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

Meeting held on Tuesday, August 20, 2002, at
2:00 p.m. at the Oak Harbor High School, Oak Harbor, Ohio,
taken by me Marie B. Fresch, Registered Merit Reporter, and
Notary Public in and for the State of Ohio.

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
Jon R. Johnson, Deputy Director
Office of Nuclear Reactor Regulation
Washington, D.C.
Douglas Simkins, NRC Resident Inspector
Melvin Holmberg, Metallurgist, Region 3

FIRST ENERGY NUCLEAR OPERATING COMPANY

Lew Myers, FENOC Chief Operating Officer
Robert W. Schrauder,
Director - Support Services
J. Randel Fast, Plant Manager
James J. Powers, III
Director - Nuclear Engineering
L. William Pearce,
Vice President FENOC Oversight
Clark Price, Manager - Business Services

1 MR. GROBE: Good afternoon.
2 My name is Jack Grobe. I'm the Chairman of the NRC
3 Oversight Panel for the Davis-Besse Nuclear Power Station.
4 This is our next in a series of monthly meetings, public
5 meetings to discuss between the NRC and First Energy
6 Nuclear Operating Company the status of the Davis-Besse
7 Plant and their approach to activities that are intended to
8 get them to restart Davis-Besse.

9 What I would like to do to start is to introduce the
10 NRC staff that are here today, and then ask Mr. Myers to
11 introduce his staff here on the stage.

12 I would like to point out also that there is a
13 handout available to members of the public out in the area
14 outside the auditorium. If you neglected to pick one up,
15 please pick one of those up.

16 Again, my name is Jack Grobe. On my immediate left
17 we have a special visitor today. His name is Jon Johnson.
18 Jon is the Deputy Office Director for the Office of Nuclear
19 Reactor Regulation in our headquarters office in Rockville,
20 Maryland.

21 On my far left is Mel Holmberg. Mel is Senior
22 Metallurgist for Region 3 Office in the Chicago NRC
23 Office.

24 Tony Mendiola is next to Mel. Tony is the
25 Supervisor of the Licensing Organization that's responsible

1 for Davis-Besse in our headquarters office.

2 Bill Dean is the Deputy Chairman, Vice Chairman of
3 the Oversight Panel. He's the Deputy Director of the
4 Division of Engineering in our headquarters offices in
5 Rockville.

6 On my immediate right is Christine Lipa. Christine
7 is the Branch Chief in Region 3 in Chicago responsible for
8 Davis-Besse.

9 (Noise)

10 We have some competing noise. If you're unable to
11 hear me for any reason, please raise a hand or throw
12 something up here, we can make sure that you hear.

13 In addition up here on the stage is Doug Simpkins.
14 Doug is the Resident Inspector. He works at the
15 Davis-Besse Plant for the NRC.

16 (Off the record/fixing microphones)

17 MR. GROBE: Maybe it's not a
18 mike problem.

19 I was introducing Doug Simpkins. Doug is the
20 Resident Inspector. He works for the NRC here at the
21 Davis-Besse Plant and lives in the community.

22 Also in the audience is Rolland Lickus. Rolland
23 raise your hand back there. Rolland is our State Governed
24 Affairs Liaison out of our Region 3 Office in Chicago.

25 In addition in the audience is Vyka Mitlyng. Vyka

1 is one of our Public Affairs Officers out of the NRC Region
2 3 Office.

3 And Nancy Keller, Resident Office Assistant, here
4 assisting us in the logistic of this meeting.

5 I also want to thank the Oak Harbor High School and
6 particularly Mr. Stucker for facilitating these meetings.
7 He's done an outstanding job.

8 Lew, why don't you introduce your staff.

9 MR. MYERS: With us today in
10 the audience we have Bob Saunders, the President of First
11 Energy Nuclear Operating Company. Raise your hand or stand
12 up. His wife, Carol. My wife, Linda.

13 Gary Leidich is the Executive Director -- or
14 Executive Vice President of the Nuclear Operating Company.

15 Steve Loehlein is with us today. Steve was the
16 person that did the Technical Root Cause Report and also
17 headed the team of Nuclear Management Root Cause.

18 David Gudger is with us. He is in charge of our
19 Corrective Action Group.

20 Tim Chambers is here.

21 Mark McCullough is with us; Containment Health.

22 Dave Baker is Reactor Head. I think he's on
23 schedule.

24 And then Mike Ross is with us today. And he's here
25 as Operation Excellence Plan.

1 Tony Seller, Restart.

2 And then Dave Eshelman is Management Performance.

3 To my left, Jim Powers at the table. Jim is the
4 Director of Engineering. He came to us from the Perry
5 Plant. He's also running the programs reviews and the
6 system reviews.

7 Bob Schrauder next to him. Bob came to us from
8 Perry also. He is the Director of Support and he's here
9 for the Nuclear Reactor Vessel Head Project.

10 And Clark Price is with us today. And Clark is
11 going to give you some status on some of our performance
12 indicators, and Clark is running the Restart Action Plan,
13 if you will.

14 Next to me is Bill Pearce. The last time you were
15 here, you asked for some quality reviews, so we brought
16 Bill with us today.

17 And then Randy Fast is with us also. Randy is our
18 Plant Manager in charge of Containment Health.

19 I'm Lew Myers, Chief Operating Officer of First
20 Energy Nuclear Operating Company.

21 MR. GROBE: Okay, thank you.

22 Sounds like we have the problem solved. That's
23 great.

24 At this time, I would like to turn the agenda over
25 to Christine Lipa. Christine is going to summarize some

1 recent activities and facilitate a discussion of our
2 research checklist, as well as recent inspection plans.

3 Christine.

4 MS. LIPA: Okay, thank you.

5 The couple other things I wanted to mention, Jack
6 mentioned we had handouts in the foyer. The Licensee also
7 brought a handout.

8 And we also have feedback forms that will enable
9 anybody who wants to give us feedback on how this meeting
10 goes, so we can incorporate those feedback items into
11 future meetings.

12 The next thing on the agenda I would like to cover
13 is the summary of the last monthly meeting that we held
14 here in Oak Harbor, as well as the meeting we held last
15 week in the Region 3 Office in Lisle, Illinois.

16 So, we'll go to the next slide.

17 This really just covers a few of the milestones that
18 have taken place since March, with the risk assessment that
19 the First Energy folks submitted in April.

20 The Root Cause Analysis Report that focused on the
21 technical issues were submitted in April, on April 18th.

22 Licensee submitted their Return to Service Plan on
23 May 21. That was revised on July 12. It's been revised
24 again just recently in August.

25 And then, of course, we held a public meeting last

1 week in the Region 3 Office in Lisle, Illinois, and we have
2 handouts that are available on the web page. The Licensee
3 will be summarizing that discussion later in this meeting
4 tonight.

