program. And we're going to strengthen that program, but more important than anything else is implementation of the program.

MR. GROBE: Lew, before you go on, the root causes that you've identified, safety focus versus production focus and technical rigor; Christine summarized earlier some violations that came out of our Augmented Inspection Team follow-up inspection; and clearly you can see threads through those violations of procedure compliance, lack of safety focus. That was a fairly narrow inspection, focused primarily on the head degradation.

Have you seen procedural compliance concerns in other areas of the plant to cross operations and health visits and engineering and maintenance?

MR. MYERS: I would say we've seen a lack of rigor in several areas, yes. For example, you know, we talked about one here, that is operability concerns. The same program implemented the same at all three sites is not the same.

So, we need to strengthen those operability concerns. And Mike Cross is working that as we speak. The operation rigor. So, yeah, we seen that pretty much across the board.

MR. GROBE: Okay.

MR. MYERS: When we did the

root cause last week, we talked about management incentive focus from safety, or the lack thereof. You know, I've been a pretty high level person in this organization many years, and I don't think that it's any programs are ever, in fact, I don't even know what incentives are, to be truthful about it, but I notice it never swayed my decision, but it's an issue and it's an issue at the high level we need to address.

I know Bob and Gary and myself, we're going to address those issues and make sure that our incentive program is properly in line.

Establish policies to support safety. We need strong operational involvement. We need good managers in the field and good decision making. We are strengthening that.

You know, in summary, if you look at this issue, I think our First Energy procedure, at one of our large staff meetings in Akron a few weeks ago, in front of every one said it best; said, you know, he has committed to returning the Davis-Besse plant to service in a safe and reliable manner.

What we really said was doing the job right the first time. That's what we need to be about; doing the job right the first time. Just find and fix the problem and quit trying to justify the way. We're committed to meet

that challenge.

That's all I have. Thank you.

MR. GROBE: Okay. Questions from the panel members?

Bill?

MR. DEAN: Lew, relative to the statement here on the next to last slide where you talk about establishing policies, report safety and in particular operations involvement, is there a vision there that you have as an organization relative to how do you see operations fitting within the overall concept of how Davis-Besse is going to operate that may be different than how it's operated in the past?

MR. MYERS: Do that again for me, I lost you somewhere.

MR. DEAN: The involvement of the operations has in leading the organizations as opposed to perhaps how it might have been in the past.

MR. MYERS: You want to comment on that, Randy?

MR. FAST: When you benchmark the industry, the best of the best, they're operation driven. License holders of the plants are our operators. It's the eyes and the ears of the plant. The expectations are that they run true to form. They set the standard for

the rest of the station, and the station follows operations.

That has not been the case at Davis-Besse of late. Part of our Operational Excellence Plan is to clearly communicate to our operations staff their leadership role and then challenge them in assuring the high standards of the plant.

In fact, we have one of our high level condition reports. We're just in the final phases of review and approval, and it reinstitutionalizes operation's role in that management process. And to ensure proper buy in, we have a meeting on this, this coming Friday, with all of our shift engineers and our shift managers, so we can clarify roles and responsibilities, and the critical role that they play in ensuring the safeguards of the plant.

So, the short story is, operations will be the leader of the future and they will set the standards for proper operation of the plant.

MR. DEAN: In your efforts in benchmarking in those organizations, what are some of the steps you need besides clarifying roles and responsibilities? Obviously, there are things that need to be done in order to drain that throughout the organization. Everyone else in the organization has to see organization as well. So, what sort of steps are you talking to ensure

that message is seen specifically across the site?

MR. FAST: Well, Bill, one of the things I would say is operation's role. Although they're in the plant, they take that for granted, but they're not bringing that information to the plant staff in the morning meetings, identifying their expectations. And when I talk with shift managers about when was the last time you were in containment, what did you see on your tour, what is it that you think needs to get attention; I get little blank stares.

And the reality is, their positions demand that they be out in the plant looking and that they bring those issues forward. And the forum we have in operating our plant on daily meetings, creates the spot where a shift manager can challenge the leadership team in the issues that they see in the plant.

Another area that we would, we pointed out at the last public meeting was operability justifications; and as Lew has identified, we don't want to justify, we want to evaluate and properly disposition issues.

We've challenged our operations staff to raise those issues and to call on plant staff to bring the information to the control room, so they can be properly dispositioned. And our operations staff is being asked to push back, ask those tough questions to ensure that the

issues are fully evaluated and fully resolved before we identify the corrective action that's necessary. And that's some of the examples of things.

We are seeing some improvement in those areas, but there is lots of work yet to do.

MR. DEAN: In your pursuit of this, have you established, are there some things you can point to as being ones that would give you signals or signs that they are having some success in that area?

MR. FAST: Bill, those are some of the things that we're institutionalizing as part of corrective action in the root cause. I'm not prepared to talk at length about that, however the matrix of the performance indicators will be clarified and tracked on a crew basis.

MR. MYERS: One of the things we said as managers, it's important hearing what operations people said. Now you have me, you have shift supervisors, and ops managers and Randy. That's a pretty strong message by itself. And it may cause us pain for what the message is, but that's where they sit in the morning meeting, and they're at the head table where they belong.

MR. MENDIOLA: I don't have a question per se, I just want to clarify a point I thought I heard. Intrigued by your survey of the staff, and I

understand the results aren't necessarily collected and haven't been evaluated. I guess I would see a little bit of, will you be coming to us sometime in the future maybe next meeting or so, with a full understanding of those results and what steps you will take from your findings from the surveys?

MR. MYERS: Absolutely.

