UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
101 MARIETTA STREET, N.W.
ATLANTA, GEORGIA 30323

Report Nos.: 50-424/89-15 and 50-425/89-17

Licensee: Georgia Power Company
P. O. Box 1295
Birmingham, AL 35201

Docket Nos.: 50-424 and 50-425 License Nos.: NPF-68 and CPPR-109

Facility Name: Vogtle 1 and 2

Inspection Conducted: May 22-26, 1989

Inspectors: William B. Gloersen 6/29/89
W. B. Gloersen Date Signed

R. B. Shortridge 6/30/89
R. B. Shortridge Date Signed

Approved by: John Potter 6/30/89
J. P. Potter, Chief Date Signed
Facilities Radiation Protection Section
Emergency Preparedness and Radiological
Protection Branch
Division of Radiation Safety and Safeguards

SUMMARY

Scope:

This routine, unannounced inspection was conducted in the areas of occupational exposure, shipping and transportation; radiation protection startup; and followup on previous inspector identified findings.

Results:

Based on interviews with licensee management, supervision, personnel from station departments, and records review, the inspectors found the radiation protection program to be be adequate. The licensee's programs for controlling solid radwaste and transporting radioactive material appeared effective. One weakness was noted in the quality of the audit program in the areas of radwaste shipping, waste classification, and waste characterization. One unresolved item was identified for the possible failure to provide certified calibration data for each containment high range monitor (Unit 2) as required by NUREG-0737, Table II.F.1-3. This item was resolved during a telephone conversation on June 29, 1989.

REPORT DETAILS

1. Persons Contacted

Licensee Employees

*A. Desrosiers, Superintendent, Health Physics Support
B. Fortson, Foreman, Instrumentation and Controls
*G. Fredrick, Quality Assurance Site Manager, Operations
*W. Gabbard, Senior Specialist, Nucelar Safety and Compliance
*C. Garrett, Engineer, Nuclear Operations
*H. Handfinger, Manager, Maintenance
*M. Hobbs, Superintendent, Instrumentation and Controls
*W. Kitchens, Assistant General Manager
*I. Kochery, Superintendent, Health Physics
*R. LeGrand, Manager, Health Physics and Chemistry
*M. Lyon, Coordinator, Quality Concerns
*A. Mosbaugh, Manager, Plant Support
*R. Odom, Supervisor, Plant Engineering
M. Seepe, Lab Supervisor III (Radwaste)
J. Sutphin, Supervisor, Instrumentation and Controls
J. Wilcox, Senior QA Field Representative

Other licensee employees contacted during this inspection included engineers, technicians, and office personnel.

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*J. Potter, Chief, Facilities Radiation Protection Section, RII
*J. Rogge, Senior Resident Inspector

*Attended exit interview

2. Occupational Exposure Shipping and Transportation (83750)

a. Organization

The inspectors reviewed the licensee's organization, staffing level, and lines of authority as they relate to the radiation protection program and noted that organization changes had been made and a reorganization of the Health Physics (HP) and Chemistry departments were pending approval. An individual with a strong operational and management background was selected to become the Manager of HP and Chemistry upon his transfer from the Operations Department. The new manager had previous experience as an HP technician, a senior reactor operator, an operations shift supervisor and as a superintendent of radwaste. The inspectors and the Chief of Facilities Radiation Protection, RII, discussed with the Manager of HP and Chemistry the

program initiatives that were planned or had been implemented in his tenure of four months.

The manager of HP and Chemistry stated that a new position of Laboratory Supervisor had been established at the same level as the two superintendents' of HP and of Chemistry. This group would have six positions and would be responsible for solid radwaste processing, shipping and transportation of radioactive material, laundry processing, and decontamination of the plant. The Manager of HP and Chemistry was authorized 50 HP technicians for job coverage and was staffed at 46. In addition, the department had a support staff of 31 people and 20 contract HP technicians.

No violations or deviations were identified.

b. External Exposure Control

Personnel Exposure Control

The inspectors monitored licensee personnel performing the sluicing of resin from the Boron Recycle System (BRS) Resin Hold Tank Demineralizer #2 to the Spent Resin Storage Tank in accordance with Radiation Work Permit (RWP) 89-0260. HP performed pre-job and post job radiation surveys, established high radiation areas, and monitored the piping during the operation. Upon completion of the resin transfer, the piping utilized for the operation was flushed to assure that radioactive hot spots were not created. The post job radiation survey verified that no hot spots remained. The inspectors observed that the operation was conducted in accordance with procedures and good radiological work practices. Radiation dose was minimal since the licensee representatives conducted the operation in accordance with ALARA concepts.

