

9 Twin Orchard Drive
Oswego, NY 13126
June 5, 2005

James L. Caldwell
Regional Administrator
USNRC Region III
2443 Warrenville Road, Suite 210
Lisle, IL 60532-4352

Dear Mr. James L. Caldwell:

I have these comments on *Perry Integrated Inspection Report 05000440/2005002*.

Pages 9, 10 of 73

When it was determined that the test of ECCW 'B' pump did not prove operability, the pump was not declared inoperable. No, the remedy was to simply attempt to code the test as "no credit". (This way there would not be a failure, I guess.) With an apparent lack of a questioning attitude, the test was performed in a consistent manner (on February 1, 2005), and did not pass again. However, since it took until February 5, 2005 to review the test, they did not know this until the test was too late. (Ref. page 40 of 73)

Page 40 of 73

"On February 5, 2005, the licensee identified that the procedure had been incorrectly performed and entered TS 3.0.3 for a missed TS surveillance."

Note this: "'The discharge pressure value should have been requested by the test performer and provided by the in-field non-licensed operator at step 5.1.15.b.'" Does this mean the problem here was actually an inadequate procedure?

Page 10, 11

By operating an RHR 'A' valve on February 27, 2005 (and not paying attention to the actual system configuration), "8,500 gallons" were dumped on the floor of the auxiliary building. (Ref. Page 44 of 73)

I find it more interesting that, when "Flood Protection Measures" are covered in Section 1R06, the auxiliary building is ignored and an area with "No findings of significance.." is selected, instead. (Ref. Pages 21, 22 of 73)

Page 54 of 73

The inspectors routinely reviewed issues to determine, among other things, that adequate attention was being given to timely corrective actions. But, if you look in the "Findings"

JUN 21 2005

section, you will not see mention of the sluggish Perry response to the ESW failures. (Recall that these started 9-1-03 according to slide 5 of 40 from May 26, 2005. Also, slide 19 of 40 appears to state that "Actions to address the second ESW pump failure" are still not complete (as I read it.))

Well, that's it. This plant that can't hook up IRMs according to procedure, can dump 8500 gallons on the floor because they don't know the plant configuration and can't complete corrective action on their ESW system, still is allowed to run at 100% power.

This is Letter 2, I need no reply.

Thank you,

Tom Gurdziel

Copy: D. Lochbaum

9 Twin Orchard Drive
Oswego, NY 13126
June 4, 2005

James L. Caldwell
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Lisle, IL 60532-4352

Dear Mr. James L. Caldwell:

I have begun to read Perry Integrated Inspection Report 05000440/2005002 and have these comments.

Page 1 of 73

“On February 7, 2005, the NRC reviewed Perry operational performance, inspection findings, and performance indicators during the fourth quarter of 2004. Based on this review, we concluded that Perry is operating safely.”

Since this inspection report is dated May 5, 2005, it is my opinion that the last three words above should read “WAS operating safely.” However, more importantly, you will find out (on the sixth page) that this report covers the period from January 1 through March 31, 2005. Was the plant operated safely then?

“However ...and because they have been entered into your corrective action program, the NRC is treating these findings...”

Slide 18 of 40, dated May 26, 2005 of the Supplemental Inspection under Inspection Procedure 95003 Exit Meeting, as I read it, tells the reader that not only is the implementation of the Corrective Action program inconsistent, there also has been NO SUBSTANTIAL improvement since the plant entered the Repetitive Degraded Cornerstone. (Slide 5 of 40 tells me that this date was August 12, 2004). Now you may say that these slides are dated later than the Inspection Report. You are right. However Slide 11 of 40 states that the Corrective Action Inspection was done January 10 to 28, 2005. So, knowledge of the shape of this program was available before this conclusion was drawn.

(Suppose a regulatory agency inspected an industrial building and found a lot of fire hazards, but would not cite the building operator since all the hazards were known to the assigned fire department. And, the same regulatory agency had determined that the assigned fire department provided inconsistent fire protection. Wouldn't that be pretty much the same thing?) (I think it would.)

