



# Fact Sheet

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## The Accident At Three Mile Island

The accident at the Three Mile Island Unit 2 (TMI-2) nuclear power plant near Middletown, Pennsylvania, on March 28, 1979, was the most serious in U.S. commercial nuclear power plant operating history(1), even though it led to no deaths or injuries to plant workers or members of the nearby community. But it brought about sweeping changes involving emergency response planning, reactor operator training, human factors engineering, radiation protection, and many other areas of nuclear power plant operations. It also caused the U.S. Nuclear Regulatory Commission to tighten and heighten its regulatory oversight. Resultant changes in the nuclear power industry and at the NRC had the effect of enhancing safety.

The sequence of certain events - - equipment malfunctions, design related problems and worker errors - - led to a partial meltdown of the TMI-2 reactor core but only very small off-site releases of radioactivity.

### Summary of Events

The accident began about 4:00 a.m. on March 28, 1979, when the plant experienced a failure in the secondary, non-nuclear section of the plant. The main feedwater pumps stopped running, caused by either a mechanical or electrical failure, which prevented the steam generators from removing heat. First the turbine, then the reactor automatically shut down. Immediately, the pressure in the primary system (the nuclear portion of the plant) began to increase. In order to prevent that pressure from becoming excessive, the pilot-operated relief valve (a valve located at the top of the pressurizer) opened. The valve should have closed when the pressure decreased by a certain amount, but it did not. Signals available to the operator failed to show that the valve was still open. As a result, cooling water poured out of the stuck-open valve and caused the core of the reactor to overheat.

As coolant flowed from the core through the pressurizer, the instruments available to reactor operators provided confusing information. There was no instrument that showed the level of coolant in the core. Instead, the operators judged the level of water in the core by the level in the pressurizer, and since it was high, they assumed that the core was properly covered with coolant. In addition, there was no clear signal that the pilot-operated relief valve was open. As a result, as alarms rang and warning lights flashed, the operators did not realize that the plant was experiencing a loss-of-coolant accident. They took a series of actions that made conditions worse by simply reducing the flow of coolant through the core.

Because adequate cooling was not available, the nuclear fuel overheated to the point at which the zirconium cladding (the long metal tubes which hold the nuclear fuel pellets) ruptured and the fuel pellets began to melt. It was later found that about one-half of the core melted during the early stages of the accident. Although the TMI-2 plant suffered a severe core meltdown, the most dangerous kind of nuclear power accident, it did not produce the worst-case consequences that reactor experts had long feared. In a worst-case accident, the melting of nuclear fuel would lead to a breach of the walls of the containment building and release massive quantities of radiation to the environment. But this did not occur as a result of the Three Mile Island accident.

The accident caught federal and state authorities off-guard. They were concerned about the small releases of radioactive gases that were measured off-site by the late morning of March 28 and even more concerned about the potential threat that the reactor posed to the surrounding population. They did not know that the core had melted, but they immediately took steps to try to gain control of the reactor and ensure adequate cooling to the core. The NRC's regional office in King of Prussia, Pennsylvania, was notified at 7:45 a.m. on March 28. By 8:00, NRC Headquarters in Washington, D.C. was alerted and the NRC Operations Center in Bethesda, Maryland, was activated. The regional office promptly dispatched the first team of inspectors to the site and other agencies, such as the Department of Energy and the Environmental Protection Agency, also mobilized their response teams. Helicopters hired by TMI's owner, General Public Utilities Nuclear, and the Department of Energy were sampling radioactivity in the atmosphere above the plant by midday. A team from the Brookhaven National Laboratory was also sent to assist in radiation monitoring. At 9:15 a.m., the White House was notified and at 11:00 a.m., all non-essential personnel were ordered off the plant's premises.