No violations or deviations were identified.

c. Control of Radioactive Material and Contamination, Surveys, and Monitoring

(1) Survey Results

During plant tours, the inspectors examined radiation level and contamination survey results in selected rooms in radiologically controlled areas (RCAs). The inspectors performed independent radiation level surveys using NRC equipment and compared them with licensee survey results. Radiation survey by the inspectors compared favorably with licensee survey results. The inspectors also examined licensee instrumentation and verified that all equipment observed was in current calibration. The inspector also verified that containers of radioactive material were labeled as required and that proper controls were established.

(2) Contamination of Personnel and Areas

Through May 22, 1989, the licensee had reported 33 personnel contamination events (PCEs). The licensee's goal for 1989 was to remain under 80 PCEs. The PCEs when analyzed showed a trend of unnecessary shoe contaminations. In discussions with the inspectors, the HP Laboratory Supervisor stated that some contaminations could be reduced if more containments were used and floor drains were unblocked. The supervisor stated that the floor drains were considered pressure boundaries to rooms in the RCA and design changes were required to unblock the floor drains to reduce personnel and area contaminations.

The contaminated area of the plant has remained low. Less than one percent (%) or 4,397 square feet (ft^2) of the total controllable area of both units, approximately 485,000 ft^2, was contaminated.

(3) License Condition for Leak Testing Fission Chambers

Licensee Condition 12 of Materials License Number SNM-1981 states that the licensee shall leak test the fission chambers in accordance with the enclosed, "License Condition for Leak Testing Fission Chambers." License Condition A for leak testing fission chambers states that each fission chamber shall be tested at intervals not to exceed six months. In the absence of a certificate from a transferor indicating that a test has been made within six months prior to the transfer, the sealed source shall not be put into use until tested. License Condition D states that the periodic leak test required by this condition does not apply to fission chambers that are stored and not being used. The chambers excepted from this test shall be tested for leakage prior to any use or transfer to another person unless they have been leak tested within six months prior to the date of use or transfer.

The inspectors verified that leak tests had been completed prior to use and that the records were properly documented for the incore detectors used in Unit 2. The leak tests were performed on February 23, 1989. All tests indicated that there was less than 0.005 microcuries of removable contamination present.

No violations or deviations were identified.

4. Containment High-Range Radiation Monitors (NUREG-0737, II.F.1, Attachment 3) (83526)

NUREG-0737, Item II.F.1, Attachment 3 requires the licensee to have the capability to detect and measure the radiation level within the reactor containment during and following an accident. Table II.F.1-3 of NUREG-0737 specifies the following requirements:

- Range - 1 rad/hr to 1E+8 rads/hr (beta and gamma) or alternatively 1 R/hr to 1E+7 R/hr (gamma only)

- Response - 60 keV to 3 MeV photons, with linear energy response (±20%) for photons of 100 KeV to 3 MeV. Instruments must be accurate enough to provide usable information.

- Redundant - A minimum of two physically separated monitors (that is, monitoring widely separated spaces within containment).

- Special Calibration - In situ calibration by electronic signal substitution is acceptable for all range decades above 10 R/hr. In situ calibration for at least one decade below 10 R/hr shall be by means of a calibrated radiation source. The original laboratory calibration is not acceptable due to the possible differences after in situ installation.

- Special Environmental Qualification - Calibrate and type-test representative specimens of detectors at sufficient points to demonstrate linearity through all scales up to 1E+6 R/hr. Prior to initial use, certify calibration of each detector for at least one point per decade of range between 1 R/hr to 1E+3 R/hr.

