Florida Power & Light Company, 6501 S. Ocean Drive, Jensen Beach, FL 34957

November 5, 2009

L-2009-250
10 CFR 50.4

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

Re: St. Lucie Unit 2
Docket No. 50-389
Date of Event: October 6, 2009
Technical Specification Special Report
Sodium Hypochlorite Spill Greater Than 100 Pounds

On October 6, 2009, at 2115 hours, an estimated 240 pounds of sodium hypochlorite was discharged from a holding tank onto plant grounds. This spill exceeded the reportable quantity of 100 pounds.

The attached report is being submitted pursuant to the requirements of Section 5.4.2 of the St. Lucie Units 1 and 2 Environmental Protection Plan to provide the description to the event.

Please contact us if there are any questions.

Sincerely,

Eric S. Katzman
Licensing Manager
St. Lucie Plant

ESK/CAA

IE22
NRR

I. TITLE

Sodium Hypochlorite Spill Greater Than 100 Pounds.

II. EVENT DESCRIPTION

On October 6, 2009, sodium hypochlorite was added to the St. Lucie Unit 2 main condenser as a normal operating procedure to decrease biological growth in the condenser tubes. A routine system flush was initiated at 1545 hours after the sodium hypochlorite was added. This system flush consisted of backwashing the system with city water to remove chlorine residue from system components. The city water valve that was supplying the tank was not completely closed upon completion as required by plant procedures.

At 2115 hours the sodium hypochlorite tank was found to be overflowing into its secondary containment. A large label affixed to the side of the tank had peeled up and diverted some of the overflow filling the secondary containment onto the graveled area adjacent to the tank. The liquid spill on the gravel was conservatively estimated to be 240 pounds of sodium hypochlorite, which exceeds the reportable quantity of 100 pounds.

The city water valve was closed upon discovery thus terminating the release. The impacted graveled area was immediately washed down with city water to mitigate any possible hazard to plant personnel, or to the environment. The spill was confined to the immediate area adjacent to the tank and did not reach any surface water or the storm water drainage system.

III. CAUSE OF THE EVENT

The valve supplying the holding tank with city water was required to be closed as per plant procedures. Human error caused this valve to be mis-positioned.

IV. ACTIONS TAKEN

1) The open valve was closed immediately upon discovery.
2) The individual responsible for flushing the system was coached and counseled.
3) The tank vendor subsequently inspected the tank for extent of condition. No issues were identified that had could have contributed to this event.

V. AGENCIES NOTIFIED

1) The National Response Center was notified on October 7, 2009 at 0328 hours.
2) The State Emergency Response Commission was notified on October 7, 2009 at 0328 hours.
3) The Florida Department of Environmental Protection was notified on October 8, 2009 at 1000 hours.
4) The State Siting Coordination Office was notified on October 8, 2009.