DPO Case File for DPO-2011-002

The following pdf represents a collection of documents associated with the submittal and disposition of a differing professional opinion (DPO) from an NRC employee that focused on NRC inspector access at LES, "need-to-know" decision making for NRC staff, NRC staff training, and documentation in inspection reports and inspection planning, among other issues.

Management Directive (MD) 10.159, "The NRC Differing Professional Opinions Program," dated May 16, 2004, describes the DPO Program.
http://pbadupws.nrc.gov/docs/ML0417/ML041770431.pdf

The DPO Program is a formal process that allows employees and NRC contractors to have their differing views on established, mission-related issues considered by the highest level managers in their organizations, i.e., Office Directors and Regional Administrators. The process also provides managers with an independent, three-person review of the issue (one person chosen by the employee). After a decision is issued to an employee, he or she may appeal the decision to the Executive Director for Operations (EDO).

Because the disposition of a DPO represents a multi-step process, readers should view the records as a collection. In other words, reading a document in isolation will not provide the correct context for how this issue was considered by the NRC.

The records in this collection have been redacted prior to discretionary release to the public.

Document 1: DPO Submittal
Document 2: Memo Forwarding DPO from DPOPM to Director, NMSS
Document 3: Memo from Director, NMSS Establishing DPO Panel
Document 4: DPO Panel Report
Document 5: DPO Decision

DPO Submittal

NRC FORM 680 (11-2002) NRCMD 10.159

U.S. NUCLEAR REGULATORY COMMISSION

DIFFERING PROFESSIONAL OPINION

FOR PROCESSING USE ONLY

1. DPO CASE NUMBER: DPO-2011-002

INSTRUCTIONS: *Prepare this form legibly and submit three copies to the address provided in Block 14 below.*

2. DATE RECEIVED: 11/2/2011

3. NAME OF SUBMITTER	4. POSITION TITLE		5. GRADE
Dennis C. Morey	Branch Chief		GG-15
6. OFFICE/DIVISION/BRANCH/SECTION	**7. BUILDING**	**8. MAIL STOP**	**9. SUPERVISOR**
NRR/DLR/RPB1	OWFN	O11-F1	Melanie Galloway

10. DESCRIBE THE PRESENT SITUATION, CONDITION, METHOD, ETC., WHICH YOU BELIEVE SHOULD BE CHANGED OR IMPROVED.
(Continue on Page 2 or 3 as necessary.)

Please see attached document.

11. DESCRIBE YOUR DIFFERING OPINION IN ACCORDANCE WITH THE GUIDANCE PRESENTED IN NRC MANAGEMENT DIRECTIVE 10.159.
(Continue on Page 2 or 3 as necessary.)

Please see attached document.

12. Check (a) or (b) as appropriate:

- [x] a. Thorough discussions of the issue(s) raised in item 11 have taken place within my management chain; or
- [ ] b. The reasons why I cannot approach my immediate chain of command are:

SIGNATURE OF SUBMITTER	DATE	SIGNATURE OF CO-SUBMITTER *(if any)*	DATE
[signature]	10/27/11		

13. PROPOSED PANEL MEMBERS *ARE (in priority order)*:

1. **Marshall Kohen**
2. **Oleg Bukharin**
3. **Rebecca Clinton**

14. Submit this form to:
Differing Professional Opinions Program Manager
Office of:
Mail Stop:

15. ACKNOWLEDGMENT

THANK YOU FOR YOUR DIFFERING PROFESSIONAL OPINION. It will be carefully considered by a panel of experts in accordance with the provisions of NRCMD

SIGNATURE OF DIFFERING PROFESSIONAL OPINIONS PROGRAM MANAGER (DPOPM)
Renée Pedersen

PRE-CONDITIONS MET | DATE OF ACKNOWLEDGMENT

DIFFERING PROFESSIONAL OPINION
ATTACHMENT: NRC FORM 680

BLOCK 10

Describe the present situation, condition, method, etc., which you believe should be changed or improved.

Summary of the Concern

Management allows the operators of the LES gas centrifuge facility to interfere with NRC inspection activities at the site contrary to the requirements of 10 CFR 70.55(c)(3) and 10 CFR 19.15(a). As a result, NRC is not fully meeting its statutory obligation to assure the safety of the facility.

On October 5, 2011, NRC issued inspection report 70-3103/2011-201 (Reference 1) describing a criticality safety inspection at the LES facility near Eunice, New Mexico. During the inspection, the inspectors experienced significant interference by the licensee and the matter was not resolved by the end of the inspection. Licensee interference with inspection 70-3103/2011-201 is not documented in the inspection report. Also, NRC or licensee-imposed limitations on inspection activities by authorized and cleared agency staff members at NRC-licensed facilities have not been authorized in regulations, policies, or procedures.

Inspection Report 70-3103/201-201 should contain a complete discussion of licensee interference with the inspection and the interference should be addressed through enforcement. Any deviation from the Code of Federal Regulations or approved NRC policies and procedures affecting inspections at LES should be addressed through rulemaking and revisions to Inspection Manual Chapters or inspection procedures so that NRC staff and the public are aware of the regulatory basis for decisions involving LES. NRC staff performing inspections or other regulatory functions at the LES facility should receive training on the sensitivity of the facility and any constraint or special procedure related to access.

Description of the Situation

During the first week of inspection 70-3103/2011-201 at the LES facility in March 2011, NMSS inspectors requested access to the Centrifuge Assembly Building (CAB) to review a classified safety issue that had been raised during a previous inspection, 70-3103/2010-203 (Reference 2), and documented in the report for that inspection. Prior to inspection 70-3103/2011-201, the inspectors submitted a plan (Reference 3) indicating that a classified issue would be reviewed during the inspection. The inspectors were denied access to the LES CAB by the licensee, licensee staff refused to answer questions regarding the issue at subsequent meetings, and the matter was not resolved by the end of the inspection. After the first week of the inspection was completed, I presented management with a draft inspection report which discussed the licensee interference. Management extended the inspection until July 2011, and a substantial effort was undertaken over the next four months, including government-to-government (i.e., diplomatic) contact, to arrange inspector access to the LES CAB. A subsequent week of inspection was performed in July 2011, and the inspectors were allowed escorted entry into the LES CAB. At that time, licensee staff responded to inspector technical questions related to the classified issue at a meeting supervised by licensee managers. Following completion of the inspection, the inspectors were told by management that future entry would require similar advance arrangements.

When the draft inspection report for inspection 70-3103/2011-201 was presented to me, I noted that it contained no discussion of license interference and I submitted a non-concurrence on October 3, 2011. Management responded to my non-concurrence on October 5, 2011 (the management response is erroneously dated November 5, 2011). Reference 4 is an unredacted and non-publicly available version of the non-concurrence. Reference 5 is a redacted and publicly available version of the non-concurrence.

Management stated in its response to the non-concurrence that the United States and the foreign governments controlling the LES facility[1] (Great Britain, The Netherlands, and Germany; referred to as the Troika governments) had developed a process to gain access to classified and proprietary information at LES, that the inspectors and their management were aware of the process, and that the process was not followed during the March 2011 inspection. The management response to the non-concurrence also stated that inspection plans for the LES facility were required to be more detailed than other inspection plans and that deviation from an inspection plan required management approval.

BLOCK 11

Describe your differing opinion in accordance with the guidance presented in NRC Management Directive 10.159.

The required elements are summarized on page 3 of the MD 10.159 Handbook on Differing Professional Opinions. These elements are discussed below.

(a) A summary of the prevailing staff view, the existing management decision or stated position, or the proposed or established agency practice involving technical, legal, or policy issues.

The prevailing management position is documented in the response to my October 3, 2011, non-concurrence to inspection report 70-3103/2011-201. There is no other source for the management position because NMSS does not have a written policy regarding access to LES or other classified fuel cycle facilities. The management decision involves three interrelated issues that I will discuss separately.

Inspection Planning

The prevailing management position on planning inspections at LES is that inspections must be planned in advance, that inspectors may deviate from inspection plans only with management approval and that inspection plans for LES must be more detailed than other inspection plans. Management relates this position to the level of classified information available at LES[2] (Secret Restricted Data). The prevailing management position on inspection planning is represented by the following excerpt from the management response to my October 3, 2011, non-concurrence (my emphasis is added by underlining).

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1 Foreign control of the LES facility is documented in Reference 6, a DOE letter recommending that NRC waive restrictions on foreign ownership and control of LES.

2 Secret Restricted Data is present at other NRC-licensed fuel cycle facilities where inspector access is not restricted.

[redacted]

Management does not cite any source or authority for this position.

Access to the LES Facility

[redacted]

Violation of 10 CFR 70.55(c)(3) by URENCO

[redacted]

(b) A description of the submitter's views and how they differ from any issues discussed in item (a) above.

Background

The LES gas centrifuge facility in New Mexico is operated by URENCO which is jointly owned by Great Britain, The Netherlands, and Germany. As Reference 6 demonstrates, the LES facility is foreign owned and controlled. Some URENCO technology is held solely by another company, ETC, which is owned equally by URENCO and AREVA (AREVA is owned by France). This means that URENCO and ETC officials are effectively foreign government officials[3]. The basic framework for the LES facility was formalized in the 1990 Quadripartite agreement (Reference 7) and working arrangements for the facility were made in the 1992 Washington agreement[4] (Reference 8). These documents designated NRC as the responsible U.S. agency and contain no language restricting access by NRC staff[5]. These diplomatic arrangements were made over 20 years ago allowing time for rulemaking if the U.S. government had intended that its officials would not be allowed access to the LES facility. No rulemaking related to this issue regarding the conduct of inspections at LES has taken place in the intervening 20 years and no exemption to access requirements for inspectors was granted in the LES license. None of the above information was made available to inspection staff prior to initial visits to the LES facility.

Interference with access during an NRC inspection violates 10 CFR 70.55(c)(3) which requires immediate, unfettered access to the licensed facility. When inspectors were allowed to interview ETC employees in July 2011, the interviews were not conducted in accordance with 10 CFR 19.15(a) which requires that inspectors may consult privately with workers to the extent the inspectors deem necessary for the conduct of an effective and thorough inspection. During the July 2011 interviews, inspectors reported that ETC management interfered with questioning and sought to quash questions[6]. The same inspection procedures are used at LES that are used to perform inspections at other classified and non-classified facilities and inspectors are required to reach the same conclusions at LES as at other facilities where access is not restricted. Any differences in regulatory oversight at LES including limited access for inspectors or restrictions on contact with licensee employees should be addressed in appropriate agency policy and procedure. The specific details of the licensee interference at the LES facility should be documented as an apparent violation for further review by the staff. If necessary, 10 CFR 70.55(c)(3) and 10 CFR 19.15(a) should be modified or an exemption granted to account for any limitations on inspector activities or access.

