IN THE SUPREME COURT OF FLORIDA

FLORIDA POWER CORPORATION,

Appellant,

vs.

GERALD L. GUNTER, JOSEPH P. CRESSE and JOHN R. MARKS, III, in their official capacity as and constituting the Florida Public Service Commission,

Appellee.
_____/

Appeal from an order of the Florida Public Service Commission

CASE NO. 64,209

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PRELIMINARY STATEMENT

Appellant Florida Power Corporation will be referred to in this brief as "FPC" or "the Company." Appellee Florida Public Service Commission will be referred to as "the PSC" or "the Commission."

References to the record on appeal will be indicated as "R." References to the transcript of the hearings will be indicated as "Tr." Commission Order No. 9775, dated January 30, 1981, will be referred to as the "O." and a copy is set forth in the Appendix to this Brief at Tab 1. The opinion of the Florida Supreme Court in this case, dated December 16, 1982, will be referred to as the "Op." and a copy is set forth in the Appendix at Tab 2. Commission Order No. 12240, dated July 13, 1983, will be referred to as the "R.O." and a copy is set forth in the Appendix at Tab 4. All references to the Appendix are designated "A. Tab ___."

All emphasis is supplied unless otherwise noted.

STATEMENT OF THE CASE

By Order No. 8482 dated September 15, 1978, the Florida Public Service Commission instituted an investigation of the March 1978 "loose parts" outage of FPC's Crystal River nuclear plant. The investigation ultimately focused upon an incident occurring during that outage when a test weight was accidentally dropped on a stored fuel assembly.

By Order No. 9775 dated January 30, 1981, the Commission imposed responsibility for this incident upon FPC's management, holding that "policies, decisions and procedures which were undisputedly the functions of management were lacking in this instance." [O. 5; A. Tab 1]. In particular, the Commission found that "the single most damaging indictment of those responsible for the activity" was their failure to classify the work as "safety-related" and to follow the stringent procedures required for the performance of such work.[1/] [O. 6]. The Commission concluded that FPC should be responsible for the incremental replacement fuel costs incurred during the period of the outage attributable to this incident.

1/ The term "safety-related" refers to "work involving the risk that radioactive material might be released outside the plant." [Op. 3; A. Tab 2].

Florida Power witnesses testified that this incident extended the original outage by a total of 14 days. No contrary evidence was presented. The Commission's engineering and legal staffs both recommended that the refund be limited to the fuel costs incurred during that 14 day period. [R. 351]. The Commission rejected this uncontroverted evidence and instead held that Florida Power failed to prove that the time expended on certain other activities was necessary. [O. 7]. On this basis, the Commission concluded that "55 days of the forced outage must be associated with the dropped test weight incident." [O. 10].

Based on these findings, the Commission required Florida Power to refund $11,056,000 in replacement fuel costs to its customers.[2/]

On December 16, 1982, this Court reversed the Commission's Order. Florida Power Corporation v. Public Service Commission, 424 So.2d 745 (Fla. 1982). [A. Tab. 2]. Among other things, the Court rejected the PSC's "post-accident" determination that this test activity should have been labeled "safety-related," stating that:

2/ The initial refund of $12,859,251 was later reduced to $11,056,000. Order No. 9936, dated April 8, 1981.

> Our independent review of the record discloses that the particular task which resulted in the accident was but a small part of the extended repairs to the fuel transfer mechanism. The record further indicates that the repair work, per se, was not safety-related, and this was, in part, why the use of the test weight was not recognized as being safety-related. [Op. 3].

The Court concluded that the Commission therefore incorrectly applied nuclear safety considerations which involved "a very different risk and a much higher standard of care than were involved in this case." [Op. 4].

The Court further held that the PSC improperly relied upon the notice of violation issued by the Nuclear Regulatory Commission (NRC), and upon the report of FPC's nuclear general review committee (NGRC), a committee set up pursuant to NRC requirements. Noting that both reports were issued after the accident, the Court declared that "hindsight should not serve as the basis for liability in this instance." [Op. 4]. The Court also noted that both reports focused on nuclear safety-related concerns. Finally, the Court emphasized that the purpose of the NGRC's report was "not to find fault" but to suggest improved procedures after an accident occurs. Id. The Court concluded as follows:

> After a careful review of the record and of the PSC's order no. 9775, we believe that

> the PSC relied excessively on the NGRC report and the NRC notice of violation. While these documents are undoubtedly useful for numerous purposes, they should not serve as the primary source of evidence in a fault-finding determination. Such use of these documents would be analogous to using evidence of subsequent repairs and design modifications for the purpose of showing that the original design was faulty. This would clearly violate Florida's strong public policy in favor of post accident investigations. [Op. 4.]

Without reaching the other points on appeal, the Court reversed the order and remanded this cause to the PSC "for reconsideration in light of the views expressed in this opinion." [Op. 4].

On remand, briefs were filed with the Commission and oral argument was held on March 1, 1983. [A. Tab. 3]. Oral argument related almost exclusively to the question whether the PSC could rely on remand on the NRC and NGRC reports. [R. Vol. XIII].