5 Just to go over what we covered at last month's
6 public meeting here in Oak Harbor, is the next slide. It's
7 a summary of that meeting and we focused on the Licensee's
8 Return to Service Plan and their 7 Building Blocks.

9 I wanted to point out that the transcript, this
10 meeting tonight is being transcribed, by the way, but also
11 the transcript for that July 16th meeting is available on
12 our website, with more detailed discussion.

13 Here is some of the highlights of what we talked
14 about last month. We talked about the Licensee's efforts
15 on the reactor head resolution. They purchased the Midland
16 head, cleaned it, moved it here and are preparing to
17 install it, by opening the containment.

18 Then we also talked about the Containment Health
19 Plan. One of the things in there was that the Licensee had
20 expanded the scope of their efforts in looking at
21 containment health and looking at other compliments besides
22 those affected by boric acid in the containment. Looking
23 at the vessel liner in terms of integrity of the vessel
24 liner; also looking at the containment air coolers.

25 Then we talked about the System Health Assurance

1 Plan and the progress that they've made. And looking at
2 their programs, they gave us a sense of where they're
3 headed with what types of things they're looking at in
4 those programs. And we do plan some future inspections on
5 all of these plans, but at the public meetings we discussed
6 their progress and the systems that they were focusing on
7 and what else they were planning to do, and what they were
8 doing with those findings.

9 Again, that's what Clark Price is planning to talk
10 with us about later, the various findings that come out of
11 these reviews.

12 And then we also talked about Management and Human
13 Performance Excellence Plan, and that was really a big
14 focus of the meeting that was held last week in the Region
15 3 Office, was to understand what this months of effort in
16 looking at the root cause and trying to determine what it
17 really was, what the root causes were and what the plans
18 are for corrective action.

19 We really didn't focus too much on the last two of
20 the Building Blocks at last month's meeting. So, that
21 covers the first two items on today's agenda.

22 The third item on today's agenda is a discussion of
23 NRC Restart Checklist. We did discuss this last month and
24 there have been a few changes, but we'll just go through
25 the, for your reference.

1 The first page is basically unaffected from what you
2 saw last month. This was issued, by the way, on August
3 16th by the NRC. The Licensee has a copy of it. This will
4 be available on our website.

5 The second page is not too much change, but I did
6 want to talk about Item 6, which is what we call Licensing
7 Issue Resolution. And this covers various license
8 amendments and relief requests that are formal documents
9 between the Licensee and the NRC that cover very specific
10 items. And we have six of them listed between this page
11 and the next page.

12 And right now, these are the ones that we've
13 identified that are necessary for restart, but we're still
14 working with, with NRC and with the Licensee to ensure that
15 we have a common understanding of which particular ones do
16 need to be resolved before we start, and if there are any
17 new ones.

18 Then on the third page of the checklist, there is a
19 new item here, which is number 7. All along we had planned
20 to do this piece, but we thought it was appropriate to
21 include it as part of the restart checklist.

22 Item 7 is a Confirmatory Action Letter Resolution in
23 March and it was revised in May. And that has very
24 specific items on it that the Licensee has agreed to do
25 before restart.

1 As part of our O350 process, we will be assessing
2 each of those items, and closing each of those items. And
3 one of them in particular that we've added to the checklist
4 here is verification that all the Confirmatory Action
5 Letter Items are resolved. One of those include a public
6 meeting to discuss Readiness for Restart.

7 Okay. On the next item under agenda, Item 3 is a
8 status of the NRC inspections. And, recently we completed
9 the Augmented Inspection Team Follow-up. And just to
10 explain this a little bit. Back in April here, we had an
11 exit of the Augmented Inspection Team findings. And that
12 was, we had that exit here in April and their report was
13 issued on May 3.

14 Then I did find a lot of findings, a lot of
15 observations. It was summarized as several missed
16 opportunities for the Licensee to have identified the
17 condition over the years before it was identified in March
18 of 2002.

19 So, that report was issued in May. It's Report
20 2002-03. That's available on our website.

21 So, what we did as part of the follow-up for that,
22 we held an Augmented Inspection Team Follow-up Inspection.
23 And we had, the exit meeting for that inspection was held
24 August 9th. It was not a public meeting. So, that's why
25 we're discussing the results today. And those results will

1 be documented in Inspection Report 2002-08, which will be
2 on our website. It's still being prepared right now.

3 And in that report, the results that we have will be
4 considered as unresolved items until our risk assessment is
5 complete. And our risk assessment is one of the items that
6 we have been working on in NRC.

7 The next slide.

8 On the Augmented Inspection Team result is a little
9 more detail of the results of that inspection and numerous
10 apparent violations in five areas. And I'll go through
11 those five areas and I'll give you some examples, but I
12 just wanted to a little bit before we got into that,
13 explain the way this inspection works is the inspector goes
14 to the plant, reviews the documents, gathers the facts,
15 tries to put those facts together and then has an exit
16 meeting with the Licensee. After that, they come back to
17 the regional office and those findings go through the
18 management review.

19 So, we're in the management review phase. So, the
20 findings are still considered preliminary until the report
21 is signed off.

22 All the items that we looked at as part of this
23 Augmented Inspection Team Follow-up are considered directly
24 related to the Vessel Head Degradation Issue. So, the
25 significance is being worked together.

1 In accordance with our Inspection Manual 0612, which
2 is our guidance for regular inspection reports, all of
3 these issues, even though some of them appear to be
4 noncompliances or violations, will be characterized as
5 unresolved items. They're apparent violations whose
6 significance has yet to be determined.

7 When our significance determination process or risk
8 determination is completed, we will be able to issue those
9 violations and they will no longer be resolved --
10 unresolved items.

11 So, let me get into some of the examples. The first
12 one is an apparent violation of Technical Specifications,
13 which requires that there be no pressure boundary leakage;
14 and obviously because there were leakage, there was leakage
15 at the cracks in the nozzles, that is pressure valve
16 leakage, that is a violation of Technical Specifications.

17 The next area of violation was the adequacy of
18 corrective actions. And there were several apparent
19 violations of 10 CFR 50 which is a Code of Federal
20 Regulations, Regulation B16 for inadequate corrective
21 actions.

22 And the examples are numerous missed opportunities
23 to have identified the condition of the degradation of the
24 reactor vessel head, and some of the examples include the
25 deferral of the surface structure modification that would

1 have permitted access for adequate cleaning and inspection
2 of the vessel head.

3 Also inadequate corrective action for the radiation
4 monitor plugging that was going on inside the containment.
5 And the containment air cooler bin found that was going on
6 in the containment.

7 The next area of apparent violation is in
8 procedures, following procedures. And there were several
9 examples of procedures that were not being followed in the
10 boric acid, specifically the Boric Acid Corrosion Control
11 Procedure and the Corrective Action Procedure.