Specific management positions are addressed below.

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3 NRC foreign travel training makes clear that employees of foreign government-owned companies are considered foreign government officials during official interactions.

4 Section 123 of the Atomic Energy Act, "Cooperation with Other Nations," is the usual means for this type of cooperation on nuclear deals between the U.S. and other nations. The Washington Agreement is the vehicle by which the U.S. cooperates with URENCO in the operation of the LES facility since the U.S. does not have 123 agreements with these nations.

5 The agreements appear to make U.S. access subject only to the discretion of NRC.

6 ETC employees generally refuse to answer inspector questions unless directed by their management.

Inspection Planning

Formal inspection planning is required for NRC inspections. Within NMSS, plans for criticality safety inspections are required by the Technical Support Branch procedure (Reference 9). Section 1.3.3 in Chapter 1 of the procedure addresses inspection planning and makes no mention of special planning requirements for inspections at LES. In fact, no special planning requirements were ever communicated to the criticality safety inspectors prior to the March 2011 LES inspection. The inspectors had submitted a plan prior to inspection 70-3103/2011-201 indicating that Unresolved Item 70-3103/2011-201-01 (the classified issue) would be reviewed during the inspection. Access to the LES CAB was sought pursuant to review of the open item. This is the type of information denied to the inspectors by URENCO during the March 2011 LES inspection. During my tenure as a criticality safety inspector, which encompassed almost the entire existence of the program, criticality safety inspectors had significant latitude in conducting inspections and no formal guidance other than three inspection procedures (References 10, 11, and 12) and the previously mentioned branch procedure. New and changed analysis, facility operations, open items, and selected non-credible accident sequences are all within the scope of criticality safety inspection procedures. The management response to the non-concurrence assumes that an NRC inspector reviewing an aspect of an open item in an approved inspection plan, where that aspect is within the scope of the inspection procedure and within the licensed facility, is somehow deviating from the inspection plan. Criticality safety inspection requires knowledge of dimensions, composition, material flows, and chemical changes in order to reach the conclusions required by the inspection procedures. It is in fact normal for NRC inspectors to pursue safety issues identified during inspections while keeping management informed as occurred during the March 2011 criticality safety inspection at the LES facility. The expectation is that inspectors will use good professional judgment and management will give direction as needed.

Recommendation: The prevailing management position regarding inspection planning should be rejected. Any special requirements for planning or conducting inspections at the LES facility should be documented in approved agency policy[7], incorporated into procedures, communicated to staff, and made publically available.

Access to the LES Facility

No special process or protocol for gaining access to sensitive portions of the LES facility such as the CAB was communicated to NMSS inspectors prior to the March 2011 LES inspection and no special process or protocol is documented anywhere including the Quadripartite and Washington Agreements. The Washington Agreement is almost exclusively concerned with the protection of classified information[8]. The "data room" mentioned in the management response to the non-concurrence is actually a process for exchanging classified information for specific purposes such as developing the technology guide mentioned in the Washington Agreement. The "data room" derives its name from the type of classified information it addresses, specifically, "restricted data[9]." The process arises due to U.S. law governing the sharing of restricted data with foreign governments and personnel and not from foreign ownership of the information. The relationship of the "data room" to an NRC inspection is dubious and would appear be applicable to a very

7 In this case, Inspection Manual Chapter 2600 (Reference 13).
8 Specifically, the agreement is concerned with preventing the transfer of restricted data to URENCO.
9 Prevention of the transfer of new restricted data to URENCO is the primary purpose of the "data room" procedure. URENCO may only receive restricted data already in its possession.

narrow range of discussions that NRC inspectors might want to have rather than whenever the inspectors ask a question that the licensee does not want to answer. Entering the LES CAB and asking questions of U.S. citizen employees within it about classified equipment that they work on in the facility should not require a "data room." The original intent of the request to enter the CAB was to view classified components and question local ETC employees about material composition and centrifuge crash behavior. ETC intends that employees working at the LES CAB will perform centrifuge post mortem and these employees receive training in Europe regarding centrifuge crash behavior such that they could be expected to be able to answer the questions that the inspectors had during inspection 70-3103/2011-201. Although some of the information sought by inspectors was in Europe, most was available at the site. The "data room" procedure is also problematic because ETC security and management personnel are present and, during the July 2011 "data room" meeting, sought to interfere with questioning contrary to 10 CFR 19.15(a).

Recommendation: The prevailing management position regarding access to the LES CAB should be rejected and management should develop a clear procedure for inspector access to LES. Use of the "data room" procedure should be carefully defined such that it is only used for narrow purposes and does not interfere with inspections.

Assignment to an inspection at LES is the need-to-know[10] and NRC staff should not be assigned to perform inspections there without the access described in 10 CFR 70.55(c)(3). Failure to resolve this issue prior to the inspections places this management decision onto the inspectors. The decision to invoke a diplomatic process should not be punted to inspection staff. Criticality safety cannot be assured unless the inspector has access throughout the facility to any safety-related information requested. A misconception in the LES situation is that the absence of fissile material in the LES CAB eliminates the need to enter. In fact, verification of centrifuge and cascade operational assumptions is not possible without access to components that can only be seen in the CAB[11]. The management position on need-to-know at LES appears to be that a non-expert, third party opinion regarding the technical issue or the need to even review a technical issue should be the basis for need-to-know for an inspection rather than the judgment of the inspector and the inspectors supervisor. In this case, NMSS licensing management opposed entry by inspectors into the LES CAB because the NMSS licensing manager for LES decided that centrifuges were safe under any upset condition and that this opinion was already approved by NRC. In fact, the information provided by LES for the ISA Summary regarding mass accumulation in the cascade was inaccurate as the July 2011 inspection revealed. The classified technical issue under review was only brought to light because I was allowed into the CAB during an inspection in October 2010, and discovered a discrepancy in the understanding of centrifuge crash behavior[12]. If the prevailing management position had been enforced at that time, the issue would never have been identified[13] because I would have had no basis for my entry other than a hunch.

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10 See the attached e-mail (Reference 14) for the management position on inspector need-to-know. The manager doesn't believe that an inspector assigned to the inspection, who has raised an issue, and who is concurring on the inspection report discussing the issue, does not need to know how the issue was resolved.

11 An example of the prevailing management position on need-to-know at LES is that regional inspectors are barred by their management from seeking access to the CAB. As a result, the regional project inspector, who led the ORR team, did not enter until July 2011, and no other regional inspectors have entered.

[redacted]

13 Another issue identified during inspection 70-3103/2011-201 was that ETC has criticality controls on centrifuge post mortem which contradicts its technical position on the classified open item.

Recommendation: The prevailing management position on need-to-know for sensitive information at the LES facility should be rejected and the inspection should be the need-to-know as at other classified facilities.

Access to the LES facility should not be restricted in a way that compromises the NRC safety mission. The requirement to make arrangements in advance of entry effectively leaves the facility without NRC oversight, in this case, for nine months based on the starting point of the October 2010 inspection. NRC is not meeting its obligations under the Atomic Energy Act if it allows a foreign government to operate a nuclear facility in the United States without oversight. How the agency would handle an emergency involving this facility is a significant issue when access requires months of negotiations between governments.

Recommendation: A clear agency policy on access to the LES facility should be developed that balances information security with other agency interests such as facility safety.

I was never aware of any special access process at LES; in fact, the only thing I was aware of prior to the March 2011 criticality safety inspection at LES was that the NMSS licensing manager for LES believed that I did not have a need-to-know to enter either the CAB or cascade buildings[14] which would have precluded criticality safety inspection at the LES facility. When I contacted my manager during the March 2011 inspection and informed her that the inspectors had been denied access to the LES CAB, she did not act as if she was aware of a special process for access at LES. Instead, she acted as if she did not know what to do other than to go and discuss the matter with the same licensing manager mentioned above.

Recommendation: The management position that inspectors were familiar with the Washington agreement prior to the March 2011 LES criticality safety inspection has no basis and should be rejected along with the position that there was a special process for entry to sensitive areas[15].

In addition to not being briefed on special access procedures, I was not given any information regarding international agreements or the special status of the LES facility as being foreign owned and controlled. I was also not briefed on safeguards or the special sensitivity of the information and equipment at LES. The only information provided me by NMSS management was that I should not enter the LES cascade halls or CAB. Upon arrival at the LES site, I was not briefed on classified or sensitive aspects by the licensee until I requested a briefing during the October 2010 inspection. I learned most of what I currently understand about the sensitivity of the LES facility piecemeal during the two inspections and some classification issues including classified terminology and foreign classification markings remain unclear[16].

Recommendation: NRC staff assigned to perform inspections at LES and other classified facilities with particularly sensitive issues or special access procedures should be briefed on those issues or procedures before arrival at the facility.

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14 This manager expressed the same position regarding inspection of the USEC ACP facility. This was expressed as "you can't go in these areas" or "the licensee won't let you in these areas."
15 Knowing who to contact at the Tripartite Agency is not the same as having an actual process.
16 Contrast this with the USEC ACP where I was given an extensive briefing on the sensitivity of the project, international safeguards, and local access procedures before I was allowed into the facility. The briefing made clear what information USEC was protecting, how it was protecting it, and why.

Violation of 10 CFR 70.55(c)(3) by URENCO

In its response to my inspection report non-concurrence, management stated that the inspectors on the March 2011 LES inspection did not demonstrate compliance with applicable access control measures. This is a reference to the requirements of 10 CFR 70.55(c)(3) which is actually met by supplying the licensee with an NRC Form 277 (to verify security clearance and desired access) and a regional "Good Guy" letter. These requirements are documented in Section 1.3.1 of Chapter 1 of the previously discussed Technical Support Branch procedure. Upon arrival at the LES facility for the March 2011 criticality safety inspection, the inspectors had complied with the branch procedure and met all these requirements along with the local safety requirements that the licensee had communicated in advance.

[redacted] When I attempted to enter the LES CAB, I was confronted by a foreign government official who did not suggest a process for entry; instead, this official stated that NRC staff was not allowed access once licensing was complete[17]. This appears to be the policy of the foreign governments operating the LES facility. URENCO responded to NRC interest in the July 2011 inspection by transporting a senior official and several engineers from Europe to the site. The ETC official eventually allowed employees to respond to questions and even allowed access to the CAB. It seems unreasonable to assume that the problem experienced in March 2011 is resolved because of what occurred during the July 2011 inspection. In that case, URENCO reacted to the preceding government-to-government contact and the presence of NRC managers on-site during the inspection. An inspector performing a routine inspection at the LES facility in the future will likely encounter the same response to a proposed CAB entry as I did in March 2011, if the NRC does not take an enforcement action against URENCO and the employee who interfered.