The inspectors interviewed cognizant licensee representatives and reviewed the manufacturer's technical manual (Westinghouse, 9002-DRMS-002) as well as calibration procedures for the containment high range monitoring system (CHRMS). It was noted that the Unit 2 CHRMS were located in different positions in containment with respect to Unit 1. An engineering evaluation was performed (FCRB-6183 January 14, 1988) to determine the new locations in Unit 2. The inspectors observed that Final Safety Analysis Report (FSAR) Figure 12.3.1-3 had been revised (Amendment 35, 3/88) to reflect the new monitor positions. However, it was observed that FSAR Figure 12.3.1-3 did not correctly indicate the position of CHRM 2RE-0005. The licensee stated that this figure would be revised in the next FSAR amendment. The new locations provided shortened cable lengths and eliminated unnecessary junction boxes. The licensee believed that the shortened lengths would improve instrument reliability. The licensee has experienced several electrical problems with U1 CHRMs. Both CHRMs were located on the 220 ft elevation of the containment building (refueling deck). 2RE-0006 was located adjacent to the personnel hatch while 2RE-0005 was positioned near the Stair No. 1 structural wall. It appeared that the new U2 CHRM locations still provided a view of a large segment of containment atmosphere which would accommodate accurate monitoring of accident conditions.

The inspectors reviewed the calibration data for the containment high range digital radiation monitoring system provided by the manufacturer in Technical Manual 9002-DRMS-002 (April 1986). The detectors were gamma-sensitive ion chambers manufactured by Reuter-Stokes (Model Number RS-C3-1006-202). The monitoring system was assembled by Westinghouse. The detectors were designed and qualified to function during and after a loss-of-coolant accident with a maximum accident temperature of 400°F and maximum accident pressure of 50 psig. The Environmental Qualification Report for the Vogtle plant indicated peak containment temperature and pressure after a loss-of-coolant accident to be 352°F and 50 psig, respectively. The detectors had an activity range from 1 R/hr to essentially 1E+7 R/hr over an energy range of 80 KeV to 3 MeV. The detectors' energy response was essentially linear from approximately 100 KeV to 3 meV. Additionally, the manufacturer had tested representative specimens of detectors at sufficient points to demonstrate linearity from 1 R/hr to approximately 1E+6 R/hr. The inspectors noted, however, that documentation was not available at the time of this inspection certifying the calibration of each detector for at least one point per decade of range between 1 R/hr and 10^3 R/hr. Technical Manual 9002-DRMS-002 indicated that these tests were conducted but were not included in the report. The inspectors indicated that this calibration documentation was required in order to satisfy the special environmental qualification requirement of NUREG-0737, Table II.F.1-3. At the exit meeting on May 26, 1989, the licensee committed to obtain from the manufacturer these calibration data within 30 days. The inspector identified this area as an unresolved item* (URI, (50-425/89-17-01) - possible failure to provide certified calibration for each CHRM (Unit 2) as required by NUREG-0737, Table II.F.1-3.

During a telephone conversation on June 29, 1989, the inspector and a licensee representative discussed the CHRM calibration data which had been obtained from the vendor and transmitted to the NRC Region II Office. The inspector reviewed these data and observed that the ion chamber responses were essentially linear when exposed to radiation fields ranging from 10 to 1000 R/hr. The inspector had no further questions and informed the licensee the URI would be closed (URI 50-425/89-17-01).

The inspectors also reviewed the calibration procedures and records for containment high range monitors 2RE-0005 and 2RE-0006. The following procedures were reviewed:

- 43690-C, Calibration of Area Monitors, Revision 7, February 9, 1989

*An unresolved item is a matter about which more information is required to determine whether it is acceptable or may involve a violation or deviation.

- 24624-2, Containment High Range (2RE-0005) Area Monitor 2RX-0005 Analog Channel Operational Test and Channel Calibration, Revision 2, January 18, 1989

- 24265-2, Containment High Range (2RE-0006) Area Monitor 2RX-0006 Analog Channel Operational Test and Channel Calibration, Revision 2, January 23, 1989

The in situ calibrations of the CHRMS were performed by both the HP and Instrumentation and Control (I&C) groups. HP personnel used Procedure 43690-C to perform a one point calibration on February 15, 1989, by using a 250 millicurie Cs-137 source. This calibrated radiation source caused a detector response of approximately 17 R/hr. The inspectors reviewed the certificate of calibration for the 250 millicurie Cs-137 source and the radiation monitor calibration data. I&C personnel used procedures 24624-2 and 24625-2 to perform the in situ calibrations on February 7, 1989, by electronic signal substitution. The inspectors reviewed the calibration records and observed that the detectors were essentially calibrated electronically at two decades above 17 R/hr (the point at which the calibrated radiation source was used). This method appeared acceptable since the CHRMS was a digital system and as such there is essentially one range for all the decades. The inspectors consulted with representatives from the Office of Nuclear Reactor Regulation (NRR) on May 30, 1989 who, in turn, concurred with the inspectors' assessment.

