T. V. Panetta
J. S. Elrod

TELECOPY

REGIONAL ADMINISTRATOR
DEPUTY ADMINISTRATOR
ASS'T TO ADMINISTRATOR
DIRECTOR, DRP
DIRECTOR, DRS
DIRECTOR, DRSS
DIRECTOR, RMA

JAN 13 P4:40

January 13, 1986

Dr. J. Nelson Grace
Regional Administrator, Region II
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commission
101 Marietta Street N.W., Suite 2900
Atlanta, GA 30323

Subject: Crystal River Unit #3
Docket No. 50-302
Operating License No. DPR-72

This report confirms the verbal reports made to your office on January 10, 1986 and is submitted in accordance with Florida Power Corporation's Radiological Emergency Response Plan.

At 1700 on January 10, 1986, the body of a diver who had been working at the intake structure was recovered. This diver had entered the water to locate another diver who had previously entered the water and was overdue to return to the surface.

An Unusual Event was declared at 1840, after disabling raw water pumps which supply the decay heat removal heat sink.

The body of the diver who was originally missing was recovered at approximately 1900.

The Unusual Event was exited 2000 on January 10, 1986 after normal decay heat removal heat sink was established.

Please contact our Plant Staff if further clarification is needed.

Paul F. McKee

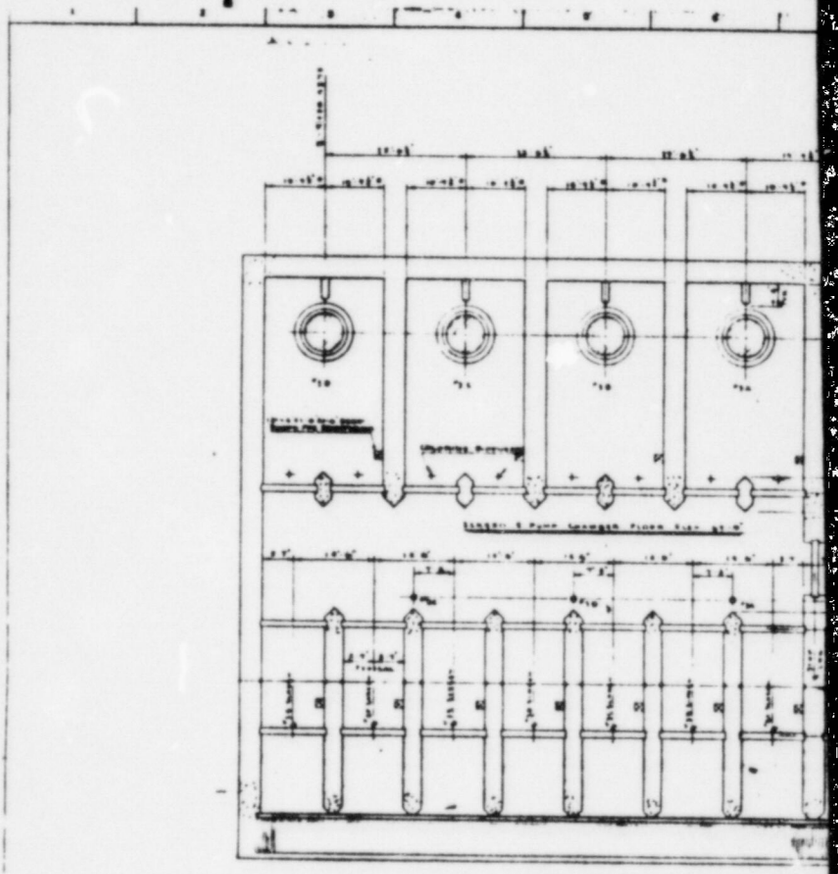
Paul F. McKee
Nuclear Plant Manager
Florida Power Corporation
Crystal River Unit #3
Crystal River, Florida 32629

VERIFICATION TELECOPY RECEIVED:

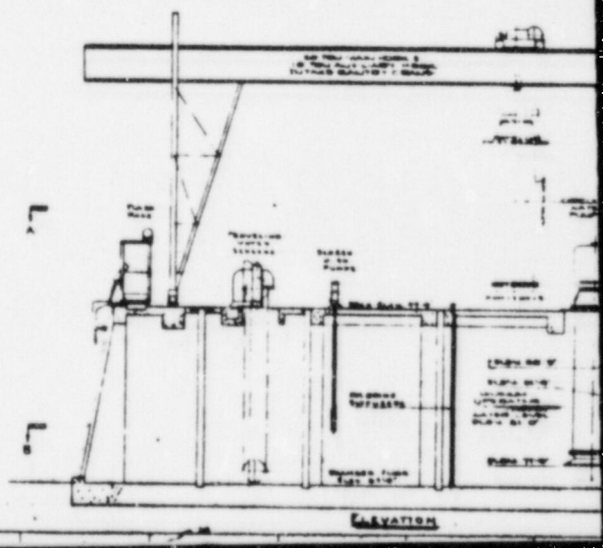
BY:_____

DATE:_____ TIME:_____

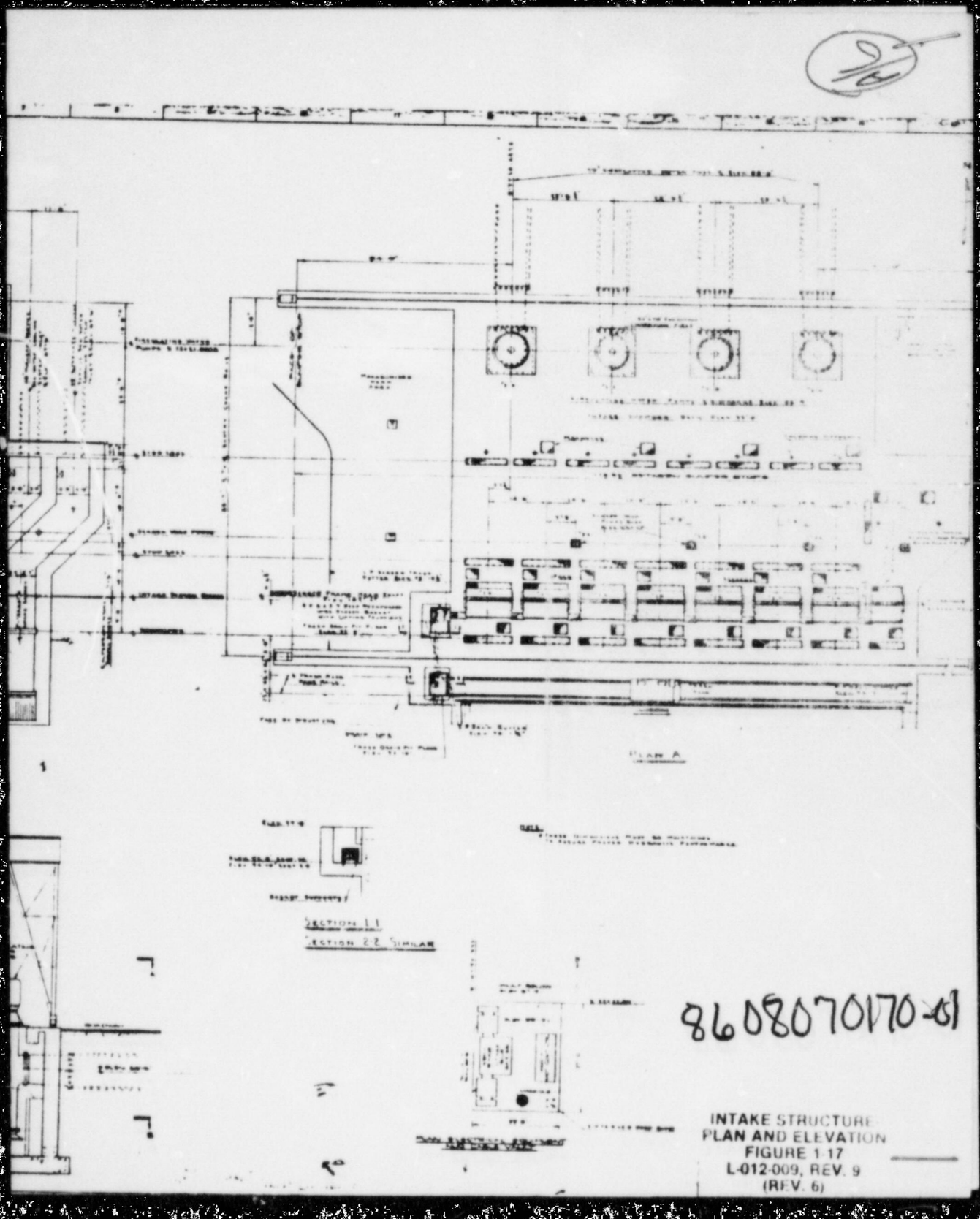
