NRC FORM 366

1. FACILITY NAME

U.S. NUCLEAR REGULATORY

RY APPROVED BY OMB: NO. 3150-0104

EXPIRES: 06/30/2007

(7-2001)

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

2. DOCKET NUMBER

3. PAGE

Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6). U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs@nrc.gov, and

to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection

does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a

San Onofre Nuclear Generating Station (SONGS) Unit 2

05000361

person is not required to respond to, the information collection

1 OF 3

4 TITLE

Operator error results in a missed shutdown margin verification required by the Technical Specifications

5. EVENT DATE			6. L	ER NUMBER	7. REPORT DATE			8. OTHER FACILITIES INVOLVED							
МО		YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	МО	DAY	YEAR	F/	FACILITY NAME		KET NUMBER			
WC	DAY	TEAR							l	None					
6	21	2007	20	07-002-00)	08	17	2007	F/	ACILITY NAME	DOCI	KET NUMBER			
9. OPERATING	9. OPERATING MODE 1			11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR ': (Check all that apply)											
MODE			20.2201(b)			20.2203(a)(3)(ii)				50.73(a)(2)(ii)(B)		50.73(a)(2)(ix)(A)			
10. POWER	10. POWER LEVEL		20.2	201(d)		20.2203(a)(4)				50.73(a)(2)(iii)		50.73(a)(2)(x)			
LEVEL			20.2	203(a)(1)		50.36(c)(1)(i)(A)				50.73(a)(2)(iv)(A)	7	73.71(a)(4)			
4.54			20.2	203(a)(2)(i)		50.36(c)(1)(ii)(A)				50.73(a)(2)(v)(A)	_ 7	73.71(a)(5)			
			20.2	203(a)(2)(ii)		50.36(c)(2) 50.46(a)(3)(ii)				50.73(a)(2)(v)(B)		OTHER			
			20.2	203(a)(2)(iii)						50.73(a)(2)(v)(C)		Specify in Abstract below or in NRC Form 366A			
1.5			20.2	203(a)(2)(iv)		50.73(a	(a)(2)(i)(A)		50.73(a)(2)(v)(D)	50.73(a)(2)(v)(D)					
The second secon			20.2	203(a)(2)(v)	Х	50.73(a)(2)(i)(B) 50.73(a)(2)(i)(C)			50.73(a)(2)(vii)			1			
			20.2	203(a)(2)(vi)						50.73(a)(2)(viii)(A)					
			20.2	203(a)(3)(i)		50.73(a	a)(2)(ii)(A)		50.73(a)(2)(viii)(B)					

12. LICENSEE CONTACT FOR THIS LER

NAME

TELEPHONE NUMBER (Include Area Code)

R. W. Waldo, VP Generation

949-368-8725

<u> </u>		13. COMPLE	TE ONE LINE F	OR EACH CO	MP(ONENT FAIL	<u>LURE DESCF</u>	RIBED IN THIS	REPORT			
CAUSE	SYSTEM	COMPONENT	MANU- FACTURER	REPORTABLE TO EPIX		CAUSE	SYSTEM	COMPONENT	MANU- FACTURER		REPORTABLE TO EPIX	
						4						
14. SUPPLEMENTAL REPORT EXPECTED							15. EXPECTED		MONTH DAY		YEAR	
YES (If yes, complete EXPECTED SUBMISSION DATE)				X	NO	SUBN D						

16. ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On June 20, 2007, Unit 2 was operating in Mode 1 at about 96 percent power. At about 1030 PDT, one channel of source range monitoring did not pass its surveillance requirements and was declared inoperable. Consistent with plant procedures, Operators placed a Limiting Condition for Operation Action Requirements/Equipment Deficiency Mode Restraint (LCOAR/EDMR) tag next to the channel indicator (the channel indicator continued to function).

At about 2240 PDT the same day, a line in the instrument air system separated at a soldered connection joint. Plant Operators manually tripped the unit, entering Mode 3. The details of that event are provided in LER 2-2007-001.

When completing the post trip actions required by Emergency Operating Instructions, a control room operator failed to notice that one channel of source range monitoring channels was out of service and failed to complete the Shutdown Margin verification by 0250 PDT, June 21, 2007, required by Technical Specification 3.3.13, Action A.2. SCE is reporting this occurrence in accordance with 10CFR50.73(a)(2)(i)(B).