MR. GROBE: I think it's about time for a break, give our transcriber's fingers a rest. But, before we do that, I want to just make a couple of comments.

We've been waiting for awhile to receive the results of your root cause analysis in the area of organizational effectiveness. We received that last Thursday. And I think that sometime this week, we're supposed to get a hard copy document on the docket. We'll make that available on our website.

I've commented in the past, and I'll reiterate this comment. The fact that boric acid as a corrosive is not a surprise to anyone. It's been known for many, many years in the industry. The fact that metals fatigue and crack eventually in service is well known. Those issues resulted in degradation of the head. It wasn't the cracking with the boric acid, it was the lack of safety focus of your staff. And I think you've captured those thoughts fairly

well.

This is the root cause of what happened at Davis-Besse. And, you have now articulated that comprehensively and you're beginning to redevelop your Management Performance Improvement Plan to address these issues. As recently as August 3rd, I highlighted this condition report. It indicates that the problem still exists.

I know that you've initiated a number of activities to begin to address this, but it's fairly clear that those activities are not yet bearing fruit. And I look forward to the Comprehensive Improvement Program laid out in your Building Block in this area, and measuring, going in the future through our inspections, as well as new performance indicators, progress in this area.

I believe that this is going to be the pacing issue. It's one of the most difficult issues to grapple with. I think one of the keys is the assessment which you're going to undertake with the first line supervisor, and find out which have the right safety focus, which can be moved to the right safety focus, and possibly which can't. And, that's critical.

So, with those few comments, I just wanted to briefly lay out how our inspection is going to proceed in this area.

We've now received your root cause. We're going to do a thorough review of that; both the NRC staff in Region 3, as well as headquarters and possibly some independent contractors who are expert in organizational effectiveness.

When we receive your Building Block, revision of your Building Block, we'll do a thorough review of that to make sure it matches the root causes and we believe addresses the issues that are identified.

We will observe through inspection implementation as well as perform independent inspection in this area. And I want to emphasize this is now just beginning, and we look forward to continuing dialogue in these meetings in the future in this area.

Why don't we take a five minute break, and give our transcriber's fingers a rest. And reconvene at 25 'til. Thank you.

(Off the record.)

MR. GROBE: Lew, I peeked ahead a bit and I definitely want to get through the next two sections on Restart Progress and Nuclear Quality Assessment. We'll take a benchmark of time at that point.

MR. MYERS: We would also like to do containment also.

MR. GROBE: Okay. Are you

ready to start back?

MR. MYERS: Clark Price will talk to you about Restart Progress and provide you some overviews for our schedules and some of the performance indicators that we look at.

MR. PRICE: Good afternoon. As Lew said, my name is Clark Price. As the slide says, I'm the Business Services Manager at Davis-Besse, but for the restart effort, I'm Restart Action Plan Processor. That was the center building block in the chart that Lew addressed at the beginning of our presentation.

I have the responsibility for coordinating all the activities in the Return to Service Plan, the building block activities and also the overall restart effort.

They've brought me up here today to talk about our excellent progress we're making, of course resumption of safe power, safe operation of the plant. I'll be presenting today a few of the key points we developed for monitoring our progress.

Let me begin by saying, our focus here at Davis-Besse is to ensure that our people, the plant and our people are meeting a high standard for restart and sustained safe operations. And further, I would like to say our restart plans are just not focused on the next few months, but for the long term safe operation of the plant.

Next slide.

Since the last public meeting in July, we've been working very hard and made considerable progress. We've developed governing procedure to control the Restart Action Plan process. We developed Restart Action Plans and we generated schedules for those plans and are completing the integration for the schedules into the Integrated Restart Schedule for the plant.

We're making excellent progress through the hard work and dedication of all the employees at the plant. A number of the milestones from the Restart Action Plan, major milestones from the plans are included on this slide. I'll briefly discuss each of those as following presenters will discuss them in more detail.

The first item, we have completed System Walkdowns. And this is a major milestone in our System Readiness and Readiness Review Programs, as part of containment -- or excuse me, the System Health Readiness Review Building Block.

We've also are nearing completion, as Mel mentioned earlier, in our containment inspection are near complete. This is a major milestone also in our Containment Health Building Block as we discover and complete all the inspections due to the boric acid center condition degradation occurred as a result of that problem.

We've completed cutting in the shield building, the concrete cutting of the shield building that is a necessary step in the replacement of the reactor vessel head. That has been completed and that operation is currently demobilized.

Our containment painting preparations are well underway. Currently, we are prepping the dome of the containment vessel for painting, and removing the existing paint, preparing that for painting, as well as many other areas of containment that are being prepped for painting.

We should complete this week an upgrade of our Containment Polar Crane. This was a modification that we performed in the Polar Crane to make it more reliable. And this is a critical activity to support the many activities that we have that are necessary with that crane, is necessary for use between now and restart of the unit.

We have removed the coils from three of our containment air coolers and those coils will be replaced in September and October when the new coils come in.

As Lew stated, and just presented, we have completed our Management Root Cause Reports. So, we have accomplished many of our milestones in our Restart Action Plans to-date.

At this time, I would like to turn over to Jim Powers to talk over a few of the slides of the results of

the system walkdowns.

MR. POWERS: Thanks, Clark.

Jack, at our last meeting you requested an update of what we were finding as part of our reviews. I wanted to give a quick rundown on what we found from the Discovery Phase of our System Health Walkdowns.

As you can see from the slide here, there was approximately 80 separate walkdowns were performed over the past several weeks. And, they were consisting of 31 systems that we have in the population of our System Health Readiness Review, as well as the five systems that we have for our Latent Issues Level Review, which is a deep slice review. So, a total of 36 systems.

