FILED 11/15/2021
DOCUMENT NO. 12709-2021
FPSC - COMMISSION CLERK

BEFORE THE FLORIDA PUBLIC SERVICE COMMISSION

In re: Fuel and Purchased Power Cost Recovery Clause and Generating Performance Incentive Factor	Docket No. 20210001-EI Filed: November 15, 2021

DUKE ENERGY FLORIDA, LLC'S
POST-HEARING STATEMENT AND BRIEF

Duke Energy Florida, LLC ("DEF"), pursuant to Order No. PSC-2021-0403-PHO-EI, hereby files with the Florida Public Service Commission ("Commission") its Post-Hearing Statement of Issues, Positions, and Brief in this matter. The sole remaining issue in this proceeding is, essentially, whether DEF acted prudently with respect to an outage earlier this year at Crystal River Unit 4 ("CR4"). The evidence (most of which is undisputed) clearly proves the prudence of DEF's actions. The Intervener Group attempts to Monday-morning quarterback the operator's actions, conveniently forgetting that the operator *did not* and *could not* have known that a Beckwith manual sync check relay located approximately a mile and a half from the operator room, which had just passed inspection months earlier, had unexpectedly failed. The Intervener Group also jumps to inadequate training and lack of adequate procedures to try and pin the incident on the Company, because apparently there should have been a policy in place to explain how to handle a synchronization re-set to govern the unforeseen failure of a highly reliable component. There are over 15,000 parts in an operating power plant – it is unreasonable and infeasible for the Company to create a policy that covers every possible failure of a component. The Intervener Group's arguments essentially take the Root Cause Report, a document created for the Company's operational purposes and not for regulatory or legal purposes, to try and string together an argument of imprudence using hindsight review and the benefit of knowledge that the operator could not have known. In support, DEF states as follows:

I. **Procedural Posture**

At the November 2, 2021 hearing, this Commission approved DEF's requested fuel and capacity costs and DEF's proposed 2022 fuel and capacity cost recovery factors as filed. The sole remaining issue for the Commission's determination is Issue 1C: "Has DEF made appropriate adjustments, if any are needed, to account for replacement power costs associated with the January 2021 to April 2021 Crystal River Unit No. 4 (CR4) outage? If appropriate adjustments are needed and have not been made, what adjustments should be performed?"

In its Prehearing Statement, DEF took the position that no adjustments were needed. The Office of Public Counsel ("OPC") and Florida Retail Federation ("FRF") took the position that DEF had not made the appropriate adjustments to account for the replacement power costs and has not demonstrated that DEF's actions related to the outage were reasonable and prudent or that the costs should be borne by customers. Florida Industrial Power Users Group ("FIPUG") and White Springs Agricultural Chemicals, Inc. d/b/a PCS Phosphate-White Springs ("PCS Phosphate") adopted the position of OPC.[1] Commission Staff, Florida Power & Light ("FPL"), Florida Public Utilities Company ("FPUC"), Gulf Power Company ("GULF"), Tampa Electric Company ("TECO"), and Nucor Steel Florida, Inc. ("NUCOR") took no position on this issue.[2]

II. **Issue and Position[3]**

[1] OPC, FIPUG, PCS Phosphate, and FRF will collectively be referred to herein as the "Intervener Group."

[2] See Prehearing Order No. PSC-2021-0403-PHO-EI

[3] As noted above, at the November 2, 2021 hearing, the Commission took action on all DEF-related issues presented for resolution with the exception of Issue 1C. Therefore, there are no further required Commission actions on those issues, and they will not be addressed herein.

Issue 1C: Has DEF made appropriate adjustments, if any are needed, to account for replacement power costs associated with the January 2021 to April 2021 Crystal River Unit No. 4 outage? If appropriate adjustments are needed and have not been made, what adjustments should be performed?

