell you that we have a need to do some of the things that

we're doing to strengthen that program.

The next area is management effectiveness in detecting and preventing retaliation. Another important issue. And, none of these issues have been previously surveyed at this site. These were ones we wanted to look at and see where we were and what we needed to do. There is not a lot of industry experience about what would be a normal amount or bad normal amount, so I'll go through them.

I have been adequately trained on the various processes for reporting and documenting nuclear quality concerns. 72 percent agree that they have had that training.

My supervisors/managers have been adequately trained on various processes for reporting and documenting nuclear quality concerns. 61 percent agree with that.

I have been subject to, the term here is H I R D; it stands for harassment, intimidation, retaliation, or discrimination; for raising nuclear quality concerns. We had 7 percent of the respondents said that they agreed that they had been subject to that.

Now, let me tell you, I've read every survey result that came back; and there is a long time period, as we all have, if we ever feel like we've been treated in that regard, it lasts for a long time in our minds; and a lot of

the issues are several years over there.

In fact, I could only think of one of them that I saw was around the issue that we had on the head. So, our next survey will give us some update in that regard.

Then the last bullet is, I know of instances in which workers in my work group have been subject to the harassment, intimidation, retaliation or discrimination for raising nuclear quality concerns. And those, some people wrote in what they are. They generally corresponded to the folks that have said that they had, had some issue with that.

So, what do you take from that? What I take from that is, that the management team has not been effective in making folks feel like that they can bring issues up and have confidence that they're going to get resolved; and preventing even the appearance of retaliation for people bringing issues up. And, so, when we talk about corrective action, we'll see how we address those.

The first thing is the Safety Conscious Work Environment Action Plan; and what we did with that action plan, as a result of this survey, we came up with the action we thought needed to take to resolve those issues.

And we then put it in what Dave was talking about earlier, the Management and Human Performance Improvement Plan. And, we also are going to add additional resources

from outside Davis-Besse to assist in implementing the action plan. We're in the process of trying to find those folks now and get them in here.

One of the big issues is willingness of workers to raise concerns and management support for raising of concerns. I see here, some of the bullets of some of the things we're doing there. We talked, for instance, we talked about the 4 C's meeting. Part of it is in my mind, is a trust issue with employees; and I think you can generally see some trust issues soon after you bring in a new management team.

So, it's important for Lew and some of the other folks to get some face time with employees to let the employees see what the values that they have are and gain some trust, so they're more willing to bring those issues forward.

The next thing, go to the next slide.

The Employee Concern Program. What we've had in the past is a Ombudsman Program, which kind of is a passive program, that waits for employees to bring issues to them. We intend to go to a proactive model, where we're going to go out and solicit issues.

Now, I'll make this a little bigger than it is in here. You heard Dave say something about the People Team. Well, the People Team is a piece of the issue and the

Ombudsman is a piece of that. That is, to find out what concerns there are out in the plant by employees, to go out and actively solicit those issues, whether they're brought forward through the, through the Condition Report Program, whether they come through the HR. We have HR themes that boil up; people are concerned about their pay or this or that. Whether they come from a discipline issue, from a performance issue, this people team is going to go look at those issues.

A subset of that is Employee Concerns, where employees have concerns that have a, some safety implication or have some concern that needs to be resolved. And a part of that is employee concerns, and of, those, as I said, we'll have a corrective model. In the past, we've used the management people in the organization to go investigate the issues that came forward. In this program, we're going to use some investigators, independent investigators to go dig into those, and make sure that the employees don't have the perception that their issues are not being treated properly, because their own management in some cases do an investigation of the issues that are brought forward.

So, that's kind of big picture of how I see we need to change the program.

MR. MYERS: One of the things

too, with all the changes we've had in management right now, the issues that we've seen here; what that does, that does monitor the effectiveness of management also.

MR. PEARCE: Right, absolutely.

MR. MYERS: So, we think that's a necessary additional ingredient that we need here, with the issues that we're seeing. So, I think you asked what are some of the key things. Right there is one of them. Investigators, I think, are going to be a key part of seeing how effective has the management been.

MR. PEARCE: Next area is management effectiveness in detecting and preventing retaliation. We're using a proven training program used a lot in the industry. And we're bringing in, in fact, we've already reviewed it. We're going to have it taught by a group of people that deal with the issue of safety conscious work environment issues. And we're going to train the officers, the directors, the managers and supervisor to, how to deal with this kind of issue, so that we avoid having any misperception of retaliation or chilling effect of this kind of issue.

And that's one of our problems, is our folks I don't think always understand how, when they respond to issues, it's taken sometimes, or perceived to be taken.

Talked about the People Team. And the Issue Management Process, the last bullet on that page, just refers to how we're going to deal with issues with the People Team or the Employee Concern Program.

Rather than go through every one of these bullets that's left, most of them are fairly self-obvious. What overall we're going to do going forward, is we're going to do another survey. And I fully expect right now at least that we're going to do another survey before we restart.

But, we've got to time it such that we get some of the things done that we see are actions from this survey before we do the next survey. And that's important, because, I mean, I wouldn't expect that we would see much difference in the results unless we do something about what they told us the first time. So, we have to get some of these actions in place and when the timing looks right, we'll redo the survey.