And these are material condition walkdowns, as we refer to them, for discovery of problems out in the plant. The Configuration Verification Walkdowns for selected systems will occur later as we get deeper into the Latent Issues Reviews, as we review modification and such, we will get out and look at specifics on systems. Although, there was an element of Configuration Review as part of this walkdown with the drawings of the system.

Over 3500 man hours were expended in this effort. We really focused our teams on getting out there and going through the walkdowns. So, it was a focused effort over approximately two weeks. So, the members of the review

teams that are doing the system reviews got out there, and in addition, management oversight participation, as well as operations and maintenance assigned to each one of the teams.

Operations provided us specifically SRO involvement on the teams. And generally, I was very pleased with the response of the individuals on the teams. It was a good opportunity for the plant staff to get together multi-discipline advice, and work together, and walkdown the plant and see what kind of standards they have been living with and identify areas which standards should improve.

I think there were a number of areas things should improve, and it was positive feedback on the overall effort and we're going to use this in the future, not only at Davis-Besse, but other FENOC plants routine walkdowns.

Here we show a few pictures of walkdowns ongoing. This is a walkdown of the Reactor Coolant System. You can see the team, several of them are sitting on top of the reactor coolant pump in the containment looking at their drawings and documents as they check off the individual components and attributes of the system that are going down.

There is a very specific procedure that we use for these walkdowns that tells the individuals exactly what to

look for and they're all trained for common basis through these walkdowns.

MR. MYERS: Those are the motors, right?

MR. POWERS: That's the motor.

MR. MYERS: You should say that's a motor.

MR. POWERS: That is one of four reactor coolant pump motors, that they're largely in the containment that they're checking out.

Here they're checking out the containment air coolers. We've talked about those in the meetings and the health of our containment air coolers in containment. Again, you can see they have documentation in containment, keep it in bags to keep it clean.

They walk through and the individuals identifying equipment, identification tags, so as we go through these; and I participated in these myself. So, we go through, we check the equipment ID, make sure it's clear which component we're on, how it matches the drawing, what's the condition of the component and note both positive and negative attributes and take digital photographs, so we have a record of what was done.

We take it back to the offices and document it all in the Corrective Action Program any discrepancies we find

or questions we have for disposition.

Here's the walkdown going on outside the containment. We have management participation actively involved. You can see there is a team that gets into details. Many times our management has been involved in construction of nuclear plants, so they bring a wealth of knowledge to the nuclear teams.

It's a very good chance to meet the people and provide expectation on the level of standards that we expect in these walkdowns and consequently in the daily operation of the plant.

Here's some examples of things we found.

MR. MYERS: Who was participating?

MR. POWERS: I think that was Mr. Leidich participating, so we have our Executive Vice President on that one. As I mentioned, many of us go out in the management team to participate.

Some of the debris we found in containment, we were not pleased with what we found. This is typical of debris we found in some of the less readily accessed areas of containment and I'll comment just generally.

The condition of the plant as Lew mentioned is pretty good, but particularly in the areas that were most actively accessed; the main walkways and around areas, can

get behind components, inside panels that are not frequently opened, indicates containment into areas did not access, we found examples of debris. The basic containment, we found nails and some screws, things like this, and duct tape and tie wrap that's been cut.

So, housekeeping issues did not meet our expectations, specifically in containment, we were concerned about the functionality of our emergency sump down there, which would need to strain any of this type debris out, which would migrate over to the drain, if it's required for excellent communication.

So, this is an example of the type of housekeeping. We are going to be cleaning up these areas, and steps for housekeeping.

In the control room is a panel, part of our Safety Feature Actuation System, which is one of the safety control systems at the plant, and this gives a good idea about the level of detail the walkdown teams have gone to looking in this case control room panel. This is a microswitch.

And the concern by the electrical engineer who is responsible for engineering for the system, the terminations and the crimping details up in the upper left flyer that you see with the blue plastic sheathing, that's the crimping details determination for the, for that one

terminal. And there is a little bit of exposed wire there, and that does not meet an electrical engineer or electrician's expectations. The insulation should be continuous on there, including that blue plastic sleeve.

And so, this is the type of issue that's written up in Corrective Action Program for this position; is that acceptable. Are the bending of the wires, is that acceptable. The angle that the plugs come in and number of plugs that are terminated on each terminal there; does that meet the design requirements and expectations. So that's the level of detail we'll get into.

Here's another example of a problem we have found that needs a more general review done, and that's going to be done as part of extended condition of Corrective Action Program. This is a fastening device. We have a nut on a bolt there. You can see that the bolt does not extend all the way through the nut. And in the industry, it's what we refer to as thread engagement. And we want to see at least one thread sticking out of the nut area, so you know all the threads are fully engaged and you have full structural capability in that fastener.

This is one we found, does not meet that requirement. And we will be looking more generally as to the condition of our fasteners and thread engagement as a result of this walkdown.

So, some of the generic issues; numerous small valve leaks. We've seen that, particularly from the Containment Health, some of our Boric Acid Walkdowns. We notice a number of valves we need to repack.

We need to improve cleanliness and proper housekeeping in less accessed areas. I mentioned the thread engagement. Not only is it for fasteners, structural fasteners, but packing followers, valves, studs, on components. It's the same issue, that we need to turn our attention to.

Also loose conduit and tubing. Walking down the systems, we checked out all the instrumentation, as well as the electrical conduit just to make sure it hadn't loosened through the vibration during operation. Found some cases where it needs to be tightened. And our maintenance people will be doing that.