By the evening of March 28, the core appeared to be adequately cooled and the reactor appeared to be stable. But new concerns arose by the morning of Friday, March 30. A significant release of radiation from the plant's auxiliary building, performed to relieve pressure on the primary system and avoid curtailing the flow of coolant to the core, caused a great deal of confusion and consternation. In an atmosphere of growing uncertainty about the condition of the plant, the governor of Pennsylvania, Richard L. Thornburgh, consulted with the NRC about evacuating the population near the plant. Eventually, he and NRC Chairman Joseph Hendrie agreed that it would be prudent for those members of society most vulnerable to radiation to evacuate the area. Thornburgh announced that he was advising pregnant women and pre-school-age children within a 5-mile radius of the plant to leave the area.

Within a short time, the presence of a large hydrogen bubble in the dome of the pressure vessel, the container that holds the reactor core, stirred new worries. The concern was that the hydrogen bubble might burn or even explode and rupture the pressure vessel. In that event, the core would fall into the containment building and perhaps cause a breach of containment. The hydrogen bubble was a source of intense scrutiny and great anxiety, both among government authorities and the population, throughout the day on Saturday, March 31. The crisis ended when experts determined on Sunday, April 1, that the bubble could not burn or explode because of the absence of oxygen in the pressure vessel. Further, by that time, the utility had succeeded in greatly reducing the size of the bubble.

## **Health Effects**

Detailed studies of the radiological consequences of the accident have been conducted by the NRC, the Environmental Protection Agency, the Department of Health, Education and Welfare (now Health and Human Services), the Department of Energy, and the State of Pennsylvania. Several independent studies have also been conducted. Estimates are that the average dose to about 2 million people in the area was only about 1 millirem. To put this into context, exposure from a full set of chest x-rays is about 6 millirem. Compared to the natural radioactive background dose of about 100-125 millirem per year for the area, the collective dose to the community from the accident was very small. The maximum dose to a person at the site boundary would have been less than 100 millirem.

In the months following the accident, although questions were raised about possible adverse effects from radiation on human, animal, and plant life in the TMI area, none could be directly correlated to the accident. Thousands of environmental samples of air, water, milk, vegetation, soil, and foodstuffs were collected by various groups monitoring the area. Very low levels of radionuclides could be attributed to releases from the accident. However, comprehensive investigations and assessments by several well-respected organizations have concluded that in spite of serious damage to the reactor, most of the radiation was contained and that the actual release had negligible effects on the physical health of individuals or the environment.

## **Impact of the Accident**

The accident was caused by a combination of personnel error, design deficiencies, and component failures. There is no doubt that the accident at Three Mile Island permanently changed both the nuclear industry and the NRC. Public fear and distrust increased, NRC's regulations and oversight became broader and more robust, and management of the plants was scrutinized more carefully. The problems identified from careful analysis of the events during those days have led to permanent and sweeping changes in how NRC regulates its licensees - - which, in turn, has reduced the risk to public health and safety.

Here are some of the major changes which have occurred since the accident:

- Upgrading and strengthening of plant design and equipment requirements. This includes fire protection, piping systems, auxiliary feedwater systems, containment building isolation, reliability of individual components (pressure relief valves and electrical circuit breakers), and the ability of plants to shut down automatically;
- Identifying human performance as a critical part of plant safety, revamping operator training and staffing requirements, followed by improved instrumentation and controls for operating the plant, and establishment of fitness-for-duty programs for plant workers to guard against alcohol or drug abuse;
- Improved instruction to avoid the confusing signals that plagued operations during the accident;
- Enhancement of emergency preparedness to include immediate NRC notification requirements for plant events and an NRC operations center which is now staffed 24 hours a day. Drills and

response plans are now tested by licensees several times a year, and state and local agencies participate in drills with the Federal Emergency Management Agency and NRC;