The cause of this event is individual personal error. The Reactor Operator (RO) failed to respond to the LCOAR/EDMR tag posted next to the Startup Channel indicator. Southern California Edison has coached the Operator and discussed this event with all other Licensed Operators.

NRC FORM 366A **U.S. NUCLEAR REGULATORY COMMISSION** (7-2001)LICENSEE EVENT REPORT (LER) **TEXT CONTINUATION** 2. DOCKET NUMBER 6. LER NUMBER 1. FACILITY NAME PAGE (3) SEQUENTIAL NUMBER YEAR REV NO

05000361

2007

--002 --

2 of 3

00

Plant: San Onofre Nuclear Generating Station (SONGS) Unit 2

Discovery Date: June 21, 2007

San Onofre Nuclear Generating Station (SONGS) Unit 2

Reactor Vendor: Combustion Engineering Mode: Mode 1 – Power Operation

Power: 96 percent

Description of Event:

Technical Specification (TS) 3.3.13, Source Range Monitoring Channels, requires two channels of source range monitoring to be operable. This specification is applicable whenever the plant is in Modes 3, 4, and 5, with the reactor trip breakers open or control element assembly drive system not capable of CEA withdrawal. When applicable and with one source range monitor inoperable, plant operators are required to, in part, perform a Shutdown Margin (SDM) verification in accordance with Surveillance Requirement (SR) 3.1.1.2, if T(ave) is greater than 200 degrees F, or in accordance with SR 3.1.2.1, if T(ave) is less than 200 degrees F. Required Action A.2 of TS 3.3.13 has a required completion time of 4 hours after entering an applicable plant condition and once every 12 hours thereafter.

On June 20, 2007, Unit 2 was operating in Mode 1 at about 96 percent power. At about 1030 PDT, one channel of source range monitoring did not pass its surveillance requirements and was declared inoperable. Consistent with plant procedures, Operators placed a Limiting Condition for Operation Action Requirements/Equipment Deficiency Mode Restraint (LCOAR/EDMR) tag next to the channel indicator (the channel indicator continued to function).

On June 20, 2007, at about 2240 PDT, Unit 2 was operating in Mode 1 at about 96 percent power when a line in the instrument air system separated at a soldered connection joint. Operators manually tripped the unit at about 2250 PDT, June 20, 2007. The details of that event are provided in LER 2007-001.

When operators manually tripped the reactor, the plant entered Mode 3 and entered the applicability of TS 3.3.13. When completing the post trip actions required by Emergency Operating Instructions (EOI), a control room operator failed to notice that one channel of source range monitoring channels was out of service and failed to complete the SDM verification by 0250 PDT, June 21, 2007, as required by TS 3.3.13, Action A.2. Southern California Edison is reporting this occurrence to the NRC in accordance with 10CFR50.73(a)(2)(i)(B).

Cause of Event:

The cause of the event was individual operator error. The Reactor Operator (RO) failed to correctly respond to the LCOAR/EDMR tag posted next to the Startup Channel indicator. When the RO performed the channel check required by procedure, he observed both channels indicating and did not question their operability.

Corrective Actions:

The Operator involved in this case has been coached on the requirement to check for LCOAR/EDMR tags when determining whether TS related components are functional. SCE also reviewed this event with all other Licensed Operators.

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION (7-2001)										
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION										
1. FACILITY NAME		2. DOCKET NUMBER		6. LER NUMBER		PAGE (3)				
San Onofre Nuclear Generating Station (S	CNGS) Unit 2	05000361	YEAR	SEQUENTIAL NUMBER	REV NO	3 of 3				
San Onone Nuclear Generating Station (S	03000301	2007	002	00	7 2 01 3 1					

Additional corrective actions will be implemented if they are identified.

Safety Significance:

There was no safety significance to this event. At about 0830 PDT on June 21, 2007, plant operators completed the required SDM verification and confirmed the SDM satisfied the requirements of SR 3.1.1.2 [T(ave) was greater than 200 degrees F.]

Additional Information:

In the last three years, there have been no other reported occurrences of a missed TS required surveillance caused by failing to notice that TS required equipment was out of service.