12 The fourth area was adequacy of procedures. And the
13 inspectors found problems with the Boric Acid Corrosion
14 Control Procedure regarding its adequacy. One example is
15 that focus was only on bolted connections and did not in
16 all cases require documentation of engineering
17 evaluations. It did refer to engineering evaluations that
18 needed to be done, but it did not require documentation.

19 The next area is completeness and accuracy of
20 information; and this is 10 CFR 50.9, Federal Regulation
21 50.9 that requires complete and accurate information. And
22 there were several documents that we looked at and there
23 are apparent discrepancies in the accuracy of some of those
24 documents, such as work orders, corrective action
25 documents, and responses to a generic letter and bulletin.

1 And, the scope of this inspection did not focus on or
2 attempt to address the intent. It was mostly focused on
3 whether the document was correct or not.

4 Now, these findings are considered unresolved
5 items. And I mentioned that earlier, because the
6 significance is not completed yet, but also NRC Office of
7 Investigation still has investigations ongoing that relate
8 to some of these issues, so they will not, they will remain
9 unresolved items until that is completed.

10 That's what I have for summary of the NRC
11 follow-up. I'll next turn it over to Mel Holmberg to talk
12 about one of the other inspections.

13 MR. HOLMBERG: Okay, thank you
14 Christine.

15 I'm not sure, can people hear me? I don't hear
16 myself out in the audience. All right, thank you.

17 As Christine said, my name is Mel Holmberg. I'm the
18 Lead Inspector for, associated with the Licensee
19 Containment Health Plan, and what I'll be discussing this
20 afternoon is the results of our NRC review on the
21 Licensee's efforts at determining the extent of condition
22 for boric acid corrosion of components inside containment.

23 Basically, the effort that I will be discussing is
24 an effort of three weeks in length that the NRC conducted
25 reviews of the activities the Licensee conducted inside

1 containment; focused on areas like dissimilar metal welds,
2 some of the containment general area inspections,
3 including components such as the service water piping, some
4 of the containment liner areas, and also review of
5 videotapes the Licensee performed on the reactor vessel.

6 As a result of this inspection, which ended July 26,
7 the NRC identified two findings, which were considered
8 violations of NRC requirements. The first finding was
9 associated with lack of acceptance criteria and
10 requirements to follow inspection plans; and the second
11 finding was associated with inadequate training and
12 certification of inspection personnel.

13 And for the walkdown inspections, the failure to
14 properly certify inspection personnel. Some of the
15 observations that we had in terms of inconsistent methods
16 to track completion of inspections, and some of the
17 observations were where we identified additional components
18 that had evidence of corrosion, led the Licensee to
19 conclusions and our staff's conclusions that these
20 inspections were not entirely effective.

21 As a result the Licensee decided to repeat these
22 inspections, and that effort is currently underway.

23 I'll describe briefly each of the findings. Tell
24 you where they're at right now with those items.

25 The first finding that was identified dealt with

1 lack of acceptance criteria requirements to follow
2 inspection plans. Here, there were three initial plans
3 that were used to actually direct field activities. And
4 these three areas that they focused on were dissimilar
5 metal welds, the reactor vessel and containment general
6 area.

7 However, these plants did not have the same quality
8 assurance program requirements that apply to the safety
9 related procedures, and they also lacked requirements or
10 acceptance criteria; failure to incorporate appropriate
11 acceptance criteria and implement requirements to adhere to
12 the plans is considered a violation of 10 CFR 50, NRC
13 Reg 5.

14 In response to that issue the Licensee has now
15 issued procedures instead of plans and has acceptance
16 criteria for each of the procedures and has begun again to
17 perform the inspections of the containment components.

18 The second finding dealt with inadequate training
19 and certification of inspection personnel. And this issue
20 centers around the standard that the Licensee had selected
21 to train personnel. It's called VT-2 Standard, and that's
22 a term that comes from the ASME or the American Society for
23 Mechanical Engineers. And to become a VT-2 inspector, the
24 requirement was to have six hours minimum training and 60
25 hours relevant work experience.

1 I identified in fact neither one of those
2 requirements was met for the inspection personnel that were
3 used to conduct the inspection.

4 And again, this was considered failure to have the
5 required inspection training and hours work experience was
6 considered a violation of 10 CFR 50, NRC Reg 5.

7 Again, to correct this issue, the Licensee has
8 currently developed a new training standard which is, at
9 this point appears to be more rigorous than previous
10 training standard, and their personnel now have specific
11 requirements that need to be met both for written testing
12 and program standards that are being applied.

13 And basically, I will turn it back over to Christine
14 for further comments.

15 MS. LIPA: Okay. Thanks
16 Mel.

17 Couple of other inspections that we have ongoing
18 right now are the inspections of the new vessel head and
19 the co-data package. Also the opening and the closing of
20 containment. And then some other upcoming inspections
21 would be a review of the license and inspection of the
22 Licensee Program Review.

23 We'll also be beginning our inspection of the
24 Management Human Performance Building Block and also
25 beginning review of the Systems Health Building Block. So,

1 those are some other upcoming NRC inspections that will be
2 discussed at the next public meeting.

3 That's all I have for Agenda Item 3.

4 Jack, do you have comments?

5 MR. GROBE: Lew, we provided
6 the results of our inspections in an ongoing fashion from
7 our staff when we were on site through regular interactions
8 with your staff, as well as at the completion of each
9 inspection through an exit interview. I wanted to briefly
10 summarize the results of inspections that have been
11 completed since our last public meeting, and give folks
12 here as well as yourselves a sense of what inspections we
13 expect to have subsequent to the results at our next public
14 meeting in September.

15 So, that's just a brief summary of the activities
16 that the NRC has had underway and expects to begin in the
17 next several weeks.

18 At this point, unless there is any other comments
19 from members of the panel, I would like to turn it over to
20 you and your staff.

21 MR. MYERS: Thank you.

22 Our Desired Outcomes today:

23 One is to, the first is to demonstrate that the
24 Integrated Schedule of activities at Davis-Besse is well
25 underway.

1 Second, to introduce the actions to achieve and
2 ensure sustained Management and Human Performance
3 Excellence at Davis-Besse.

4 We recently did a root cause with the regulator, as
5 they said last week, and we'll discuss those root causes as
6 we go through the report, and other corrective actions as
7 we go forward.

8 Three is to provide indicators that demonstrate our
9 progress to date. A lot of activities going on at the
10 plant and to give you some of our performance indicators.

11 Final, fourth is to demonstrate increased standards
12 of quality oversight of the Quality Oversight Organization,
13 if you will. One of the key things that we've done is we
14 brought Bill Pearce with us today to talk about the issues
15 in our quality area.