JLB/bc



PLAN B

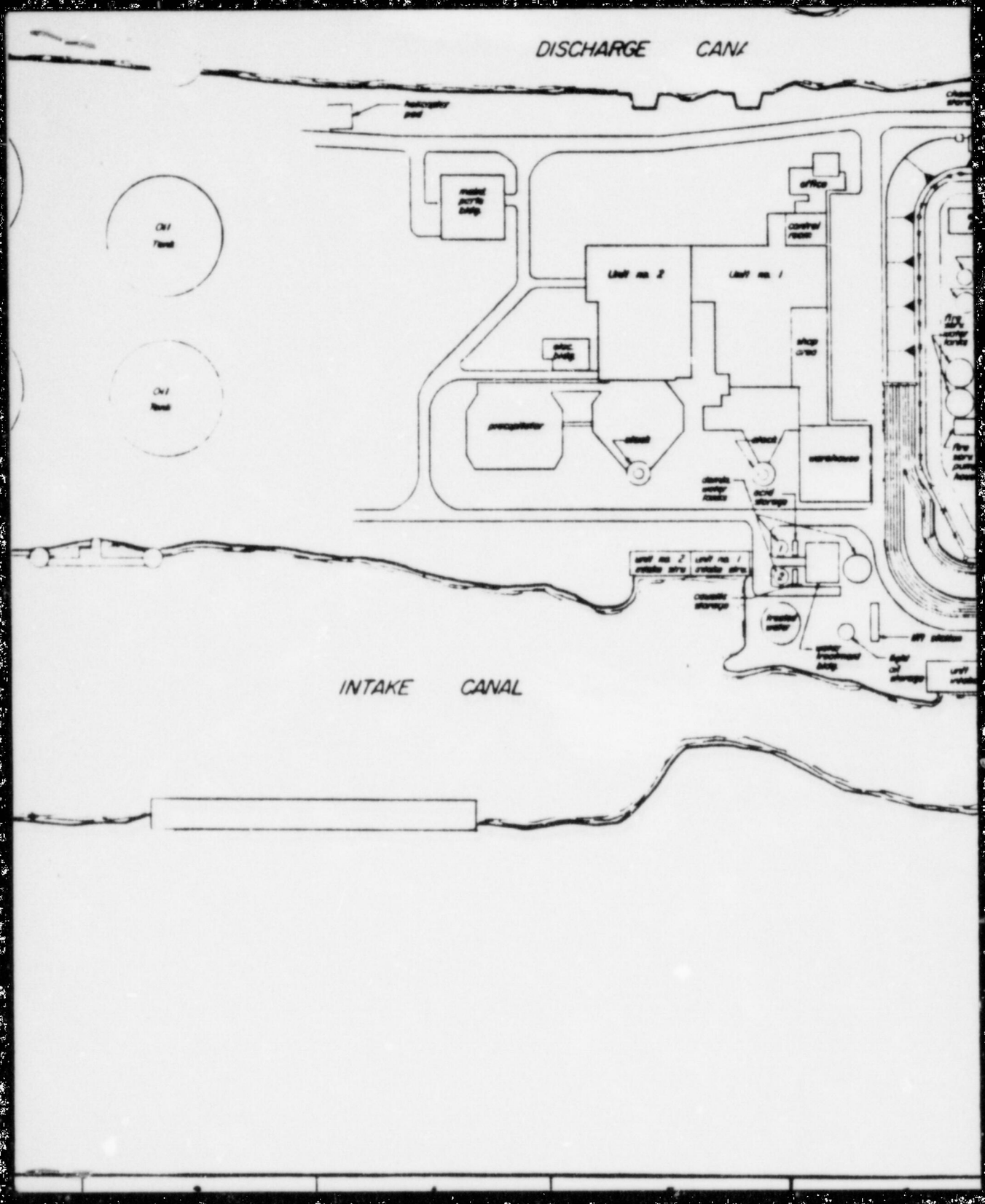


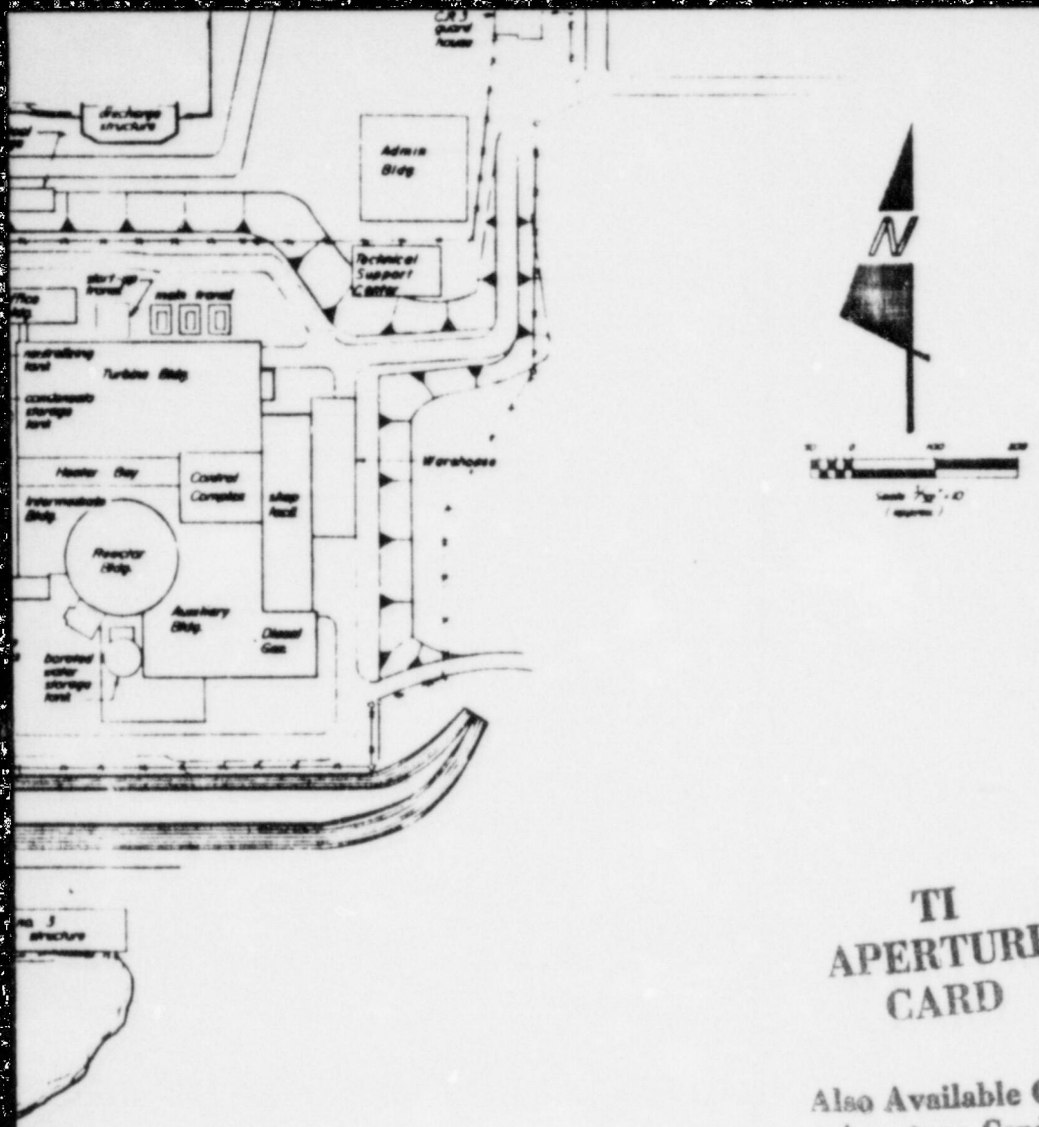
ELEVATION



8608070170-01

INTAKE STRUCTURE
PLAN AND ELEVATION
FIGURE 1-17
L-012-009, REV. 9
(REV. 6)