And I really do believe, as Lew suggested, that we're already seeing some effect from the 4 C's meeting from the All Hands Meetings, from some of the actions we've taken to communicate to the employees. I think we're seeing some things changing that are going to effect the survey, but I will wait until we get the training, especially of the managers and supervisors completed, and get that done and the case studies done, because the Safety

Conscious Work Environment is going to be part of the, of the case study training that we do for all the employees.

So, I want to get that done and then we'll be ready to do another survey and see how the results may change.

In conclusion, I guess what I would say about this is that I think we've, we had a feeling that we ought to do this survey, even though we knew with the things that had happened at the plant, and people feeling bad about themselves, their job, that survey results were probably going to be less positive than they were before this event happened. It's important for us to get this and get the feedback from the employees.

The good part about it, in my mind, is the results, even from a completely independent means, validated, to me, the Root Cause that the team came up with, using a wholly different process. It validated the second part of the Root Cause, which was the Corrective Action Program, and looked at the results in this survey on the Corrective Action Program; how the employees perceive and feel about the Corrective Action Program, is where the rubber meets the road. And, so, it validates I think the issues that we found and the Corrective Action Program also.

So, overall, although we got some negative results, I think that it helps us understand that we're headed in the right direction with the corrective actions that we're

taking to improve a lot of the processes at the plant; I guess is how I see it.

Do you have any questions?

MR. THOMAS: Bill, what, if anything, will be done to increase participation in the next survey?

MR. PEARCE: Well, one of the things I would think we're going to do is we talked about it in one of the All Hands Meetings, the results of the survey. And it's got to be voluntary. I don't want to make it a requirement for people to respond to the survey.

But at one of the All Hands Meetings, we talked about the results. And I think any time that you advertise that you have listened and you understand what folks need, it's likely to increase the participation, because they see that we're taking actions based on what they told us. So, people that do want us to get things changed are going to be more likely to participate in the survey.

MR. MYERS: We had leadership help us.

MR. PEARCE: In fact, we had a meeting with the leadership employees the other day, and we asked their help in getting our folks involved. So, we're doing a lot of things that will, that will increase the participation.

What I rationalize to myself, all I've talked about are the absolute facts, but what I rationalize to myself, if you only get one third of the people that you surveyed to respond, what does that mean? If I rationalize it, I would say that it would tell me that probably we got a higher percentage of people responding that had some issues.

You know, because if you got an employee that has an issue, it gives them a means to get their issue down. Someone who didn't have an issue of any kind, probably don't care enough to respond. So, but that's a rationalization. And these kind of instruments, you've got to look at just the facts that you get and not try to do too much conclusions or drawing conclusions from some of the stuff.

MR. MYERS: The answer to your question, we're going to get the numbers up.

MR. PEARCE: But we're not going to arm twist to do that.

MR. DEAN: I have a couple questions, and maybe a comment. In looking at the results from 1999 from the survey, there is a dramatic change between '99 and the survey you took in January; were there some positive actions that were taken by management here to address that? And if so, is there some issues here in

terms of sustaining of those?

I don't disagree, but I've seen issues like this before at the other plants, we have a traumatic event, the organization looks at itself in different light and maybe judges itself a little more harshly. So there is some I think reality associated with that. But you know, it just, it's kind of like a roller coaster here, it seems to me there should be some positive action statement.

MR. PEARCE: Bill, I can tell you that there was a, I think there was some positive changes at Davis-Besse in the years while this event was going on. There was some negative things happened; on the other hand, I think there were some positive things happened in the leadership area too. And that showed in here, is that people did feel like, for the most part, that they could bring issues more easily updated.

For some reason, and I think it's part of communications that were going on at the time, they felt that they could communicate better with their management. And that's probably just my own personal feeling about what I see was driving that.

MR. MYERS: Lot of the management came out of this organization. A lot of management we have now came out of the organization. So, there is, they don't know us. And if you look back in the

'80's, early 90's, you know, a lot of that management then didn't come out of the organization. So, we went through a roller coaster as a plant in that area.

What we've got to do now is get, I've heard it referred to as suction of the pump, developing our people from a technical skills standpoint and managerial skills, lay that out, so that we get off this roller coaster and get sustained leadership performance to this site, from a management leadership standpoint.

MR. PEARCE: Let me add one more thing to that. In January, the plant was, if you take, for face value what the values were at the time, right, from a production standpoint, from a long run standpoint, from a no visible issues standpoint, doing very, very well in January. With a 500 day run at the time. Wasn't a lot of visible problems on the table at that time.

The actions that they had taken, seemingly had produced favorable results. That probably had some influence on the survey in January.

MR. MYERS: When we bring people in, some of our outside agencies and bring them in to walk around the plant; they walk around this plant and say, this plant is in really good material condition. It really looks pretty good. Probably looks better than our

other two plants from a material condition standpoint.

So, you know, there's a lot of things that were going right at that time.

MR. PEARCE: At least it was going right in the perception for the values that were being held.

MR. MYERS: That is right.

MR. MENDIOLA: Clearly, that has some bearing maybe, if you will, on the atmospherics around the January 2000 survey, but what about the atmospherics surrounding the '99 survey, whose results are somewhat closer to currents results you just got in August?