By Order No. 12240 dated July 13, 1983, the Commission again imposed responsibility upon FPC management for this incident. [A. Tab. 4]. The Commission stated that "independent of the NRC and NGRC documents, . . . the procedures governing the work activity involving the use of the test weight device were deficient, [and] the planning and supervision of the project were inadequate. . . ." [R.O. 1]. The Commission further concluded that it could rely on the NRC and NGRC documents "as

secondary sources of evidence in requiring a refund in this case." Id. Finally, the Commission incorporated its earlier finding that this incident delayed the outage by 55 days.

Two issues are presented on appeal. First, whether, in light of this Court's decision, the Commission correctly held Florida Power management responsible for the dropped test weight incident. Second, whether the Commission correctly held that this incident extended the outage by 55 days.

STATEMENT OF THE FACTS

On March 3, 1978, Florida Power's nuclear unit was shut down to investigate the cause of certain alarms. It was discovered that one of the burnable poison rod assemblies had broken loose. Many of the individual rods had broken off, and thousands of pieces of radioactive debris from the broken rods were disbursed throughout the reactor coolant system. Considerable damage resulted to one of the unit's steam generators that had to be assessed and repaired. A major cleanup of the system was also required which necessitated the removal of all fuel from the reactor core.

After the reactor core had been defueled and the debris removed, Florida Power began to replace the fuel assemblies in the reactor. It was able to replace only a few of them before

various malfunctions in a fuel transfer mechanism required extensive repair.[3/] After these repairs were completed, it was decided that the mechanism should be tested with a load before continuing to reload the fuel assemblies. Plant personnel decided to use a test weight for this purpose. The test weight was a stainless steel pipe which weighed about 2080 pounds and had a eyebolt welded on the top of it. [Tr. 945, 961-962, 1411].

At the time the test weight activity was planned, it was not classified as "safety-related" work. [Tr. 971, 1042-1043, 1047]. As this Court emphasized, the test was "but a small part of the extended repairs to the fuel transfer mechanism." [Op. 3]. The fact that those overall repairs were not safety-related was "in part why the use of the test weight was not recognized as being safety-related." Id.

On June 8, a work crew used underwater divers in conjunction with shackles, cables and a crane to lower the test weight onto the fuel transfer mechanism. The divers removed the shackles and the mechanism was tested. At the end of the

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3/ The fuel transfer mechanism consists of two motor-driven carriages used to carry fuel assemblies on an underwater track through a canal between the reactor building and a pool of water where the fuel assemblies were stored. [Tr. 957].

shift, the test weight was lowered into the pool again and the crane was removed. [Tr. 950-970].

When the work crew on the next shift arrived on June 9 to remove the test weight, the employee in charge, a plant engineer, instructed the crew to use a "fish hook" to lift the test weight. [Tr. 871]. This hook was designed to lift 150 pounds but was not labeled as to capacity. [Tr. 1289, 1305]. The hook had been rejected for use during the first shift, despite similar instructions to use it, because the crew concluded that it would not hold the test weight. [Tr. 959-969, 985].

Although the second shift did not know that the first shift had not used the hook, the second crew independently questioned its suitability for this task. [Tr. 714, 942-943, 1021-1022, 1203, 1302, 1317-1318]. Because divers were not available to re-connect the shackles to the test weight, the crew attempted to use the hook anyway after briefly lifting the test weight to see if it would hold. [Tr. 917-918, 1025, 1042, 1279]. As the crew attempted to lift the test weight, the hook began to straighten and the test weight fell on a stored fuel assembly. [Tr. 1026-1029].

As a result of this incident, four fuel assemblies had to be replaced. [Tr. 140]. The unit's start-up was delayed for 14 days because the replacement assemblies were not on site

earlier.[4/] [Tr. 535-537]. The evidence was uncontroverted that this was the only effect on the duration of the outage. [Tr. 389-390, 530-531, 680-683, 903, 1547, 1602, 1664].

Despite this evidence, the Commission found that this incident delayed the unit's start-up by 55 days.[5/] Finding that the time spent in certain activities was not necessary, the Commission held that that time must be attributable to the dropped test weight incident. [R.O. 16-18]. In so holding, the Commission simply second-guessed FPC's activities during this first-of-a-kind repair activity.

As a result of the dispersal of radioactive debris throughout the system, a massive clean-up was required. Repairs were also being made in connection with the damage caused to the steam generator. Other repairs and maintenance were being performed as well in a highly radioactive environment. Great attention was necessary at all times to radiological shielding of personnel and decontamination-related activities.

4/ This delay occurred because the lid on the reactor had to be bolted shut before the fill and vent activity could begin. Ordinarily the reactor would have been closed while other "critical path" activities were being performed. That could not be done here because the reactor had to be left open to install the replacement assemblies. The 14 days required to install the assemblies and close the reactor correspondingly delayed the commencement of the fill and vent activity.

5/ The unit went back into operation 77 days later than the start-up date which had been projected at earlier stages. The Commission specifically found 22 days of this time was required for activities unrelated to the incident.