NRC enforcement policy requires management to have a reason for not citing an obvious violation. The only justification for not citing URENCO for interference is that either it was of minor significance or management is exercising enforcement discretion. Management has not used either of these two options. The inspectors clearly followed the existing process for access to the LES facility. If the URENCO interference is not addressed through enforcement action, LES and other facilities for which NRC has information security responsibility[18] such as AREVA Eagle Rock, USEC ACP, and Global Laser Enrichment[19], will not receive effective safety oversight. If access restrictions on NRC staff are accepted without an internally vetted and management approved process that includes different inspection procedures, the public will not be aware that inspections and other oversight at these facilities is different because inspection reports will appear the same as those for other NRC-licensed facilities with classified information.

17 The Quadripartite Agreement contains language giving NRC access to information for licensing but this language does not support the position that NRC does not have access after licensing; rather, the language seems intended to ensure that the licensing review will have sufficient information.

18 AREVA Eagle Rock will be operated under the Washington Agreement. GLE is operated under a 123 Agreement with Australia.

[redacted]

Recommendation: The prevailing management position regarding URENCO interference with the LES inspection should be rejected in favor of an enforcement action that reminds URENCO of its obligation to comply with U.S. law.

Summary of Concerns

1. Licensee actions during the July 2011 LES criticality safety inspection were a one-time concession and access to the LES facility for NRC inspectors is and will remain fettered unless NRC takes enforcement action and otherwise clarifies policy and procedure for access.

2. Inspection planning and coordination within NMSS should be clarified. It is impractical for inspectors to plan out every aspect of an inspection in advance as management suggests in its non-concurrence response. Inspectors can't always know what changes have been made, what plant conditions are, what documents will be available or where a particular question will lead prior to arrival on site. Inspectors cannot fulfill their role effectively if expected to plan the outcome of an inspection beforehand or check with management regarding every hunch.

3. Inspector need-to-know for access to buildings and information at the LES facility should be based on assignment to perform an inspection there. It is not acceptable for NRC inspectors to have to wait months to access safety information. Senior NRC management intervention and diplomatic interaction[20] to resolve an inspector hunch is an unreasonable impediment to successful inspection of the LES facility. Access arrangements made difficult or complicated due to international agreements should not be a factor in need-to-know decisions.

4. NRC staff assigned to perform inspections at sensitive facilities should receive a classified briefing from knowledgeable NRC staff on the process, equipment, international agreements, safeguards requirements and other pertinent information before entering the facility. Inspectors should be briefed on and have access to the classification guide for any classified facility that they will be assigned to inspect.

5. NMSS licensing staff and their management should receive training on NMSS and regional inspection activities so that the inspection function and its relationship to the NRC mission is clear to them. Objectives and required conclusions for specific inspection procedures should be discussed during the training along with the normal methods by which information is obtained and conclusions reached[21].

6. If staff access to the facility is restricted to any significant extent at LES or any other NRC-licensed facility (i.e., buildings that can never be entered), specific inspection procedures should be developed which do not contain requirements for NRC inspectors to make the same safety conclusions as they would normally make if unfettered access were allowed.

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20 Government-to-government contact regarding implementation of the Washington Agreement occurs between the NRC and the Tripartite Agency representing the URENCO governments.

21 The NMSS licensing manager for LES felt that I could have obtained all the information that I needed for the inspection from the SER even though little design information and almost no NCS analysis was available to technical reviewers at the time the SER was developed (see DPO-2006-005, Reference 16). This individual had decided, based on licensee assertions, that the criticality accident sequence at issue was not credible. Accepting a licensee technical position in this manner without performing an independent review defeats the purpose of performing on-site inspections.

7. If inspector access to a building such as the LES CAB is to be restricted, selected NMSS and regional inspectors and their supervisors should be given a tour of the facility in order to support credible decisions regarding need-to-know (i.e., what inspection procedures require entry).

8. An enforcement action based on violation of 10 CFR 70.55(c)(3) and 10 CFR 19.15(a) should be pursued against LES to prevent repeat interference with inspector access to the LES CAB. This is the only approach that will engage the licensee at an appropriate management level to resolve the issue.

9. An enforcement action based on violation of 10 CFR 70.9 should be pursued against LES due to incomplete and inaccurate information in the ISA Summary. The licensee had understated the amount of material that could build-up in a failed machine which is material to the failed centrifuge issue under review.

10. LES should not be allowed to start additional cascade operations until access for NRC inspectors is resolved. The technical issue the inspectors raised at LES becomes more significant as the scope of the operation increases.

(c) An assessment of the consequences if the submitter's position is not adopted by the agency.

1. The application of the prevailing management position to the LES, AREVA, USEC and GLE facilities means that NRC inspection staff will not have complete access to these facilities during routine inspections. Without full and unfettered access to facilities and information, important safety issues at these new and unique facilities may not be recognized and addressed.

2. Need-to-know decisions regarding the LES facility made under the prevailing management position are not based on technical merit and will not reasonably balance NRC interests in protecting people and the environment with providing for security.

3. If the current management position prevails, inspection reports documenting inspections performed at the LES, AREVA, USEC and GLE facilities will not reflect the limited access that the inspectors actually had and will not be full and complete representations of the inspections.

4. NRC will be unable to complete its Manual Chapter 2600 required inspections at LES within budgeted resources if every inspector hunch requires hundreds of extra staff hours, diplomatic contacts, and management participation in the on-site inspection to resolve.

5. NRC will not meet its statutory obligation to assure the safety of the LES facility under the prevailing management position. If inspection activities are impeded, NRC will not actually know whether URENCO is meeting its commitments at the facility and will, therefore, not have a basis for reasonable assurance.

6. NRC will not meet its strategic goal of Openness (Reference 15). Regulations and NRC guidance (e.g., inspection procedures) are made publicly available to foster open and accountable regulation. Fuel facility inspections should not be conducted contrary to promulgated regulations and guidance, without taking acceptable regulatory actions if alternatives are warranted (e.g., rulemaking, exemptions, enforcement discretion). This creates the false impression that inspectors fully understood the facility based on complete access when we know that they did not.

(d) The names of three potential ad hoc panel members, listed in priority order, or a statement that he or she will not provide names of potential ad hoc panel members.

Marshall Kohen, Oleg Bukharin, Rebecca Clinton (these staff members are familiar with international safeguards, treaties, and handling classified information).

(e) Copies of relevant documents referenced in the DPO that are available in ADAMS should not be attached to the DPO. The submitter should include only titles and accession numbers for such relevant documents, along with a brief statement regarding the relevance of the document to the issue being raised.

1. Inspection Report 70-3103/2011-201 and Notice of Violations (ML1110400391). This is the report from the LES inspection which experienced interference.

2. Inspection Report 70-3103/2010-203 (ML103130421). This inspection report contains an unclassified discussion of the classified issue related to crashed centrifuges that was identified during the October 2010 criticality safety inspection.

3. Plan for Inspection 70-3103/2011-201 (not in ADAMS). This inspection plan shows the scope of NMSS criticality safety inspection planning and that the open item from the previous inspection was a subject of the planned March 2011 LES inspection. A signed copy could not be located.

4. NRC Form 757, Dennis Morey Non-Concurrence on Inspection Report 70-3103/2011-201 and Management Response (ML1128002901). This is the unredacted version of the non-concurrence and management response which is quoted in the preceding DPO.

5. NRC Form 757 Dennis Morey Non-Concurrence on Inspection Report 70-3103/2011-201 and Management Response (ML1128003062). This is the redacted version of the non-concurrence and management response.

6. Letter dated March 31, 2005, from the U.S. Department of Energy to the NRC regarding its Foreign Ownership, Control, or Influence review of LES and URENCO (ML050980235). The letter notes that LES and URENCO are foreign controlled companies.

7. Quadripartite Agreement dated April 1990 (not in ADAMS). This is the original agreement setting up the framework for what would become the LES facility. The agreement identifies NRC as the U.S. Agency for implementation. Nothing in this agreement impedes NRC access to the facility.

8. Washington Agreement dated July 1992 (not in ADAMS). This is the agreement which is the basis for the LES facility. The agreement identifies NRC as the U.S. Agency for implementation. Nothing in this agreement impedes NRC access.

9. Technical Support Branch procedure dated April 2007 (not in ADAMS). This procedure shows prevailing practices for criticality safety inspections in the NMSS Fuel Cycle Division at the time of inspection 70-3103/2011-201. Chapter 1 discusses the conduct of criticality safety inspections including inspection planning.

10. Inspection procedure 88015 (available on NRC intranet). This shows what conclusions criticality inspectors are required to make regarding a licensee criticality safety program.

11. Inspection Procedure 88016 (available on NRC intranet). This shows what conclusions criticality inspectors are required to make regarding licensee criticality analysis.

12. Inspection Procedure 88017 (available on NRC intranet). This shows what conclusions criticality inspectors are required to make regarding a licensee criticality alarm system.

13. NRC Inspection Manual Chapter 2600 (available on NRC intranet). This is the basis for the fuel cycle inspection program and shows that no special procedures or compensatory actions are in place for LES. It shows that the LES facility is intended to be inspected the same way other similar facilities are inspected.

14. E-mail from Marissa Bailey to Dennis Morey dated September 27, 2011 (not in ADAMS). This demonstrates the management position that, although I was the inspector who raised the issue and participated in the inspection being reported, I did not have a need-to-know to discuss resolution of the classified issue on which I was expected to concur.

15. NRC Strategic Plan FY2008-2013 (available on NRC public website). This document contains strategic goals and values (e.g., prevent inadvertent criticality events, openness) that were not adhered to or supported. Such a significant policy as imposing constraints on NRC inspections at a sensitive facility should have been developed openly with full staff and management involvement.