No violations or deviations were identified.

5. Program for Maintaining Exposure as Low as Reasonably Achievable (ALARA) (83750)

The inspectors discussed the ALARA program with licensee representatives. During calendar year 1988, 137 person-rem were expended. The person-rem goal for 1989 was 160 with 13 person-rem expended as of May 25, 1989. This was approximately 66% below the projection of 45 person-rem.

No violations or deviations were identified.

6. Solid Waste (84722)

10 CFR 20.311(d)(1) requires that any generating licensee who transfers radioactive waste to a land disposal facility prepare all waste so that the waste is classified according to 10 CFR 61.55 and meets the waste characteristics requirements in 10 CFR 61.56.

The inspectors reviewed radioactive waste classification documentation for selected radioactive waste shipments made in 1989, and determined that the waste had been properly classified and met the waste characteristic requirements of 10 CFR 61. To date, the licensee has only shipped Class A wastes in high integrity containers. During the period January 1, 1988 to May 25, 1989, the licensee had made only six radwaste shipments. Although commercially available waste classification software was available, the licensee performed the waste classification tasks manually. Presently, the licensee does not compact any dry active waste (DAW) onsite. All DAW was shipped to a vendor's supercompaction facility offsite.

Through discussions with licensee personnel, the inspectors determined that the solid radioactive waste processing activities and transportation activities had shifted from the Radioactive Waste Operations group to the HP group. At the time of this inspection, the details of that aspect of the HP organization had not been formalized. The inspectors indicated that this area will be reviewed during subsequent inspections.

No violations or deviations were identified.

7. Transportation of Radioactive Material (86721)

10 CFR 71.5 requires that licensees who transport licensed material outside the confines of its plant or other place of use, or who deliver licensed material to a carrier for transport to comply with the applicable requirements of the regulations appropriate to the mode of transport of the Department of Transportation (DOT) in 49 CFR Parts 170 through 189.

The inspectors reviewed the records of selected shipments of radioactive material performed in 1989. The shipping manifests examined were prepared consistent with 49 CFR 170-189 requirements and the radiation and contamination survey results were within the limits specified for the mode of transport and shipment classification.

10 CFR 20.311(d)(3) requires the licensee to conduct a quality control program to assure compliance with 10 CFR 61.55 and 61.56 and in addition, the program must include management evaluation of audits.

The inspectors reviewed Procedure 10200-C, Radwaste Management, Revision 2, dated November 18, 1987, and noted that the licensee utilized a "QA/QC Checklist" for waste classification, stability characteristics, and manifest reporting for each shipment.

Additionally, the inspectors reviewed the following QA audits and Technical Specification Surveillances (TSSs) that focus on radioactive waste control and shipments:

- QA Audit of Radioactive Waste Control, OP05-88/09, April 6, 1988
- QA Audit of Radioactive Waste Control, OP05-88/55, December 29, 1988

- QA Audit of Radioactive Waste Control, OP05-89/15, March 31, 1989
- TSS 1-A05-88-016, Radwaste Shipments and Notification, February 15, 1988
- TSS 1-A05-88-060, Radwaste Shipments and Notification, June 3, 1988
- TSS 1-A05-88-157, Shipment of Radioactive Waste, November 23, 1988

The inspectors noted that the audits conducted to assure compliance with 10 CFR 61.55, 61.56, and 71.105 were timely, however, they were generally not thorough. It was difficult to assess the quality of the audits performed in this area since they were lacking in detail with regard to the use of packages and its components, waste classification, and waste stability characteristics. The inspectors discussed the need for improvement in this area by providing additional training of personnel performing activities affecting quality as necessary to assure that suitable proficiency is achieved and maintained. The inspectors also discussed the regulatory significance of assuring that the audits are performed by technically qualified individuals and better documentation of management review of the audit results in order to show compliance with 10 CFR 20.311(d)(3).

No violations or deviations were identified.