Early in the outage, critical path schedules were prepared estimating the time it would take to perform these complex activities. Those schedules were later relied on by the Commission in finding that the test weight incident delayed start-up by 55 days. However, those early schedules were, by necessity, nothing more than a tentative plan involving considerable guesswork. [Tr. 99, 690, 692, 1546, 1699, 1701]. The ejection of the burnable poison rod assembly in its entirety from the reactor core was the first such incident in the industry. [Tr. 60, 1701]. In addition, this unit had been operating for less than a year, and this was FPC's first experience with the removal and replacement of fuel in the reactor. [Tr. 1704].

Moreover, those schedules allowed no leeway for any complications in the repair or cleanup work; this was done by design in an effort to assure that materials and equipment would be available when needed. [Tr. 1699, 1701]. Not unexpectedly, there were in fact a number of unanticipated events during the complex repair and clean-up activities which delayed the projected start-up date. [Tr. 126, 387, 544, 1701].

First, the removal of the burnable poison rod debris from the reactor turned out to be much more difficult and time consuming than initially expected, and this was not completed

until May 19 rather than May 8 as earlier scheduled. [Tr. 126, 544, 675-676, 1571; Exhibit No. 40].

Second, the fuel transfer mechanism malfunctioned and extensive repairs had to be made to it. [Tr. 1273, 1584-1586]. As a result, refueling was not completed until June 17, 1978, a delay of 15 days from the earlier schedule. [Tr. 677; Exhibit No. 40].

Third, a decay heat pump failed during the outage. Since the pump failure was safety-related, FPC's procedures, which were adopted pursuant to NRC regulations, required various analyses to be completed before corrective measures could be taken. [Tr. 1595, 1685, 1687, 1706, 1750-1751]. This caused an additional 15-day delay in plant start-up. [Tr. 577].

Notwithstanding the uncontroverted evidence that those three activities were all necessary to start-up, the Commission instead attributed the 41 days devoted to those activities to the test weight incident. Adding those 41 days to the 14-day delay which was acknowledged to have been caused by the incident, the Commission attributed a total delay in start-up of 55 days to that incident. It accordingly required FPC management to absorb over $11 million in replacement fuel costs incurred during that period.

ARGUMENT

POINT ONE

The Commission's order on remand has the same errors as the original order reversed by this Court.

a. Introduction

It is settled that there must be management imprudence before a utility's expenses may be disallowed. Management consists of the company's officers and directors. Missouri ex. rel. Southwestern Bell Tel. Co. v. Public Service Comm'n, 262 U.S. 276, 289, 43 S.Ct. 544, 67 L.Ed. 981 (1923); Metropolitan Dade County Water & Sewer Brd. v. Community Utilities Corp., 200 So.2d 831 (Fla. 3d DCA 1967). Errors of plant employees are not a legally sufficient basis upon which to disallow a utility's operating costs.

Upon the initial appeal, this Court directly addressed the issue of alleged management responsibility for the test weight incident. The Court specifically rejected the Commission's finding that management was imprudent in failing to treat this work as safety-related. [Op. 3]. The Court also found that the Commission improperly relied on NRC and NGRC post-accident evaluations because, among other things, those reports were based on hindsight and on nuclear safety

considerations presenting "a very different risk and a much higher standard of care than were involved in this case." [Op. 3-4]. Based upon its own "independent review of the record," this Court reversed the Commission's findings and remanded for reconsideration in light of the Court's opinion. [Op. 4].

Although the Commission pays lip service to this Court's decision, the Commission repeats exactly the same errors it made in its first order. The Commission again relies on the post-accident reports of the NRC and NGRC as well as its perfect "hindsight" view of the incident. Even more importantly, it has again imposed a higher, "safety-related" standard of care for this minor part of the lengthy, complex repairs to the fuel transfer mechanism -- despite this Court's finding that such a standard should not be applied here.

For instance, the Commission once again finds management imprudence as a result of deficiencies in FPC's procedures for labeling hooks. [R.O. 8]. Although the Commission purports to now make that finding on "primary" evidence other than the NRC and NGRC reports, the only "primary" evidence cited for that finding relates directly to the NRC citation for improper safety-related procedures.

As its so-called "primary" evidence of management imprudence, the Commission quotes a statement by Mr. Beatty,

the plant manager, that "our internal procedure was not adequate enough to preclude this happening because it did not require the testing of the hooks and it should have." [R.O. 9]. That quote is taken blatantly out of context. The statement was made in direct response to a series of questions concerning the deficiencies in FPC's safety-related procedure SP-601 (governing the labeling of hooks) which were the basis for the NRC's notice of violation.[6/] [Tr. 148-149].

In short, the Commission has once again relied on the NRC's after-the-fact investigation of a "safety-related" activity as a primary basis for imposing responsibility upon management.[7/] The Commission has done so in direct contravention of this Court's decision.

The Commission also points to various procedures which "might" have prevented this accident. These range from procedures stating the obvious -- "be sure to use qualified personnel on your work activities" -- to procedures detailing

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6/ This series of questions is set out in its entirety in the Appendix to this Brief at Tab 5.