MR. PEARCE: I don't have any personal knowledge. Although, I've discussed that in some regard with the ombudsman. His view was that, he was concerned in '99 when they did the survey, and he was trying to take actions, especially in the area of Employee Concern Program to improve the feeling of trust. He felt that 2001 survey was, was a great victory on the things he had been doing trying to get better feelings about the Employees Concern Program, for instance. But in some of the other areas, I really don't have any personal knowledge of.

MR. MYERS: I've got a little more knowledge there. I went to Beaver Valley in '99. And

right before that time, you remember the year before, was a tornado; the performance of the plant had gone down; we were changing some managers out at that time; a lot of things like that going on. So, prior to '99, '99 based on the '98 performance, was probably not the highlight of this plant.

It looked like we had been recognized as an excellent plant by many; I don't know how to say this; many organizations, industry organizations, a lot of plaques on the wall; and that performance decreased in '98 and '99, you know. So, you saw, you saw that beginning to happen then.

We, as a management team, at that time took what we thought were some subtle actions to make some corrections. And, you know probably not as strong as we should have been. I don't think we got down to the heart of the issue, you know. So, I understand those results in '99.

MR. PEARCE: You speculate.

MR. MYERS: Yeah, I think you do. And that was only, I was at Perry and then I was on the Oversight Board. You could tell it was a big letdown in '99, you know. I sensed that when I come over here.

MR. DEAN: The only other question I have, Bill, you might have addressed it; I might have missed it, but in terms of looking at the this data.

Obviously, it's one tool to get a pulse of the staff, and their views on this. Have any of the other activities been ongoing, the 4 C's, the ROP, the other meetings with the staff; have they touched on similar areas and is there some correlation that you're seeing there from those types of discussions?

MR. PEARCE: Yes. I believe that. In fact, Lew and I have talked about that. The conversations that we've had with employees have substantiated, however there is no numerical value you can associate with it to understand what percentage it is or anything. These issues are certainly substantiated, on the individual basis in conversation.

Wouldn't you agree with that?

MR. MYERS: Absolutely. If you go to look at the corrective action, every issue we have; writing CRs, influence to bring issues forward. One of the things we're doing in our 4 C's meetings, we have an organization effectiveness person that facilitates the need, and groups all the questions together, so it's sort of confidential; like you really didn't want to bring your question directly up to me.

And then a couple days later, after we group questions together, and they come out with a group team question rather than individual questions, I would go back

and meet with the team. And to a person, your issues about, you know, we want stability of management; we want off the roller coaster, if you will.

We want some stabilities of management. We hear that over and over again. We want stability and direction. We work hard, you know. I mean, it's not our fault. And I'll be the first one to say this; it's not their fault.

The behaviors we're seeing are a reflection of the senior management team; and you know, so you get what you expect. So, you hear a lot of same issues, exactly the same issues.

And I can also tell you that, you know, we're taking actions; we're demonstrating those actions; communications to employees. Before we had the public meeting with you guys yesterday, we had sort of a mini All Hands Meeting with employees here to tell them first what we were going to say, because they always say they read it first in the newspaper; and that's not right.

So, you know, we're trying to deal with those issues. I really believe that we will see, we've got to see a good improvement in this area for restart. I know that.

But I also think taking a survey now, we thought that was our low point. So, we took it then. You know,

when you're struggling like you were, it's a good place to benchmark at. We could have waited until we got a lot of things in place. What do you call it, get better performance indicators. This looks pretty nasty. So, we took it at our low point, we think, and we would expect to see improvement at restart, you know.

MR. DEAN: Your point about senior management and stability and so on and so forth, I think has some validity in terms of senior management setting the tenor, setting the expectations, but when it comes down to the execution and implementation, the first line supervisors that are the direct influences on assuring that people are comfortable bringing forward issues and so on and so forth.

Can you point to those things in terms of your actions where you think the direct focus with your first line supervisors is the key elements?

MR. PEARCE: Yes. In fact, Lew pointed those out earlier. Do you remember when he talked about vertical alignment? That's exactly what he's referring to. The only way to get vertical alignment is to get through the first line supervisors. And that's the most important issue, is to get the organization aligned so that all of you have the same values and follow the same principles and that type of thing. So, all that is aimed

exactly at that, Bill.

Now, from a safety conscious work environment specifically, like the training, you can see that we aim the training at the managers, the directors, and the first line supervisors to get through all the supervisors from that specific issue; but that's much too narrow to address this issue overall. It's about the vertical alignment of the organization.

And, that whole program, our whole program is set up around that. It is the most important thing that from a people perspective that we've got going right now.

MR. MYERS: There is a big, as a manager, if you're not involved; you don't get involved with the jobs, you're not going in containment, not coming in on the weekends; what your relationship with your first line supervisor, you know?

It's bad when the President of FENOC says I was in containment more than most of the managers at the last outage. They keep telling me that, so I keep repeating it.

MR. WRIGHT: Bill, one thing you alluded to a couple of times in the presentation here, but wasn't expanded on, and one of the hard things about this whole event was not only did we have, you know, the degradation of the head and degradation of programs at the

site, but you had just an overall declining expectations and performance of the entire site, which means that, you know, internal assessments by themselves aren't going to show anything, because the goals and expectations are riding down the hill with the organization.

Can you address a little bit about what you're doing and what you're looking at, to look at the organization as a whole to prevent that from occurring?