16 And then finally, is to provide the status of some
17 of our other Building Blocks as time permits.

18 Next slide.

19 As you remember, at our last meeting, we have, as we
20 got into the Davis-Besse issue, we created six Building
21 Blocks, with the center being the collection of the Restart
22 Action Plan.

23 The Building Blocks consist of the Reactor Head
24 Resolution Plan, the Program Compliance Plan, the
25 Containment Assurance Plan, which is now a total Health

1 Assurance Plan of Containment, the System Health Plan, the
2 Restart Test Plan; we got to restart test all of the
3 activities that we've done during the outage; and finally
4 is Management Human Performance Excellence Plan that
5 restart completed.

6 Responsible for that plan was Bob Saunders, my boss
7 and I was responsible to the plant at the site; and
8 finally, I believe an independent team, Steve Loehlein
9 headed that team, that completed the reports and gave that
10 to us the first of last week.

11 Now, according to the recent, the Building Blocks
12 Report through the Restart Overview Panel that we had
13 yesterday, that panel is now chaired by Leo Karns. I think
14 Leo is with us today in the audience. There he is out
15 there. He is the new chair. He came up the last time, our
16 chairman. So, Leo is taking that function.

17 That group is a group of very impressive independent
18 individuals. And anybody that don't think they're
19 independent, they could you tell you, come in and sit at
20 one of the meetings. They give us a lot of feedback on
21 some of the things we need to do as management team to
22 restart the Davis-Besse Plant.

23 In fact, what I would like to do is talk about some
24 of the things they've given us already on recommendations.
25 They've given us over 80 recommendations formally. And

1 quite a couple hundred informally.

2 One of the recommendations they gave us was to
3 expand the scope of the Containment Health, to the new
4 Containment Health Plan, not focus just on boric acid, but
5 some of the long term issues that we have in our
6 containment that we're trying to address now.

7 They also gave us some advice on developing
8 procedures and instituting stricter standards on quality.
9 And what we were finding out is these procedures, like the
10 word I use, primary word, prioritize becomes part of our
11 normal ways of doing business at the plant.

12 Finally, they place some, help us place some
13 independent oversight or review boards and subcommittees in
14 place. That can be engineering review boards that were put
15 in place. So, brought in some good talent there.

16 They suggested some specific plants that might be a
17 benchmark for management practices and standards that had
18 similar issues to our Davis-Besse Plant. We've been to
19 those plants and picked up some improvements there that we
20 would talk about later on.

21 And finally, Safety Conscious Work Environment.
22 Something we're all concerned about. I know that I have
23 meetings with the employees, our chairman, and several of
24 the members start coming to the plant and meeting with our
25 employees. And we're really stressing safety conscious

1 work environment. We're looking to be, to be more
2 proactive, looking for issues.

3 And, then finally, the extended root cause to
4 consider what effect some of the things we were finding has
5 on all of our plants. It's important as we go across these
6 issues or find these strengths, that we carry these forward
7 to our other plants.

8 The next slide.

9 At the last meeting we talked about the
10 organization. There has been a couple of changes since
11 that time. Dave Gudger is now in charge of the Corrective
12 Action Program. I think he's with us today. Dave came to
13 us from our Perry Plant.

14 And also you'll see on the slide that I have now
15 taken the duties as Site Vice President and will remain in
16 that position until after restart.

17 The first area that we want to talk about today are
18 the Management Root Causes. We had a meeting with the
19 Regulatory last week in Chicago, four-hour meeting went
20 over Root Causes, and I'll try not to spend that long
21 today, but try to brief you on what we told them.

22 Earlier investigations that we did, both from
23 Augmented Inspection Team and we did our Technical
24 Evaluation Process; both concluded one thing, that
25 management had ineffectively implemented processes and thus

1 failed to detect plant problems as opportunities arose.

2 And you heard that at the end of their investigation, that

3 opportunities to identify these problems were missed.

4 Knowing the history of the plant, we looked back and

5 decided to do the Technical Root Cause that was submitted

6 earlier this year, but we knew that since these missed

7 opportunities were management concerns, and we were going

8 to make management changes, that we had to wait to do our

9 Management Root Cause Reports, so we went ahead and did a

10 Technical Root Cause Report.

11 Before we did that, this strength in our

12 organization brought Gary Leidich in as Executive Director.

13 They promoted me to Chief Operating Officer and Executive

14 Vice President, and Bill Pearce as Vice President FENOC

15 Oversight. So, we wanted to get that out of the way.

16 Then, I was charged to come to the plant and we

17 chartered a Root Cause Team and we wanted to understand why

18 over the period of time, that Davis-Besse personnel failed

19 to identify the corrosion of the reactor pressure vessel

20 head. These were missed opportunities, if you would.

21 We wanted to go back. We had issues before that

22 failed to fix those problems, so it was important that we

23 went and go all the way down to understand the problem.

24 Let me share with you some of the things that we

25 found out. For root cause, there is never one root cause,

1 there is lots of contributing causes, lots of root causes,
2 but we've lumped those in four basic areas that we think,
3 with the exit of the AIT team a couple of weeks ago, were
4 the findings that Christine went over, our report appears
5 very much in line with some of the issues that were brought
6 up there.

7 Lists, our people over time, there is a focus on
8 production, combined with minimum actions to meet
9 regulatory requirements that resulted in the acceptance of
10 the degraded conditions.

11 That sounds real good. Let me tell you what that
12 means. At a nuclear plant or any commercial plant there is
13 also a focus on production. Always a focus on production.
14 That's what we do for a living. But we have to balance
15 that very carefully with nuclear safety and safety concerns
16 and assure that we do an appropriate technical review as we
17 find and fix problems.

18 If you look over about a five year period, what we
19 found is we had some degradation in that process, that we
20 were not thoroughly investigating issues as issues arose.
21 And that's one of the things that caused these missed
22 opportunities to exist.

23 The next area we reviewed was inadequate
24 implementation of the Corrective Action Program. We heard
25 the AIT report that the program was inadequate. Let me

1 tell you, the program did not meet all the bells and
2 whistles of the regulatory process. However, the program
3 was adequate to find and fix the reactor vessel head
4 problem. It was adequate to do that, but we failed to
5 implement the program appropriately.

6 The next area was failure to integrate and apply key
7 industry information and site knowledge and experience and
8 compare the new information to baseline knowledge.

9 The word that comes to mind there is complacency.
10 Davis-Besse over a period of years was an excellent
11 performer. And as time went by and industry experience in
12 specific issues grew, we were complacent and we failed to
13 look at the industry experience and our own requirements,
14 if you will, and improve our programs and processes to look
15 for this issue. In fact, we tend to justify why the issue
16 didn't exist.