We found crushed tubing and bent sensing lines. This is another issue with standards. These small tubes tend to get damaged during day-to-day operation of the plant and refueling outages. And it's really standards issues, that we shouldn't tolerate that, and need to go back and correct the situation rather than living with them like that.

This is more significant findings we will be following up on. I talked about the debris in containment.

There is also a lot of dust in the control room panel. It's a 25-year old plant. And in the control room panel, dust has accumulated over the years to the point where it was observed; really doesn't meet the expectations of the plant staff. We need to do a cleaning there.

There is an issue with thread engagement on pressurizer manway that's part of the Reactor Coolant System Walkdown. We found one of the studs there did not have full thread engagement.

There was another potential for motor operated valve lubrication degradation, which can occur over time due to heat in the vicinity and frequency of preventative maintenance lubrication. The effectiveness of lubrication.

We talked about the Safety Features Actuation System, and workmanship of the electrical terminations and how they are holding up in the control room cabinets. We're going to be evaluating that, support long term functionality of the system or not. That's one of the institutions that needs to be done.

Then we found some potential noncompliance, or EQ requirements for motor operated valves. These were electrical terminations, T-drains, in the Aux. Feedwater System, which is high engine line break, design considerations for the Aux. Feedwater Rooms. And there is

a contribution room to room, and we do have a high energy break, high break, steam environment. And we need to make sure that the adjacent rooms are appropriately treated and keep, to keep that moisture out. It's an area we need improvement. So, that's an extended condition for improvement as well.

MR. GROBE: Jim, how did you identify potential lubrication degradation in the leads?

MR. POWERS: I think it was in that case from the walkdown. Taking a look at the leads themselves, looking at the grease. I didn't participate on that walkdown on that particular phase, Jack, but I think they're looking for grease, which is grease hardening, which can be inhibitive on the threads.

MR. GROBE: Did you go back to look at your periodic valve testing to see if there was degradation in the test results.

MR. POWERS: We haven't done that yet. What we're doing is collecting all these issues in the Corrective Action Program. As you'll see in the coming slides, there is a large number of corrective documents passing over two hundred, and they're still finishing up the documentation. So, that will be ongoing, Jack. We'll be able to get a report out on detailed assessment.

MR. GROBE: Okay, thank you.
MS. LIPA: I have one question on these. I know you have another slide with more examples, but are you doing as-found reviews? I know you plan to fix a lot of these things before you start, but are you doing as-found reviews for reportability?
MR. POWERS: Yes, as-found conditions will be documented in Corrective Action documents. As necessary, operability determinations will be done and reportability will be followed through with the normal process for as-found conditions.
MS. LIPA: Okay, thank you.
MR. POWERS: We did find an issue with Emergency Diesel Generator, Heating and Ventilation Air Conditioning System Exhaust Hydramotor Damper. Basically, that's the motor enforcement damper on the air cooling system. There was a damper arm loose and it was bound up. And did not look like it was going to work properly for a long term. So, that was a very good find by the walkdown team, with attention to detail needed to be corrected.
We also found the exhaust silencers, which are outside the building, muffler essentially large diesel engines, tornado missle shields and where they're attached to the concrete parapet started to crack and fall. Either

through water freeze and thaw cycles or thermal growth of that shield. So, we're assessing that.

And as I mentioned, it's over 200 CRs initiated to-date. These are snapshots, but we are finding some good issues out there, and the attention to detail and standards as these teams go out is really paying off. And, we're continuing to write CRs to finish documenting up everything that we found.

With that, I'll turn it back over to Clark for further about measuring profits.

MR. PRICE: Thank you.

In the last public meeting, we presented some of the performance indicators that we were developing to monitor progress of our restart efforts and our improvement efforts. Two weeks ago, we published our first set of performance indicators and I would like to go through a few of those now.

We've established indicators to track progress on the Building Block Plans, progress on the NRC Inspection Manual Chapter 350 Restart Checklist and also progress towards meeting new standards for restart and sustained operation excellence.

The following slides are some examples of those. This first slide represents the restart actions that we've identified today through a process that we have in the

Restart Action Plan. These are all the restart actions identified for restart procedures, slightly over 800 right now.

These actions at this point are primarily in the form of condition reports; and through evaluation, these condition reports would generate approximately four to five on average corrective actions per condition reports. So you can see our volume is going to go up significantly.

We're seeing a steep incline right now, and that is expected because of our program reviews and system reviews, system walkdowns that Jim just referred to are generating a lot of condition reports through the process we have. A lot of those condition reports are being evaluated to criteria that we have in the Restart Action Plan, being identified as required for restart.

I would say probably in the last two weeks, we are seeing about 50 percent of the condition reports that were initiating or getting classified as required for restart.

MR. GROBE: Clark, let me make sure I understand this. The width of the line going up, that's the number of corrective actions completed?

MR. PRICE: Actually, this is an indicator of open restart actions, so everything there is currently open. What we have right now are the condition reports were making up the major portion of our

open actions. Over time, we would expect what will happen is the dark line, which is the corrective actions, will become the larger volume and the condition reports will become smaller.

And at restart, the condition reports will be essentially all turned into corrective actions and completed.

MS. LIPA: I have a couple questions on this. So, the corrective action is an outcome following condition report?

MR. PRICE: Yes, corrective actions through the evaluation and condition report, are the corrective actions that come out of that, are the Restart Station Review Board that we have evaluates both the condition reports up front, and then the corrective actions as they're developed, to determine whether they meet restart criteria. And the ones out here met restart criteria.

MS. LIPA: Okay. I was looking at your plan earlier and there is a flow chart, and at one point you decide whether it becomes a restart list item or restart action item. These must be restart action items.

MR. PRICE: These are all restart action items.