DISCHARGE CANA
INTAKE CANAL



C/E

TI
APERTURE
CARD

Also Available On
Aperture Card

8608070170-02

CRYSTAL RIVER 1, 2 & 3
SITE PLOT PLAN
FIGURE 1-2
CR3-G86-D, REV. I
(REV. 6)

Florida Power

MESSAGE

informed Ted Suerth 1/23/86, 0730

T Jr Lankford

1/22/86 - MEDIA STATEMENT RE: JANUARY 10, 1986 DIVING ACCIDENT

The following statement was released to the news media today by the corporate communications department.

The tragic events of Friday, January 10th, 1986, not only devastated two families, but also sadly impacted many friends, relatives, Florida Power employees, and the management of this company. The diving accident, which claimed the lives of two well-respected men, should not have happened.

Florida Power has said repeatedly we would give a report on the incident after our investigation was completed.

Our investigation is now over. The main question has been whether the divers were warned about the pumps being on. We have found no evidence that the divers were specifically warned that the pumps were on at the time they were diving, nor is there any indication that they were diving in an area they were not authorized to be in. This entire incident has involved serious communications problems and we still are uncertain of precise communications that occurred among those planning the diving, those actually diving, and those controlling the pumps. We want to emphasize that we did not say, nor did we intend to imply to the Florida Public Service Commission, that we warned divers or that they knew that the pumps were in operation.

We regret any communication which may have resulted from the recent newspaper story and subsequent stories, which said we had warned the divers that the pumps were running. During our investigation, non-Florida Power people made comments to reporters which have resulted in this confusion.

There now appears to be a substantial chance of litigation and because of that, it would be inappropriate for us to respond to further questions regarding this tragedy.

-0-

Official Copy 19

about 4 to 4 Jan 10

A diver that was cleaning the intake structure A was detained to be down too long. He had an tether. A second diver with a tether was sent to find the first diver at about 5 pm the he began very light - the diver was pulled out dead. suspecting the first diver may have been swept into the wrecked service sea water pit about 600 feet from the intake, personnel neared the pit cover. bubbles were noted in the pit. A diver recovered the first man.

From 5 to 8 PM cooling water load AC Temp rose from 95° to 175°

Normal RCS cooling modes: re established after the first

C i & SW.

Plant was drained to the maintenance level raising RCS level was considered but not needed.

UE at 1816 — SPC 2000 securing the cooling

experienced divers.

Offsite review comm <

9.7

all of agt work SD this weekend.

Fig 1-15 shows pumps under floor of aux blds.

Running. 2 Pumps A pit A train
RWP 3 A
3 Pumps A pit B train
1 2B 3B

2 "

Dive Tech International
Pinellas Park, FL.
(Clearwater St Petes)

Gary Westafer –
4 hours.

Project

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30323

FEB 12 1986

Florida Power Corporation
ATTN: Mr. W. S. Wilgus
Vice President Nuclear Operations
P. O. Box 14042, M.A.C. H-2
St. Petersburg, FL 33733

Gentlemen:

SUBJECT: REPORT NO. 50-302/85-44

On November 26, 1985 - January 17, 1986, NRC inspected activities authorized by NRC Operating License No. DPR-72 for your Crystal River facility. At the conclusion of the inspection, the findings were discussed with those members of your staff identified in the enclosed inspection report.

Areas examined during the inspection are identified in the report. Within these areas, the inspection consisted of selective examinations of procedures and representative records, interviews with personnel, and observation of activities in progress.

The inspection fincings indicate that certain activities violated NRC requirements and that other activities appeared to deviate from a commitment to the NRC. The violations and the deviation, with pertinent references and elements to be included in your response, are presented in the enclosed Notices. Due to the apparent repetitive nature of Violation 2 with that identified in NRC Inspection Report 50-302/85-41, we requested, in correspondence dated January 24, 1986, that you submit a supplemental response to that report. Therefore, no further response to this violation is required.