16. DPO-2006-005. This DPO shows the extent of licensing review of USEC ACP and, by inference, LES.

Respectfully submitted,

10/27/11

Dennis C. Morey
Chief
Projects Branch 1
Division of License Renewal
Office of Nuclear Reactor Regulation

Memo Forwarding DPO from DPOPM to Director, NMSS

November 8, 2011

MEMORANDUM TO: Catherine Haney, Director
Office of Nuclear Material Safety and Safeguards

FROM: Renée M. Pedersen, Differing Views Program Manager ***/RA/***
Office of Enforcement

SUBJECT: DIFFERING PROFESSIONAL OPINION INVOLVING INSPECTION ACCESS AT LES GAS CENTRIFUGE FACILITY (DPO-2011-002)

The purpose of this memorandum is to advise you of a Differing Professional Opinion (DPO) that was submitted to me while serving as the agency's Differing Professional Opinions Program Manager (DPOPM). I received the DPO on November 1, 2011, and in coordination with the Director, Office of Enforcement, screened it in accordance with the guidance included in Management Directive (MD) 10.159, "The NRC Differing Professional Opinions Program." On November 3, 2011, I notified senior management and the submitter that the preconditions for acceptance were met and that the submittal was accepted for review within the DPO Program as DPO-2011-002.

The DPO (Enclosure 1) raises multiple concerns with management's position on whether or not the operators of the LES gas centrifuge facility interfered with an NRC inspection. The employee initially raised concerns on this issue through the Non-Concurrence Process (NCP) and is raising a DPO on management's response documented in Section C of the NCP Form.

In accordance with Section (D)(3)(c) of the MD Handbook, I am forwarding this DPO to you for appropriate action.

MD 10.159-036 specifically addresses your responsibilities as an Office Director. In brief, you are required to:

- ❑ Establish an independent ad hoc panel (DPO Panel) to review the issue, draw conclusions, and make recommendations to you regarding the disposition of the issues presented in the DPO.

CONTACT: Renée M. Pedersen, OE
Renee.Pedersen@nrc.gov.
(301) 415-2742

- ❑ Provide appropriate oversight of and support to the DPO Panel to ensure a thorough and timely review of the DPO (while maintaining process independence).

- ❑ Review the DPO Panel's report to ensure that it clearly, accurately, and completely addresses the tasks outlined in your memorandum establishing the panel. Issue a DPO Decision to the submitter within the 120-day timeliness goal.

- ❑ Request EDO approval for DPO extensions beyond the 120-day timeliness goal. (Requests should be forwarded thru the DPOPM with the reason for the delay and a new completion date.)

- ❑ Forward status updates during the disposition of the DPO and until the time that all follow-up actions are complete. (Updates should be emailed to the DPOPM by the last day of the month and will be communicated to the submitter and distributed to all DPO participants and the cognizant DEDO and the Commission in the DPO Monthly Status Report.)

- ❑ Identify and assign appropriate follow-up actions and establish completion dates within 2 weeks of issuing the DPO Decision. (The DPOPM and submitter should be copied on any follow-up action memoranda or correspondence.)

- ❑ Notify the DPOPM of follow-up action schedule delays, including the reason for the delay and a revised completion schedule. (The DPOPM will subsequently notify the submitter, reflect it in the DPO Monthly Status Report, and report it to the applicable DEDO.)

- ❑ Forward a summary of the DPO to the DPOPM for inclusion in the Weekly Information Report. (In the event the DPO is appealed, the summary will be postponed until the DPO Appeal Decision is issued.)

- ❑ Take action to positively recognize the DPO submitter if the submitter's actions result in significant contributions to the mission of the agency.

- ❑ Review the DPO Case File for public release when the case is closed if the submitter requests public release.

Disposition of this DPO should be considered an important and time sensitive activity. The timeliness goal included in the MD for issuing a DPO Decision is 120 calendar days from the day the DPO is accepted for review. The timeliness goal for issuing this DPO Decision is March 1, 2012.

Process Milestones and Timeliness Goals for this DPO are included as Enclosure 2. The timeframes for completing process milestones are identified strictly as goals—a way of working towards reaching the DPO timeliness goal of 120 calendar days.

Although timeliness is an important DPO Program objective, the DPO Program also sets out to ensure that issues receive a thorough and independent review. Therefore, if you or the DPO Panel determines that an extension beyond 120 calendar days is necessary at any time during the process, please send me an email with the reason for the extension request and a new

completion date. I will subsequently forward this request to the EDO for approval. In an effort to support effective implementation, the OEDO will establish tracking to address the three key deliverables for the DPO process:

(1) DPO Decision (March 1, 2012);
(2) Follow-up action memorandum (March 15, 2012); and
(3) Weekly Information Report summary (March 15, 2012).

Please ensure that all DPO-related activities are charged to Activity Code ZG0007.

Because this process is not routine, I will be meeting and communicating with all parties during the process to ensure that everyone understands the process, goals, and responsibilities. I will be subsequently sending you information intended to aid you, the DPO Panel, and support staff in implementing the DPO process.

An important aspect of our internal safety culture includes respect for differing views. As such, all employees involved in the process should be instructed to exercise discretion and treat this as a sensitive matter. In an effort to preserve privacy, minimize the effect on the work unit, and keep the focus on the issues, employees should be instructed to simply refer to the employee as the DPO submitter. Managers and staff should be reminded to not engage in "hallway talk" on the issue.

As a final administrative note, please ensure that all correspondence associated with this case include the DPO number in the subject line, be profiled in accordance with ADAMS template OE-011, be identified as non-public and declared an official agency record *when the correspondence is issued*, and be filed in the applicable DPO case file folder (DPO-2011-002) in the ADAMS Main Library. Following this process will ensure that a complete agency record is generated for the disposition of this DPO. If the submitter requests that the documents included in the DPO Case File be made public when the process is complete, you will be provided specific guidance to support a releasability review.

Enclosures:
1. DPO submittal, ML11311A186
2. Milestones and Timeliness Goals

cc: (w/o enclosures)
M. Weber, DEDMRS
N. Mamish, AO

completion date. I will subsequently forward this request to the EDO for approval. In an effort to support effective implementation, the OEDO will establish tracking to address the three key deliverables for the DPO process:

(1) DPO Decision (March 1, 2012);
(2) Follow-up action memorandum (March 15, 2012); and
(3) Weekly Information Report summary (March 15, 2012).

Please ensure that all DPO-related activities are charged to Activity Code ZG0007.

Because this process is not routine, I will be meeting and communicating with all parties during the process to ensure that everyone understands the process, goals, and responsibilities. I will be subsequently sending you information intended to aid you, the DPO Panel, and support staff in implementing the DPO process.

An important aspect of our internal safety culture includes respect for differing views. As such, all employees involved in the process should be instructed to exercise discretion and treat this as a sensitive matter. In an effort to preserve privacy, minimize the effect on the work unit, and keep the focus on the issues, employees should be instructed to simply refer to the employee as the DPO submitter. Managers and staff should be reminded to not engage in "hallway talk" on the issue.

As a final administrative note, please ensure that all correspondence associated with this case include the DPO number in the subject line, be profiled in accordance with ADAMS template OE-011, be identified as non-public and declared an official agency record *when the correspondence is issued*, and be filed in the applicable DPO case file folder (DPO-2011-002) in the ADAMS Main Library. Following this process will ensure that a complete agency record is generated for the disposition of this DPO. If the submitter requests that the documents included in the DPO Case File be made public when the process is complete, you will be provided specific guidance to support a releasability review.

Enclosures:
1. DPO submittal, ML11311A186
2. Milestones and Timeliness Goals

cc: (w/o enclosures)
M. Weber, DEDMRS
N. Mamish, AO

DISTRIBUTION:
DMorey, NRR
DPO-2011-002 file
OE R/F
DDorman, NMSS
BDoolittle, NMSS
MGalloway, NRR

ADAMS Package Accession No.: ML11311A175 **OE-011**

OFFICE	DPOPM:OE	D:OE
NAME	RPedersen	RZimmerman
DATE	11/7 /2011	11/ 8 /2011

OFFICIAL RECORD COPY

DPO Milestones and Timeliness Goals

DPO-2011-002: Inspection Access At LES Gas Centrifuge Facility
Assigned to: Cathy Haney, NMSS

DPO Milestone	**Timeliness Goals***
Individual submits DPO (NRC Form 680)	None
DPOPM receives, screens, and accepts DPO	8 days
DPOPM forwards DPO to office manager	7 days
Office manager establishes DPO Panel	14 days
DPO Panel conducts review and issues report – meets with submitter (≈7 days) – establishes Statement of Concern (≈7 days) – confirms schedule with office manager (≈7 days) – completes review (≈ 49 days after start of review) – writes report (≈21 days after completion of review)	70 days
Office manager issues DPO Decision	21 days
DPO TIMELINESS (time from acceptance of DPO to DPO Decision)	120 days March 1, 2012

*The timeframes for completing process milestones are identified strictly as goals—a way of working towards reaching the Differing Professional Opinions (DPO) timeliness goal of 120 calendar days.

The timeliness goal for dispositioning a DPO (i.e., DPO Decision) will be established as 120 calendar days after a DPO has been accepted for review under the DPO Program.

Office managers should send requests for extension beyond the 120-day timeframe to the Differing Professional Opinions Program Manager (DPOPM), who will forward the request to the Executive Director for Operations with a recommendation.

Memo from Director, NMSS
Establishing DPO Panel

December 9, 2011

MEMORANDUM TO: Frederick D. Brown, Panel Chair
Marshall D. Kohen, Panel Member
Amy M. Snyder, Panel Member
John R. Wray, Panel Member

FROM: Daniel H. Dorman, Acting Director **/RA/**
Office of Nuclear Material Safety and Safeguards

SUBJECT: AD HOC REVIEW PANEL - DIFFERING PROFESSIONAL OPINION INVOLVING INSPECTION ACCESS AT LES GAS CENTRIFUGE FACILITY (DPO-2011-002)

In accordance with Management Directive (MD) 10.159, "The NRC Differing Professional Opinions Program," I am appointing you as members of a Differing Professional Opinion (DPO) Ad Hoc Review Panel (DPO Panel) to review a DPO that was forwarded to me to disposition.

The DPO (Enclosure 1) raises multiple concerns with management's position on whether or not the operators of the LES gas centrifuge facility interfered with an NRC inspection.

I have designated Fred Brown chairman of this DPO Panel and Amy Snyder as a DPO Panel member. Marshal Kohen was proposed by the DPO submitter and serves as the third member of the DPO Panel. Because this DPO involves an issue for which enforcement action was not taken but the submitter believes enforcement action should have been taken, John Wray is serving as the fourth member. In accordance with the guidance included in MD 10.159 and consistent with the DPO Program objectives, I task the DPO Panel to do the following:

- ❑ Review the DPO submittal to determine if sufficient information has been provided to undertake a detailed review of the issue.

- ❑ Meet with the submitter, as soon as practicable, to ensure that the DPO Panel understands the submitter's concerns and scope of the issues. (Normally within 7 days.)