- Establishment of a program to integrate NRC observations, findings, and conclusions about licensee performance and management effectiveness into a periodic, public report;
- Regular analysis of plant performance by senior NRC managers who identify those plants needing additional regulatory attention;
- Expansion of NRC's resident inspector program - first authorized in 1977 - whereby at least two inspectors live nearby and work exclusively at each plant in the U.S to provide daily surveillance of licensee adherence to NRC regulations;
- Expansion of performance-oriented as well as safety-oriented inspections, and the use of risk assessment to identify vulnerabilities of any plant to severe accidents;
- Strengthening and reorganization of enforcement as a separate office within the NRC;
- The establishment of the Institute of Nuclear Power Operations (INPO), the industry's own "policing" group, and formation of what is now the Nuclear Energy Institute to provide a unified industry approach to generic nuclear regulatory issues, and interaction with NRC and other government agencies;
- The installing of additional equipment by licensees to mitigate accident conditions, and monitor radiation levels and plant status;
- Employment of major initiatives by licensees in early identification of important safety-related problems, and in collecting and assessing relevant data so lessons of experience can be shared and quickly acted upon;
- Expansion of NRC's international activities to share enhanced knowledge of nuclear safety with other countries in a number of important technical areas.

## **Current Status**

Today, the TMI-2 reactor is permanently shut down and defueled, with the reactor coolant system drained, the radioactive water decontaminated and evaporated, radioactive waste shipped off-site to an appropriate disposal site, reactor fuel and core debris shipped off-site to a Department of Energy facility, and the remainder of the site being monitored. The owner says it will keep the facility in long-term, monitored storage until the operating license for the TMI-1 plant expires at which time both plants will be decommissioned. Below is a chronology of highlights of the TMI-2 cleanup from 1980 through 1993.

<u>Date</u>	<u>Event</u>
July 1980	Approximately 43,000 curies of krypton were vented from the reactor building.
July 1980	The first manned entry into the reactor building took place.
Nov. 1980	An Advisory Panel for the Decontamination of TMI-2, composed of citizens, scientists, and State and local officials, held its first meeting in Harrisburg, PA.
July 1984	The reactor vessel head (top) was removed.
Oct. 1985	Defueling began.
July 1986	The off-site shipment of reactor core debris began.
Aug. 1988	GPU submitted a request for a proposal to amend the TMI-2 license to a "possession-only" license and to allow the facility to enter long-term monitoring storage.
Jan. 1990	Defueling was completed.
July 1990	GPU submitted its funding plan for placing \$229 million in escrow for radiological decommissioning of the plant.
Jan. 1991	The evaporation of accident-generated water began.
April 1991	NRC published a notice of opportunity for a hearing on GPU's request for a license amendment.
Feb. 1992	NRC issued a safety evaluation report and granted the license amendment.
Aug. 1993	The processing of accident-generated water was completed involving 2.23 million gallons.
Sept. 1993	NRC issued a possession-only license.
Sept. 1993	The Advisory Panel for Decontamination of TMI-2 held its last meeting.
Dec. 1993	Post-Defueling Monitoring Storage began.

### **Additional Information**

Further information on the TMI-2 accident can be obtained from sources listed below. The documents can be ordered for a fee from the NRC's Public Document Room at 301-415-4737 or 1-800-397-4209;

e-mail [pdr@nrc.gov](mailto:pdr@nrc.gov). The PDR is located at 11555 Rockville Pike, Rockville, Maryland; however the mailing address is: U.S. Nuclear Regulatory Commission, Public Document Room, Washington, D.C. 20555. A glossary is also provided below.