MR. PEARCE: I sure can. If you remember looking at the, Dave Eshelman talking about your Quality Assurance Program, that is the root cause of the quality assurance issue. It set the standards and behaviors of the Quality Assurance Organization parallel to the line organization, because they reported to them; and as they, as the standards, declined in the line organization, so went the Quality Assurance Organization.

Some of the actions that were taken in that regard is, we're setting expectations in the line organization. And, you heard us talk about the Operations Group, for instance, doing that. In addition, the Engineering Group has already done that. And the Maintenance Group, I don't know how far they are along, but they are in the process of the same issue.

But just as importantly, is the Oversight Function. One of the most important ways to me to raise standards is

to use, we can use the Quality Assessment Organization to do that. And what we're doing there is, we're going to bring a very heavy focus on Appendix B.

For the audience, what those are, those are the bedrock standards that's been in our industry for a long number of years, and the focus on those issues clearly is what segregates the nuclear standards from the standards of the other industries. And we're all familiar with it, I was just trying to define it for you for those of you who don't understand what it means.

But we're going to focus our quality assurance on the Appendix B issues and make sure our folks will understand that, what that means to us, make sure that we have it internalized; and if we go out and then look at the organization for their conformance to those standards.

In addition, another place we failed, in my opinion, was in the Company Nuclear Review Board. What that is, is an oversight panel of out -- comprised of outside, people outside any of our company organizations that are supposed to oversee not only the Quality Assurance Group, but the operation of the plant overall. And we failed to detect the issues in that organization also.

And although I haven't completed the actions, and I really am not at liberty to put out some of this stuff yet. One of the things I can tell you is, in that organization,

we're going to focus on safety issues and not management issues. That's one of the main findings, is that it got, it started looking at management issues and how we're managing the plant and not standing back and staying focused on the safety issues of the plant.

Like I said earlier, some of the indications of this issue are almost apparent from those of us that do this a lot for a living. They should have been more apparent. And, the fact that we failed to detect them is hard to understand, but we should have been able to.

Had we focused more on what are the safety issues, how do we make sure we've got those well in hand, and now and only then can we start looking at the operational issues and some of the management issues and that kind of thing. That to me, going forward, is what we've got to get fixed.

So, I think that's how I see. I think what your question is, right?

MR. WRIGHT: Yes.

MR. GROBE: Bill, I'm a little concerned about, you say, Concept of Safety Conscious Work Environment Survey. Clearly, the surveys to-date, one you did in August, provided you keen insights on this.

As Scott mentioned earlier, it's a little disappointing that the contribution was at a fairly low

level, but it provided you insights.

This area of performance is going to be a key in restarting the plant.

MR. PEARCE: No question.

MR. GROBE: And my concern is that, recognizing that, people might learn how to answer the questions correctly to give the right answer to get the plant restarted.

Have you thought about that, and how are you going to address that as a potential problem?

MR. PEARCE: I've thought about it, Jack, but it's a hard question to answer.

MR. MYERS: Let me answer that. I don't think you can answer that question from a simple survey. I think you've got to stand back and look at the assessments that we'll do, the ROP Team will do, the People Teams, the 4 C's Meetings. I think you've got to look at all that.

If you -- I mean, people aren't bashful. That's one of the things that I can guarantee you from meetings I've had, is they're not bashful. And you know, I think that I'm, you're going to have to look at all that and do a management assessment, using the survey and the other tools, to allow me to think the safety culture is improving here.

MR. GROBE: Lew, do you have some sort of way that you are regularly integrating the information that you're going to be receiving from these various sources to get a broader sense of the health of the people in this area?

MR. MYERS: I think the answer to that is yes. I believe, if you go look at this whole building block, we try to take the results of this survey, try to take the results of 4 C's, we're getting back out of the employee meetings we're having with the ROP Panel. For example, the ROP Panel gave me some feedback a week ago, and we met with the team and we've already taken some actions there.

What you find is the feedback that they were giving me is actually the same feedback we're getting out of 4 C's. So, it had to do with the overtime boxes. That went, that went from a complaint to a compliment at the last meeting. So, we're just going to keep raising issues.

MR. PEARCE: Let me address one more thing. Some of the issues that are culturally based, it takes a long period of time to change someone's culture, but it doesn't take so long to change a behavior. And in some cases, I know you recognize this, because the O350 Process does not stop at plant restart.

I'm sure we're going to end up with some issues at the end that we see that we have not gotten totally resolved or don't, maybe it's just that we're unable to demonstrate in some method that they're totally resolved to our satisfaction.

And in those cases, we may have some extra barrier, extra method of monitoring whatever the performance issue is, such that -- and I'll give you an example. How about some of the extra oversight that we have in Corrective Action Program. We may choose to continue that even after restart, because we want to make sure that the, some of the issues that we have there, continue to stay fixed until we can assure ourselves that the, that the normal program is going to take care of them.

But, the requirement is, or the thought is in my mind, that we need to make sure when we restart, that we're getting corrective actions dealt with properly, we can demonstrate that, we feel confident that we've got that, but that may take some, some extra barrier for some period of time even after restart for us to get through some of the longer term internalization of our employees and that kind of stuff.

