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November 1, 1999

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Ms. Blanca S. Bayo, Director
Division of Records and Reporting
Florida Public Service Commission
2540 Shumard Oak Boulevard
Tallahassee, Florida 32399-0850

Re: Fuel Adjustment - 1999
Docket No. 990001-EI

Dear Ms. Bayo:

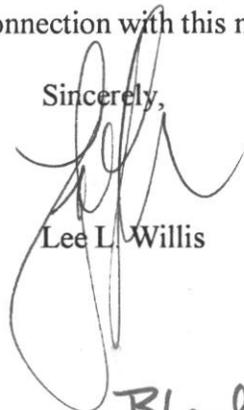
Enclosed for filing in the above proceeding on behalf of Tampa Electric Company are ten (10) copies of the following:

1. Rebuttal Testimony and Exhibit of Charles R. Black
2. Rebuttal Testimony of Thomas L. Hernandez
3. Rebuttal Testimony and Exhibit of W. L. Brown
4. Rebuttal Testimony and Exhibit of Mark D. Ward

Please acknowledge receipt and filing of the above by stamping the duplicate copy of this letter and returning same to this writer.

Thank you for your assistance in connection with this matter.

Sincerely,



Lee L. Willis

AFA _____
 APP _____
 CAF _____
 CMU _____
 CTR _____
 EAG _____
 LEG _____
 MAS _____
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 PAI _____
 SEG _____
 WAW _____
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LLW/bjd
Enclosures
37 cc's
All Parties of Record (w/encl.)

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Ward
DOCUMENT NUMBER - DATE
13386 NOV - 1 99
FPSC-RECORDS/REPORTING

Brown
DOCUMENT NUMBER - DATE
13385 NOV - 1 99
FPSC-RECORDS/REPORTING

Black *Hernandez*
DOCUMENT NUMBER - DATE DOCUMENT NUMBER - DATE
13383 NOV - 1 99 13384 NOV - 1 99
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of Tampa Electric Company's Rebuttal Testimonies of Charles R. Black, Thomas L. Hernandez and W. L. Brown have been furnished by hand delivery (*) or U. S. mail this 1st day of November, 1999 to the following:

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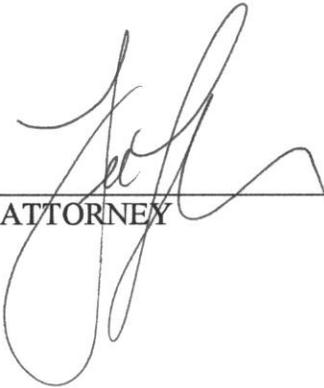
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ATTORNEY

ORIGINAL

TAMPA ELECTRIC COMPANY

DOCKET NO. 990001-EI

FILED: 11/1/99

1 BEFORE THE FLORIDA PUBLIC SERVICE COMMISSION

2 PREPARED REBUTTAL TESTIMONY

3 OF

4 CHARLES R. BLACK

5
6 Q. Please state your name, address, occupation and employer.

7
8 A. My name is Charles R. Black. My business address is 702
9 North Franklin Street, Tampa, Florida 33602. I am Vice
10 President-Energy Supply for Tampa Electric Company
11 ("Tampa Electric" or "company").

12
13 Q. Are you the same Charles R. Black who submitted testimony
14 in this proceeding on October 1, 1999?

15
16 A. Yes, I am.

17
18 Q. What is the purpose of your rebuttal testimony in this
19 proceeding?

20
21 A. The purpose of my testimony is to point out that the
22 position and certain statements made by Florida
23 Industrial Power Users Group ("FIPUG") witness Kent D.

DOCUMENT NUMBER-DATE

13383 NOV-1 99

FPSC-RECORDS/REPORTING

1 Taylor regarding the Gannon Unit 6 accident are false and
2 are inconsistent with sound regulatory policy.

3
4 Q. Have you prepared an exhibit to your testimony?

5
6 A. Yes, I have. My rebuttal Exhibit No. ____ (CRB-2) was
7 prepared under my direction and supervision and consists
8 of one document.

9
10 Q. What do you disagree with in Mr. Taylor's testimony?

11
12 A. FIPUG's witness incorrectly states that Tampa Electric
13 has not presented evidence to support the recovery of
14 fuel and purchased power associated with the Gannon Unit
15 6 accident. Tampa Electric has responded to every
16 interrogatory and production of document request related
17 to the accident in a timely manner. My pre-filed
18 testimony and the testimony of Mark D. Ward provides
19 evidence necessary to support the appropriateness of
20 recovery for replacement fuel and purchased power.

21
22 Q. Do you agree with Mr. Taylor's conclusion that the OSHA
23 investigation has placed responsibility for the explosion
24 on Tampa Electric?