7/ Similarly, in the Staff recommendation which was approved by the Commission's order, Mr. Beatty's testimony that the procedures violated NRC regulations is expressly relied on as primary support for the finding of procedural deficiencies. [R.O. 33, Appendix A at 14; A. Tab 4].

the exact manner in which this test was to be performed. With the 20-20 vision of hindsight, it is, of course, a simple matter to pinpoint everything that might have been done to prevent the accident.

More importantly, the Commission has once again based its decision on FPC's failure to follow "safety-related" work requirements, despite this Court's rejection of the finding that the work should have been treated as safety-related. Although detailed written procedures are required for "safety-related" work, there is no evidence that this is normal industry practice for other activities. To the contrary, if written procedures had to be developed and followed for every minor work activity, outages would often be unnecessarily extended.

Incredibly, in this very case, the Commission penalized Florida Power for a delay experienced because it followed safety-related procedures. Although FPC's procedures required specific analyses to be performed before replacement of a safety-related pump could be made, the Commission second-guessed the necessity for those analyses and held that the time spent in that connection was not "justified." [R.O. 17]. Yet, at the same time that the Commission finds that the time required to comply with those procedures for safety-related repairs was not justified, the Commission is urging the necessity of such procedures for repairs which were not per se safety-related.

The Commission cannot have it both ways. If management prudence requires the preparation of written procedures for every activity performed in a nuclear plant because of the "potentially adverse economic consequences" of its shut-down,[8/] then this is a new, higher standard of care which in simple fairness should only be imposed prospectively. Most importantly, the Commission cannot then penalize management for the additional time required to prepare and comply with such procedures, and the customers must be prepared to absorb the extra replacement fuel costs incurred during that time.

The central fact which this Court expressly found and which the Commission continues to ignore is that this particular task "was but a small part of the extended repairs to the fuel transfer mechanism." [Op. 3]. As the Commission's own expert testified, it is not possible to write a procedure for every activity in the plant. [Tr. 1493]. In the final analysis, a company must inevitably rely on the judgment and common sense of its employees who are on the spot. [Tr. 1208, 1493].

Basically, the Comission does not point to new evidence on remand but instead simply recasts its original findings of

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8/ [R.O. 8].

management imprudence in different form. Those findings are no different in substance from its original findings. They are no more sufficient now than they were before.

Finally, although the Commission protests at every turn that it is not relying on the NRC and NGRC reports as "primary" but only "secondary" evidence of management imprudence, it is undeniable that the Commission again relies extensively upon those reports. Indeed, the entire oral argument and the bulk of the Commission's order were devoted to consideration of those reports. Although acknowledging that the Court sought to protect Florida's "strong public policy in favor of post accident investigations," the Commission concluded that "neither the primary nor secondary use of the NRC/NGRC documents" would violate that policy because these reports were prepared pursuant to governmental mandate. [R.O. 2, 10-19].

The Commission's conclusion is contrary to the direct holding of this Court. This Court's opinion reflects on its face the fact that the NRC and NGRC reports were prepared pursuant to governmental regulations. Nevertheless, it held that such reports were improperly relied on by the Commission for several different reasons, including Florida's prohibition of the use of post-accident reports to establish liability.

That holding is, of course, the law of this case and the Commission was required to adhere to it on remand. Instead,

the Commission quarrels with that holding and improperly attempts to distinguish it away.

b. There is no "primary" evidence of management imprudence.

As its "primary" evidence of management imprudence, the Commission first notes, as it did before, that the test weight device was fabricated for a different test. [R.O. 8; O. 5]. It was used here because the "dummy" fuel element which would otherwise have been used was stuck in the fuel transfer canal and could not be moved into the storage pool. [Tr. 969, 981, 1033]. The Plant Review Committee specifically approved the use of the device under those circumstances. [Tr. 945]. In short, this device was used to minimize the economic consequences that would have otherwise occurred from a delay in the test.[9/]

The Commission also complains that there were no written procedures governing the use of this device. However, the Commission's expert made it clear that such instructions were

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9/ At the outset of its order, the Commission emphasizes that "time was of the essence" during this outage because "replacement fuel costs were approximately $200,000 a day." [R.O. 7]. At no time, however, does the Commission acknowledge the length of time that would have been required to perform this test under the stringent procedures which the Commission now concludes should have been used.

"certainly" not the responsibility of company management or even the plant manager but rather of the supervisor responsible for the work. [Tr. 1114-1115]. Moreover, there is no suggestion in any way that the use of this device contributed to the accident. The test weight worked fine. The only problem was the hook used to lift it.

As was the case in its original order, the Commission again criticizes FPC's procedures governing the labeling of hooks. [R.O. 8-9; O. 5-6]. However, the testimony of Mr. Beatty -- which is the only "primary" evidence cited for this finding -- was simply an explanation of the reason why FPC's procedure for labeling hooks violated NRC regulations. [Tr. 148-149]. As this Court has held, that NRC citation "should not serve as the primary source of evidence in a fault-finding determination." [Op. 4].