DEF: ** No adjustments are necessary because DEF's actions related to the outage were reasonable and prudent. The testimony and exhibits clearly demonstrate that DEF could not have known that the highly reliable Beckwith manual sync check relay failed. While the operating procedures were changed as a result of this incident, it was not reasonably foreseeable for DEF to have planned for this unexpected failure in advance of the incident at issue. ****

III. Brief in Support of DEF's Position.

As the utility seeking to recover its fuel costs, DEF has the burden of proving by a preponderance of the evidence that it was prudent in its actions and decisions. *In Re: Investigation into Extended Outage of Fla. Power & Light Company's St. Lucie Unit No. 1.*, 85 FPSC 12:284 (Dec. 23, 1985); *Fla. Power Corp. v. Cresse*, 413 So. 2d 1187, 1191 (Fla. 1982). The standard for determining prudence is what a reasonable utility manager would have done, in light of the conditions and circumstances that were known, or should have been known, at the time the decision was made. *S. Alliance for Clean Energy v. Graham*, 113 So. 3d 742, 750 (Fla. 2013). Hindsight cannot form the basis of a prudence determination. *Fla. Power Corp. v. Public Service Comm'n*, 456 So. 2d 451, 452 (Fla. 1984).

DEF met its burden and demonstrated by a preponderance of the evidence that it was prudent in its operation of CR4 and should recover its replacement power costs. Specifically, DEF submitted the testimony (pre-filed and live) of Joseph Simpson, an engineer with 15 years in the industry and actual experience in the control room when generating units, like CR4, are started. (Tr. p. 440, ll. 19-23).[4] DEF also submitted various exhibits to meet its burden of proof. No Intervener Group submitted testimony to rebut Mr. Simpson's testimony regarding the prudence of DEF's actions.

A. <u>The Root Cause Analysis, and Mr. Simpson's Testimony and Exhibits, demonstrate that DEF was Prudent at all times in Operating the Unit.</u>

On December 17, 2020, as CR4 was being brought back on-line following a planned outage, the CR4 generator failed to synchronize (sync) with the power system when the breaker closed, resulting in an out of phase event. (Tr. p. 335, ll. 9-11). Generator synchronization is the process of connecting the generator to the 230kV transmission or power system by matching the generator and power system's electrical parameter. During synchronization, the generator voltage and frequency are adjusted to match the system voltage and frequency, and the angle is monitored to ensure the breaker close circuit is completed when the angle "matches." Closely matching these parameters ensures torques are minimized as the power system begins to govern the prime mover's rotating field. (*Id.* at ll. 11-18). After electrical testing, the unit was placed in reserve shutdown as it was not needed to serve system demand until January 7, 2021; when DEF attempted to bring the unit back on-line, the damage[5] to the generator rotor resulting from the out of phase event was discovered; given the type of damage at issue, this is the earliest date the damage could have been

---

[4] Citations to the Nov. 2, 2021 Hearing Transcript are provided in the following format: Transcript page(s), and line(s) (*e.g.,* Tr. p. XX, ll. A-B); hearing exhibits are cited as identified in the Comprehensive Exhibit List (Ex. 1).

[5] Based on questioning from PCS Phosphate's counsel, it appears they intend to sensationalize the extent of the damage. (Tr. pp. 434-36; pp. 442-43). DEF does not dispute that the out-of-phase sync caused damage, but the extent of the damage, or the "size" of the impact caused by the damage, is frankly irrelevant to the determination at hand. DEF's actions should be judged by what the operator knew, or should have known, at the time he tried to re-set the sync switch after the failed auto sync attempts and whether DEF's actions in light of that knowledge were prudent.

discovered. (*Id.* at p. 335, ll. 10-11; p. 364, ll. 13-22; p. 366, ll. 1-19). The resulting outage lasted until March of 2021.

Standard, preferred operating Procedure for CR4 is to synchronize the unit to the grid in automatic mode, but it does permit manual synchronization. Manual synchronization has been used at CR4 both before and after this event. (*Id.* at p. 335, ll. 19-24). Prior to the event, the operator attempted three (3) times to synchronize the unit in automatic mode.[6] After the attempts were unsuccessful, the operator green-flagged the breaker and placed the sync switch in manual mode. The operator then red-flagged breaker 3233 expecting a failed synchronization allowing repositioning of the sync switch handle back to automatic. Unknown to, and unknowable by, the operator, the Beckwith manual sync check relay ("Beckwith relay") had failed, allowing the breaker close circuit to be completed, causing the turbine/generator to attempt to sync to the grid out of phase. (*Id.* at p. 336, ll. 1-11; p. 450, ll. 4-17; Ex. 8, at pp. 2-3).

