

DEFENSE NUCLEAR FACILITIES SAFETY BOARD

April 12, 2024

TO: Timothy J. Dwyer, Technical Director
FROM: D. Gutowski, Resident Inspector
SUBJECT: Los Alamos Activity Report for the Week Ending April 12, 2024

Staff Activity: D. Gutowski was on leave. M. Bradisse provided resident inspector coverage.

Plutonium Facility–Emergency Management: This week, management held a second fact finding meeting related to last week’s response to an inadvertent fire alarm (see 4/5/2024 report). The intent of the meeting was to discuss the actions that had been taken to release work, clarify aspects of the event timeline, and discuss potential corrective actions. The work pause issued by the operations center last Wednesday night was lifted the following morning for day shift workers after management directed all supervisors to brief their work crews on proper alarm response prior to work that day. The pause was also lifted for night shift work after briefings occurred that afternoon. These verbal briefings will be followed by supplemental training, currently in the early stages of development, for all workers on the response to alarms and public address announcements. Facility management is further considering potential improvements to public address system annunciators such that they are more audible throughout the facility.

Plutonium Facility–Glovebox Safety: There were two glovebox glove breaches last week in the Plutonium Facility. The first occurred in an oxide characterization glovebox. As a worker attempted to loosen a thumbscrew on a component for maintenance purposes, the thumb of the glove caught between the thumbscrew and component and tore a small hole. The second occurred in a glovebox used for direct metal oxidation. As a worker attempted to close a spool door between two adjacent gloveboxes, the latch did not align properly, resulting in the worker needing to use more force than usual to close the door; when the door suddenly shut, the thumb of the glove snagged in the mechanism, creating a small tear. In both events, the workers recognized the potential glove breach and called for radiological control support. Technicians responded promptly, assisted the workers in getting out of the damaged gloves, and performed appropriate scans for contamination. There was no contamination spread in either event. At the combined fact finding meeting for these events, management personnel noted that both events were caused by pinch hazards. As an overall action, management tasked glovebox safety personnel to evaluate broader use of overgloves to reduce or remove this type of hazard. For the first event, personnel also committed to call out this particular pinch point in the integrated work document, in addition to a general statement about pinch hazards that is already present. They also discussed the potential for using additive manufacturing to create a tool to help workers with the specific task that led to the breach. For the second event, participants in the meeting noted that this is not the first instance of problems with spool door latches and committed to an action for engineering personnel to investigate the issue further.

Plutonium Facility–Operations: Safety basis personnel determined that the existing safety basis covers hazards associated with a newly installed glovebox with high levels of volatile organic compounds (see 3/15/2024 report). Facility workers have completed recovery actions to purge the compounds from the glovebox environment and install monitoring equipment, and have connected the glovebox to the facility ventilation system.