17 Some steps in the Boric Acid Corrosion Control
18 Procedure were not followed. If you go to look at the
19 procedure we had in place, there were several times that we
20 had missed opportunities that we were just not clearly
21 following the procedure that we identified.

22 So, we've gone back and really strengthened the
23 procedure to have sign-offs and checklists to make sure
24 that we have a very strong, healthy Boric Acid Procedure
25 Control Program at all of our nuclear plants. It's now a

1 common process at all of our plants.

2 With that, let me go into some of the contributing
3 causes. Some decisions were made without considering the
4 need for safety analysis. What that's got to do, we tend
5 to identify things and put them into our Corrective Action
6 Program, but we did not perform the detail analysis that
7 many times, that we should have. To say, what could be
8 causing this issue? Missed opportunities again.

9 Corrective Action Program was not state-of-the-art.
10 What we find there is some differences, sometimes in
11 improvements, but also that there were times that the
12 programs at our Davis-Besse Plant was not quite the same
13 program as we have at our other plants, nor was it
14 implemented the same way. We'll talk about some of those
15 corrective actions.

16 Now, let me take a few minutes in each one of these
17 areas to talk about the corrective actions, if you will.
18 As we went into this issue, we developed our Restart Action
19 Plan consisting of Building Blocks. The Building Blocks
20 themselves were designed to help us with many of the
21 corrective actions.

22 The System Health Assurance Plan provides a rigorous
23 system review, if you will. We've got people out in the
24 two-step plan looking at our system, that went through the
25 systems, looking at long term issues, looking for system

1 health problems, walkdowns, and we brought in a lot of
2 system expertise, lessons learned from other plants like
3 D.C. Cook, as we're doing this.

4 So, these System Health Reviews are really
5 strengthening the rigor of looking at our systems, system
6 health.

7 Program Compliance Plan ensures programs meet the
8 industry high standards. We're going back to a large
9 number of our programs. We have a two-phase approach.
10 There is five programs right now that we're doing a very
11 in-depth latent issues review with a large integrated
12 team.

13 On the other programs, we're going through what we
14 call Phase One Review, and we're looking at each and every
15 program to ensure its compliance phase, it has good
16 ownership, and the implementation appears to be adequate.

17 Those two plans, if you will, were designed to help
18 us with recovery of the plant.

19 Finally, Management and Human Performance Excellence
20 Plan will ensure that we have strong and sustained safety
21 focus. What do we mean by that? Well, let me go through
22 the issues, and what I'll do is spend some time with each
23 issue talking about the corrective actions.

24 The first issue that I talked about earlier was
25 Nuclear Safety Focus. Well, we've strengthened our

1 corporate oversight. As I said, my position didn't exist.

2 Bill's position didn't exist as Nuclear Oversight,

3 Executive VP. And then the Executive VP, Gary

4 Leidich's position didn't exist. So, we've really

5 strengthened our corporate oversight of the plant.

6 Now, that was the first thing that we did. Then, we

7 turned around and we wanted to look at the Davis-Besse

8 team. One of the major issues that we had was management

9 involvement in day-to-day activities and leadership. We

10 now have in place a new Senior Team at Davis-Besse that are

11 proven high standard people, with proven industry

12 performance. We think that team will take the plant

13 forward.

14 New Management Observation Program. It's really not

15 a new program. We have a very good computerized Management

16 Observation Program at both Perry and Davis-Besse, and at

17 Beaver Valley plant. We're bringing that program over to

18 Davis-Besse, and we'll start using it as the program here

19 to perform the next bullet, Scheduled Management

20 Observation.

21 It's our intention to have managers in the field

22 observing scheduled work activities each and every week to

23 make sure that we have good ownership, we're following our

24 procedures, and good rigor in activities we perform; both

25 in routine maintenance activities, engineering activities,

1 and last but most important training activities.

2 We've created a case study. That's sort of a simple
3 word. It's not really a case study, it's more than that.
4 We're sitting down with each and every group at our plant
5 and going over this issue in great detail. We're looking
6 at the root causes by group and explain to each group how
7 they affected this issue; how they can prevent it from
8 happening.

9 At the end of that, we're going through the
10 standards of each group and then we're giving a test to
11 each and every employee. At least we'll know what the
12 standards are and we can go on from there.

13 Then, we're reinforcing our safety conscious work
14 environment every day. Now, we have several programs in
15 place, the four stages I'll talk about later; the
16 management review of our employees, what we call town
17 meetings to improve our safety focus at the Davis-Besse
18 Plant.

19 Continuing with Nuclear Safety Focus. We've staffed
20 organizational effectiveness experts, that are now on our
21 staff in helping us with our organization as we go forward;
22 that's employees.

23 Our four C's Meetings are Compliments,
24 Communications, Concerns, and Changes. We had the first
25 meeting a couple weeks ago. We had another meeting today.

1 And we'll close another meeting out on Friday. I did that
2 to meet with our employees individually, let them do a
3 facilitative, bring up their concerns, their issues, their
4 compliments. So, it's anonymous. And then I come back
5 after they do that, and look at the issues independently.
6 And it's sort of an anonymous proactive process to
7 strengthen our safety culture.

8 Ownership for excellence review of all of our
9 managers and directors. Our plan for evaluating the
10 attributes of the managers and directors is through
11 ownership and excellence.

12 We've done this at other plants. We're improving
13 our ownership programs. As we start up and go forward,
14 we'll be performing ownership for excellence reviews of
15 each and every manager and director at our plant.

16 Competency assessment is something we picked up from
17 one of the other plants, that they were building into
18 leadership in action, for each one of our supervisors. All
19 of our key supervisors, we'll do competency assessments on;
20 four different groups as we go prior to start up.

21 That concludes our actions on Nuclear Safety Focus.

22 The next area --

23 MR. GROBE: Lew, before you go
24 on, did I hear you correctly, you said the Ownership for
25 Excellence Review of Managers and Directors and Competency

1 Assessment of Supervisors; that will all be completed prior
2 to restart?

3 MR. MYERS: There is about
4 four groups of people. Ops, I forget the groups, but we'll
5 complete those prior to restart, yes.

6 MR. GROBE: Okay. Is this
7 described in the Building Block on Management and Human
8 Performance Excellence?

9 MR. MYERS: It will be in
10 Management Review Performance Excellence Plan.

11 MR. GROBE: So, that plan is
12 going under revision right now?

13 MR. MYERS: Right.

14 MR. GROBE: I would like to go
15 back, if I could one slide. You indicated that you're
16 reinforcing the safety conscious work environment.

17 You recently completed I believe a study of the
18 safety conscious work environment at the plant. Has that
19 been completed?