## **Additional Sources for Information on Three Mile Island**

NRC Annual Report - 1979, NUREG-0690

"Population Dose and Health Impact of the Accident at the Three Mile Island Nuclear Station,"  
NUREG-0558

"Environmental Assessment of Radiological Effluents from Data Gathering and Maintenance Operation  
on Three Mile Island Unit 2," NUREG-0681

"Report of The President's Commission on The Accident at Three Mile Island," October, 1979

"Investigation into the March 28, 1979 Three Mile Island Accident by the Office of Inspection and  
Enforcement," NUREG-0600

"Three Mile Island; A Report to the Commissioners and to the Public," by Mitchell Rogovin and George  
T. Frampton, NUREG/CR-1250, Vols. I-II, 1980

"Lessons learned From the Three Mile Island - Unit 2 Advisory Panel," NUREG/CR-6252

"The Status of Recommendations of the President's Commission on the Accident at Three Mile Island,"  
(A ten-year review), NUREG-1355

"NRC Views and Analysis of the Recommendations of the President's Commission on the Accident at  
Three Mile Island," NUREG-0632

"Environmental Impact Statement related to decontamination and disposal of radioactive wastes  
resulting from March 28, 1979 accident Three Mile Island Nuclear Station, Unit 2,"  
NUREG-0683

"Answers to Questions About Updated Estimates of Occupational Radiation Doses at Three Mile Island,  
Unit 2," NUREG-1060

"Answers to Frequently Asked Questions About Cleanup Activities at Three Mile Island, Unit 2,"  
NUREG-0732

"Status of Safety Issues at Licensed Power Plants" (TMI Action Plan Reqmts.), NUREG-1435

Walker, J. Samuel, Three Mile Island: A Nuclear Crisis in Historical Perspective, Berkeley: University  
of California Press, 2004.

### Other Organizations to Contact

GPU Nuclear Corp, One Upper Pond Road, Parsippany, NJ, 07054, telephone 201-316-7249;

Three Mile Island Public Health Fund, 1622 Locust Street, Philadelphia, PA, 19103, telephone  
215-875-3026;

Pennsylvania Bureau of Radiation Protection, Department of Environmental Protection, Rachel Carson  
State Office Building, P.O. Box 8469, Harrisburg, PA, 17105-8469, telephone 717-787-2480.

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## Glossary

**Auxiliary feedwater** - (see emergency feedwater)

**Background radiation** - The radiation in the natural environment, including cosmic rays and radiation from the naturally radioactive elements, both outside and inside the bodies of humans and animals. The usually quoted average individual exposure from background radiation is 360 millirem per year.

**Cladding** - The thin-walled metal tube that forms the outer jacket of a nuclear fuel rod. It prevents the corrosion of the fuel by the coolant and the release of fission products in the coolants.

Aluminum, stainless steel and zirconium alloys are common cladding materials.

**Emergency feedwater system** - Backup feedwater supply used during nuclear plant startup and shutdown; also known as auxiliary feedwater.

**Fuel rod** - A long, slender tube that holds fuel (fissionable material) for nuclear reactor use. Fuel rods are assembled into bundles called fuel elements or fuel assemblies, which are loaded individually into the reactor core.

**Containment** - The gas-tight shell or other enclosure around a reactor to confine fission products that otherwise might be released to the atmosphere in the event of an accident.

**Coolant** - A substance circulated through a nuclear reactor to remove or transfer heat. The most commonly used coolant in the U.S. is water. Other coolants include air, carbon dioxide, and helium.

**Core** - The central portion of a nuclear reactor containing the fuel elements, and control rods.

**Decay heat** - The heat produced by the decay of radioactive fission products after the reactor has been shut down.

**Decontamination** - The reduction or removal of contaminating radioactive material from a structure, area, object, or person. Decontamination may be accomplished by (1) treating the surface to remove or decrease the contamination; (2) letting the material stand so that the radioactivity is decreased by natural decay; and (3) covering the contamination to shield the radiation emitted.

**Feedwater** - Water supplied to the steam generator that removes heat from the fuel rods by boiling and becoming steam. The steam then becomes the driving force for the turbine generator.

**Nuclear Reactor** - A device in which nuclear fission may be sustained and controlled in a self-supporting nuclear reaction. There are several varieties, but all incorporate certain features, such as fissionable material or fuel, a moderating material (to control the reaction), a reflector to conserve escaping neutrons, provisions for removal of heat, measuring and controlling instruments, and protective devices

**Pressure Vessel** - A strong-walled container housing the core of most types of power reactors.

**Pressurizer** A tank or vessel that controls the pressure in a certain type of nuclear reactor.

**Primary System** - The cooling system used to remove energy from the reactor core and transfer that energy either directly or indirectly to the steam turbine.