Your attention is invited to the unresolved item identified in the inspection report. This matter will be pursued during future inspections.

The responses directed by this letter and the enclosures are not subject to the clearance procedures of the Office of Management and Budget issued under the Paperwork Reduction Act of 1980, PL 96-511.

Should you have any questions concerning this letter, please contact us.

Sincerely,

Roger D. Walker

Roger D. Walker, Director
Division of Reactor Projects

Enclosures: (See page 2)

8602190081 1pp.

A/S

ATLANTA GEORGIA 30323

UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30323

Report No.: 50-302/85-44

Licensee: Florida Power Corporation
3201 34th Street, South
St. Petersburg, FL 33733

Docket No.: 50-302 License No.: DPR-72

Facility Name: Crystal River 3

Inspection Conducted: November 26, 1985 - January 17, 1986

Inspector: S. Gwertman for 2/11/86
T. F. Stetka, Senior Resident Inspector Date Signed

Accompanying Personnel: J. E. Tedrow, Resident Inspector

Approved by: S Elrod 2/11/86
S. A. Elrod, Section Chief Date Signed
Division of Reactor Projects

SUMMARY

Scope: This routine inspection involved 266 inspector-hours on site by two resident inspectors in the areas of plant operations, security, radiological controls, Licensee Event Reports and Nonconforming Operations Reports, and licensee action on previous inspection items. Numerous facility tours were conducted and facility operations observed. Some of these tours and observations were conducted on backshifts.

Results: Two violations and one deviation were identified: Failure to make a one hour report to the NRC Operations Center as required by 10 CFR 50.72, paragraph 6.b; Failure to adhere to the requirements of a Radiation Work Permit, paragraph 5.b(5); Deviation from a commitment to an NRC violation, paragraph 5.a.

c. On January 10, 1986, the licensee contracted divers to clean and remove trash from the plant's intake structure, which provides cooling water to the plant from the Gulf of Mexico. During this period, the plant was in a cold shutdown (Mode 5) condition with reactor cooling being provided by the decay heat removal (DHR) system. The DHR system utilizes pumps (RWPs) that take water from the Gulf via the intake structure to provide a cooling heat sink.

At about 4:30 p.m., it was reported that one of the divers was missing. Shortly thereafter, it was reported that a second diver, who had gone into the water to look for the first diver, had died. During this time period, the running RWPs were secured thus leaving the plant without cooling water.

While attempts were underway to locate the missing diver, the plant operators cross-connected cooling systems to provide some plant cooling. At the beginning of this event, the reactor coolant temperature was approximately 95 degrees. With the main cooling water systems secured and other ancillary systems cross-connected, the reactor coolant system (RCS) began to heat up at a rate of approximately 30 to 35 degrees per hour. Because of this lack of cooling water, the licensee declared an Unusual Event at 6:40 p.m.

At approximately 7:32 p.m., the second diver was located in the vicinity of the RWPs and retrieved. Upon notification of the retrieval of the second diver, plant operators immediately restarted the RWPs and a normal plant cooldown was begun. The highest RCS temperature attained during the time the cooling water was secured was approximately 175 degrees. The plant secured the Unusual Event at approximately 8:00 p.m.

The inspector arrived onsite shortly after the first diver was found dead and monitored the licensee's activities with respect to the diver search and plant status. The licensee and personnel from the Occupational Safety and Health Administration (OSHA) are continuing to investigate this event.

This event involves a problem with industrial safety which is under the purview of OSHA. The NRC will review the OSHA findings to determine whether further actions are required.

This event will be tracked as IFI 302/85-44-08: Review the OSHA findings concerning the death of two divers while diving in the intake structure.

9. Review of Offsite Review Committee Activities

The inspector attended meetings and reviewed activities of the licensee's offsite review committee, the Nuclear General Review Committee (NGRC). This review included a determination that TS requirements were being met with regard to:

- committee quorum;
- committee composition with respect to disciplines and expertise;
- qualification of committee members; and
- review activities of the committee.

No violations or deviations were identified.