MS. LIPA: Okay, thank you.

MR. PRICE: Any additional questions on this slide?

Okay, if we move to the next report. This is a progress report here. Performance measures more in the form of progress report. This is one that we use to monitor the progress of the reactor vessel head project.

And primarily what it is, you can see the bars identify, the yellow bar is our schedule, target schedule, and the blue bars are the current schedule. And you can see that project, we're pretty much right on schedule.

No questions on that, I'll move on.

The next slide is our System Readiness Reviews. This is the progress report that we have for the 31 systems reviews that are going through the System Readiness Review Process under the System Health Building Block.

The small inset box notes Progress Review Process; and until the box on the right starts filling up, we don't get any actual report completions here.

The schedule, as you can see right now, looks like we're not making any progress; however, what that schedule represents right there is the walkdown period that we've just gone through. It has been completed and now the reports will start coming out of that process over the next few weeks; we'll be completing all those reviews.

MR. GROBE: Clark, just so I understand. So, none of the system reviews have been completed such that the report has developed and presented to your Engineering Review Panel?

MR. PRICE: That is correct. That have not been completed.

MR. GROBE: When will the panel receive the first completed report?

MR. PRICE: As soon as possible looks like about next week, should start seeing reports being completed based on the schedule.

MR. GROBE: I see, okay. So, it goes from 31 to 30.

MR. PRICE: Right. That would identify the reports based on the schedule should be available for review.

MR. GROBE: Just out of curiosity, do you know which system that is?

MR. PRICE: No, I do not.

MR. POWERS: I think it might be 125, Jack, that was pretty well on the head, moving along. I think that was it. I'll get back to you on detail with that.

MR. GROBE: Okay. We're going to want to see the results of these early on, so we can get

a sense and give feedback on our view of the adequacy of the review, as well as the adequacy of the oversight by the panel.

MR. PRICE: We did provide, Jack, we did provide a schedule that has all the projects laid out in detail and represent what shows up on the performance indicators. So, we'll make sure you understand that schedule you receive, that will identify the systems.

Any additional questions on this? Okay.

Okay, the last one that we have to measure progress, that we got as a sample today is on our phase and program reviews. And as you can see in this particular slide, we're a little bit behind schedule on some of those reviews.

We've gone through a learning process on a number of these Phase 2 Program Reviews and, however what we feel, even though we're a little behind schedule, we'll have much better progress as a result of incorporating what we've learned to date through that process.

We did have early on inspection visit by Ken O'Brien. He provided a lot of insight on review of a couple of programs. And we've taken those comments and incorporated them into our plans.

If there is no additional questions on those, the last two charts I have; this one is on Root Cause Quality.

These are more performance indicators, are looking at performance improvements. And, as we rebaseline our standards and improve on our programs, we have some performance measures here that are trying to measure our progress where we're at and where we want to be.

This particular performance indicator looks at Root Cause Quality, our significant condition reports. We have a Corrective Action Review Board, as we discussed earlier, Randy is the Chairman of the that. And that committee, that board has established new standards for approval of Root Causes to assure that the quality is there, to assure that the corrective actions will prevent repeat efforts.

And as you can see right now, the raising of the bar, the standard, we have a long way to go yet to get the root causes through the Corrective Action Review Board the first time. This is measuring basically what is approved the first time through and what requires rework, before it's going to come back and get rereviewed and approved.

So, right now we're averaging around 40 percent and our goal is to be at 90 percent approval rate. So, we have a long way to go here.

Randy, any additional comments?

MR. FAST: I was going to say, as part of the change in the standards, we review the specific conditions adverse to quality, and if we don't see

them; one of the typical problems we see is, if we have a good story, tells what happened, doesn't say why it happened. And we want to see why things happen.

We also look to see was there a direct correlation between the root causes and the corrective actions. There should be a one-to-one correlation for every root cause for corrective action.

As well, the teams that have done the root causes have identified or provided supporting documentation. What type of root cause was performed; we have tap root as an example of more or some other process. That wasn't identified nor was that documentation provided, so we're asking that documentation be provided.

So, we've got lots of room for improvement, but we're actually enforcing high standards to ensure that significant conditions adverse to quality meet those expectations. So, it's been a learning experience for all of us. I believe it will help our program moving forward.

MR. PRICE: The last performance indicator we have today is on the Engineering Quality. We have an Engineering Assessment Board that's chartered to review the products that come out of the engineering organization in the areas of design, safety evaluations and conditional report evaluations, for example.

The Engineering Assessment Board has a process by which they grade the products that come out of engineering on a zero to four scale. And we have a goal to be at a scale of 1. Zero being the best score, 4 being the worst score.

And as you can see here, through the first four weeks of really tracking this, we're not meeting the goal; however, we have seen it oscillate a little bit. It depends on the population of the products coming through the board at any one time.

The Engineering Assessment Board is challenged with again raising the standards and changing, rebaselining the standards for the engineering organization.

Jim, do you have any comment?

MR. POWERS: I think they've done a good job and found a number of issues through and brought change of quality of products depending on the individual preparing it. And what we're finding, for a large part, is how the staff integrates together when it produced for example a design, how they integrated to get all the various aspects of that design cap purchased as part of the review and what stage does that happen.

And, the design modification process that has been in place at the plant rests on the interdiscipline review at the end of the preparation of the design product; and

consequently, they prepare at the end and have missed an element that really should be in it.

And we're changing that process. Actually, it's in the process of being changed this month. We're going to have a common process modification process with FENOC. It's in place with the other two plants, at Perry and Beaver Valley. And we're going to be adopting it at Davis-Besse.