MR. MYERS: I'm excited, I mean I am excited about investigators that we're bringing in. We've got independent investigators, you know. First

that sends a chilling effect, especially if you're a manager or supervisor.

MR. PEARCE: Definitely chilling.

MR. MYERS: But it does. You say, why would you want those investigators, don't you trust us? It's not a question of trust, because you do trust them. But your first instinct is, why would you do that?

Well, you do that, because you want some independent assessment of the behaviors, so you can make the corrections you need to make. All right?

It's not a question of trust, but the first time we say that we're going to have these independents, rather than doing it in-house by the groups, that we're going to have these independent investigators do these assessments, you know, concerns; what do you think the reaction is going to be from the managers. You don't trust us. They're after us. I can tell you what they are.

But we've got to overcome that. I'm excited about that opportunity, because I think it's going to help us assess our own behaviors at the management level and make the adjustments for the supervisors that we need to make, you know, to be independent. It's hard to see it yourself.

MR. GROBE: Many of the areas that you're assessment performancing are fairly easy to assess with relative indicators. This is an area that is much more complicated to assess. And you've described in each of the sections, we went through some of them rather briskly, but you've described a number of performance indicators, and I think you've indicated that might develop some more.

It might be worth while to put some effort into looking at how you're assessing the coherence of how you're assessing performance in this area, and how you're bringing together all those areas of performance indicators to give you an effective indication of organizational effectiveness.

MR. PEARCE: Okay.

MR. GROBE: And how you're going to review that, who is going to review that and what period you're going to review it.

MR. PEARCE: Okay. We'll look at that, Jack.

MR. MYERS: You know, we do, one of the major tools that I use in that area, is this link in the Associates Group. We've got them working in our Maintenance Organization, Operations Organizations and the 4 C's. You know, what is the overall organizational

effectiveness of the actions we're taking, you know? I would hope they could help us with that question you just asked too, so.

MR. GROBE: Other questions?

Okay, why don't you go on, Lew.

MR. MYERS: Let me get a little closer here.

You know, we shared with you and the public that we completed our Root Causes. So, what I wanted to clarify today, there is a lot of root causes and they all feed into a group of toolboxes, if you will, five areas of the Management Improvement Plan. I think we did that.

We've developed Corrective Actions, a group of tools, if you will, that we're taking in each one of those areas. And we'll continue to share those Corrective Actions in our work plans as we go forward.

To-date, you know, we've changed a lot of managers here at the plant. We've changed a lot of managers out at FENOC, at the senior level. I also have the title of Chief Operating Officer that I didn't have before. Sooner or later, there will be another vice president at the site.

I'm handling both positions now, but we're going to make sure that the leadership is consistent. It's not going to be a roller coaster. That's my job. I'm proposed to do that.

We've developed engineering standards. We've done safety culture survey to benchmark. Engineering Assessment Board has been established. It's becoming part of our internal organization.

Then finally, the Restart Oversight Panel will not go away at restart either. You know, maybe I need to change their name.

We've added an executive in operations, that will be with us for fairly extensive length of time. We've got weekend coverage requirements now. Project Review Committees have been, have enhanced oversight. Corrective Action Board is now chaired by the Plant Manager, has performance indicators.

The Restart Oversight Panel. They are really high level group of independent executives, providing us feedback of the needs of our own employees. Takes nerve to let them go out and have meetings with your employees, but that's that management courage we're talking about. Then augmentation of our Engineering Organization.

So, we've taken those actions. And then the 4 C's Meetings, Town Hall Meetings, the equipment upgrades. Key important part, I think, that we haven't talked much about is the restart of the plant. I mean, if you want to set the standards, improve the quality of the asset. If you want to set the standards, improve the quality of the

asset. So, we have to demonstrate that we're improving the quality of the asset, you know, to set the standards of employees.

On the way up, we intend to start up with, by addressing a lot of mods, that we have to make; a lot of material condition improvements, like reactor coolant pump maintenance, thermal walls that we're working on, feed water heaters. Improve the quality of the asset. Training programs. So, we'll have to do that.

I would conclude by saying behaviors, once again, it's not necessary to sit up here talking about the Davis-Besse employees. Let's talk about us. Behaviors are a reflection of the management team.

We focused today on the Improvement Plan. Key process there is Corrective Action Program. We've got to have that, so we think it's ready for restart.

Engineering Assessment Boards have to ensure the quality, engineering products are good. Corrective Action Review Board; make sure we're properly classifying our CRs and doing, we're identifying stuff. The Management/ Supervisor Assessments; that's to make sure our standards are being implemented on procedure adherence.

Prejob Briefings in the field. If we had done a better job of that before we found the head problem. Vertical alignment of our values and we have to measure

that effectively. And our standards and our safety culture, we talked a lot about that.

And finally, improving trends and material condition. That's got to be a key element of restart. Are you improving the quality of your asset? You know, I would be asking that.

And so, if we do those things, I believe we will be able to come to you and tell you, we feel the management team is ready for restart. Thank you.

MR. GROBE: Any final questions?

I have a couple remarks I would like to make before Christine wants to take a brief recess and then we'll go to public questions and answers.

First off, I want to thank you for your comprehensive presentation today. It was comprehensive. Necessitated us to breeze through a couple of the areas. We have the materials here, they're on our website for the public. And the root cause report is also on our website. It's publicly available. So, the information that we rushed through is available.