- ❑ Promptly after the meeting, document the DPO Panel's understanding of the submitter's concerns, provide the Statement of Concerns (SOC) to the submitter, and request that the submitter review and provide comments, if necessary. (Normally within 7 days.)

- ❑ Maintain the scope of the review to not exceed those issues as defined in the original written DPO and confirmed in the SOC.

- ❑ Consult with me as necessary to discuss schedule-related issues, the need for technical support (if necessary), or the need for administrative support for the DPO Panel's activities.

- ❑ Perform a detailed review of the issues and conduct any record reviews, interviews, and discussions you deem necessary for a complete, objective, independent, and impartial review. The DPO Panel should re-interview individuals as necessary to clarify information during the review. In particular, the DPO Panel should have periodic discussions with the submitter to provide the submitter the opportunity to further clarify the submitter's views and to facilitate the exchange of information.

- ❑ Provide monthly status updates on your activities via email to Renée Pedersen, Differing Views Program Manager (DVPM) about the last day of the month. This information will be reflected in the Milestones and Timeliness Goals for this DPO and included in the Monthly Status Report on the DPO Program that is forwarded to the Commission. Please provide a copy of email status updates to the submitter and to me.

- ❑ Issue a DPO Panel report, including conclusions and recommendations to me regarding the disposition of the issues presented in the DPO. The report should be a collaborative product and include all DPO Panel member's concurrence. Follow the specific processing instructions for DPO documents.

- ❑ Consult me as soon as you believe that a schedule extension is necessary to disposition the DPO.

- ❑ Recommend whether the DPO submitter should be recognized if the submitter's actions result in significant contributions to the mission of the agency.

- ❑ As part of your review, address conclusions and recommendations regarding the adequacy of NRC processes to ensure sufficient NRC license reviewer and inspector access to accomplish the NRC's safety and security mission while ensuring the proper protection of classified matter within the scope of the DPO.

- ❑ In addition, address conclusions and recommendations regarding the adequacy of NRC procedures and processes for resolving reviewer and inspector access to facilities and information where the licensee asserts a conflicting information protection interest; specifically whether procedures exist and are well understood by the staff and by licensees who possess classified matter.

Disposition of this DPO should be considered an important and time sensitive activity. The timeliness goal included in the MD for issuing a DPO Decision is 120 calendar days from the day the DPO is accepted for review. The timeliness goal for issuing this DPO Decision is March 1, 2012.

Process Milestones and Timeliness Goals for this DPO are included as Enclosure 2. The timeframes for completing process milestones are identified strictly as goals—a way of working towards reaching the DPO timeliness goal of 120 calendar days. The timeliness goal identified for your DPO task is 70 calendar days.

Although timeliness is an important DPO Program objective, the DPO Program also sets out to ensure that issues receive a thorough and independent review. The overall timeliness goal should be based on the significance and complexity of the issues and the priority of other agency work. Therefore, if you determine that your activity will result in the need for an

extension beyond the overall 120-day timeliness goal, please send me an email with the reason for the extension request and a new completion date. I will subsequently forward this request to the DVPM who will forward it to the EDO for approval.

Please ensure that all DPO-related activities are charged to Activity Code ZG0007.

Because this process is not routine, the DVPM will be meeting and communicating with all parties during the process to ensure that everyone understands the process, goals, and responsibilities. The DVPM will be subsequently sending you information intended to aid you in implementing the DPO process.

An important aspect of our internal safety culture includes respect for differing views. As such, you should exercise discretion and treat this matter sensitively. Documents should be distributed on an as-needed basis. In an effort to preserve privacy, minimize the effect on the work unit, and keep the focus on the issues, you should simply refer to the employee as the DPO submitter. Avoid conversations that could be perceived as "hallway talk" on the issue. We need to do everything that we can in order to create an organizational climate that does not chill employees from raising dissenting views.

As a final administrative note, please ensure that all correspondence associated with this case include the DPO number in the subject line. All documents that do not contain classified or Safeguards information shall be profiled in accordance with ADAMS template OE-011, be identified as non-public and declared an official agency record *when the correspondence is issued*, and be filed in the applicable DPO Case File folder (DPO-2011-002) in the ADAMS Main Library. If you find it necessary to create, handle, store, process, or dispose of records involving classified or Safeguards information in the course of your work, those records must be managed in accordance with Management Directive 12.2, "NRC Classified Information Security Program," or MD 12.7, "NRC Safeguards Information Security Program," as appropriate. Following this process will ensure that a complete agency record is generated for the disposition of this DPO. If the submitter requests that the documents included in the DPO Case File be made public when the process is complete, you will be provided specific guidance to support a releasability review.

I appreciate your willingness to serve and your dedication to completing an independent and objective review of this DPO. Successful resolution of the issues is important for NRC and its stakeholders. If you have any questions, you may contact me, Beth Doolittle, NMSS OCWE Champion, or Renée Pedersen, DVPM, at (301) 415-2742 or email Renee.Pedersen@nrc.gov.

I look forward to receiving your independent review results and recommendations.

Enclosures:
1. DPO-2011-002
2. Milestones and Timeliness Goals

cc w/o Enclosure:
Submitter
DVPM

the DVPM who will forward it to the EDO for approval.

Please ensure that all DPO-related activities are charged to Activity Code ZG0007.

Because this process is not routine, the DVPM will be meeting and communicating with all parties during the process to ensure that everyone understands the process, goals, and responsibilities. The DVPM will be subsequently sending you information intended to aid you in implementing the DPO process.

An important aspect of our internal safety culture includes respect for differing views. As such, you should exercise discretion and treat this matter sensitively. Documents should be distributed on an as-needed basis. In an effort to preserve privacy, minimize the effect on the work unit, and keep the focus on the issues, you should simply refer to the employee as the DPO submitter. Avoid conversations that could be perceived as "hallway talk" on the issue. We need to do everything that we can in order to create an organizational climate that does not chill employees from raising dissenting views.

As a final administrative note, please ensure that all correspondence associated with this case include the DPO number in the subject line. All documents that do not contain classified or Safeguards information shall be profiled in accordance with ADAMS template OE-011, be identified as non-public and declared an official agency record *when the correspondence is issued*, and be filed in the applicable DPO Case File folder (DPO-2011-002) in the ADAMS Main Library. If you find it necessary to create, handle, store, process, or dispose of records involving classified or Safeguards information in the course of your work, those records must be managed in accordance with Management Directive 12.2, "NRC Classified Information Security Program," or MD 12.7, "NRC Safeguards Information Security Program," as appropriate. Following this process will ensure that a complete agency record is generated for the disposition of this DPO. If the submitter requests that the documents included in the DPO Case File be made public when the process is complete, you will be provided specific guidance to support a releasability review.

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I look forward to receiving your independent review results and recommendations.

Enclosures:
1. DPO-2011-002
2. Milestones and Timeliness Goals

cc w/o Enclosure:
Submitter
DVPM

DISTRIBUTION:
RidsNmssOd

OFFICE	NMSS				
NAME	DDorman				
DATE	12/09 /11				

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DPO Panel Report

March 2, 2012

MEMORANDUM TO: Catherine Haney, Director
Office of Nuclear Material Safety and Safeguards

FROM: Frederick D. Brown, Director **/RA/**
Nuclear Reactor Regulation, Division of Inspection and Regional Support

Marshall D. Kohen, Senior Program Manager **/RA/**
Nuclear Security and Incident Response

Amy M. Snyder, Technical Assistant **/RA/**
Office of New Reactors, Division of New Reactor Licensing

John R. Wray, Senior Enforcement Specialist **/RA/**
Office of Enforcement

SUBJECT: DIFFERING PROFESSIONAL OPINION PANEL REPORT ON LICENSEE INTERFERENCE WITH NRC INSPECTION ACTIVITIES (DPO-2011-002)

In a memorandum dated December 9, 2011, you appointed us as members of a Differing Professional Opinion (DPO) Ad Hoc Review Panel (DPO Panel) to review a DPO regarding "Inspection Access at LES Gas Centrifuge Facility". In addition, to ensure a complete, detailed, objective, and impartial review, you assigned us the tasks of: (1) conducting record reviews, interviews, and discussions as deemed appropriate; and (2) addressing recommendations and conclusions regarding the Nuclear Regulatory Commission's (NRC) procedures and processes for inspector access to facilities and information where the licensee asserts a conflicting information protection interest.

The DPO Panel has reviewed the DPO in accordance with the guidance in Management Directive 10.159, "The NRC Differing Professional Opinions Program." The results of the DPO Panel's evaluation of the concerns raised in the DPO are detailed in the enclosed DPO Panel Report.

The Panel commends the submitter's commitment to the NRC's value of Integrity in that he consistently pursued what he believed to be an important issue within the available NRC processes.

Please do not hesitate to contact us if you have any questions regarding the enclosed report.

Enclosure:
DPO Panel Report

cc: Dennis Morey, NRR
Roy Zimmerman, OE
Renée Pedersen, DPOPM
Elizabeth Doolittle, NMSS, OCWE Champion

March 2, 2012

MEMORANDUM TO: Catherine Haney, Director
Office of Nuclear Material Safety and Safeguards

FROM: Frederick D. Brown, Director **/RA/**
Nuclear Reactor Regulation, Division of Inspection and Regional Support

Marshall D. Kohen, Senior Program Manager **/RA/**
Nuclear Security and Incident Response

Amy M. Snyder, Technical Assistant **/RA/**
Office of New Reactors, Division of New Reactor Licensing

John R. Wray, Senior Enforcement Specialist **/RA/**
Office of Enforcement

SUBJECT: DIFFERING PROFESSIONAL OPINION PANEL REPORT ON LICENSEE INTERFERENCE WITH NRC INSPECTION ACTIVITIES (DPO-2011-002)

In a memorandum dated December 9, 2011, you appointed us as members of a Differing Professional Opinion (DPO) Ad Hoc Review Panel (DPO Panel) to review a DPO regarding "Inspection Access at LES Gas Centrifuge Facility". In addition, to ensure a complete, detailed, objective, and impartial review, you assigned us the tasks of: (1) conducting record reviews, interviews, and discussions as deemed appropriate; and (2) addressing recommendations and conclusions regarding the Nuclear Regulatory Commission's (NRC) procedures and processes for inspector access to facilities and information where the licensee asserts a conflicting information protection interest.

The DPO Panel has reviewed the DPO in accordance with the guidance in Management Directive 10.159, "The NRC Differing Professional Opinions Program." The DPO Panel Report is enclosed for your consideration.