Pages 7,8, of 73

Starting at the bottom of page 7 of 73 and continuing is what appears to be a simple story of failure to follow procedures when erecting scaffolding. It is not. I find the primary cause to be procedures so complicated that it would take a team of lawyers to figure them out.

Page 8 of 73

Before we jump over to page 17 of 73 for the fuller explanation in section 1R04, there are these words:

“The finding was determined to be of very low safety significance because, assuming HPCS was rendered inoperable following a seismic event due to non-seismic scaffolding, Significance Determination Process Phase 3 analysis determined the issue to not be greater than Green due to the low frequency of seismic events..”

In other words, even though a seismic event has happened, it doesn't matter since it doesn't happen too frequently. Does this really sound right? Because if it does, why bother worrying about seismic scaffolding at all?

Pages 17, 18, 19 20 of 73

On March 4, 2005, inspectors looked at some scaffolding. They found that the scaffold was too close to the Division 3 EDG right bank air start regulator pilot valve piping and told the shift manager. Later in the same day, the inspectors returned. Here is what they found: scaffolding now did not meet requirements near BOTH the right and left air pilot valves.

On March 7, 2005 inspectors noted problems with scaffolding in the HPCS pump room.

“The inspectors discussed the observed seismic scaffolding issues with the maintenance services superintendent.” They were told that “scaffolding was not required to be built to the seismic requirements..” “the inspectors became concerned that scaffolding throughout the plant had not been constructed per seismic requirements in safety-related areas. This was further validated by a spot check of scaffolding on the safety-related emergency service water (ESW) system.”

“Additionally, interviews with maintenance personnel revealed that the failure to follow scaffold procedures was a broad program-wide deficiency..”

(I should mention here that this program-wide deficiency apparently either was corrected or wasn't considered important when, on May 26, 2005, the NRC stated on slide 15 of 40 that “Programs and processes are adequate”)

Two IRMs were not operable in one trip system upon reactor start-up.

Let me take a moment here to recall personal experience from about a quarter century ago at Nine Mile I (when it was owned and operated by Niagara Mohawk). At that time I was part of one of two (combined) shifts for a plant outage. We had done everything necessary to start up the plant except for one IRM or SRM (I don't remember exactly) which did not work. Now there were "joysticks" on "E" panel that would allow the bypass of 1 of 4 SRMs and, I believe, 1 of 4 IRMs in each RPS trip channel. Our opinion was: "put it in "Bypass" and let's get going." Here is what we were told. We do not start up the plant with ANY nuclear instrumentation not working. After the plant is running, we would bypass as allowed, if it then became necessary.

Frankly, I was disappointed to hear that Perry, (and apparently other BWRs), now start up with inop nuclear instrumentation. I consider this a non-conservative upper management decision.

The Inspection Report states: "The primary cause of this finding was the failure to implement appropriate procedures during maintenance activities on IRM 'A'."

"Additionally, the maintenance procedure lacked appropriate acceptance criteria for determining that the maintenance had been satisfactorily accomplished."

But let's go to Section 1R19 for something I find more significant.

Pages 29, 30, 31, 32 of 73

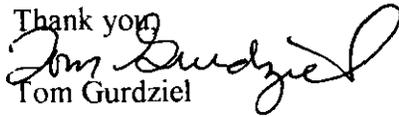
"The last two instructions of section 5.2.3 state "Deenergize HVPS [High Voltage Power Supply] and disconnect all test equipment. Inform RO [reactor operator] detector may be placed in desired position with regard to current plant operational conditions." The ICI-C51-7 procedure omitted steps requiring re-connection of the cable to the pre-amp and otherwise failed to provide appropriate acceptance criteria to ensure the cable was properly attached."

Let's just think about this a moment. If the I&C technicians had actually followed their (I assume reviewed) procedure, NONE of the IRMs worked on would have been connected, since the procedure did not tell them to do this. Yet, Slide 40 of 40 from May 26, 2005 states: "Summary, Perry Nuclear Plant continues to operate Safely".

Do you really feel this is a proper assessment?

This is Letter 1, I need no reply.

Thank you

A handwritten signature in cursive script that reads "Tom Gurdziel". The signature is written in black ink and is positioned to the right of the typed name.

Tom Gurdziel

Copy: D. Lochbaum

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