I also want to thank you for your candor. I believe our goals have been achieved for this meeting. And our goals, the NRC's goals were to begin to further understand the Root Cause Assessment. Asking any questions that we

have at this point, and begin to further understand your plans for improvement.

I want to make it clear that our goal today was not to endorse or accept or approve either of those areas, but simply to further gain some understanding of those areas.

You describe the Root Cause that's comprised of four areas. That's your Root Cause Analysis Report, which we received last month and gave a presentation to us publicly on August 15th of that.

Last week, we received the analysis of operation's role, as well as the analysis of all the assessment groups' role in contribution to this problem at Davis-Besse.

And, you told us today that you're finalizing your assessment of the corporate nuclear review group's contribution to the problem. We have not yet received that report.

I think this is a good focus. I'd just like to, the hardware design of the plant is built upon defensive effort; the organization of the plant is also built upon defensive effort; and your focus in this area is looking at the broad spectrum of operations, organizational improvement, organizational assessment, quality assurance and appropriate review boards is a good approach.

You described today your Performance Improvement Program. I think I can speak for the board, that many of

the necessary elements are included in your plan. As indicated by our questions today, there is still some issues that are outstanding.

I don't want to prejudge by any stretch of the imagination the outcome of our inspection in this area. Geoff described a little earlier, the team that he's leading up. It's a diverse team of experts both from within the organization, the NRC, and outside consultants; and they're just beginning phase one of their review.

Phase one is a review of your root cause assessments in these four areas; one of which we don't have yet, as well as review of the alignment between your Corrective Action Programs and those Root Causes.

Phase two and three, which cannot be scheduled yet, cover phase two would be implementation of your Corrective Action Program; observing how you recognize it and how you're monitoring it. And then phase 3 would include our assessment of your performance in this area. So, not only watch your implementation, but performing these assessments.

As we've heard today, several of your improvement initiatives are just beginning; several are still in the formative stages. The fact that you're doing Safety Conscious Work Environment Evaluations is good. That's very important.

The results, quite frankly, of the survey are sobering. Less than four out of ten of your people believe that senior management cares more about safety than schedule. Less than half of your people have confidence in Corrective Action Program. And only six in ten believe that your ombudsman is effective. That's not good news. It's news that you need, but it's not good news.

During these kinds of discussions, we're always at risk of losing focus on what the real issue is. We talk in terms of management improvement, organization; and we're at risk of forgetting that all of this is people. Whether they're managers, supervisors or workers, they're all people.

Rarely have I seen a program that was not a good program. Programs don't cause improvement. Programs don't result in good performance. It's people that result.

Your challenge is substantial. Your challenge is to get into the hearts and minds of the people at every level of your organization. You must use the word, vertical alignment. That's an excellent concept. You need to have vertical alignment and safety as your principle focus. You're clearly not there yet.

Every day, when each of those people comes through the gate, at the start of the workday, safety has to be their principle focus. If it's not, quite frankly, they

don't belong in any part of this.

Your approach in the past, based on the information we received today, I believe your approach in the past should result in improvement. I want to emphasize, you're just beginning. Your efforts are just starting to have coherence. They're just starting down a path that should bring results.

The issues that we've discussed today are key issues. These are the root causes of what happened over the last several years, that resulted in the degradation of the head, resulted in your failure to identify cracks. And as your finding now through all your discovery efforts, resulted in a number of other issues.

They must be fixed before this panel will be satisfied that it's able to recommend to NRC Senior Management that Davis-Besse can be restarted and operated safely.

In addition to all of the effort that we are putting in, we will be putting in assessing the readiness of the hardware. We're going to be putting in a substantial effort in monitoring your performance in this area.

With that, Christine, I would suggest that we probably want to take a brief recess.

MS. LIPA: Right, five minutes.

(Off the record.)

MS. LIPA: What we're going to do now is start the Q and A session. An important part of today's meeting will be questions and comments from members of the public. This portion of the meeting is to allow members of public to ask questions of us, the NRC, before this meeting is adjourned.

Also the questions, statements and answers will be transcribed for future reference. We would like to establish some ground rules. What we're going to do is start with public in here in the room, local members of the public first and public officials, and then we'll go to other members of the public in this room; and then go to questions from people on the phone lines.

We have, we had earlier about 45 people on the phone lines, and I'm sure that some of those may have some questions for us.

Each speaker should clearly pronounce their name for the transcriber, and then you'll be given about five minutes to make a question or comment.

So, let's go ahead and begin; if there's anybody in here that has a question, they can come to the microphone and we will be happy to answer a question for you.

Any local members of the public or public officials that want to come up and ask a question or make a

statement?

Are there any other members of the public in the room that would like to come up and ask a question?

HOWARD WHITCOMB: Ms. Lipa, gentlemen, my name is Howard Whitcomb. I'm a resident of Oak Harbor.

As an outspoken individual labeled as a critic, I'm sure I have had the criticism myself of being a Monday morning quarterback. To that I will take ownership of that label if that's the case.

Mr. Myers isn't here. I did have a comment directed to him. I had an opportunity to review the graphic he put together on the vision, mission and objectives of the company. And I thought it was an excellent job summarizing all that information on one pictorial. So, if you can carry that back to him, that's a compliment. I thought he did a great job on that. And I think he's proud of it as well.