20 MR. MYERS: Yes.

21 MR. GROBE: Is that going to
22 be discussed in some of your succeeding slides?

23 MR. MYERS: I can discuss
24 that, if you like.

25 Bill, do you want to discuss that?

1 MR. GROBE: Sure, I think that
2 would be helpful.

3 MR. PEARCE: Okay.

4 MR. MYERS: Go ahead.

5 MR. PEARCE: You want me to do
6 it now?

7 MR. GROBE: Sure.

8 MR. PEARCE: We did a survey, a
9 survey, it's industry standard survey that we've done
10 several times in the past. And what we're trying to do in
11 doing that is understand where are we in the issues of
12 people being able to bring issues forward in the
13 organization, feel comfortable without reprisal, that they
14 can bring issues up and that kind of thing.

15 And of course, what's been seen in the industry over
16 a number of years is when you have this kind of problem,
17 that our employees or all employees kind of get a feeling
18 that, that they can't bring an issue forward as well as
19 they normally can. So, that's why we wanted to do the
20 survey, was to see where are we now in that regard.

21 What we discovered was that we had done a survey in
22 1999, I forget which month, early in 1999, and we had done
23 another one this year in January. And, so now we're doing
24 a third one. All the same survey and all we changed on it
25 was we added a couple of questions because of the issue

1 we're in, but generally the same survey.

2 And what it told us is that we had some issues in
3 1999 that were kind of low range in the area that we're
4 requesting. And at the first of this year before we found
5 the head problem, our ratings were actually pretty strong,
6 good. And now, the one taken in August, we're back to
7 where we were in the ratings in about the 1999 time frame.

8 So, you know, it was good and now it's bad again.
9 Overall, what does that mean? I think it means that, that
10 we have to put together a proactive plan to solicit those
11 issues from employees and make sure that we work a lot of
12 communication and trust issues, so that our folks believe
13 that without any question that we want them to bring issues
14 up; we value the information when we get it; and that we'll
15 act on it without hesitation.

16 And, of course, in that regard, they always have the
17 right if we don't act on it, to go to NRC, which is
18 guaranteed under law.

19 But that's kind of the baseline what we found on the
20 survey, Jack.

21 MR. GROBE: Bill, do you think
22 that, in fact, there was improvement in the safety culture
23 of the organization between '99 and 2001, or do you think
24 that was a fidelity problem in the survey?

25 MR. PEARCE: Well, in my heart

1 looking back at what we've looked at, I would have to
2 conclude that we probably thought even down in the
3 organization that we were in a better condition for those
4 issues than we actually were, and now we've maybe come back
5 more toward reality. I guess that's how I see it.

6 MR. MYERS: Let me answer that
7 too. You go look at the plant back in the last survey
8 we've done, just completed a very long run. The
9 performance has been outstanding. The employees felt good
10 about the status of the plant at that time.

11 When you go through an event like we're going
12 through now, the question is how did we get here. You
13 know, we trusted different groups. We trusted management.
14 We trusted everybody to keep us out of the situation. This
15 is our livelihood. How did we get here? It puts a
16 terrible stress on an organization.

17 So, the results that I'm seeing now, I would expect
18 to see. What we've got to do now is understand these
19 faults and move forward, be very proactive.

20 MR. GROBE: The word that's
21 often used in describing, what I think you're describing is
22 complaisant. Is that what you're sensing, that the
23 organization had become complaisant and tolerated lower
24 standards and that's why you were ranked higher in your
25 survey?

1 MR. PEARCE: Yes.

2 MR. MYERS: That's a good
3 analysis.

4 MR. GROBE: There was a
5 condition report initiated earlier this month and I'll just
6 read this. This is a description of the condition
7 identified. Says, based upon interviews conducted as part
8 of the Phase 2 Detailed Review and Corrective Action
9 Program, hesitancy to document our organization, human
10 performance and problematic issues on our condition reports
11 due to a fear of retaliation, as well as other reasons,
12 including the boomerang effect, continues to exist.

13 Could you help me understand what that means, and
14 why it continues to exist four or five months after a
15 shutdown of the plant?

16 MR. MYERS: Well, I think if
17 you look at some of our employees, it's hard to tell your
18 managers that you have problems with them, and there is
19 probably some hesitancy to do that, to right the management
20 issues or complaints that are management issues.

21 That's one of the reasons I started the Four C's
22 Program, anonymous way for a group of people to get
23 together and complain back to me if they want to; I can
24 come and address that issue.

25 So, it's difficult for people to do that. And then,

1 often when you do write something like that, it's a
2 boomerang effect. What happens, you wind up trying to
3 solve the problem, puts more work on you, you're already
4 working hard already.

5 I think that's the argument under the times, that's
6 probably an appropriate CR, and it's driven us, it's
7 driving us to take some actions to communicate better, be
8 more proactive in that area.

9 MR. GROBE: So, the corrective
10 action you laid out hereto, reestablishment of some
11 standards, new managers, your observation program having
12 managers in the field, case study, the four C's meetings,
13 these things will turn around this condition report
14 document in early August?

15 MR. MYERS: Sure.

16 MR. PEARCE: Jack, that's part
17 of it. Right now, we're formulating exactly what we're
18 going to do. As you know, we just had the survey completed
19 within the last week. And we're formulating exactly where
20 we're going from here. What are the additional actions
21 that we need to take going forward beyond what some of the
22 things we had already put in place. And I think that
23 certainly it's going to change some of the things we do
24 going forward.

25 I've already worked on power plants, so I know we're

1 going to do some things differently. We're not prepared to
2 present that today, but the next meeting we could, if you
3 wish.

4 MR. GROBE: Okay. The, one of
5 the artifacts of this kind of a situation that you've got
6 yourself into, is a number of issues or deficiencies or
7 concerns or problems that may not have gotten documented.
8 How are you trying to identify those, unearth them, get
9 them out of the drawers and into the systems?

10 MR. MYERS: You know, if you
11 look, one of the things we found consistently is our, from
12 a plant material condition standpoint, our people have
13 documented their concerns, CRs at a very, fairly low rate.
14 So, from a plant standpoint, that's sort of what we're
15 saying. Now, from a management standpoint, this is a
16 process of a lot of clearing.

17 Now to answer that question, how we look at those
18 things. There is Program Reviews that we're doing and a
19 System Reviews. As we go through the Program Reviews and
20 the System Reviews, we're specifically looking for those
21 long term latent issue type problems that's been laying
22 around, long-term type problems, trying to address those.
23 Meeting with the system engineers, and we have some outside
24 vendors in.

25 So, we're looking for those type of long-term

1 material condition issues as we go through this. They're
2 problematic.

3 Let me add this too. In general, the overall
4 material condition of the Davis-Besse plant as we walk the
5 system down, is in general good. You know, we are finding
6 a lot of, several hundred CRs that were written.
7 Generally, when you walk our plant down, you look at the
8 material condition, it's pretty good.