8. Radiation Protection - Startup (83521)

a. Biological Shield Surveys - Unit 2

10 CFR 20.201(b) requires surveys to be made as may be necessary to comply with 10 CFR Part 20 and are reasonable under the circumstances to evaluate the extent of radiation hazards that may be present. FSAR Sections 14.2.3 and 1.9.68.1 commit the licensee to conformance with Regulatory Guide (RG) 1.68, Initial Test Programs for Water Cooled Nuclear Power Plants, August 1978. RG 1.68, Appendix A, Section 5.b.b requires the performance of neutron and gamma radiation surveys at the 50% and 100% power levels to establish the adequacy of shielding and to identify high radiation zones as defined in 10 CFR 20, Standards for Protection Against Radiation. ANSI/ANS 6.3.1-1980 describes a test program to be used in evaluating biological radiation shielding in light water reactors under normal operating conditions including anticipated operational occurrences.

The inspectors discussed with licensee representatives the administrative organization and scheduling of the Unit 2 startup test program. The operations manager had the overall responsibility for the startup test program during power ascension. The Operations Supervisor, Startup, and the Shift Test Directors were responsible for ensuring the performance of the test programs. Individual startup tests were conducted by test supervisors who reported to the Shift Test Directors. A radiological test supervisor was temporarily

reassigned from the HP Department to develop and implement the startup radiological survey procedures. The inspectors reviewed the Test Supervisor's training and qualification records and determined that the records were complete and that the individual had completed the training and qualification program for startup test supervisors.

The inspectors reviewed the following procedures that were related to the startup radiological survey program:

- 2-600-05, Biological Shield Survey, Rev. 0, December 8, 1988
- 43000-C, Radiation Surveys, Rev. 3, February 16, 1989
- SUA-03, Startup Shift Test Director/Test Supervisor Qualification Checklist, Rev. 1, January 24, 1989
- 43676-C, Calibration of the ASP-1, with the NRD Neutron Rem Detector, Rev. 2, June 6, 1988
- 43670-C, Calibration of the RO-2/RO-2A Dose Rate Meters, Rev. 4, November 17, 1988

The licensee established Radiation Base Point (RBP) locations in the reactor building and the auxiliary building consistent with the radiation zones identified in the FSAR. The RBPs were listed in Data Sheet 7.1 of Procedure 2-600-05. The procedure required both neutron and gamma measurements at each RBP. The inspectors discussed the survey methods with the HP startup test supervisor. Based upon the interviews, it appeared that the licensee utilized the survey scanning methods for horizontal and vertical shields suggested by ANSI 6.3.1 - 1980. The scanning methods were generally described in Procedure 2-600-05. The licensee organized two survey teams to perform the biological shield surveys. Each team consisted of one data recorder, one technician performing gamma surveys, and one technician performing neutron surveys.

The inspectors reviewed the startup radiation survey results performed at 30%, 50%, and 100% power levels. Additionally, surveys had been performed prior to startup to establish a background baseline. Each of the surveys had been reviewed by the test supervisor and HP supervision to ensure that the results were acceptable and that power ascension could proceed. The 100% power shield survey data were reviewed by the HP supervision against FSAR, Section 12.3 to ensure that all areas were within the specified limits for full power operation. According to the licensee, no changes will be required in plant facilities or procedures as a result of the bioshield surveys. Additionally, all RBPs surveyed during zero and power range testing exhibited gamma exposure rates and neutron dose equivalent rates that were consistent with design criteria provided by the architect engineer. The HP review of the 100% power survey data was completed on May 17, 1989. At the time of

this inspection, the inter-departmental review by the design organization, startup organization, operations organization, plant review board, and the general manager had not been completed. The licensee had planned to complete these reviews by early June.

In addition, the licensee had a contract with Battelle/Pacific Northwest Laboratories to perform neutron dose and energy spectral measurements at the 50% and 100% power levels. The report was not available for review during this inspection.

b. Biological Surveys - Unit 1 First Refueling Outage

The inspectors reviewed the licensee's biological shield survey program of the fuel transfer tube and surrounding areas during Unit 1's first refueling outage. The fuel transfer tube survey was performed in three stages. During the initial transfer of a spent fuel assembly, the transfer carriage was stopped approximately one quarter of the way in the tube between the Unit 1 containment and the fuel handling building, and comprehensive radiation surveys were performed around the transfer tube and at elevations above and below the transfer canal. These surveys were repeated when the fuel bundle was half-way and three quarters of the way in the transfer tube. It appeared that the licensee's control of personnel access during the surveys, pre-transfer radiation surveys, in-transit survey methods, instrument performance checks, and communications between the survey coordinator and the refueling supervisor were adequate. Additionally, it appeared that the transfer tube survey data demonstrated that the shielding was adequate for all accessible locations.

No violations or deviations were identified.