The results of the DPO Panel's evaluation of the concerns raised in the DPO are detailed in the enclosed DPO Panel Report. The Panel commends the submitter's commitment to the NRC's value of Integrity in that he consistently pursued what he believed to be an important issue within the available NRC processes.

Please do not hesitate to contact us if you have any questions regarding the enclosed report.

Enclosure:
DPO Panel Report

cc: Dennis Morey, NRR
Roy Zimmerman, OE
Renée Pedersen, DPOPM
Elizabeth Doolittle, NMSS, OCWE Champion

ADAMS Accession Number: ML12059A471

OFFICE	NRO/DRNL	NSIR/DSP/FCTSB	OE/EB	NRR/DIRS
NAME	ASnyder	MKohen,	JWray	FBrown
DATE	3/2/12	3/2/12	3/1/12	3/2/12

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Differing Professional Opinion (DPO) on Licensee Interference with NRC Inspection Activities at LES (DPO-2011-002)

DPO Panel Report

/RA/

_____

Fred Brown, Panel Chair
Director, Division of Inspection and Regional Support, NRR

/RA/

_____

Marshall Kohen, Panel Member
Senior Project Manager, NSIR

/RA/

_____

Amy Snyder, Panel Member
Technical Assistant for Licensing Operations, NRO

/RA/

_____

John Wray, Panel Member
Senior Enforcement Specialist, OE

Concern #1	Panel Finding #1
• The submitter believes that a legitimate inspection was impeded because NRC inspection staff were not permitted "immediate unfettered" access, in accordance with 10 CFR 70.55(c) (3), to sufficient information (and were not permitted to conduct interviews in accordance with 10 CFR 19.15(a)) to effectively inspect LES/URENCO USA. The submitter believes that members of both NRC line management and licensee management are responsible in this regard.	Based on interviews of selected individuals and a review of applicable documentation, the Panel concludes that NRC inspectors were afforded "…*immediate unfettered access, equivalent to access provided regular plant employees, following proper identification and compliance with applicable access control measures for security*…" as required by 10 CFR 70.55(c)(3). However, NRC management did not communicate the process and rationale behind the control measures for security consistently throughout the inspection activity, and this contributed to miscommunication and changes to the intended inspection. Access is afforded NRC inspectors who make the proper pre-inspection arrangements and demonstrate a need-to-know. Portions of the Centrifuge Assembly Building (CAB) contain classified and proprietary information, access to which is controlled in accordance with the Enrichment Technology United States (ETUS) Standard Practice Procedures Plan, as required by 10 CFR Part 95. It should be noted that there are two multilateral agreements among the United States and Germany, The Netherlands, and Great Britain (the Washington Agreement and the Quadripartite Agreement, and agreement with the State Department) which play a vital role in the manner in which access to the information is controlled. As a result, access to the production area of the CAB is not controlled by LES (an NRC licensee)—but, rather ETUS which is not an NRC licensee. Other NRC personnel, who had satisfactorily demonstrated a need-to-know and completed required pre-arrangements had been provided access to the CAB prior to the submitter's inspection. Indeed, access was provided to NMSS criticality inspectors after the submitter's inspection when the proper protocol was followed and a need-to-know was established. During the initial inspection referenced by the submitter, NRC line management and licensee management followed the protocol they understood was in place for information exchange and CAB access, and denied immediate access because: (1) the

	submitter had not completed pre-arrangements, and (2) no immediate safety concern existed. 10 CFR 19.15(a) states, in part, that inspectors may consult privately with workers concerning matters under NRC purview, as they deem necessary for the conduct of an effective and thorough inspection. The submitter and another criticality inspector expressed concern that the "Data Room" process involved a licensee representative designated to ensure that the provisions of the Facility Clearance and access controls for foreign Restricted Data (RD) were implemented, and that licensee contractors looked to this individual for guidance on "need-to-know" questions. The Panel determined that although §19.15(a) requires that workers be allowed to meet privately with an inspector, it does not require that workers provide classified information to an inspector without confirmation from competent authority that the inspector has the requisite "need-to-know" for obtaining such information. The Panel found that subsequent inspectors were permitted to interview licensee and contractor personnel and concludes that they obtained sufficient information to conduct an effective and thorough inspection. These interviews were conducted in the presence of the European company holding the enrichment technology RD to ensure that classified information was not disclosed when not required for the inspection, as presented in the Inspection Plan and explained by the inspectors. Information was provided to inspectors in a "Data Room," a process agreed to by NRC for exchanging sensitive information related to the centrifuge technology. Information obtained during the follow-up inspection via this method was sufficient for the NRC to conclude that there were no safety concerns.
	Panel Recommendation #1
	The Panel recommends that NMSS provide training to staff and management on the requirements for access to facilities and information to prevent the submitter's experiences from being repeated in the future. The Panel determined that NRC management did not communicate the process and rationale behind it consistently throughout the inspection

	and this contributed to delays and miscommunication. This training should include direction on how to adequately pre-plan inspection activities to ensure that access is permitted to classified information, including portions of the CAB when required, and to ensure that the appropriate knowledgeable licensee/contractor staff (located in Europe) is made available to address questions needed to conduct an effective and thorough inspection.
Concern #2-1	**Panel Finding #2-1**
• The submitter disagrees with the outcome and timeliness of "need-to-know" decision making for NRC staff performing inspections at LES/URENCO USA. 1. The submitter believes that NRC inspection staff is not adequately trained with respect to the pre-inspection process for requesting and obtaining access to classified and proprietary information.	Based on the people interviewed, the Panel concludes that the training at the time of the March 2011 inspection was inadequate. The Panel also noted that the Inspection Plan used at that time lacked the detail necessary for adequately determining what information the inspector(s) would need to access. While training has been provided to Regional staff who inspect at LES since the time of the inspection, the Panel concludes that additional training is appropriate to ensure that inspectors understand the Data Room process for exchanging for specific classified information onsite and the process for arranging access to information that cannot be provided by onsite employees, i.e., ETC employees come from Europe to provide information. Additionally, the Panel noted that there were not yet any formally documented procedures (e.g., MDs, IMCs, ROIs, or OIs) describing the process for gaining access to the RD associated with LES.
	Panel Recommendation #2-1
	The Panel recommends formal procedures be developed to govern NRC access to RD at LES, including the "Data Room/Exchange" process and that training be developed on the process for NRC access to RD at LES. In addition, it appears that the Inspection Plan guidance could be modified to direct inspectors to be more specific in their inspection planning. The general nature of the inspection plan guidance and format may contribute to the lack of detail necessary for complex or special cases, such as LES.

Concern #2-2	Finding #2-2
• The submitter disagrees with the outcome and timeliness of "need-to-know" decision making for NRC staff performing inspections at LES/URENCO USA. 2. The submitter believes that NRC inspection staff is not adequately trained with respect to information security restrictions at the LES facility.	Based on interviews and a review of documents, the Panel concludes that staff is not adequately trained with respect to information security restrictions at the LES facility. Specifically, the Panel found that there was not a common understanding amongst NMSS management, NMSS staff, Regional management, and NSIR/Information Security regarding who determines an individual's need-to-know for access to classified or proprietary information at LES. The Panel noted that there is no documentation to this effect and that the LES security plan does not discuss the process for determination of need-to-know. Further, while interviews led the Panel to understand the "data room/exchange" process for discussion of classified information, the Panel understands the process not to have been communicated to Headquarters inspectors prior to the inspection in question.
	Panel Recommendation #2-2
	The Panel recommends that NMSS define the process by which a need-to-know decision is made, including the level of NRC management that has the ultimate responsibility. In addition, the Panel recommends that NMSS formalize training for staff involved in licensing and inspection of the LES facility regarding: 1) the applicability of the Washington Agreement (specifically, Articles III-VI) and the Quadripartite Agreement (specifically, Articles IX-XI); and the agreement with the State Department [email] and 2) what technology/information at LES is classified. The Panel is encouraged that Region II is working on a procedure for granting and tracking need-to-know decisions and recommends that regional management continue to keep inspection staff abreast of procedures for access to information at the LES facility, in particular, need-to-know determinations regarding technology and equipment about which inspection staff requires knowledge in order to perform their duties.

Concern #2-3	Panel Finding #2-3
• The submitter disagrees with the outcome and timeliness of "need-to-know" decision making for NRC staff performing inspections at LES/URENCO USA. 3. The submitter notes that there does not appear to be a documented justification for what types of information inspectors are permitted to access.	The Panel found that everyone interviewed had a similar belief - that if a properly cleared NRC employee (including an inspector) was appropriately assigned a task involving classified information, that individual had a "need-to-know" for any and all information that is necessary to perform/complete the assigned task. Interestingly, there was nearly universal inconsistency in who interviewees believe is required/authorized to make the "need-to-know" determination for foreign RD that is not currently in the possession of the NRC (for material in the possession of NRC, we are trained that the person holding the information makes the "need-to-know" determination). The Panel reviewed NRC Management Directives 12.2 and 12.3 to determine what the Agency policy is for establishing need-to-know, who is authorized to make the need-to-know decision for the Agency, and how need-to-know decisions are communicated to licensees. The Panel could not find a clear answer to these questions. MD 12.3, Part II, "Control of Visits Involving Classified Information," paragraph (C)(6) states "…NRC Form 277 or other written request for visit or access approval should be approved by the NRC office or division sponsoring the contact for certification of the individual's need-to-know,…," but does not specify whether this requires an Office or Division Director's signature. The Form 277 contains a signature space for a "NRC Official," also without specifying who is authorized to sign (paragraph (B) (2) says that officials may be supervisors, for example). Neither the MD nor the Form 277 identifies any specific scope of material for which need-to-know is being identified (e.g., whether a security inspector has a need-to-know for enrichment process information or if a safety inspector has a need-to-know for access control systems). The Panel was not able to identify how the NRC communicates need-to-know decisions beyond the contents (apparent blanket need-to-know with no specificity on who can make the certification) of the Form 277 (if used) to NRC licensees covered by 10 CFR Part 95. This is a

	potential weakness in the NRC's program for protection of classified information since licensees covered by 10 CFR Part 95 are not authorized to make the need-to-know determination for NRC employees, as they are for all other "persons." The Panel believes that the existing process for communicating with licensees is based on informal communications among access control specialists, and while confident that it is being handled in an effective manner, the absence of Agency-level documentation makes conflicts such as occurred in this case more likely to recur in the future.
	Panel Recommendation #2-3
	The Panel recommends that NMSS coordinate with NSIR to develop guidance (consistent with that of other Federal Agencies) on the conduct of need-to-know determinations (e.g., verification that the individual is currently assigned a task that requires access to the information). Part of this improvement should be clearer guidance on who is delegated the authority to make need-to-know decisions for access to classified information in the possession of NRC licensees (beyond "NRC Official," as referenced in the Form 277). NMSS, in coordination with NSIR, should consider establishing a documented methodology for communicating NRC need-to-know decisions to NRC licensees covered by Part 95 (specificity that is currently lacking in Form 277) who possess classified information, especially where the information has special sensitivity, including information held by foreign countries/entities that are not covered by Agreements for Peaceful Cooperation ("123" Agreements).
Concern #2-4	**Panel Finding #2-4**
• The submitter disagrees with the outcome and timeliness of "need-to-know" decision making for NRC staff performing inspections at LES/URENCO USA.	The Panel concludes that there are points in the regulatory process where effective criticality safety evaluations require broad access to information on the enrichment system, equipment, and facility. In evaluating the circumstances of the inspections covered by the DPO, the Panel