That calls for an interim interdiscipline review to get those comments by the various specialists and experts that reside at the plant or are available in the industry to us, to get their input to a product before the end.

So, some of the comments that are asked by the Engineering Assessment Board will find weaknesses in the technical areas on specifics. And that's not a surprise to us. I think it's good. It shows it's good probing going on and good learning going on by the staff at the station.

MR. GROBE: Jim, could you describe in a little more detail what an item is, like calculation item?

MR. POWERS: Pardon me, Jack?

MR. GROBE: If the, it says Engineering Items Reviewed. I'm trying to understand what an item is.

MR. POWERS: An item could be

an operability determination or it could be a modification package, it could be corrective action investigation report. So, an item is an engineering product. It can be a calculation also.

And we've got four subcommittees that are reviewing the Building Blocks. We have one for Programs, one for Systems Health, one for the Containment Health and then one for Modifications Operability Determination Calculations, and the balance of engineering products. So, we have special subcommittees focused on those areas.

MR. GROBE: Do each of those subcommittees include site staff as well as independent experts from other parts of the industry?

MR. POWERS: What we've, thus far we've got industry expertise. We have an individual from site staff that's on the board. And we also when we do review such programs, we bring in all the site staff owner, but also his peer owners from the other two stations. We can share experiences and drive a higher standard within FENOC and use it as a beneficial tool to us.

We plan to integrate more of the line staff in that process as we go on with time, but we're not fully engaged with all line staff as far as we want to go yet.

MR. GROBE: I found it

interesting that you chose that your engineering staff are aspiring to be zeros.

MR. PRICE: Are there any additional questions?

Christine, I know you have additional questions that you mentioned earlier.

MS. LIPA: I spent a lot of time reviewing the plant and this helps, combined with your discussions.

MR. PRICE: If there is no other questions, I would like to turn this over to Bill Pearce, who will talk Nuclear Quality.

MR. PEARCE: Thank you, Clark.

Good afternoon, I'm Bill Pearce. I'm the Vice President of Oversight for FENOC.

Since this is the first time I've attended this public meeting this afternoon, I thought I'd give you a little background about myself. I've worked in this industry for many years, primarily in the area of Plant Operations. And I've been a Senior Line Management position for a long time, many years, but this is the first time I've ever been in Quality Assurance Organization.

And I guess to tell you what my expectation is, I believe I can bring something to improve the Quality

Assurance Organization. I think I can help us get to more of an operational focus. So, enough introduction about myself.

First thing I want to go over is the root, we've done a Root Cause Evaluation of Quality Assurance and its performance; and we did this, because we acknowledge our failure to identify the reactor head issue, just like the line organization. So, we like the line organization did a Root Cause Evaluation.

The evaluation was performed by a team, and the team was made up, we brought in an outside team leader, because it was well experienced in quality assurance. The team also consisted of Perry and Beaver Valley folks from our other two sites.

And we did an independent root cause of missed opportunities; where could we have failed issues or brought issues forward and gotten them resolved that would have precluded this head issue that we have. Finally, as we did this, we came up with some things that we wanted to get corrected. We started looking at that.

Next, let's look at the preliminary results of this. This root cause is not all fully completed yet, but we're far enough along to be able to look at some of the preliminary conclusions.

Here is the Root Cause. FENOC Nuclear Safety

Values; behaviors and expectations were inadequate to enable oversight to effect needed positive change in station operations.

Now, I know that's a complex statement. Let me explain it in a different way to try to, for you to gain some understanding. What it's really saying is there is no differentiation between standards of the QA Organization and standards of the rest of the site organization. This was caused by a lack of independence.

The QA Organization reported into the management of the plant, and then forward to where the standards of the plant went, QA went with it. And this is what it's trying to explain, there should have been an oversight group.

So, thus QA was not holding itself to a higher set of standards; and really, this is one of the reasons I am here now, is this gives me independence. I report directly to the President of FENOC, and I don't report to the line organization of the plant.

So, the Quality Assessment Group can look at the plant and not be affected by the things that affect the rest of the plant and have an opportunity to raise issues or elevate issues outside the plant if it becomes necessary to get those resolved. That's kind of what the Root Cause was about.

There are also in the preliminary conclusions some

contributing causes. Ineffective training of the Quality Assurance Group for a previous event we had that had, it had boric acid involved in it. It was involved with the Reactor Coolant System. It involved some unexpected degradation.

And we did a root cause, training our folk on the causes of that degradation and how it should be treated, but obviously this was ineffective, because we saw some of those same issues on the head. We were ineffective at recognizing those and the importance of those issues in getting the issue brought up and resolved.

The second one kind of, sounds kind of odd. The process for providing oversight of the oversight function. For every group, including us, we provide oversight to the line organization, but there are organizations that provide oversight of us, such as the company's Nuclear Review Board; Joint Utility Management Assessment, which is all the nuclear utilities participate and we go assess each other.

It's a Quality Assurance Organization and gives a report on how we stand; a self-assessment that we do of ourselves; and then of course management oversight of ourselves. What this is, what this is telling us is those two failed too recognize that our performance was inadequate to recognize this type of issue and get it

resolved.

The third one is an interesting one. For a period of time the management of the audit/evaluation process was not independent from the management of the corrective action process.

What it really means is the person that was in charge of the oversight function actually had other responsibilities in the organization that would not let the Quality Assessment Organization be independent of the line organization, which kind of gets back to the first part again of it. The fact that the standards in quality assessment were the same as the rest of the site, so therefore where we stand on the site, so went the quality assessment.

With that said, that's enough about the conclusion or the causes. I would like to talk a minute about what are some actions that we're taking going forward.