MR. ESHELMAN: Certainly.

MR. WHITCOMB: In listening to the comments collectively this morning; first of all, I'm not here to tear apart FirstEnergy's efforts in everything they've done. Clearly you've done a lot of work; and to your credit, that's a plus.

I've been a resident in this community for 17

years. And I've had the opportunity to review events as they've come up in the papers. A lot of you folks are new and don't have the benefit of that historical perspective.

Mr. Pearce, I think that you're right on target. I think that there was, or has been a sense at Davis-Besse, all the way back to the beginning of commercial ops in 1977, there has been a resistance or reticence on the part of workers to come forward and try to do the right thing.

Now, that's not to say they're bad workers. That's just to say the environment, the climate in which they've been operating has been, for whatever reason, adverse in their minds.

By your admission, and I agree with Mr. Grobe, even the QA Organization had some, I guess, resistance to independently verify on their own the state of affairs, so they relied on information that was written and did no independent verification. At a QA Organization, certainly you understand that that is a major downfall in the whole process. And, you need to address that.

Now, one thing though, I would like to say is this. My major comment is, FirstEnergy has failed today to present any basis or justification as to why this Corrective Action Plan will succeed where prior plans and efforts have failed; particularly the System Review and Test Program that was done in the mid 1980's. And I was

part of that.

A lot of what you've identified was identified even at that time, but today, you made a comment about the lack of independent verification. I would like to read to you a statement by a former vice president of this, of Toledo Edison, in response to an inquiry by the NRC as to the completeness of an investigation he was supposed to perform.

He states, quote, "If the Senior Vice President says that the wall is brown, why should I ask the cleaning lady what color the wall is." That was in August of 1988.

You're wrestling with problems that have existed since day one. And they haven't been addressed.

So, my comment is, today, you have failed to provide assurance that your Corrective Action Plan is going to succeed where others have failed. A lot of money was spent in the mid 80's. A lot of money is being spent today.

We, the public, want to be confident that what you're doing isn't going to be a repeat performance of what's happened before. Thank you.

MS. LIPA: Thank you for your comments, Howard.

Does anybody else have any questions for us?

BEATRICE MIRINGU: My name is Beatrice Miringu, and I work for Ohio Citizens in Action.

I think what you have told us today is the problems that you are experiencing today are more of failing to adhere to regulation and expectant standard from the industry.

What concerns me more is if you go back to your slide 59, the percentages that you have on how your employees feel comfortable with what you're doing is very, very low. Now, if your employees don't feel that the Corrective Action Plan is really making any progress, how do we in the community interpret what you're doing?

I think you need to demonstrate to us that your Corrective Action Program is doing something, but at this point, I think if your employees don't think that peer issues in CAP prioritize appropriately and investigated thoroughly and that they will be resolved; we in the public would have a higher, a bigger problem understanding that.

I also want to suggest that when you make your presentation next time, please set one slide where you explain what all these acronyms mean. That would make it easier for us to follow that.

MS. LIPA: Thank you.

Anybody else have any questions for us?

Okay, we'll go to anybody on the phonelines that has a question for us. Go ahead.

PHONE OPERATOR: The first question

is from Ray of Manchester.

SPEAKER1: Thank you. This is my question for the NRC, wondering if you could maybe outline for us what the NRC measures, (inaudible) the standards are that are required?

MR. GROBE: I think I understood the question was what are the matrixes that the NRC is monitoring, and how do we -- I believe the question was, what are the matrixes the NRC is monitoring, and how are we going to assess whether or not the company is ready for restart.

We don't have a set of matrixes. The company is developing performance indicators and matrixes and we're going to evaluate those. Most important to the NRC is the results of our inspections. And we have a series of inspections ongoing now and also plan for the future.

I believe there is five inspections that are ongoing today; one is into the evaluation of the adequacy of containment equipment that is inside containment; second one has to do with the replacement of the head.

As we speak, there is already activities ongoing to repair the hole that had to be cut in the containment structure itself to get the new head into containment and the old one out. So, we have inspectors here observing that.

We've talked about Geoff Wright's inspection into the Management/Human Performance area. We have another inspection that is headed by an individual named Ken O'Brien. It's a team of folks that are looking at program evaluations and program effectiveness.

And another inspection that is also on site this week, headed by Marty Farber, which is looking into the adequacy of systems outside containment.

So, there is a series of inspections that are ongoing now. The results of those inspections will contribute to our evaluation of readiness for restart as well as our continuing evaluation of the company's matrix and their performance evaluation.

SPEAKER1: Maybe just one follow-up. I guess. (inaudible)

MR. GROBE: Did you understand that?

MS. LIPA: We're having trouble hearing the question.

SPEAKER1: (inaudible) restart, any response to that?

MR. GROBE: Could you ask the question one more time? Could you ask the question one more time?

SPEAKER1: Sure, can you hear

me?

MS. LIPA: Yes.

SPEAKER1: The question addresses the company prefers December 7 restart, just how do you respond to that?

MS. LIPA: Your question is, the company has established a December 7th restart. And the answer to that question is, the NRC panel has a lot of work to do. We're not driven by the Licensee's schedule. So, we have inspections that we have ongoing. We have assessments that we need to make. We're not working to the Licensee's schedule. That's really all I have to say about that.

