CATEGORY 1

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SUBJECT: Special rept:on 960104,#12 Containment H & O Monitors declared inoperable due to air inleakage through failed pump diaphragm.Replaced original diaphragms w/new vendor recommended Nordel/Nomex diaphragms.

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January 18, 1996
NMP1L 1023

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

RE: Nine Mile Point Unit 1
Docket No. 50-220
DPR-63

Subject: *Special Report*

Gentlemen:

In accordance with Nine Mile Point Unit 1 (NMP1) Technical Specification Table 3.6.11-1, "Accident Monitoring Instrumentation," Action Statement 4.a, Niagara Mohawk Power Corporation is submitting the following Special Report concerning the inoperability of the #12 Containment Hydrogen Monitoring Unit (HMS).

Description of Event

On January 4, 1996 at 1330 hours, with the reactor mode switch in the "RUN" position during normal power operations, the #12 HMS was removed from service to allow for corrective maintenance on the sample pump for the #12 Containment Hydrogen and Oxygen Monitors.

Cause of Event

The #12 Containment Hydrogen and Oxygen Monitor was declared inoperable following a Channel 12 Oxygen Level High annunciation received on January 4, 1996. The #11 HMS was verified operable. Corrective maintenance was performed on the #12 HMS requiring removal of the system from service. Removal of #12 HMS from service for corrective maintenance necessitates a Special Report in accordance with Technical Specification Table 3.6.11-1, Action Statement 4.a.

Maintenance activities revealed that the cause of the elevated oxygen concentration was air inleakage through a failed pump diaphragm. This event is similar to one which occurred in July 1995 when #11 HMS was declared inoperable due to a failed pump diaphragm. The cause of the diaphragm failure in the #12 HMS is under investigation. The failed diaphragm will be sent to the vendor for a root cause evaluation.

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Corrective Actions

The original diaphragms were replaced with new vendor recommended Nordel/Nomex diaphragms. Torque specifications also recommended by the vendor were included in the replacement procedure and used during this maintenance. The #12 HMS was restored to operable status following successful calibration on January 18, 1996.

The vendor recommended corrective actions will also be completed on #11 HMS by February 16, 1996. In addition, corrective actions based on the results of the Teledyne Brown Engineering root cause analysis will be incorporated into future corrective and preventative maintenance activities.

Further, NMPC was advised of a 10CFR Part 21 report on this equipment submitted by the vendor, Teledyne Brown Engineering on October 31, 1995. The root cause in that report does not appear to be the root cause of current diaphragm failures based upon our assessment at this time. However, the above corrective actions taken to date include those recommended by the vendor for correcting the earlier diaphragm failures.

Very truly yours,

N. L. Rademacher
Plant Manager - NMP1

NLR/TWR/kap

xc: Mr. Thomas T. Martin, Regional Administrator, Region I
Mr. Barry S. Norris, Senior Resident Inspector