As more thoroughly discussed in DEF's Root Cause Analysis (the "RCA", Ex. No. 8), there were two Root Causes of the occurrence: (1) failure of a component, specifically the Beckwith relay; and (2) the previous success in the use of a rule reinforced to continued use of the rule. As explained by Mr. Simpson, the RCA's "sole purpose is to identify the cause of the event with the intent of preventing future similar issues from occurring . . . and was not done to support any regulatory proceeding." (Tr. p. 336, ll. 21-23 & p. 337, ll. 5-7; *see* Ex. 8, p. 1[7]).

[6] OPC spent a significant amount of time questioning Mr. Simpson about the various timestamps included in the RCA associated with these various steps. (Tr. pp. 404-08; pp. 413-17). However, Mr. Simpson testified the time stamps may vary depending on the internal clock of the particular device or component from which the data point was taken. (*Id.* at p. 404, l. 25 – p. 405, l. 5; Tr. 415, l. 25 – p. 417, l. 11). Thus, the exact timestamps provided in the table are of little import, as "a man with two watches never knows the time." (*Id.* at p. 405, l. 3; *see* Tr. 415, l. 25 – p. 417, l. 11). To the extent OPC intends to argue that the operator rushed through or did not actually perform the automatic sync process properly, there is absolutely no evidence in the record to support such an argument. In fact, the only evidence in the record, Mr. Simpson's testimony, firmly rejects such a conclusion. (*See id.* at p. 406, ll. 2-25; p. 407, l. 13 – p. 408, l. 2; p. 414, ll. 8-14).

[7] The disclaimer language from the cover page of the RCA provides:

1. <u>The First Root Cause, Failure of a Component, was not Reasonably Foreseeable to DEF.</u>

As to the first root cause identified, the Beckwith relay is supposed to prevent the generator/unit from attempting to sync to the grid in an out-of-phase condition; that is, ***its purpose is to prevent exactly what occurred*** at CR4. The Beckwith relay is a highly reliable component designed with the aerospace industry with extremely low known incidents of failure, so the failure was unforeseen and unforeseeable prior to the event. (Tr. p. 338, ll. 4-8; p. 341, ll. 8, 13-21; p. 449, ll. 4-13). DEF regularly tested the relay, performing such testing even more often than would be required by NERC had the Beckwith relay been a part of the Bulk Electric System (which it is not), and in fact it was found to be operating properly when tested just six (6) months prior to the incident. (*Id.* at p. 341, ll. 8-11). At some point between the most recent testing and the incident, a soldered component of the relay failed, as confirmed by the component's manufacturer. (*See id.* at ll. 11-13; Ex. No. 9). Unfortunately, the operator had no way to know of the Beckwith relay failure and if the unit had synced to the grid in automatic mode, or if the operator had red-flagged the breaker within the range for synchronization (i.e., just one second later), DEF would still be

---

This cause analysis evaluates important conditions adverse to quality through the use of a structured evaluation process. The information identified in this report was discovered using all the data available to the root cause evaluation team at the time of writing using the benefit of hindsight. Cause analyses performed after the fact for Duke Energy have been established as a responsive means to document and assure that conditions adverse to quality are promptly identified and corrected and, as required, to assure that actions are taken to reduce the risk of repetition of the event or condition adverse to quality.

As such, this cause analysis is not intended to make a determination as to whether any of the actions taken or the decisions made by management, vendors, internal organizations, or individual personnel prior to or at the time of the event were reasonable or prudent based on the information that was known or available at the time they took such actions or made such decisions. Any individual statement or conclusion included in the evaluation as to whether errors may have been made or improvements are warranted is based solely upon information the root cause team considered, including information and results learned after-the-fact. Nothing in this evaluation should be construed as an admission of negligence, liability, or imprudence.

unaware of the failure and the event may well have occurred at a later date. (Tr. p. 339, ll. 6-9; p. 341, ll. 13-14; p. 374, l. 23 - p. 375, l. 6).