SPEAKER1: Thank you.

MS. LIPA: Thank you.

Any other questions?

PHONE OPERATOR: The next question is from Dan Horner.

DAN HORNER: My name is Dan Horner. I'm with McGraw Hill Publications. I had a couple questions. First one, to Jack Grobe.

You had mentioned early on in the meeting about the issue of arriving from an inaccurate information. I wonder if you could explain how that plays into the restart position, particularly for example, just finally determined

that FENOC provided inaccurate information to NRC, and adversely how that would effect the restart date, if it was found they deliberately provided inaccurate information; would that push the restart date back further or are those processes delayed? What are you going to do about that?

MR. GROBE: Okay. Thank you. That was Dan Horner from McGraw Hill. He asked the question, regarding inaccurate records, and inaccurate information provided outside the company, how the NRC's assessment of that might impact on restart.

The NRC has requirements at 10 CFR 50.9 that those requirements, there is two of them. One is that, records are required to be kept by the NRC -- I'm sorry, required by the NRC to be kept by the company. Have to be complete and accurate, and submissions, and information provided by the company to the NRC has to be complete and accurate.

And the results of the AIT follow-up, that's the Augmented Inspection Team Follow-up Inspection that was completed several weeks ago, indicated that there were violations in both of those requirements. That there were records that were required to be kept by the company that were not accurate, and that there were, there was information and submissions to the NRC from company that were not accurate.

Those issues have to be fixed prior to restart; and, that's an issue that the, corrective actions for which we'll be evaluating going forward.

The second part of Dan's question was whether, if the NRC concludes that any of those violations were deliberate, what actions would be taken.

At this point, we have an ongoing investigation into a number of issues that are, that occurred over the last several years; and I wouldn't want to speculate on the results of that. And based on the results of that investigation, appropriate actions, regulatory actions will be proposed.

So, it's much too early to focus on that issue, because we don't have the results of the investigation.

DAN HORNER: When you say we had investigated it, you mean specifically, you talking about the OI investigation?

MR. GROBE: No, I apologize for not being clear. When I said we, I meant the Nuclear Regulatory Commission. The 0350 Panel does not do investigations. The NRC Office of Investigations looks into matters that might potentially have been more than just mere errors or mistakes by people, that might have been willful. And the Office of Investigations has an investigation into a variety of issues at Davis-Besse

ongoing at this time.

The panel will receive the results of that investigation when it's completed. And the panel will evaluate the results of that investigation, and make whatever recommendations it believes are appropriate for action to be taken by the agency.

DAN HORNER: The investigation conducted by OI, the 0350 Panel, will receive those results and they will not make conditions on restart until they receive information from OI; is that correct?

MR. GROBE: I believe I understood your question, Dan, was whether or not the panel has received information from OI, and the results of its investigation, and it has not. OI has not completed their investigation.

DAN HORNER: I'm sorry, there must have been a sound problem. My question was, does the O350 Panel's decision on restart, can an 0350 Panel make a decision on restart without having received the information of OI, or is this information from OI going to be a factor in the decision on restart?

MR. GROBE: It's our current plan that we receive the investigation results and determine what actions may be appropriate prior to restart. And I emphasize that's our current plan.

DAN HORNER: Okay. I have another question for one of the representatives of FENOC, if I could. I obviously can't see who's on the panel. I understood from the conversation, Mr. Myers has left. But, I believe at the beginning, you talked about the importance, of the process, of going to address problems, or going to take necessary measures to address problems, emphasizing sort of the need to address these problems down the road.

I wonder how that squared with what seems to be a very aggressive schedule made out yesterday for restart on December 4th. So, if could you explain how those two statements fit together.

MR. GROBE: Dan, the purpose of this question and answer period is for you to provide comments to us, or ask questions of the NRC staff. That's actually a fairly complicated question, and I would suggest that you contact FirstEnergy separately if that would be okay.

DAN HORNER: Okay, thank you.

MS. LIPA: Any other questions?

PHONE OPERATOR: No other questions at this time.

MS. LIPA: Okay, thank you.

Any other questions in the room here, before we close?

PAUL RIDZON: I'm Paul Ridzon. Jack said you wanted documentation problems cleared up before restart. Would that be a retroactive or just you want to see things, the process cleaned up going forward?

MR. GROBE: I apologize for not being clearer. What I meant to say, was that Licensee, we expect the Licensee to correct violations, this is violations of NRC requirements. We'll be evaluating the corrective actions for those violations. That would include, I believe, correcting the specific violations, as well as taking action to prevent recurrence in the future. So, those would be the things that we expect to see prior to restart.

PAUL RIDZON: Just a question to FENOC. Could you give some light, I believe you said the participation in the survey was about one third. Was that just the most recent or was that kind of all of them, going back to '99?

MR. PEARCE: I don't know the percentage of respondents past, the most recent survey, but I can find that out for you and give you that information the next meeting that we have.

PAUL RIDZON: Thank you.

MS. LIPA: Anybody else have any questions?

Any other questions?

Okay. I would like to thank you all for coming today; and, the results of this will be, the transcript will be on our web page in a couple weeks.

Thank you.

(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 30th day of September, 2002.

Marie B. Fresch, RMR

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