• Experience of the JCO Criticality Accident

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IEM9, Vienna, April 21st, 2015

Points

• What we assessed and prognosticated

- A criticality accident really has occurred?
- How is the criticality?
- How can we terminate it?
- How should the public behave?
- o Review of the judges
 - Fission chain reaction, adequately judged
 - Social actions, insufficient technical base



Criticality Accident Really Has Occurred?

- First word (~ 12:00)
 - radioactive material release?
 - chemical accident of fluoride?
- News media report (~ 13:00)
 - criticality accident (casualties, blue flush light)?
- Voluntary mobilization of specialists (~ 15:00)
 - facility/equipment failure?
 - unknown condition of fissile material?

How Is Criticality?

- First detail information (~ 15:00)
 - intentional manual feed of fissile solution
 - into a vessel with an unsafe shape
- Immediate judges
 - sustaining criticality
 - inevitable intervention
- o Confirmation (~ 16:30)
 - neutron measurement

(> 4 mSv/h)

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criticality accident," Nuclear Safety Commission, STA, Japan (1999) (in Japanese)

Japan Atomic Energy Agency



How Can We Terminate It?

- More detail information: cooling water
 - jacket of the vessel
 - circulation
- Removal of the water (the next day 2:30~6:15)
 - disconnection of piping
 - purge by compressed gas
 - neutron monitoring

Neutron poison injection

(the next day ~8:50)



How Should Public Behave?

- o 350-m range
 - γ-rays and neutrons from fissions
 - evacuation (12:30~)
- o 10-km range
 - γ-rays from released FPs
 - no immediate risk
- indoor sheltering



350-m range

47 homes

150 people

JCO Tokai-works

Fission Chain Reaction, Adequately Judged

- No unknown information of fissile material
 composition, quantity, location, etc.
- Ongoing TRACY experiment program
 - simulation of criticality accident using uranyl nitrate solution
- ICNC (September 20-24, 1999)
 - opportunity of a case study of criticality accidents





Social Actions, Insufficient Technical Base

• The indoor sheltering

 just because of the slight increase of dose rates detected by monitoring posts



train, road, school, shops, etc.



• Assessment and Prognosis must be based on objective data, rich background information, and clear criteria for decision making in emergency.



Appendix JCO Criticality Accident Summary

Date & Time :	
Duration of Criticality	:
Location :	

Process of Accident : Cause of Accident :

Amount of Uranium : Total Fission Number :

Casualties :

10:35, September 30, 1999 \sim 19 and half hours at the Precipitation Vessel in Conversion Test Building, JCO Tokai-works, Tokai-mura

Uranium refinement by reconversion Overfeed of uranium nitrate solution into a non-safe shape vessel beyond mass limit of criticality safety

16.6 kgU (18.8% U-235 enrichment) 2.5×10^{18} fissions

2 workers dead who were manually feeding the uranium solution





Appendix Chart Record of γ-ray Monitor in PF1



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Appendix "Burst" & "Plateau"

<u>Total Fission Number : 2.5×10^{18} </u>: Total fission number of the accident is derived from the FP density analysis of uranium solution sample taken from the precipitation vessel.

<u>The First 12 sec. may be Missed</u> : Maximum 12-second record of just after the accident occurrence may be missed in the chart and no quantitative information about the initial burst of the accident available. Therefore, overall shape of the chart record cannot be normalized using the total fission number : 2.5×10^{18} .

JAERI-Naka Neutron MP asserts "Burst : Plateau" = 0.3 : 2.2

A monitoring post of JAERI-Naka detected neutrons emitted from the precipitation vessel. The post sensed 13% of total neutron counts of the accident in the first 30 minutes which is called as "burst" part. The remaining is called as "plateau" part and shares 87% of fissions, e.g. 2.2×10^{18} fissions.





AppendixPower Profile