The Intervener Group, apparently recognizing that the unexpected failure of this highly reliable relay is the weakest part of their case, attempted to call into question the vintage of the relay, arguing that it was "salvaged." (Tr. p. 357, ll. 20-25). Mr. Simpson, the only witness testifying on this matter, disputed the characterization of the relay as "salvaged." (*Id.* at p. 358, ll. 1-13). Rather, the Beckwith relay, because it was frequently tested and so reliable, was prudently removed from a retired substation and placed in another substation at the same site. (*Id.*). As a regulated utility, bound to spend its customers' dollars prudently, the Commission and groups representing DEF's customers expect DEF to utilize all assets, paid for by customers, to the fullest extent possible. The relay has no manufacturer-identified expected life and is so reliable the manufacturer provides no recommended testing cadence. (*Id.* at p. 451, ll. 8-13; p. 352, ll. 1-4; p. 354, l. 5 – p. 355, l. 6). Nonetheless, DEF's internal policies call for the component to be inspected at least every 6 years (*id.* at p. 352, ll. 4-7), and in practice it is inspected more often than this policy requires. (*Id.* at p. 354, ll. 13-21 ("When a generating facility is off-line and outage schedules, they vary, sometimes 18 months, sometimes 24 months, but if you have the opportunity and the unit is off-line, it's never a bad thing to test more frequently. So depending on outage schedules and the resource availability, they were tested multiple times, much more than the manufacturer would recommend -- I am sorry, much more than NERC would recommend or require."). Thus, with no manufacturer-stated lifetime and no evidence of equipment degradation from periodic testing, there is no compelling reason to replace the relay solely based on age.

The bottom line is the argument that the Beckwith relay was "salvaged" and should have been replaced prior to its failure is a red herring intended to distract from the fact that the Beckwith relay is highly reliable and there was no reason for the operator, or DEF, to have known that it had failed. (*See, e.g., id.* at p. 450, ll. 4-17).

Because DEF prudently inspected and maintained the Beckwith relay, this first root cause was beyond DEF's reasonable ability to control or prevent.

2. <u>The Second Root Cause, Previous Successes in Use of Rule Reinforced Continued Use of Rule, was a Human Performance Error beyond DEF's Reasonable Control as the Operator was Properly Trained and DEF had Appropriate Policies and Procedures in Place, and the Error Would Not Have Resulted in Damage Absent the Unforeseeable Failure of the Beckwith Relay</u>.

The second identified root cause is essentially another way of saying the operator had previously performed a task in a certain way with no adverse consequences, and therefore believed it there would be no adverse results in this instance. (Tr. p. 338, ll. 8-12). The operator believed the generating unit would not be permitted to attempt synchronization to the grid even if it was red-flagged (i.e., the breaker commanded to close) because the Beckwith relay would prevent out of phase synchronization and allow the operator to reset the unit to automatic and continue the sync attempt in automatic configuration. (*Id.* at ll. 16-21). As Mr. Simpson explained, manual synchronizations are not always successful, but when an operator has a failed manual sync attempt and the sync check relay operates properly, the synchroscope simply continues its revolution until the next potential window for an additional sync attempt. (Tr. p. 446, ll. 15-23). This is what the operator expected to occur based on past experience, and had the Beckwith relay functioned properly, this is what would have occurred. (*Id.* at ll. 6-25; p. 340, ll. 6-10, 17-21; p. 374, ll. 23-24).

During cross-examination, the OPC asked a series of questions exploring the "Contributing Causes" identified in Section VI of DEF's RCA in an apparent effort to argue that the Operator and/or the Operations Team Supervisor ("OTS") was/were improperly trained or provided inadequate procedures to guide their actions (*see, e.g., id.* at pp. 383-96); however, as Mr. Simpson explained at hearing, for a number of reasons this line of questioning represents a failure to understand both the RCA's findings and ultimate conclusions as well as the Operator's training and experience.

As described above, the RCA determined that there were two root causes of the event – failure to adequately train either the Operator or OTS was ***not*** identified as a root cause, rather "Practice or 'hands-on' experience LTA[8]" of the OTS (not the operator, *see id.* at p. 386, ll. 5-10; Ex. 8, p. 4) was identified as one (1) of seven (7) contributing causes. A contributing cause in an RCA is an issue identified by the team that should be addressed through a corrective action, procedural enhancement, or some other action in the interests of continual improvement, but whether it occurred or not, the outcome of the event would have been the same -- i.e., it did ***not*** cause the event being investigated. (*See* Tr. p. 395, l. 16 – p. 397, l. 3; p. 447, l. 12 – p. 448, l. 3; Ex. 8). Of course, the purpose of DEF's Corrective Action Program is to continually evaluate and improve performance and processes (Tr. p. 426, ll. 16-24; p. 447, l. 12 – p. 448, l. 3; Ex. 8, p.1), and therefore the contributory causes and associated corrective actions represent prudent utility management, but inclusion of those issues in the RCA should not be understood as agreeing either expressly or by implication that they caused the event[9] – they did not and there is no evidence to the contrary.