First of all, we want to elevate standards. I believe this is extremely important. We hold the Quality Assurance Organization to a higher standard. And then we can hold the Line Organization accountable to a higher standard, but first we have to get our own standards raised to where they need to be.

Increased intrusiveness. We've got to put a lot more attention in making sure that the Quality Assessment

Group is out in the plant being intrusive, looking at things that are happening in the plant, and being involved in seeing what's going on.

In fact, I just got this today. I had name tags made for all the Quality Assurance folks. I had a little thing put on it, says, "I know, because I looked." I think that that says a lot. And it's about standards, you know, it's the standard of we don't accept just what we read in reports. We go out and look and we know what's going on in the plant.

We need to raise tough issues, make sure we bring issues forward that are not comfortable to deal with, and we get them on the table, so that we can make sure we get the things resolved that need to be resolved.

We need a method to escalate unresolved issues to higher management and we have that now. We're formalized, but we're putting that in place, so that finally if we can't resolve things between the line management at the plant, myself, we can escalate it to the President of FENOC and even to the Nuclear Board, if necessary, for resolution.

Now, that was about the Root Cause. The next thing I want to do is examine where quality assurance is involved in the recovery process. I want to talk about the next few slides about that.

First of all, we are assessing key activities that are going on. When you heard them talk of the line guys talking about the boards that are meeting, we sit in independent oversight of that and overview what's going on in the boards and the right kind of things being talked about. There are things that we know of that are not being brought forward.

We do in-depth technical reviews, independent of the engineering organization for engineering products. So, we're looking at the engineering products coming out and making sure that we believe that the products are of quality that are being brought forward.

Field verification of actual conditions. This is our participation in the field activities, the walkdowns. We do parallel walkdowns, and also independent walkdowns. Then independent parallel reviews.

The next thing I'm sure you're asking, what are we finding. On the next page, I'm going to show you a big overview of what we're finding.

These are numbers of condition reports. When we in Quality Assurance find something, we write a condition report about it to ensure it gets in our Corrective Action Program and gets resolved. And you can see these are the number of condition reports written by the Quality Assurance Organization per month. And you can see, this is

a twelve-month period, or actually 13 months. You can see how the numbers have increased as we've tried to become more intrusive.

But let's, but now let me tell you about some things that we've really found. In the area of increased intrusiveness, the most recent assessment, we identified 77 issues. Now, all of these are not huge issues, but they are nevertheless issues and are recorded in the Corrective Action Program.

We're doing real time assessments. We're out looking at operational performance or real time performance in the plant and not just reviewing paper. I think this is important, because we are reviewing to not just minimum regulatory requirements, but we're trying to hold the site to a set of standards that are above that.

I know that sounds kind of negative about the regulatory requirements, but just meeting the regulatory requirements doesn't get us to where we want to be as a station. We've got to focus on real nuclear safety and things that are not required in the regulation, like people's behaviors, how they think, are they thinking about the right things. The requirements are there. They've got to be met, no question about that. But beyond that, there are other things that we need to focus on as an organization.

Next slide is, here's some examples of real time issues we've identified. First one is operation's group failure to request engineering rigor for operability determinations. This is an example of prestandards that we're pushing in the organization. I think you heard some of the rest of them talk about it. We've been effective at moving the standard within the organization, and getting a change in the behaviors for improvement in that area.

Another one we found was failure of the Line Organization to recognize containment painting as a design change. That was something else that we've done in Quality Assurance Organization.

Under the area of Ensuring Product Quality, vendor errors with implementation of the feedwater flow modification. Here's an example of finding something in the engineering area, looking at their product.

The second one there is failure to comply with quality program requirements during overhaul of the decay heat pump, which is a safety related pump and the issue was how we dealt and the oversight we provided in a vendor that was not a quality vendor, and the issues around that.

The next one is under the area of Elevating Standards. Posting and protection of protected train equipment. For those of you don't know what that is, for our safety equipment, almost always at nuclear power plant

there are two trains. So, if you take one out to work on it, beyond it being an amount of time sometimes, it limits how long both of them, or one of them can be out.

We also try to protect it, so that somebody doesn't go in the area and work on the remaining train, so we end up with no safety trains available. While that doesn't, does not meet the regulatory minimum requirements on no trains, we want to do something beyond that to make sure we protect the remaining train.

So, we do that by installing barriers and signs and making sure something inadvertently doesn't happen. Raising the standard of how we protect that remaining train is what this is about and what was being brought forward by the Quality Assurance Organization.

Documentation standards for unit log keeping. This is documentation of like, what constitutes operability when an operability determination is being made. What are the specific issues that the equipment is called operable based upon, making sure that those type of details are in the log and well documented, so oncoming shifts will know exactly what those kind of issues are, so if they are affected by what goes on in the future, the folks that are coming on will know what the issue is.

Potential corrosion of the containment vessel. Quality Assurance Organization brought up the microbe

induced corrosion issue for the containment vessel, and documented that earlier in the containment inspection.

Untimely corrective actions for previously identified Corrective Action Program weaknesses. You've heard Lew talk about the Corrective Action Program and what they found during the program review. This was actually documented well before that. Quality Assurance Organization had written condition reports demonstrating some of the same weaknesses found in the condition, in the Program Action Reviews.

Here's some examples I think of being tough, or raising the standards. In our second quarter assessment, which is the overall assessment of all the departments at the site, we found that five of the eleven areas had marginal performance. I think if you look back in time, you would see that that's almost a step increase in how we've been looking at things prior to that. And we found two unacceptable performance issues in our last quarterly assessment. So, I think that's an example of us raising standards in the organization.

MR. GROBE: Bill, do you recall what those were?