4. In submitter's view, the proper performance of criticality safety reviews requires broad access to information on the enrichment system, equipment, and facility, but there does not appear to be any recognition of that in deciding "need-to-know" by the responsible line management.	concludes that there was a lack of agreement about how broad the access to information needed to be at the time of the criticality program implementation inspection in March of 2011. The Panel concludes that this lack of agreement stemmed from differences in understanding of what verification activities had occurred during the operational readiness review for the facility. The Panel found that managers assumed that critical characteristics of the centrifuges (volumes, geometries, failure mechanisms) had been verified/validated/confirmed during the Operational Readiness Review for start-up of the LES first cascade. Once verified, these characteristics should not need to be reevaluated or re-verified unless a modification is made to the centrifuges. The inspectors knew that the Operational Readiness Review had not included verification of these critical characteristics. As discussed elsewhere in our report, the Inspection Planner did not adequately convey this. More importantly, the NMSS program apparently did not include a formal process for ensuring that critical characteristics (other than Items Relied Upon for Safety (IROFS)) were identified during licensing, then tracked into the Operational Readiness Review inspection procedures or plans or even into subsequent inspection activities. This appeared to be particularly relevant when the application stated that the nature (volume, dimensions, construction) of a component rendered failure so unlikely that an IROFS that would otherwise be required was not established based on the assertion within the application. Evaluating the need to verify/confirm such assertions should have been recognized and addressed given the previous concerns identified in this area.
	Panel Recommendation #2-4
	NMSS should evaluate establishing a formal process to identify critical characteristics (in addition to IROFS) that have obviated the need for an IROFS during the licensing review. These critical characteristics should be considered for verification/confirmation during an Operational Readiness inspection, or subsequent inspections, as appropriate. There is an important back-fit related distinction here

	between verification/confirmation (which the Panel recommends) and re-evaluation of the licensing decision (which the Panel does not recommend).
Concern #2-5	**Panel Finding #2-5**
• The submitter disagrees with the outcome and timeliness of "need-to-know" decision making for NRC staff performing inspections at LES/URENCO USA. 5. The submitter believes that, in this case, NMSS management made a "need-to-know" determination based on a faulty belief that inspectors could obtain sufficient information in other ways, e.g., documentation and personal interviews.	The Panel's interviews led to the conclusion that the lack of regimented decision-making regarding need-to-know caused misunderstandings between NMSS management and inspection staff regarding conduct of the inspection. Inspection staff continually stated their need to have visual access to equipment to perform the safety inspection, and management maintained that the "Data Room" process would suffice. The fact that LES is a "special case" due to the classified and proprietary information involved does not obviate the requirement for inspection staff to obtain necessary and sufficient information to complete the inspection.
	Panel Recommendation #2-5
	The Panel recommends that NMSS capture in its documentation that while there are various ways to get information, visual physical access is an essential element of an inspection. Whether this is communicated verbally and/or in written form from management to inspection staff, the ultimate goal would be to have reflected in the Inspection Plan, to the degree appropriate and possible pre-inspection, the manner by which inspectors intend to obtain necessary information. This way, at least NMSS management and inspection staff will be aligned on methodology prior to the inspection.
Concern #2-6	**Panel Finding #2-6**
• The submitter disagrees with the outcome and timeliness of "need-to-know" decision making for NRC staff performing inspections at LES/URENCO USA.	The Panel concludes that the international agreements cited by NMSS management and ETUS as rationale to deny inspectors access to information do not contain specific language to this effect. Thus, it was NMSS' and ETC's interpretation of these agreements, which interpretation appears not to be documented, that was conveyed to the inspection staff. Indeed, the Quadripartite Agreement states in

6. The submitter believes that NMSS and LES/URENCO management incorrectly used international agreements (the Washington and Quadripartite Agreements) on the use of the technology in question as a reason to deny inspectors access to information.	Article IX that "…access to such information is provided only to individuals authorized by the United States Agency [the NRC] or by one of the national agencies of the Three Governments…" The Washington Agreement states in Article VI that "…access to documentary information deemed classified or determined to be proprietary under this Agreement may be afforded to persons, as necessary for purposes of the NRC licensing process in accordance with United States regulations providing appropriate protective restrictions from general disclosure." It is reasonable that inspectors, who are appropriately cleared for the level of information, believed that they could be granted access to the information in support of their inspection duties based on these provisions.
	Panel Recommendation #2-6
	Similar to Panel Recommendation 2-2 above, NMSS, with the assistance of NSIR/Information Security, should institute training on these agreements for staff involved with licensing and inspection of the LES facility. The training should relate how the various provisions of the agreements are applied at the LES facility. This implies that managers in the appropriate NRC offices have gained alignment on this implementation.
Concern #2-7	**Panel Finding #2-7**
• The submitter disagrees with the outcome and timeliness of "need-to-know" decision making for NRC staff performing inspections at LES/URENCO USA. 7. The submitter does not understand why the "need-to-know" decision seems to be made differently for inspections of different uranium enrichment licensees.	The Panel determined that the decision regarding a need-to-know for an inspection at LES is made differently than at other uranium enrichment facilities because of the uniqueness of the technology- in that some of the design characteristics are Secret RD. This condition initially drove the countries involved to develop multilateral agreements that limit the exchange of classified and proprietary technological information to those individuals who demonstrate a need-to-know to complete their regulatory responsibilities, and for classified information, to those with proper access authorization (clearance). Further, access to information and facilities at LES, unlike access to similar information and facilities at the General Electric-Hitachi Global Laser Enrichment facility, does not involve an Agreement as set forth in Section 123

	of the Atomic Energy Act of 1954, as amended. The above international agreements established for LES are legally binding and were developed to support an accelerated construction and start-up schedule. No other operating uranium conversion facility has such agreements at this time. However, it is expected that the facility being licensed at Eagle Rock will have similar agreements.
	Panel Recommendation #2-7
	Consistent with the recommendations above, the Panel recommends that NMSS coordinate with NSIR to ensure that criteria for determining a need-to-know for access to specific information and site facilities at any uranium enrichment facility are well documented and are based on requirements to conduct effective and thorough security and safety inspections. Associated guidance should specify who makes the need-to-know determination. The Panel recommends that the staff be trained to facilitate providing management the necessary information to make a need-to-know determination prior to inspections.
Concern #3	**Panel Finding #3**
• The submitter believes that the issues associated with access to the CAB should have been documented in the Inspection Report 70-3103/2011-201 and evaluated for enforcement.	Based on interviews and a review of applicable documents, the Panel concludes that the issues outlined in the DPO do not constitute a finding/violation and therefore should not have been documented in the Inspection Report or evaluated for enforcement. The Panel also concludes that if a violation of 70.55 (c) (3) or 19.15(a) had occurred, then the violation should have been discussed in the inspection report and should have been considered for enforcement action. The Panel found that the licensee implemented its program consistent with information sharing protocols which included verbal agreement with NRC management, and therefore a performance deficiency or finding was not an issue. It appears that at the time of the inspection, a clear and consistent message from NRC management to the inspectors as to what the information sharing protocols were and the rationale behind them did not occur and therefore created a

	misunderstanding regarding access to sensitive information at the LES facility. The Panel believes that an observation could have been documented in the inspection report, if it had been an indication of the licensee's lack of understanding of how to apply access to the CAB, which could be an indication of the licensee's performance. However, because it was not clear to the inspector what the licensee and NRC management agreed to regarding these protocols, it does not constitute a violation or performance deficiency on the part of the licensee.
	Panel Recommendation #3
	Because no violation occurred, the Panel concludes that the IMC 0616, Paragraph 04.03 (e) places the responsibility on NMSS management to determine what issues are discussed in the Inspection Report.
Concern #4	**Panel Finding #4**
• The submitter believes that excessively restrictive "need-to-know" decisions impair safety (security over safety) because the inspection staff cannot fulfill their responsibilities. The submitter is concerned that if such decisions continue to be made, seemingly favoring information security over safety, and without a documented, approved procedure (rather than seemingly at the whim of line and licensee management), future inspections will be compromised and there is a potential for a future safety incident.	Based on interviews, the Panel concludes that both safety and security requirements have statutory and regulatory basis and that each needs to be evaluated in relation to the other. Further, the Panel agrees with the premise that safety and security organizations need to ensure that their respective requirements are working in concert, if not synergistically. It is clear, as addressed in several findings above, that a more proceduralized and widely understood approach to need-to-know determinations is warranted. Further, it is the Panel's understanding that a sampling is done and not every design or aspect of the design is confirmed, nor does it have to be confirmed by an inspector. While it is possible that the lack of such a well-reasoned, structured approach and/or the absence of communication to staff could lead to ineffective inspections in the future, the Panel found no evidence that an immediate safety concern exists at the LES facility nor that such a concern was unable to be documented due to the need-to-know determination in this case. The Panel has also determined that the decision by management at the time of the expanded inspection was based on demonstration of a need-to-know, required for access to certain site facilities and information, and

	did not prevent the completion of inspection responsibilities as outlined in the Inspection Plan.
	Panel Recommendation #4
	The Panel believes that the changes made by NMSS and Region II since the March, 2011, inspection, along with the recommendations of the Panel, address this concern.
Concern #5	**Panel Finding #5**
• Criticality safety inspection staff continue to disagree with the approval of the "safe by design" concept in the LES/ URENCO USA license which the submitter believes informs the need for information at LES.	Based on the interviews, the Panel concludes that the staff's point is valid in that it is reasonable for inspectors to verify designs that were evaluated when the application was being reviewed before licensing, even if such designs or controls are deemed "safe by design." The Panel recognizes that drawings may not have the detail that is necessary to confirm certain aspects of the design and that in these situations, it is important to see the actual equipment and/or assembly to verify the as-built condition. The safe-by-design concept recognizes a passive engineered control which - by its geometry and configuration alone - will prevent a criticality accident from occurring. This implies that all nuclear criticality parameters, except geometry and interaction, are assumed to be in the optimum or worst case credible condition. The safe-by-design concept is not in the regulations, but rather it is an agreement with the NRC and the licensee that concludes that a specific IROFS for nuclear criticality is not necessary. The Panel agrees that a safe-by-design control or design should not be excluded for inspection just because it is deemed "safe-by-design". The Panel believes it is reasonable for an inspector to check the geometry and configuration by visual inspection to assure that the design or control was built and installed as licensed and that a sampling verification of safe-by design designs or controls is prudent. The Panel found that a safe-by-design design was inspected as part of the extended inspection at LES. In addition, the Panel was informed during its interview with a criticality inspector, that its inspectors sample design aspects in inspection space and do not duplicate evaluations that were conducted under licensing.