Moreover, in contrast to the portrayal of the Operator as inadequately trained or experienced, DEF provided documentation showing completed training courses spanning more

[8] "Less than Adequate". (*See* Tr. p. 372, ll. 17-10).

[9] Indeed, as Commissioner Fay correctly pointed out at hearing, simply because an action is taken after an event occurs, it is not a recognition that the action is intended to correct a cause of the event. (*See* Tr. p. 448, ll. 17-23).

than twenty (20) years in the industry,[10] including fifteen (15) as an operator (*see* Ex. 54),[11] as well as Mr. Simpson's testimony describing the operator as highly qualified and experienced. Mr. Simpson explained that the Operator is "highly regarded by his peers and leadership", that he has both management and journeyman experience in his 15 years of operator experience, and that he is frequently "stepped-up" to perform oversight responsibilities when an absence occurs or a special project is undertaken. (*See* Tr. p. 452, ll. 8-20). Over his 15+ years of operating, the Operator would have had numerous occasions to start the machine and get it on-line. (*See id.* at p. 400, ll. 19-22; p. 372, l. 21 – p. 373, l. 17).

Mr. Simpson received questions regarding the adequacy of the operating procedures available to the operator, based in part on a contributing cause identified in the RCA.[12] However, Mr. Simpson explained that all of the substantive information necessary to perform the task was included within the procedure in question and the issue that required a corrective action was one of "branching" or the mapping of the process. (*See id.* at p. 388, l. 5 – p. 389, l. 3). That is, the procedure directed the operator to an enclosure which contained certain steps for the operator to follow, but then that enclosure failed to specifically direct the operator to return to the main body of the procedure after completing the steps provided in the enclosure. (*See id.*). As such, the procedure was complete in the sense that all relevant information the operator required was included, but "incomplete" when it came to providing an easy to follow sequence for the operator to follow. Like with the other contributing causes discussed above, the RCA team determined that

[10] The twenty (20) years includes a three (3) year hiatus where the operator was employed by another utility performing analogous responsibilities. (Tr. p. 379, ll. 10-15).

[11] Notably, the twelve (12) pages of training courses completed by the operator, do not include on-the-job training or simulator sessions (Tr. p. 377, ll. 18-19), but nevertheless include over 500 discrete training sessions. (*See* Ex. 54, pp. 20212001-DEF-000075 – 2021-DEF-000086).

[12] "A5B2C08 – Incomplete/situation not covered." (*See* Ex. 8, p. 4; Tr. p. 388).

this issue presented an opportunity to enhance an existing procedure, but also determined it was not a root cause of the event and the event would have occurred regardless. (*See* Ex. 8; Tr. p. 447, l. 12 – Tr. p. 448, l. 23; *supra* p. 9).

Finally, Staff asked a series of questions regarding whether the operator properly followed the procedure for syncing to the unit to the grid. (*See* Tr. pp. 444-47). Mr. Simpson explained that the operator was not attempting to manually sync the machine at the time of the event; rather, he was engaged in troubleshooting regarding the failed auto sync attempts and was attempting to return to a known condition to reset the auto sync function. (*Id.* at p. 444, ll. 9-21; p. 445, ll. 12-24). Mr. Simpson explained that troubleshooting is not an activity that lends itself to a written procedure, as it is based on identifying potential causes of the issue (in this case, failure to automatically sync to the grid) and then systematically eliminating those potential causes until the issue is resolved. (*Id.* at p. 453, ll. 6-11 ("So, you know, a very basic analogy: I went into my bedroom and the light didn't turn on. Okay, what could it be? Do I have a bad switch? Do I have a bad breaker? Do I have a bad bulb? You know, those are the things you systematically eliminate them until the problem is resolved.")).[13] As noted above, the operator on shift was experienced, highly regarded, and had the support of the on-shift OTS during the trouble-shooting process. (*See,* Tr. p. 445, l. 25 – p. 446, l. 4; *supra* p. 10).

Thus, while the operator was performing a task that does not lend itself to being governed by a readily identifiable checklist, he was able to rely on years of experience and the ability to collaborate with other qualified employees until he was able to return to a "known state" governed by written processes.

[13] Underscoring the impracticality, if not impossibility, of creating a process to govern troubleshooting is the fact that the operator is responsible for monitoring some 40 DCS screens and more than 15,000 components that could be causing whatever issue is being resolved. (*See* Tr. p. 405, ll. 13-17).

