DEFENSE NUCLEAR FACILITIES SAFETY BOARD

March 21, 2025

TO: Technical Director
FROM: Los Alamos Site Resident Inspectors
SUBJECT: Los Alamos Activity Report for the Week Ending March 21, 2025

Plutonium Facility–Conduct of Operations: On Tuesday, a resident inspector observed workers responding to an abnormal event: a chilled water leak in a laboratory room during the day shift. The workers declared a potential process deviation and exited the room. Operations, Criticality Safety, and Radiological Control personnel responded and worked together with the programmatic personnel from the room to resolve the situation. In the opinion of the resident inspectors, the available resources on day shift made the response more effective than the recent night shift response to water leakage (see 3/7/2025 report). One small contamination area remains near the initial source of the leak and the rest of the room is released for operations.

This week, Weapons Production management initiated a new approach to improve housekeeping in the Plutonium Facility, partly to support increasing multi-shift operations and to improve the efficiency of shift turnovers. Near the close of both day shift and night shift, a team will perform a walkdown to identify transient combustible compliance, emergency egress, waste documentation, and general housekeeping concerns. These walkdowns are currently being piloted in portions of the plant. A resident inspector accompanied one of the first walkdowns and observed the team identifying several low-level bags waste for expeditious removal.

Plutonium Facility–Radiological Protection: Last Friday, an individual inadvertently remained in a room being used for radiography activities. This is the second recent event involving personnel control during radiography. Neither event resulted in any excess dose for the individuals. Management stopped work on these radiography activities pending completion of corrective actions.

PF-400–Glovebox Safety: On Monday, a glovebox worker discovered an approximately one-eighth inch hole in a glove after performing housekeeping activities. Radiological control technicians responded, determined there was no contamination spread, and placed the glovebox out of service pending glove changeout. Facility management held a fact-finding meeting and determined the hole was most likely made by either a pipette tip or the related plastic storage box. Glovebox safety personnel are following up to determine whether operations in this glovebox can make use of tools with less puncture risk. Facility management noted an improvement in the response actions compared to a similar glove event in PF-400 in January in which the response procedure was not fully followed. A resident inspector performed a field observation of the event location and did not observe any additional health or safety issues.

Site Communications: On Monday, there was another disruption to site communications due to a severed line offsite (see 3/14/2025 report). N3B management again suspended operations at Area G and performed accountability on all personnel in the facility. As an improvement from the response last week, N3B promptly sent a shift operations manager with a radio to the site Emergency Operations Center to rapidly establish reliable communications. Triad nuclear facilities did not experience significant disruptions.