MR. PEARCE: Which ones?

MR. GROBE: The two unacceptable performances?

MR. PEARCE: Yes, sir.

Within the engineering functional area, the plant modification process was identified as unacceptable. It did not meet all the required items for Appendix B an ANSI Standard November 45.2.11 requirements. It says, Nuclear Quality Assessment would have exercised a stop work authority if the line organization had not implemented acceptable interim compensatory measures.

Then it says, additionally, the area of radiation protection, the implementation of Corrective Action Program was rated as unacceptable. Those were the areas.

Well, my conclusion, I guess, is that the Quality Assurance Organization is already improving our standards. We are not yet where we need or want to be, but we have identified our weaknesses and are formulating an improvement plan to get us where we want to be.

I thank you for your attention. Are there any questions that you have?

MR. DEAN: I have a couple of questions. One is, earlier we talked about the efforts to try and move Davis-Besse towards an operations focus organization. We talked about benchmarking and some of the results of that.

Have you done a similar effort relative to the QA organization and how it was performing previously and what

your approach is now; how does that benchmark against other high performing organizations?

MR. PEARCE: As we did the Root Cause, we brought one outside person in. And then at the end, we actually brought a person from, well, from Florida Power and Light and one from Intergy in and went through all the facts to narrow down the conclusion.

We intend to continue to do that. In fact, last week, for instance, the Quality Assurance Manager was on vacation last week, and to fill in for him while he was gone, I brought the Quality Assurance Manager from Perry over and he filled in for him. Just to give a different set of eyes in the actual management position. It's a lot easier to see things if you haven't been in the middle of them for some period of time. That gives us some outside view.

We intend going forward not only views of Perry and Beaver Valley people a lot, and in fact I believe that either last week or this week, we had eight folks from Perry and Beaver Valley at Davis-Besse helping us go look at these programs. And there is a lot of advantage to that. Not only does it give them some help and go out and look at what we're doing, they take those standards back with them.

You know, I really believe that a lot of times the

cutting edge for standards in our industry is produced at the plants coming out of trouble. I think we can get a lot of learning for the other two sites by making sure that the quality assurance folks from the other two plants get over here and be involved, so that they get the learning that we're getting out of this and take it back to the other two sites.

And, we intend to bring in some folks at times from other companies within in the industry.

MR. DEAN: How about the, pertaining to the line, you talked about raising the QA standards above what regulatory is required, organizations like INPO, which is intended to promote excellence throughout industry. Have you gone to them and sought any assistance from them?

MR. PEARCE: In fact, on our Restart Oversight Panel yesterday, we had two members of INPO. One is a member and the other was a visitor, who I guess now he's in charge of all -- what is he in charge of? It's a help --

MR. MYERS: Assistance.

MR. PEARCE: But, he's in charge of all the systems for INPO, and he was at our Restart Oversight. And that's in fact why he is here, to make sure if we need some assistance that we're getting the

help that we need from the rest of the industry and, you know, I think that's an example of how we're getting help by INPO, not only from the plant, but from the Quality Assurance Organization.

MR. DEAN: Second question I wanted to raise relative to reorganizing and restandarding the QA Organization. For a period of time, went along, you were part of the staff, essentially; you were in the staff. And so, a certain line stayed true to form between your QA staff and their relationships. What's being done in bringing fresh blood or different talent or different mind set into the organization?

MR. PEARCE: I think we're doing a lot, like I said, we're trying to bring in people from Perry and Beaver Valley and a lot of them, instead of totally supplementing our needs here with contractors from outside, what we decided to do is use those, those folks from Beaver Valley and Perry to supplement, but that is outside, an outside look. I mean, we have not ever spent a lot of time together like that in looking at those standards.

In addition, we have got, we have gotten some engineering people that have come out to some of the more recent trouble plants and seen what standards are in those areas and they're in working supplementing our organization

now, looking at some of the engineering products, for instance; and using that to help build the standards up.

And personally, myself, I'm a line person, my whole life, and now in quality assurance, and I've got a background in operations; and I can help us raise our focus on operational performance and not just meeting program requirements.

MR. DEAN: Has there been an effort to go to other parts of the organization, say I'm looking for somebody that's a top notch engineering or top notch operations person to come over to QA and give me some discussions?

MR. PEARCE: Surprisingly enough, I didn't do this. This happened before I got there. That's been done recently at this site. I think we have, I think we have a real good set of folks. And, I invite you to come down. I would be glad to let you meet them, but I think you'll think so too.

And they are, we've got a good mixture of people who have had responsible positions within the organization, a lot of places in the organization and then some professional QA folks. We have got a pretty good mixture, I think, at Davis-Besse.

MR. MYERS: We have. And, I was asking, do we have plans to do some permanent cross

pollenization from people of other sites to the Davis-Besse Plant?

MR. PEARCE: Yes, we do.

MR. MYERS: And that's sort of what you asked awhile ago. We intend to do some of that; we have some ideas in mind.

MR. DEAN: We'll ask more about that later.

MR. MYERS: Okay.

MR. MENDIOLA: I know you don't like to be here.

MR. MYERS: Pretty much be a good time to look at a new job (laughter) public meetings.

MR. MENDIOLA: Okay. Knowing that Quality Assurance Programs are often incorporated, corporately across all the plants associated with the company. For example, yourself and First Energy; is there, well, I guess, to summarize your presentation basically, I would understand that the Quality Assurance Program is implemented more appropriately across First Energy, but had gaps at Davis-Besse.

Is there a corporate oversight function here that needs to be discussed or revealed or possibly brought anew?

MR. PEARCE: That was the Root Cause; wasn't it?