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A. No. OSHA placed the responsibility for the explosion on an inadequate job briefing by the work crew's supervisor on the morning of the accident. While Tampa Electric received a citation containing four items from OSHA as a result of its investigation of Gannon Station, only one item was directly related to the accident that occurred on April 8, 1999. OSHA attributed the accident to an inadequate job briefing by the work crew's supervisor on the morning of the accident in that the work procedures and hazards involved were not discussed adequately.

Q. Please discuss each of the OSHA citations in more detail.

A. The scope of OSHA's investigation arising out of the April 8, 1999 accident involved Gannon Station. OSHA also conducted a separate and later investigation of Big Bend Station. Four of the citations received by the company related solely to Big Bend Station observations associated with work area activities. Specifically, these Big Bend Station citations related to the company's lack of development and implementation of an emergency response plan for electro-hydraulic fluid, the lack of identification on

1 certain nonpotable water pipes, poor housekeeping and
2 inadequately enclosed sprocket wheels and chains at
3 Big Bend Unit 4. None of these citations relate in
4 any way to the accident at issue in this proceeding.
5

6 **Q.** Please describe the OSHA citation that related to Gannon
7 Station.
8

9 **A.** As I mentioned above, only one violation directly related
10 to the accident. That was Citation 1, Item 1, which
11 states that:
12

13 The briefing conducted by the person in charge
14 did not cover the hazards associated with the
15 job, work procedures involved, and special
16 precautions associated with the work to be
17 performed. For the work being conducted at the
18 Tampa Electric Company, Gannon Station, Unit #6
19 Generator, the briefing that was conducted on the
20 morning of April 8, 1999 did not effectively
21 cover, or inform members of the maintenance crew,
22 of the following hazards associated with the job,
23 or special precautions and work procedures
24 associated with the job.

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Q. Please describe Citation 1, Item 2A and 2B.

A. Citation 1, Items 2A and 2B were combined and relate to procedures that existed and are used for the control of potentially hazardous energy. The documented procedures for which employees were trained did not contain specific written procedures for shutting down and securing equipment to control hazardous energy nor did they include written procedures for testing equipment to determine and verify the effectiveness of energy control measures and tag out devices. These procedures were not related to the cause of the accident. These procedures come into play after the decision is made to release the equipment for the required maintenance. These procedures assure the desired state of shut down occurs before the placement of a tagging device indicating the machine or equipment is ready for the required maintenance.

Related to the accident, there had been no request that the equipment be tagged out and therefore the subsequent procedures to accomplish the shut down and placement of the tag simply did not come into play.

1 The tagging procedures would come into operation only
2 after the unit had been purged of hydrogen and then
3 checked to be sure the equipment was shut down,
4 isolated, blocked and secured. A tag then would be
5 issued which would then be signed by the supervisor who
6 would then advise the crew it was safe to proceed. The
7 particular concern here was that the procedures for
8 physically shutting down and securing the equipment
9 were not specified in writing. However, the procedures
10 are well known and, in fact, are used by the company to
11 physically shut down and secure equipment before
12 equipment is tagged and released to maintenance.

13
14 Q. Please discuss Citation 1, Item 3.

15
16 A. Citation 1, Item 3 cited the company for not conducting
17 an annual inspection of the energy control procedure,
18 which is a technical violation and unrelated to the
19 accident.

20
21 Q. Please discuss Citation 1, Item 4.

22
23 A. Citation 1, Item 4 related to the company's tagging
24 procedures in place at the time of the accident. The

1 tagging procedure used by Tampa Electric at the time of
2 the accident is consistent with that used throughout the
3 electric utility industry. OSHA, the Edison Electric
4 Institute (the electric utility trade association), and
5 the IBEW International had been engaged for a number of
6 years in ongoing discussions with respect to the
7 applicability of certain aspects of the OSHA "lock out,
8 tag out" standard to the industry. That issue was
9 finally clarified by OSHA in a directive issued on
10 October 14, 1999.

11
12 The central issue here is whether a supervisory tagging
13 system or a group tag out system was the appropriate
14 procedure in light of the industry's belief that the
15 supervisory tagging system met the system operator
16 provisions of the applicable OSHA standard. Tampa
17 Electric and the rest of the utility industry followed
18 the system operator system which allowed, but did not
19 require, each crew member to sign the tag before working
20 on a piece of equipment. OSHA did not finally clarify
21 its position on this issue until well after this
22 accident. Consequently, we believe that it is entirely
23 inappropriate to consider in any way a measure which
24 could be received as an improvement to the system and,

1 which in hindsight, may now be considered the appropriate
2 procedure to follow.

3
4 **Q.** Did Tampa Electric have specific written instructions with
5 respect to the required job briefing by the person in
6 charge?

7
8 **A.** Yes, most definitely. Such instructions are clearly
9 provided in the Company's Safe Practice Procedures
10 Manual. These instructions are included in my exhibit
11 entitled "Job Planning Procedure."

12
13 **Q.** What was the experience level of the person who was
14 required to provide the briefing on the morning of the
15 accident?