9 MR. GROBE: In addition to the
10 structured reviews you have, are you also asking all the
11 staff to lift the carpet and bring the issues back out from
12 underneath?

13 MR. MYERS: Let me go to my
14 next slide.

15 MR. GROBE: Okay.

16 MR. MYERS: The next area of
17 corrective action, if you will, concerns our Corrective
18 Action Program.

19 For the audience, what is Corrective Action Program?
20 That is the program that is sacred to us as managers of our
21 plant that we use to identify and fix our problems; for the
22 material condition problems, procedural problems, or
23 program problems, it's our, it's our life's blood for
24 documenting, finding and fixing our problems.

25 One of the things we're doing now, is that program

1 appeared to have some, at least some problems of
2 implementation as we went looking back on the record,
3 vessel head events. So, prior to even doing the root
4 cause, we decided that was one of the programs we were
5 going to do the Latent Issues Review on.

6 So, we've had a group of industry experts in here
7 and they're finalizing a report now where they spent time
8 going back and looking at our Corrective Action Program and
9 the health of that program. So, that's coming to
10 completion.

11 We're improving, one of the things in the management
12 performance area, the criteria for categorizing our CRs
13 that were really, was not effectively implemented.

14 And, let me explain that. We let people write CRs,
15 condition reports, on just about any issue. The required
16 program is very limited from a regulatory standpoint, but
17 we allow our people to write condition reports on broken
18 trucks, if they want to.

19 And, as we take, as we generate these CRs, every
20 morning we review the CRs to ensure that they're properly
21 categorized. Are they conditions adverse to quality of our
22 plant or are they just nonconforming conditions, or
23 nonquality conditions, or are they just management issue
24 type of conditions. So, we categorize those, the CRs that
25 are written each and every day; except on the weekends.

1 What we found as we went through the Management
2 Human Performance Review, was we had not properly
3 categorized several of the CRs that we looked at.

4 For example, you know, condition reports that were
5 written on containment coolers were not, not at high level,
6 not considered condition adverse to quality. It should
7 have been classified higher. We didn't do that well.

8 So, what we're doing now, we've already reviewed the
9 criteria. Every morning at the morning meeting, we're
10 going over the CRs that are generated, and we're
11 effectively implementing the corrective actions
12 categorization.

13 Bill is monitoring that. I monitor that.

14 Existing longstanding conditions are now being
15 reviewed as significant conditions adverse to quality.
16 What we mean by that? Well, as we go through the program
17 reviews, as we go through system reviews, we're looking for
18 longstanding issues, things the system is telling us, this
19 has been around for five years, ten years, hasn't worked
20 well.

21 So, we'll take those issues and we'll try to
22 reclassify those as appropriate, not every one of them, as
23 a significant issue adverse to quality. And what that will
24 do is give a detailed management review of root cause, if
25 you will, to make sure that the strong corrective action is

1 effected.

2 We've strengthened the review board. It's called
3 the Corrective Action Review Board. And what happens there
4 is, the causes, when we try to find and fix problems, go to
5 that board, make sure that we've done a good job of
6 reviewing for root causes if need, or parent causes or
7 whatever.

8 We now have a Director. In fact, it's our Plant
9 Manager, Randy Fast. He's the chairman of that board. So,
10 we've strengthened the management ownership of the board.

11 As we move forward, we will routinely for the next
12 year or two, anyway, perform assessments categorization.
13 You know, we think we got a categorization, could step
14 down, but we can't afford to step back. We're reviewing
15 every CR at the morning meetings every day.

16 Now, repeat conditions are being evaluated for the
17 significant conditions adverse to quality. One of the
18 things, containment air coolers, became the norm; became
19 the norm. Write a condition report; write a condition
20 report. And none of them high priority.

21 So, as we look for repeat conditions, we'll be
22 really strengthening on the ownership of those and try to
23 classify them as inappropriate, significant conditions
24 adverse to quality.

25 Require the use of formal cause determination

1 techniques for root cause and basic cause evaluations to
2 ensure analytical rigor is applied. If you go look at all
3 the CRs, we write thousands of CRs a year, there is only a
4 handful that are really significant issues and get detailed
5 root causes. Typically, we do apparent causes or basic
6 causes and what we find is we haven't done a good job of
7 training people to do those type of evaluations. So, we'll
8 be strengthening that area.

9 Define and implement training for cause
10 evaluations. That's to get the root causes and evaluations
11 consistently performed at each of our sites.

12 Improve guidance on reviews for effectiveness of
13 corrective actions. If you take the corrective action,
14 it's important to spend some time and you go back and make
15 sure those corrective actions really solve the problem.
16 Were effective and we're strengthening that process and in
17 fact we're providing guidelines for effectiveness reviews.

18 Implement an effective site-wide equipment trending
19 program. We typically do engineering reports on our
20 systems, probably on a quarterly basis. We're going to
21 strengthening our process to look for trending of
22 degradation. We do an adequate job at any rate.

23 Technical rigor, the next area, if you will.

24 MR. GROBE: Lew, before you go
25 on, did you have a question?

1 MR. DEAN: I'm sorry. I
2 wanted to get back to a question that related to the
3 surveys and the meeting you had with your staff. Is that
4 reinforcing some of the things that you saw on the survey,
5 safety conscious work environment survey in terms of --

6 MR. MYERS: Yes.

7 MR. DEAN: Can you describe
8 the global perception that you see on the part of the
9 staff?

10 MR. MYERS: Well, in the
11 meeting that I had, it's very independent so far. Our
12 staff will tell you they know their performance has
13 declined. They see that now. They openly tell me that.
14 They openly tell me the management bottom had decayed away,
15 which is exactly what we saw on the root cause, you know,
16 where we looked at managers to see how the containment is
17 doing, is relevant.

18 They also tell me that once you get talking to them,
19 they're not the least bit shy. And they tell me, we
20 haven't done a very good job of communicating to them.
21 Also they found things out through the newspaper before
22 they find out from us. And we're trying to strengthen that
23 communication in our newsletters and online television
24 system.

25 One of the things we did last week as a result of

1 that was, for feedback, is prior to going to meet with NRC
2 on the root cause, the day before, right before we left, we
3 had an all hands meeting with a couple hundred employees to
4 go over the results of the management review before we did
5 it with you; and to talk about the safety culture survey we
6 had just completed.

7 So, we did that last week. So, each one of those
8 areas that they give us, we try to address.

9 MR. DEAN: Thank you.

10 MR. GROBE: You described your
11 corrective actions for nuclear safety focus and now
12 corrective action program. That's a fairly broad set of
13 corrective action going forward. Two questions. One, the
14 Corrective Action Review Board.

