NRC FORM 366
(7-77)

LICENSEE EVENT REPORT

Update Report; previous Report Date 10-19-79
(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK: (1)

0 1 | G A E I H 2 (2) | 0 0 - 0 0 0 0 - 0 0 (3) | 4 1 1 1 1 (4) | (5)
8 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 57 CAT 58

CON'T
0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 3 6 6 (7) | 1 0 1 1 7 9 (8) | 0 1 6 0 4 8 1 (9)
8 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On 10-11-79, while in cold shutdown for valve maintenance 2 IRMs were re-
0 3 | placed. While tagging them with SNM tags it was noted that an IRM that
0 4 | had been removed October 1978, was not in the area where it had been left.
0 5 | A similar event happened on Unit 1 (see LER 50-321/1979-054). This was
0 6 | the first opportunity to check Unit 2 since the occurrence on Unit 1.
0 7 | This event is contrary to requirements specified by Tech Specs 6.9.1.8.f
0 8 | and 10CFR73. No consequences were realized from this incident.
7 8 9 80

0 9 | SYSTEM CODE M D (11) | CAUSE CODE A (12) | CAUSE SUBCODE X (13) | COMPONENT CODE Z Z Z Z Z Z (14) | COMP. SUBCODE Z (15) | VALVE SUBCODE Z (16)
7 8 9 10 11 12 13 18 19 20

(17) LER/RO REPORT NUMBER: EVENT YEAR 7 9 (21 22) | — (23) | SEQUENTIAL REPORT NO. 1 1 2 (24 26) | / (27) | OCCURRENCE CODE 0 6 (28 29) | REPORT TYPE X (30) | — (31) | REVISION NO. 1 (32)

ACTION TAKEN G (18) | FUTURE ACTION H (19) | EFFECT ON PLANT Z (20) | SHUTDOWN METHOD Z (21) | HOURS (22) 0 0 0 0 (33 34 35 36 37 40) | ATTACHMENT SUBMITTED Y (23) | NPRD-4 FORM SUB. N (24) | PRIME COMP. SUPPLIER Z (25) | COMPONENT MANUFACTURER Z 9 9 9 (26)
41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | Replaced detectors present radiation problem initially and are left in
1 1 | drywell to decay. Drywell was considered closed zone and units were not
1 2 | tagged SNM while stored there. A cleanup was done in drywell during
1 3 | which IRM and trash were removed. IRM was moved to TIP room without
1 4 | authorization. Procedures revised to require tagging while in drywell.
7 8 9 80

1 5 | FACILITY STATUS G (28) | % POWER 0 0 0 (29) | OTHER STATUS (30) NA (44) | METHOD OF DISCOVERY C (31) | DISCOVERY DESCRIPTION (32) Physical Inventory (80)
7 8 9 10 12 13 45 46

1 6 | ACTIVITY RELEASED Z (33) | CONTENT OF RELEASE Z (34) | AMOUNT OF ACTIVITY (35) NA (44) | LOCATION OF RELEASE (36) NA (80)
7 8 9 10 11 45

1 7 | PERSONNEL EXPOSURES NUMBER 0 0 0 (37) | TYPE Z (38) | DESCRIPTION (39) NA (80)
7 8 9 11 12 13

1 8 | PERSONNEL INJURIES NUMBER 0 0 0 (40) | DESCRIPTION (41) NA (80)
7 8 9 11 12

1 9 | LOSS OF OR DAMAGE TO FACILITY TYPE Z (42) | DESCRIPTION NA (80)
7 8 9 10

2 0 | PUBLICITY ISSUED N (44) | DESCRIPTION (45) NA (68) | NRC USE ONLY (69 80)

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CPO 917-528

LER #: 50-366/1979-112, Rev. 1
Licensee: Georgia Power Company
Facility Name: Edwin I. Hatch
Docket #: 50-366

Narrative Report
for LER 50-366/1979-112, Rev. 1

While Unit 2 was in cold shutdown 2 IRMs were replaced on 10-11-79. While tagging them with the special nuclear material tags it was noted that an IRM which was removed in October of 1978 was not where it had been left. A search of the drywell and radwaste was conducted; neither TIP room was searched. The detector was not found in either the drywell or radwaste. At this time it was thought that the IRM had been processed with contaminated equipment and trash from the drywell and shipped offsite for burial. An LER (50-366/1979-112) was submitted stating the IRM was shipped offsite for burial. However, on 5-4-81, while transferring detectors from 55-gallon drums to an SNM storage box, the IRM was found in Unit 1 TIP room. The 55-gallon drum in which it was found was not tagged. Detector replacement procedures have been revised to require the tagging of detectors in the drywell and personnel have been instructed so as to prevent a recurrence. There was no impact to the other unit, and neither public health and safety nor safe plant operation were affected by this incident.