	Panel Recommendation #5
	The Panel recommends that NMSS consider establishing a process to ensure that critical characteristics are identified and included in the scope of Inspection Planning and execution.
Concern #6	**Panel Finding #6**
• The submitter believes that the Part 70 licensing approach that was the subject of DPO 2006-005 relies heavily on Operational Readiness Reviews such that information is required to be reviewed during inspections that is not reviewed during licensing in order to achieve reasonable assurance of safety at LES. Criticality inspection staff believe that criticality inspection "supplements the original licensing review."	Through interviews with the DPO submitter, a representative of Region II, and a Headquarters criticality inspector, the Panel found the DPO's contention to be supported. Specifically, designs or aspects of designs that were not completed in licensing space should be subject to review during inspections. One important way that this can be achieved is through the Operational Readiness Review. The Panel found that discretion on part of the inspector and a lack of resources played a role in the level of detail of the Operational Readiness Review that was conducted at LES. In hindsight, the Panel found that given the fact that the inspector was the only person at the time assigned to the Operational Readiness Review, the inspector probably would have identified the need to inspect the centrifuge internals, given that a violation was eventually found during a subsequent inspection.
	Panel Recommendation #6
	The Panel believes that the previous recommendations of the Panel address this concern.
Concern #7	**Panel Finding #7**
• The submitter believes that LES/URENCO USA criticality safety staff do not have sufficient information on the cascade equipment and operation to be able to adequately perform their required function.	In addition to the information contained in the DPO, the Panel was informed that the head of the licensee's criticality safety staff did not have a clearance at the time of the facility Operational Readiness Review. Potentially mitigating these concerns, the Panel was told by one individual that the LES criticality staff should have the access to the same information as the NRC as long as the appropriate protocol for establishing need-to-know is observed. For the sake of being timely, the Panel did not independently review the LES license to determine the scope of the licensee's criticality safety program as it relates to the "black box" concept for protecting the classified enrichment

	technology.
	Panel Recommendation #7
	The Panel recommends that NMSS evaluate the expectations for the licensee's criticality safety program and staff with respect to information that is contained inside the "black box" portions of the facility. If the LES staff need access to "black box" information in order to perform their duties under Part 70 and the license, then NMSS should verify that they have the necessary access (including both clearances and a scrutable method for establishing need-to-know) to gain that access.
Concern #8	**Panel Finding #8**
• The submitter believes that NRC inspection staff are not adequately trained with respect to the actual equipment operation and configuration of the LES/URENCO cascades and that this lack of training can impair their ability to perform their functions.	Based on interviews of selected individuals and a review of applicable documentation, the Panel concludes that the NRC inspection staff are not adequately trained with respect to the actual equipment operation and configuration of the LES/URENCO cascades. The centrifuge technology used at LES is new and very few people are knowledgeable of the details of this proprietary technology. The Panel determined that seasoned, experienced fuel cycle inspectors conducted the required research when preparing for the Operational Readiness Review inspection and, because of this research into the different technology used at LES, were able to conduct a thorough inspection. Less experienced inspectors not knowledgeable of basic centrifuge operation, need additional training to be able to conduct effective inspections.
	Panel Recommendation #8
	The Panel recommends that NMSS should develop and provide inspectors adequate training on centrifuge technology in enough detail, commensurate with specific ETC proprietary restrictions, to conduct effective criticality inspections.

Panel Observations Beyond the Scope of the DPO

After having conducted interviews with some members of the staff concerning the issues outlined in the DPO, the Panel became aware of a need to have a security classification review of Inspection Reports which could potentially contain sensitive/classified information. The Panel realized that the absence of a classification review by authorized classifiers could inadvertently lead to the release of sensitive/classified information to members of the staff and/or public who do not possess a "need-to-know" and/or required clearance. Thus, acknowledging the fact that provisions may be in place to ensure that sensitive information is not inadvertently released, the Panel found that provisions were not in place to ensure that inspection reports, whereby the inspections involved access to classified/sensitive information, underwent a thorough classification review to ensure that such information was not documented in the inspection report. The Panel recognized that in those instances, it was left to the inspector's discretion to handle the information properly.

Recommendations Beyond the Scope of the DPO**

The recommendation of the Panel is to assign or train a member of the staff as an original or derivative classification authority whose function would be to ensure that sensitive/classified information is not referenced in inspection reports. The Panel also recommends that provisions for inspection reports be in place for instances where information that had not been previously perceived as sensitive/classified information but due to a number of circumstances is now perceived as sensitive/classified information is handled appropriately. The Panel is aware that fuel cycle resident inspectors were previously trained as derivative classifiers so that they could perform this function when preparing their inspection reports.

Summary of Recommendations

(1) Recommend NMSS coordinate with NSIR to evaluate process for establishing need-to-know and the individual responsible for authorization
(2) Recommend NMSS train all staff on the requirements for access to facilities and expectations during/after inspections, including: pre-inspection planning, understanding provisions or agreements in place at a facility, following protocol, preparing inspection reports
(3) Recommend NMSS formalize the "data room/exchange" process by documented procedures or policies and inform all staff of the process
(4) Recommend NMSS provide training on the different centrifuge technologies located at the facilities
(5) Recommend NMSS evaluate establishing process to identify critical characteristics that should be considered for verification/confirmation during inspection/review
(6) Recommend NMSS evaluate the expectations for the licensee's criticality safety program and staff with respect to information that is contained inside the "black box" portions of the facility

Additional Recommendations

(1) Recommend NMSS evaluate establishing a process for reviewing draft reports for classified information by trained classification authority**

DPO Decision

April 2, 2012

MEMORANDUM TO: Dennis C. Morey, Branch Chief
Office of Nuclear Reactor Regulation

FROM: Catherine Haney, Director **/RA/**
Office of Nuclear Material Safety
and Safeguards

SUBJECT: DIFFERING PROFESSIONAL OPINION DECISION INVOLVING INSPECTION ACCESS AT LES GAS CENTRIFUGE FACILITY (DPO-2011-002)

On November 1, 2011, in accordance with Management Directive 10.159, "The NRC Differing Professional Opinions Program," you submitted a differing professional opinion (DPO) regarding inspection access at the LES gas centrifuge facility near Eunice, New Mexico. Specifically, your DPO addressed U.S. Nuclear Regulatory Commission (NRC) inspector access at LES, "need-to-know" decision making for NRC staff, NRC staff training, and documentation in inspection reports and inspection planning, among other issues. The purpose of this memorandum is to notify you of the decision that I have made in response to your DPO.

On December 9, 2011, Daniel H. Dorman, Acting Director, Office of Nuclear Material Safety and Safeguards (NMSS), established a DPO Ad Hoc Review Panel (the Panel) and tasked it to meet with you, review your DPO submittal, and issue a DPO report, including conclusions and recommendations regarding the disposition of the issues presented in your DPO. The Panel met with you to establish a concise statement of your concerns, and on January 11, 2012, the Panel finished a clarification of the issue. On March 2, 2012, after conducting a records review, conducting interviews with relevant individuals, and completing its own deliberations, the Panel issued its report to me (enclosure). You were cc'd on the Panel's report.

The Panel concluded that a number of the concerns in your DPO had merit. For example, although the Panel concluded that NRC inspectors were afforded immediate unfettered access, equivalent to access provided regular plant employees, following proper identification and compliance with applicable access control measures for security, NRC management did not communicate the process and rationale behind the control measures for security consistently throughout the inspection activity, and this contributed to miscommunication and changes to the intended inspection. Similarly, the Panel concluded that the training at the time of the March 2011 inspection was inadequate. The Panel's report addresses fourteen findings (one for each of your eight concerns, including #2-1 through #2-7), with corresponding recommendations, where appropriate. A summary of recommendations provided six specific recommendations. In

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(301) 492-3557

addition, the Panel made a finding and recommendation of its own, during the course of the review (regarding NMSS evaluating establishing a process for reviewing draft reports for classified information by a trained classification authority).

Following receipt of the Panel's report, I met with Panel representatives on March 27, 2012, and with you on March 28, 2012, by telecon, to discuss the DPO and the Panel's report. I also asked my own staff, Region II, and Office of Nuclear Security and Incident Response (NSIR) for feedback on the report.

After reviewing the Panel's report, considering the information provided in my meetings with the Panel representatives and you, and considering associated background information, I agree with the Panel's recommendations, with one minor change, as follows. With regard to the Panel's recommendation that NMSS coordinate with NSIR to evaluate a process for establishing need-to-know and the individual responsible for authorization, I believe that the agencywide lead for this action should be with NSIR, and NMSS should assist NSIR on the action. NSIR has agreed to accept the lead for this action. We will work closely with NSIR to assure that it is completed.

As a result of the Panel's recommendations, I will be issuing a separate memorandum tasking the Director, Division of Fuel Cycle Safety and Safeguards, to develop, track, and implement follow up actions to address the recommendations summarized in the Panel's report, including the Panel's additional recommendation. You will receive a copy of the memorandum and will be kept informed of the completion for the follow up actions.

Thank you for raising your DPO concerns and for your participation in the DPO process. By examining issues such as these, we strengthen our regulatory process and ensure that our regulatory programs remain strong and effective. A summary of the DPO and the DPO decision will be included in the Weekly Information report to advise interested employees of the outcome when the case is closed. If you have any questions or would like to discuss the matter further, please do not hesitate to contact me.

cc: Frederick Brown, NRR
Marshall Kohen, NSIR
Amy Snyder, NRO
John Wray, OE
Roy Zimmerman, OE
Renee Pedersen, DPOPM
Elizabeth Doolittle, NMSS, OCWE Champion

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