The real cause of the accident was not a procedural deficiency relating to hooks but a failure of judgment on the part of the crew actually performing the work. Employees on both crews had serious doubts that this hook was strong enough to hold the test weight. [Tr. 942-944, 960, 968-969, 1307, 1405-1407, 1417]. Unlike the first crew, the second shift proceeded in violation of existing management procedures and policies which precluded use of the hook in the face of such concerns.

It is undisputed that existing procedures required a consideration by those employees of what might happen in handling the test weight. [Tr. 1164, 1170, 1174]. This was not done. In addition, existing procedures authorized these employees to refuse to perform a task they considered unsafe.[10/] [Tr. 1303, 1342-1343, 1429, 1555]. There was no such refusal here. The plant engineer in charge of the test acknowledged that, under Company procedures, he should not have used the hook but should have taken "the conservative path which was available." [Tr. 1295, 1303, 1351, 1355, 1360-1361].

Although the Commission points to various other procedures which "might" have prevented this incident, the fact inescapably remains that FPC management had procedures in place which would have prevented this incident if they had been followed by the plant employees. The Commission's expert repeatedly emphasized that the cause of this incident was not the absence of procedures but the crew's failure to follow the existing ones. [Tr. 1164, 1170, 1174]. This Court similarly emphasized that the principal purpose of the NGRC's report was "to reinforce and strengthen existing procedures, not to propose

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10/ Plant employees had invoked those procedures "many times." [Tr. 1555].

new ones." [Op. 4]. This is simply a case of employee error, not imprudent management procedures.

The Commission also complains, as it did originally, that there were no procedures prohibiting the use of an unqualified crew for this work. [R.O. 8; 0. 6]. It should not be necessary to have a written procedure directing nuclear engineers to use persons qualified to do the work; common sense dictates that. In any event, the point is moot. Regardless of the extent of their training, the crew members were immediately able to recognize the potential problem with the hook.11/ Existing Company procedures required them to "follow the conservative path" and obtain more qualified personnel once those concerns were raised. [Tr. 1338].

The Commission next finds that FPC's procedures failed to provide for exchange of information between plant sections and shifts. [R.O. 8]. In fact, logs were maintained by the shift supervisors, thus providing continuity between shifts. [Tr. 1620]. Proper coordination was further provided by

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11/ The Commission states that the crew was unqualified because they were "substantially untrained in rigging." [R.O. 8]. They were, however, qualified engineers with some experience in rigging. [Tr. 1064-65, 1338, 1362]. More importantly, there is no evidence that substantial experience in rigging was required for this test. The problem that arose was not with the rigging but with the use of an improper hook.

submission of the plan governing this test to the plant-wide Review Committe. [Tr. 945].

Furthermore, the second shift independently recognized the potential inadequacy of the hook. In view of its similar concerns about the sling, the crew obtained a different sling -- even though it believed the sling in question had been used the day before. [Tr. 1347]. Its failure to do the same for the hook is nothing more than an inexplicable human lapse. That is, however, a classic example of employee error for which management cannot be held liable.

Finally, the Commission complains that, even disregarding nuclear safety considerations, there should have been specific written procedures governing "the movement of the test weight device over irradiated nuclear fuel assemblies. . . ." [R.O. 8]. Thus, the Commission incorporates nuclear safety considerations at the very same time that it is claiming to disregard them!

Despite the Commission's disclaimer, it is plainly re-asserting its original, and erroneous, finding that FPC management was imprudent in failing to recognize the possibility that the test weight could fall on the irradiated nuclear fuel assemblies and therefore failing to institute safety-related procedures. [O. 6]. Now the Commission faults management for

not recognizing that possibility and instituting those extraordinary procedures because of the economic consequences of such a fall. [R.O. 8]. Regardless of how it is phrased, the Commission is holding FPC management responsible for not anticipating the possibility of this fall.

The same reasoning that made the original finding erroneous applies again. As this Court declared, "our independent review of the record discloses the particular task which resulted in the accident was but a small part of the extended repairs to the fuel transfer mechanism." [Op. 3]. At the time, not one of the twenty persons actually involved in that work thought it possible that the test weight could come in contact with the fuel assemblies stored in the pool. [Tr. 1304, 1351, 1423-25, 1493, 1551, 1641-42]. It is not proper to nevertheless expect management to have anticipated the potential of such a fall.

On their face, the Commission's findings are formulated with the benefit of after-the-fact investigations of this incident, and they are further founded upon stringent nuclear safety concerns. As this Court has already held, such evidence is inappropriate as a basis for finding management imprudence. [Op. 4]. No reason exists for a different application of that principle on this second appeal. There is, accordingly, no

"primary" evidence establishing management responsibility for this incident.

c. The Commission erred in again relying on the NRC and NGRC post-accident reports to assess fault here.