15 Randy, you're fairly new to the organization. You
16 chaired that. Are there other members of the Corrective
17 Action Review Board that are either independent or new to
18 the site?

19 MR. FAST: We have some
20 engineers, but we also have some oversight, so both the
21 quality comes in to monitor those meetings, as well we have
22 independent assessment that provides feedback to us about
23 the things that they see as we review the significant
24 conditions of first quality, and the reports.

25 MR. GROBE: Like I said, this

1 is a, this is going to be a good going forward. Have you
2 queried the staff about issues or concerns that they've had
3 in the past that they did not bring up, because of this
4 problem with corrective action program, and safety focused
5 concerns?

6 MR. MYERS: I would say that
7 we're doing that now. All those details brought in place.

8 One of the things we chartered, is an action from
9 the Restart Oversight Panel, is Buzz Galbraith, our
10 Chairman, and Jere Witt, from the county, is starting some
11 individual independent meetings with our employees, and
12 giving us feedback as a management team at the Restart
13 Oversight Panel.

14 That's another action we're getting ready to take.
15 I just looked at the charter for that action today.

16 MR. GROBE: Okay. That's
17 probably something that before our next public meeting is
18 to spend some time out at the plant talking with the
19 staff.

20 MR. MYERS: Good.

21 MR. GROBE: Finding out what
22 they're thinking.

23 MR. MYERS: We would invite
24 that.

25 The next area is Technical Rigor. What do we mean

1 by that? That's a level of detail that we go into when
2 we're solving problems.

3 It appeared to be problems there. So, one of the
4 things we found was that we were given mixed messages on
5 some of our standards. At the FENOC level we have
6 policies, our business plans. Our business plans
7 specifically say that our priorities are the following:
8 Safety first, people second, reliability third, and finally
9 cost. That's our priorities in that order.

10 We found there is documents at our Davis-Besse Plant
11 that don't support some of the, policies that don't support
12 our business plan in FENOC's vision. We've come back and
13 made a list of all of those policies and procedures. One
14 of the things we do at FENOC, we went and we have completed
15 already and approved a Nuclear Operating Procedure that now
16 makes it a requirement that any time you generate one of
17 these site causes that could be, give you misleading
18 information, that's got to come to the Executive Team to be
19 reviewed and approved by us, for us to generate policy at
20 Davis-Besse.

21 We strengthened that, and we did that by creating a
22 Nuclear Operating Procedure that talks about, and our
23 approval process we talk about. That's complete.

24 We've established an Engineering Assessment Board
25 that reinforces our standards of engineering. And once

1 again, it's built with these type of changes that we have
2 now, rebaseline your standards, if you will. That puts
3 stress on the people in the organization that reinforced
4 the products that we didn't have to. And when that
5 happens, it tends to cause issues. And, that's another
6 reason we have to be sensitive to the issues we discuss
7 while we go.

8 We have established a Periodic System Walkdown
9 Program. You know, let me talk about the engineering a
10 moment. We've established a Periodic Engineering Program
11 Review Process. As we've gone through these reviews of our
12 programs and systems, the question comes to mind, why did
13 we have a procedure in place that our system engineers use
14 all the time for system reviews. They are supposed to be
15 doing routine system reviews and bringing their peers over
16 from the other plants to help them do reviews.

17 So, we've taken the documents and the lessons
18 learned from this issue, and the Buildings Blocks, and
19 we've turned those into, are turning those into permanent
20 processes that will be integral to all of our plants before
21 it's over with. So, the System Review and Program Review
22 is part of the normal culture, if you would.

23 We've rebaselined the standards and expectations
24 into each of our groups. We've already done that with
25 engineering, and we're going to look at rebaseline and

1 making sure those standards are right with us there. That
2 should help us with technical rigor.

3 The next area we talked about is Procedure
4 Compliance. You know, that's an area that people have been
5 storing away for years. It seemed like it went away too
6 far to the right. We've established a training program to
7 applicable Boric Acid Inspectors.

8 If you go look at, we talked a little while ago
9 about VT-2 qualifications. What we really found when we
10 looked at VT-2 qualifications, I think that most people
11 use, is that we really did not train the people
12 adequately.

13 So, we went back and created our own training,
14 training program for Boric Acid Inspections. And we
15 believe that that's going to be a program that will take
16 off here at our sites and be recognized as a leader in the
17 industry before it's over with.

18 Reinforce the standards and expectations for
19 procedure compliance and the need for work-practice rigor.
20 That gets back to the management observations. As we
21 scheduled these management observations and risk work, on
22 training, we expect to see a strong enforcement of
23 procedure implementation and stress the need for good rigor
24 on the procedures.

25 The next area is implement the Management

1 Observation Program with weekly schedules. It's not
2 something we've really done at other plants. We have
3 Management Observation Programs, but we haven't scheduled
4 each and every manager.

5 To show where we are at our Davis-Besse Plant, we're
6 going to schedule our managers to perform weekly
7 inspections. So, as we look at our weekly work of
8 training, maintenance style, we'll have our managers in the
9 field, and monitor this Management Observation Program.

10 And then Bill and his group are going to provide
11 oversight of how effectively our managers are calling out
12 issues as they see them.

13 Perform independent assessments of procedure
14 compliance. You know, we typically have Assessment
15 Programs, so since this has been such a big issue, we will
16 build that in as self-assessment for the next couple years
17 anyway to make sure we have the right rigor procedure in
18 compliance, because it's not the kind of thing you can lay
19 down. Strength today, then be in compliance; and if you
20 don't stay on it for a couple of years, you won't get back
21 to where you really want to be.

22 Discuss procedure compliance regularly at our
23 morning meetings. What we mean there is we look at all the
24 CRs written. We're looking for our procedure compliance in
25 the morning meetings and we'll receive training and we'll

1 attack those trainings.

2 One of the things we talk about is contributing
3 causes. We'll address some of the contributing causes,
4 we've established the FENOC decision-making process at
5 Davis-Besse, including the hazard analysis.

6 That's a really nice bunch of root cause type
7 words. What that means is we have a doc called Tech 19
8 that we use at both our Perry and Davis-Besse Plants.
9 We're turning that into a nuclear operating procedure. It
10 has a lot of philosophies in it on how to address equipment
11 and plant problems.

12 And if we had had that and used that process as we
13 went through our Corrective Action Program, we would have
14 done a better job of doing safety reviews when need to,
15 doing stronger technical reviews. It forces you through
16 that process.

17 So, we're going to turn that into a nuclear
18 operating procedure and formalize that process at all three
19 of our sites.

20 Perform corrective action procedure benchmark. We
21 now, as I said, we're doing that as we speak. We have a
22 group of experts that are a pretty impressive team of
23 industry, industry experts.

24 We're doing a latent issues review of our Corrective
25 Action Program, and there are some issues with that