Because DEF prudently trained the operator and provided proper and adequate policies and procedures, this second root cause was not within the reasonable control of DEF.

IV. Conclusion

As demonstrated by the record in this proceeding, DEF was at all times prudent in its operation of CR4, including its inspection and maintenance of the facility, the training of its employees, and the development of reasonable and appropriate processes and procedures. As DEF has acted prudently, it should be permitted to recover its prudently incurred replacement power costs.

RESPECTFULLY SUBMITTED this 15th day of November, 2021.

s/ Matthew R. Bernier
DIANNE M. TRIPLETT
Deputy General Counsel
299 1st Avenue North
St. Petersburg, Florida 33701
T: (727) 820-4692
F: (727) 820-5041
E: dianne.triplett@duke-energy.com
MATTHEW R. BERNIER
Associate General Counsel
106 East College Avenue, Suite 800
Tallahassee, Florida 32301
T: (850) 521-1428
F: (727) 820-5041
E: matthew.bernier@duke-energy.com
STEPHANIE A. CUELLO
Senior Counsel
106 East College Avenue, Suite 800
Tallahassee, Florida 32301
T: (850) 521-1425
F: (727) 820-5041
E: Stephanie.Cuello@duke-energy.com
FLRegulatoryLegal@duke-energy.com

Attorneys for Duke Energy Florida, LLC

CERTIFICATE OF SERVICE
Docket No. 20210001-EI

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished via electronic mail to the following this 15th day of November, 2021.

Suzanne Brownless / Stefanie Jo Osborn
Office of General Counsel
FL Public Service Commission
2540 Shumard Oak Blvd.
Tallahassee, FL 32399-0850
sbrownle@psc.state.fl.us
sosborn@psc.state.fl.us

J. Beasley / J. Wahlen / M. Means
Ausley McMullen
P.O. Box 391
Tallahassee, FL 32302
jbeasley@ausley.com
jwahlen@ausley.com
mmeans@ausley.com

Russell A. Badders
Gulf Power Company
One Energy Place, Bin 100
Pensacola, FL 32520-0100
russell.badders@nexteraenergy.com

Kenneth A. Hoffman
Florida Power & Light Company
134 W. Jefferson Street
Tallahassee, FL 32301-1713
ken.hoffman@fpl.com

Jon C. Moyle, Jr.
Moyle Law Firm, P.A.
FIPUG
118 North Gadsden Street
Tallahassee, FL 32301
jmoyle@moylelaw.com
mqualls@moylelaw.com

Peter J. Mattheis / Michael K. Lavanga
Stone Mattheis Xenopoulos & Brew, PC
Nucor
1025 Thomas Jefferson Street, NW
Suite 800 West
Washington, DC 20007-5201

R. Gentry / P. Christensen / A. Pirrello / S. Morse / C. Rehwinkel / M. Wessling
Office of Public Counsel
111 W. Madison St., Room 812
Tallahassee, FL 32399-1400
christensen.patty@leg.state.fl.us
morse.stephanie@leg.state.fl.us
rehwinkel.charles@leg.state.fl.us
pirrello.anastacia@leg.state.fl.us
gentry.richard@leg.state.fl.us
wessling.mary@leg.state.fl.us

Paula K. Brown
Regulatory Affairs
Tampa Electric Company
P.O. Box 111
Tampa, FL 33601-0111
regdept@tecoenergy.com

Maria Jose Moncada / David M. Lee
Florida Power & Light Company
700 Universe Blvd. (LAW/JB)
Juno Beach, FL 33408-0420
david.lee@fpl.com
maria.moncada@fpl.com

James Brew / Laura W. Baker
Stone Law Firm
White Springs/PCS Phosphate
1025 Thomas Jefferson St., N.W.
Suite 800 West
Washington, DC 20007
jbrew@smxblaw.com
lwb@smxblaw.com

Mike Cassel
Florida Public Utilities Company
208 Wildlight Avenue
Yulee, FL 32097
mcassel@fpuc.com

Beth Keating

mkl@smxblaw.com
pjm@smxblaw.com

Gunster, Yoakley & Stewart, P.A.
FPUC
215 South Monroe Street, Suite 601
Tallahassee, FL 32301
bkeating@gunster.com