The Commission again relies heavily on the NRC and NGRC post-accident reports, characterizing them as "cumulative" evidence supporting its "primary" finding of management imprudence. Conceding that this Court's decision sought to protect "Florida's strong public policy in favor of post-accident investigations," the Commission nevertheless concludes that the Court did not prohibit all use of such documents here. As the Commission put it, "neither the primary nor secondary use" of the post-accident NRC and NGRC reports would harm that policy since these reports were prepared at governmental direction. [R.O. 11].

The Commission's renewed reliance on those post-accident reports is erroneous for several reasons.

First, this Court knew that those reports were prepared at governmental direction. Obviously, the NRC citation was "governmental," and the Court specifically pointed out that the NGRC was a "committee set up by FPC pursuant to NRC requirements." [Op. 4]. Nevertheless, this Court squarely

held that the Commission's use of those documents would violate Florida public policy because it "would be analogous to using evidence of subsequent repairs and design modifications for the purpose of showing that the original design was faulty." [O. 4]. Thus, this Court did not draw the distinction that the Commission now urges should be made.

The Court's holding was, as a matter of law, binding on the Commission as the law of the case. Greene v. Massey, 384 So.2d 24 (Fla. 1980); Strazzulla v. Hendrick, 177 So.2d 1 (Fla. 1965). The Commission's effort to avoid that holding is completely improper and should not be countenanced by this Court.

Second, the Commission's interpretation of Florida law is simply incorrect. Numerous Florida decisions, as well as an explicit Florida statute, confirm that post-accident repairs are not admissible as proof of defendant's negligence.[12/] See, e.g., City of Miami Beach v. Wolfe, 83 So.2d 774 (Fla. 1955); Seaboard Air Line Ry. Co. v. Parks, 89 Fla. 405, 104 So. 587 (1925); see also, Fla. Stat. § 90.407 (1976).

12/ Many of these cases were cited by Florida Power in support of its contention on the original appeal that Florida law precluded the Commission's use of those reports to assess fault. See, Initial Brief of Appellant at page 13, fn. 11. The Commission made no attempt there to distinguish those cases on the basis it now urges.

Disregarding those decisions as well as the Court's holding in the instant case, the Commission instead relies on the Fifth Circuit Court of Appeals' decision in Rozier v. Ford Motor Co., 573 F.2d 1332 (5th Cir. 1978) and the First District's decision in Hartman v. Opelika Machine & Welding Co., 414 So.2d 1105 (Fla. 1st DCA 1982). Neither decision supports the Commission's interpretation of the law.

In Rozier, the Court indicated that a trend cost estimate did not violate the subsequent repair doctrine. There the estimate was actually prepared prior to the accident. The Court's comments on the "subsequent repair" doctrine were therefore dicta.

In Hartman, the plaintiff, an employee of Monsanto, was injured while working on a machine fabricated by the defendant but designed by Monsanto. At trial, the defendant introduced evidence of Monsanto's post-accident design changes to the machine. While recognizing that post-accident design changes are not admissible as proof of the defendant's negligence, the district court held that such evidence was admissible "under the limited circumstances" where the changes were made by one who is not a party to the litigation. 414 So.2d at 1110. In contrast, here the post-accident evidence

relates solely to FPC's own procedures and is directly relied on by the PSC to show FPC's management imprudence.

Third, the reports relied on here were not all made by governmental mandate as stated by the Commission. In particular, the Commission relied heavily upon a letter to Florida Power from one of the members of the NGRC. [R.O. 14-15]. That letter was not a part of the report itself. To the contrary, the writer emphasized that "these comments are strictly intended to be constructive and to help the plant personnel avoid problems of this nature in the future. . . ." [R.O. 76, Appendix D at 2; A. Tab. 4]. The Commission's use of this letter to assess fault here has exactly the chilling effect upon such free and frank communications that this Court sought to preclude.

As further justification for its continued reliance upon these documents, the Commission seizes upon isolated words in the Court's opinion. Noting that the Court stated that these documents "should not serve as the primary source of evidence in a fault-finding determination," the Commission concludes that it can rely on them as "secondary" evidence.

The Commission's view of this Court's holding defeats the entire purpose of Florida's policy. At the time the post-accident evaluation or recommendation is made, it cannot be known whether that will be later labeled as "primary" or as

"secondary" support for findings of fault. Florida's policy encouraging such evaluations is inevitably jeopardized by any use of such evidence in later assessing liability.

Finally, the Commission completely ignores the other, independent grounds for the Court's rejection of the use of these documents in this type proceeding. [Op. 3-4]. As the Court held, those reports were based on hindsight and, in addition, focused on nuclear safety considerations which are not the standard for a proceeding such as this. The Commission's continued reliance on those reports contravenes that whole aspect of the Court's opinion.

It is clear that the Commission has again relied heavily upon those reports. They are quoted from at great length by the Commission, and they constitute a substantial part of the evidence relied upon by the Commission on remand, just as they did in the first instance. Under the Court's prior ruling and under well-established Florida law, the Commission erred in relying upon such evidence.

POINT TWO

There is no competent, substantial evidence that the dropped test weight delayed start-up by 55 days.