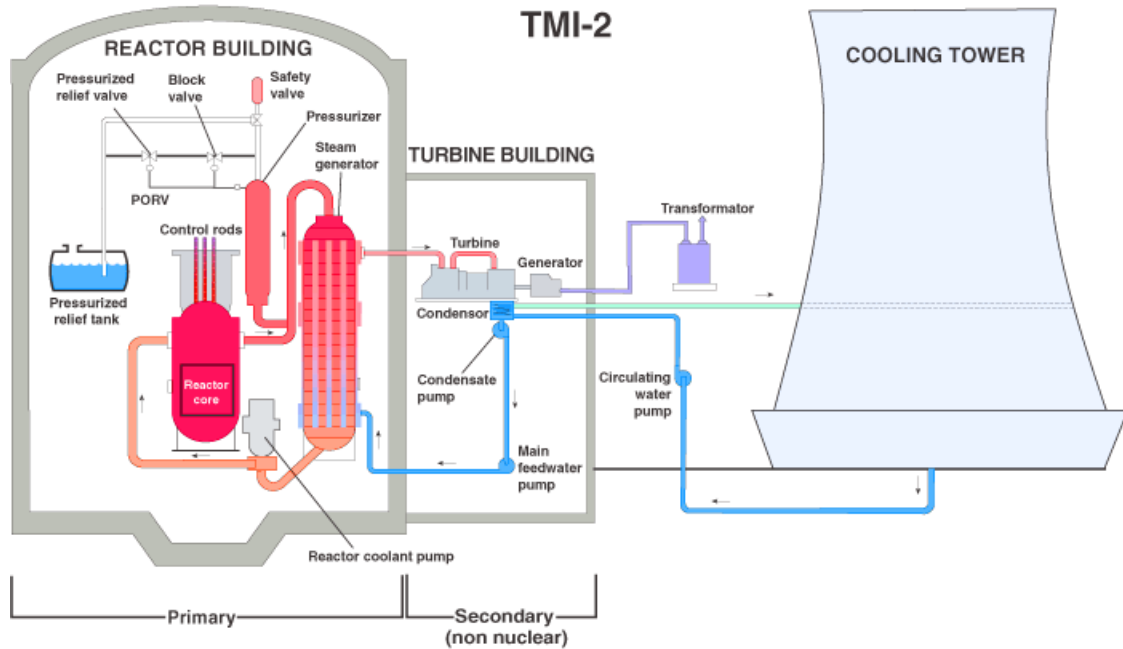
**Radiation** - Particles (alpha, beta, neutrons) or photons (gamma) emitted from the nucleus of an unstable atom as a result of radioactive decay.

**Reactor Coolant System** - (see primary system)

**Secondary System** - The steam generator tubes, steam turbine, condenser and associated pipes, pumps, and heaters used to convert the heat energy of the reactor coolant system into mechanical energy for electrical generation.

**Steam Generator** - The heat exchanger used in some reactor designs to transfer heat from the primary (reactor coolant) system to the secondary (steam) system. This design permits heat exchange with little or no contamination of the secondary system equipment.

**Turbine** - A rotary engine made with a series of curved vanes on a rotating shaft. Usually turned by water or steam. Turbines are considered to be the most economical means to turn large electrical generators.



1. The catastrophic Chernobyl accident in the former Soviet Union, in 1986, was by far the most severe nuclear reactor accident to occur in any country; it is widely believed an accident of that type could not occur in U.S.-designed plants. For more detail on the accident at Chernobyl, see Fact Sheet at <http://www.nrc.gov/reading-rm/doc-collections/fact-sheets/fschernobyl.html>.