

CHAIRMAN Resource

From: Tom Gurdziel <tgurdziel@twcny.rr.com>
Sent: Saturday, December 10, 2016 8:16 AM
To: CHAIRMAN Resource
Cc: Screnci, Diane; ESTRONSKI@aol.com; T Holden; Lyon, Jill:(NMP); Bridget Frymire; Barkley, Richard
Subject: [External_Sender] Three Mile Island, Unit 2 Accident
Attachments: M.O. Bypass Valve.jpg

Good morning,

I have just finished reading the description of the Three Mile Island, Unit 2 accident in Section 2.1 of NUREG/CR-6042, Rev. 2. I am having some trouble with the explanation given in the paragraph at the top of page 2.1-2, left hand column.

Here is what I think happened.

The operators couldn't move the resin (they were attempting to transfer) by using service air as their source of compressed air, so they switched over to instrument air. (I believe instrument air would have been at a higher pressure than service air.) During the process of applying (instrument) air pressure and releasing it (to dislodge the stuck resin), demineralizer resin flowed backwards, into the instrument air system. It then prevented adequate instrument air pressure from keeping the isolation valves for the demineralizers/condensate polishers open. Those (air operated) isolation valves closed and the accident began.

Looking at Figure 2.1-3 on page 2.1-27, (attached), there appears to be one action that might have restored condensate (water) flow: open demineralizer/condensate polisher bypass valve CO-V-12. Would this one action have been sufficient to prevent core destruction? (This valve is not air operated.)

Thank you,

Tom Gurdziel



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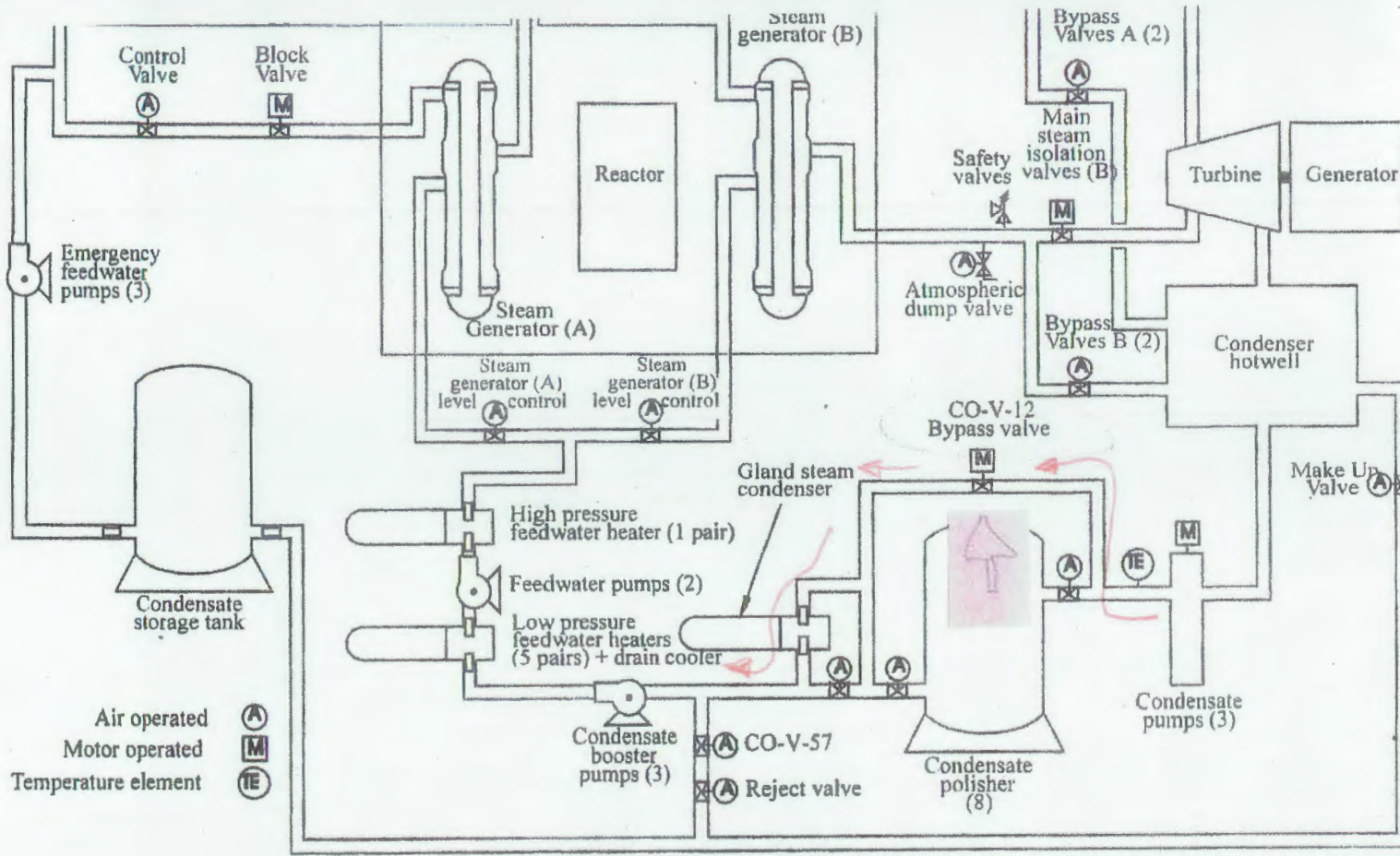


Figure 2.1-3 Condensate and feedwater systems

T.G. 12-10-2010