It is fundamental that the Commission's finding that the dropped test weight incident extended the outage an additional 55 days must be supported by competent, substantial evidence. DeGroot v. Sheffield, 95 So.2d 912 (Fla. 1957); Duval Utility Co. v. Florida Public Service Commission, 380 So.2d 1028 (Fla. 1980). There is no such evidence here. To the contrary, the record is uncontradicted that that incident delayed start-up of the unit by no more than 14 days.

Florida Power's plant personnel consistently testified that the test weight extended the outage by 14 days. [Tr. 389-390, 530-531, 535-537, 674-675, 680-683, 687, 903, 1548, 1602, 1618, 164, 1715-1716; Exhibits 38,40]. The only activity delayed was the commencement of the fill and vent of the reactor cooling system. [Tr. 535]. That work would have begun on August 10 but because of the need to replace the fuel assembly damaged by the dropped test weight, it did not actually begin until August 24, some 14 days later. [Tr. 535]. There was no effect of this incident on any other activity and no other delay was attributable to it. [Tr. 680-681].

Rejecting this uncontradicted evidence, the Commission attributed an additional 41 days of the outage to the dropped test weight. [R.O. 17]. To reach this result, it simply refused to accept the unrefuted evidence that this time was required for repair activities unrelated to that incident. Then, with this self-created absence of an "acceptable" explanation, the Commission arbitrarily assumed that all of the now "unexplained" outage time was necessarily attributable to the test weight incident.

The Commission's disregard of the evidence and its attribution of repair time required for other activities to this incident is unjustified. Indeed, the Commission's action is contrary to the record and to plain common sense. It is also contrary to the recommendations of its own legal and engineering staffs, both of which concluded that the test weight incident only extended the outage by 14 days and that the other 41 days of clean-up and repairs were <u>independent</u> of that incident and were necessary to plant re-start. [R. 351].

1. <u>Cleaning and Debris Removal from Core Support</u>.

Mr. Beatty testified that "the time estimated for debris removal in the initial May 2nd schedule did not adequately recognize the complexity of the task." [Tr. 675]. The debris first had to be located by underwater cameras and then removed

by custom-designed tools. [Tr. 676, 1570-1571]. It is undisputed that this activity actually took 11 days longer to complete than was originally anticipated. [Tr. 675, 1571-1574].

There was no evidence, and the Commission did not find, that this period was unreasonably long or the result of any mismanagement. Rather, the Commission found the Company's explanation of this work to be "unacceptable" because the critical path schedule was not immediately revised to reflect this delay. [R.O. 17]. Mr. Beatty spoke to this precise point, however.

Although the cleaning activities had taken 11 additional days to complete, the Company hoped at first that "some [time] could be picked up at other portions of the schedule." [Tr. 1572]. At the same time, Florida Power recognized that some time had been irretrievably lost, and it was for this reason that the NRC was advised on May 23 that the plant would re-start during the first 10 days of July rather than July 3 as previously projected. [Tr. 1573-1574]. There is no reason to disbelieve Mr. Beatty's testimony that this time was utilized for necessary clean-up activities, and the Commission has suggested none.

Moreover, the delay in that work could not possibly have been attributable to the test weight incident since that incident had not yet even occurred. As acknowledged by the

Commission, all debris clean-up, including the 11 additional days, was completed in May, well before the test weight incident. [R.O. 17; Tr. 1571]. There is simply no basis for assuming any association between this work and that later incident.

2. Refueling.

Mr. Beatty also testified that refueling was delayed by 15 days because of the continuous malfunctioning of the fuel transfer mechanism. [Tr. 677, 891-892, 1584-1586]. The Commission did not find that the fuel transfer mechanism did not malfunction as testified by Florida Power. To the contrary, the Commission's orders acknowledge "[c]hronic difficulties with the fuel transfer mechanism." [O. 4; see also, R.O.3]. Nevertheless, the Commission concluded that "[t]he company has failed to place the cause for the time spent in refueling following the dropped test weight incident on matters other than the necessity of replacing the damaged fuel element." [R.O. 17].

In actual fact, as the Commission's own order reflects, the delay in the refueling occurred before the dropped test weight incident.[13/] Stating that "[t]he delay in the earlier

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13/ Only 13 fuel elements had been placed in the reactor prior to the dropped test weight whereas "the company succeeded in transferring 160 in only 4 days thereafter." [R.O. 17].

phase of refueling" has not been adequately explained, the Commission incredibly went on to attribute this delay to the later test weight incident. [R.O. 17]. As in the case of debris removal, there is obviously no way that this delay could possibly have been caused by an incident that had not yet occurred.

Moreover, the Commission's finding ignores the uncontroverted evidence that the delay in refueling was caused solely by the breakdown of the fuel transfer mechanism. [Tr. 677, 880-881, 892, 974, 1588, 1604-1605; Exhibit 40]. The various problems were so severe that ultimately the whole mechanism was completely redesigned. [Tr. 1273-1274, 1586, 1677, 1681]. This Court specifically found that "extensive repair was required" because of these malfunctions. [Op. 7]. As a result, refueling was delayed. [Tr. 677, 1585-1586, 1604-1605, 1677].