16
17 **A.** The person who was in charge is a well respected and
18 experienced supervisor who had been in a supervisory
19 position for many years and who had supervised this same
20 maintenance job numerous times. Since long prior to the
21 April 8, 1999 accident, Tampa Electric has had in place a
22 training program designed to insure that work crew
23 supervisors provide adequate job briefings prior to work
24 commencement. This supervisor was well aware of the

1 condition of the unit and was responsible for requesting
2 that the generator be tagged out for the crew. He had
3 not made that request at the time of the briefing and did
4 not advise the crew of the status of the generator.

5
6 **Q.** Was the job briefing held on the day of the accident?

7
8 **A.** Yes. However, while the supervisor believed he
9 communicated to the crew the status of the generator, the
10 crew understood his remarks differently. While the crew
11 was not given specific instruction to proceed to open the
12 access cover to the generator, from the best we have been
13 able to ascertain, the employee who opened the cover made
14 the decision to proceed based on his belief it was safe
15 to do so after the briefing.

16
17 **Q.** What action should the Commission take in this proceeding
18 with respect to the Gannon 6 accident?

19
20 **A.** The Commission should allow the full cost of recovery of
21 replacement fuel and purchased power which was required
22 as a result of the accident. The accident was the result
23 of an unfortunate miscommunication by a valued and
24 dedicated employee and certainly was not the result of

1 any willful misconduct by anyone. The supervisor
2 responsible is well trained with many years of experience
3 in performing and supervising generator maintenance. The
4 specific job briefing required is clearly set out in
5 written instructions in the company's Safe Practices
6 Manual. The company had a history over the years of
7 safely performing generation maintenance before this
8 accident occurred.

9
10 This accident was not caused by management's imprudence.
11 The company had the appropriate procedure in place, but
12 in this situation, all of the necessary elements of the
13 "Job Planning Procedure" were not covered. It is
14 important to define responsibility in a way that permits
15 a regulated utility to continue to conduct its affairs
16 consistent with the realities of company rights and
17 obligations. Unlike unregulated private industry, public
18 utilities are not entitled to benefits of uneconomic
19 gains nor are they free from a duty to deliver service.
20 It would not be fair then to saddle a utility with the
21 burden of economic loss in a case like this. There is no
22 evidence of a cavalier or irresponsible attitude by Tampa
23 Electric or any of its employees toward efficiency or
24 safety. Indeed a very high standard of care is the

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general rule at Tampa Electric in all matters, and particularly, related to safety.

The real cause of the accident was not any management deficiency, procedural or otherwise but on unfortunate miscommunications between dedicated, hard working, and experienced employees.

Q. Does this conclude your testimony?

A. Yes, it does.

**Rebuttal Exhibit No. ____ (CRB-2),
Document No. 1**

Job Planning Procedure



Tampa Electric Company

SAFE WORK PRACTICES

SECTION 100 GENERAL

EXHIBIT NO. _____
DOCKET NO. 990001-EI
TAMPA ELECTRIC COMPANY
(CRB - 2)
DOCUMENT NO. 1
FILED: 11/1/99
PAGE 1 OF 2

- .03 Maintain adequate ventilation when work tasks such as cleaning, etc., may create potential airborne irritants.
- .04 Maintain good housekeeping and minimize dusts and particulates. Avoid exposures through restricted uses of aerosols, solvents or other vapor producing products.
- .05 Report unusual conditions or concerns to Building Services Dept. or your supervisor.

128 JOB PLANNING

- .01 The employee in charge shall conduct a job briefing with the employees involved before they start each job. The briefing shall cover at least the following subjects: hazards associated with the job, work procedures involved, special precautions, energy source controls, and personal protective equipment requirements.
- .02 The person in charge shall assemble the crew and explain the work to be done, outline the steps to be followed, personal protective equipment required, and point out the hazards of the job. The person in charge should ensure that each member of the crew understands the instructions.
- .03 If the work or operations to be performed during the work day or shift are repetitive and similar, at least one job briefing shall be conducted before the start of the first job of each day or shift. Additional job briefings shall be held if significant changes, which

might affect the safety of the employees, occur during the course of the work.

- .04 A brief discussion is satisfactory if the work involved is routine and if the employee, by virtue of training and experience, can reasonably be expected to recognize and avoid the hazards involved in the job. A more extensive discussion shall be conducted: if the work is complicated or particularly hazardous, or if the employee cannot be expected to recognize and avoid the hazards involved in the job.

- .05 An employee working alone need not conduct a job briefing. However, the employee shall ensure that the tasks to be performed are planned as if a briefing were required.

- .06 The person in charge is responsible for accounting for all employees upon the completion of each job.

129 LADDERS

- .01 Only approved ladders shall be used in a safe manner. Manufacturers' weight limit shall not be exceeded.
- .02 Ladders shall be visually inspected before they are used.
- .03 Defective ladders shall be tagged and removed from service. If they are not repairable, they shall be destroyed.