9. Followup on Allegations (99014)

a. Statement of Concern (Allegation No. RII-89-A-0022)

The alleger reported that the whole body count (WBC) results he viewed at the dosimetry office on the day of his termination and the copy of the results he received later in the mail were not the same. Also, the alleger stated that he was not provided a copy of the WBC results on the day of termination.

Discussion:

10 CFR 19.13(e) in part requires that, at the request of a worker who is terminating employment in a given calendar quarter with the licensee in work involving radiation dose, or of a worker who, while employed by another person, is terminating assignment to work involving radiation dose in the licensee's facility in that calendar quarter, each licensee shall provide to each such worker, at termination, a written report regarding the radiation dose received

by that worker, or provide a written estimate of that dose if the facility determined personnel monitoring results are not available at that time.

After receiving a termination WBC at the dosimetry office, the alleger reviewed the preliminary WBC results noting trace elements on the page containing the peak energy analysis. At this time, the alleger did not request a copy of WBC results. During the exit interview with a quality concerns person, the alleger asked why he did not receive a copy of his WBC results. The interviewer called the dosimetry office and requested a copy. Dosimetry personnel stated that it was not in accordance with policy to provide terminating employees with copies of WBC results but they would provide the employee with a written estimate of his dose. The alleger stated that he did not want an estimate of his dose since he thought that dosimetry personnel had already provided him with a verbal estimate.

Finding:

The inspectors interviewed licensee personnel in dosimetry, HP management, and the person in quality concerns that conducted the exit interview. The inspector determined, based on written reports and interviews with licensee representatives, that had the alleger asked for a written estimate of his radiation dose, he would have received a summary of his internal deposition (WBC). The licensee's estimate of radiation dose contains summary information for both external and internal radiation dose.

The inspector observed that the licensee on two occasions had offered to explain the difference in appearance of the preliminary WBC results and the summary WBC results to the alleger but the offer was declined.

Conclusion:

The allegation was not substantiated in that the employee did not request a written estimate of radiation dose from the licensee.

10. NRC Information Notices (INs)(92701)

The inspectors determined that the following INs had been received by the licensee, reviewed for applicability, distributed to appropriate personnel, and that action, as appropriate, was taken or scheduled:

88-79 Misuse of Flashing Lights for High Radiation Area Controls

88-101 Shipment of Contaminated Equipment Between Nuclear Power Stations

89-27 Limitations on the Use of Waste Forms and High Integrity Containers for the Disposal of Low-Level Radioavtive Waste

11. Action on Previous Inspection Findings (92702, 92701)

(Closed) Violation 50-424/88-48-01: Failure to follow RWP access requirements. The inspectors reviewed the licensee response to the violation documented in a letter dated December 29, 1988. The inspectors also reviewed the corrective actions which appeared adequate. The corrective actions included the following: (1) the individual involved in the RWP violation was counseled under the licensee's positive discipline program; (2) the individual reread the requirements of Procedure 00930-C, Radiation and Contamination Control; and (3) deficiency card (1-88-3241) was initiated on October 26, 1988 to identify the procedural violation. To prevent recurrence, the plant manager issued a memo (dated December 20, 1988) to operations personnel to make those individuals aware of this incident and to re-emphasize the requirements of Procedure 00930-C. This item is considered closed.

(Closed) Inspector Followup Item (IFI) 50-425/88-62-01: Review calibration records and procedures for containment high range monitors. This area was reviewed in detail and documented in Paragraph 4 of this report. This item is considered closed.

12. Exit Interview

The inspection scope and results were summarized on May 26, 1989, with those persons indicated in Paragraph 1. The inspectors described the areas examined and discussed in detail the inspection findings. The licensee acknowledged the inspection findings and took no exceptions. During the exit meeting, the licensee committed to obtain from the manufacturer of the CHRMS within 30 days certified calibration data for 2RE-0005 and 2RE-006 as required by NUREG 0737, Table II.F.1-3. This area was identified as an URI. During a telephone conversation on June 29, 1989, the inspector and a licensee representative discussed the CHRM calibration data which had been transmitted to the NRC Region II Office. During that conversation, the inspector informed the licensee that the URI would be considered closed (Paragraph 4). Licensee management was informed that one violation and one IFI were closed. Although the licensee did identify as proprietary some of the vendor-supplied information associated with the containment high range monitoring system, proprietary information was not included in this inspection report.