3. Decay Heat Pump Repair.

Florida Power also presented evidence, which was never controverted, that repairs on a decay heat pump delayed start-up by another 15 days. [Tr. 892, 1638]. That work was not affected by the dropped test weight and, once again, the Commission points to no way in which the incident could have delayed that work. Instead, the Commission simply found that the Company failed to justify the time spent on these repairs

because "NRC clearance was not necessary . . . ."[14/] [R.O. 17].

Even though the NRC did not have to specifically clear the investigative work itself, it expressly required that it be done.[15/] [Tr. 1685-1687, 1706-1708, 1750-51, 1769-1775]. This pump was safety-related equipment, and NRC regulations required that all failures of such equipment be evaluated to determine the cause and possible means to prevent future failures. 10 C.F.R. Part 50, Appendix B, Section XVI (1980).

Pursuant to those regulations, Florida Power had established procedures requiring such an evaluation. [Tr. 1751, 1769]. The testimony was unequivocal that this evaluation was "absolutely essential" before Florida Power could proceed. [Tr. 1751].

By its finding that this time was not justified, the Commission has directly penalized FPC management for complying

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14/ The Commission also observed that "Mr. DuBois was unable to state whether the task affected the critical path." [R.O. 17]. However, Mr. DuBois was not responsible for the critical path planning nor was he even assigned to the nuclear plant. [Tr. 1760, 1776]. Mr. Beatty directly confirmed that the decay heat pump repair was treated as a critical path item. [Tr. 1676]. Exhibit 40, which is the actual critical path schedule, specifically shows this task on the schedule.

15/ Such a finding presumes that only repairs mandated by the NRC are reasonable. This ignores FPC's responsibility to make all necessary repairs, whether mandated by the NRC or not.

with procedures governing work clearly recognized to be safety-related. Yet, at the same time, it seeks to penalize management for not having such procedures for work activities which this Court found were not safety-related per se. The manifest unfairness of the Commission's effort to jump either way on this issue, depending upon the effect on the customers' bills, is evident.

Finally, this finding is squarely contrary to the Commission's findings in its investigation of the 1980 "circuit board" outage of the Crystal River unit. The Commission specifically found there that the "net effect" of the pump repairs during the earlier "loose parts" outage "was to extend the 1978 outage by some 15 days."16/

That finding is patently inconsistent with its present finding that the pump repair time did not extend the 1978 "loose parts" outage by 15 days and that that repair time was instead associated entirely with the test weight incident. Once again, the Commission cannot have it both ways. Having found in that

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16/ Commission Order No. 9950 at 3, Docket No. 810001-EU, April 15, 1981 [A. Tab. 6], aff'd, Florida Power Corporation v. Cresse, 413 So.2d 1187 (Fla. 1982). The Commission concluded that this should have caused Florida Power to order a replacement pump following that outage, and the Commission accordingly assessed certain replacement fuel costs incurred during the 1980 outage against FPC management.

later proceeding that the pump repairs did delay this outage by 15 days, it cannot now jump the other way and say that they did not.

4. Florida law requires the Commission's findings to be supported by competent, substantial evidence.

The Commission may not avoid the requirement that its findings must be based on competent, substantial evidence by simply rejecting the Company's uncontroverted testimony. Fleet Transport Co. v. Mason, 188 So.2d 294, 297-298 (Fla. 1966); Bowling v. Department of Insurance, 394 So.2d 165, 175 (Fla. 1st DCA 1981). Rather, there must be independent evidence that this incident actually delayed start-up by 55 days.

Florida Bridge Co. v. Bevis, 363 So.2d 799 (Fla. 1978), is directly on point. There this Court reversed a Commission order because, as here, its findings were simply based on the rejection of the utility's evidence, not on other competent evidence. The Court noted that:

> While the Commission is ordinarily free to disbelieve the testimony of any witness, the combination of circumstances as offered in explanation by Florida Bridge was legally sufficient to require the Commission to produce, by some means, competent evidence of a malevolent or fraudulent purpose for the destruction of records, of inaccuracy in the accountant's testimony, or impropriety in the dollar amount asigned to the franchise asset. Id. at 802.

The recent decision of the First District Court of Appeal in Citizens v. Florida Public Service Commission, 8 Fla. Law Weekly 330 (Fla. 1st DCA January 14, 1983), speaks to this same point. There the PSC held that the utilities failed to support an inflation-attrition allowance. The Court reversed, holding that, although the burden of proof initially rested on the utility to establish the necessity for such an allowance, the PSC could not "allow 'zero' for attrition simply because it is dissatisfied with the figures proposed by the Utilities." Id. at 331. Instead, once the utilities presented such evidence, the burden shifted to the Commission to establish a proper figure.

Simply put, in order for the Commission's findings to be sustained, the Commission cannot just reject FPC's evidence but must instead point to other substantial testimony showing how this incident delayed start-up by an additional 41 days.

No such evidence exists here. The Commission does not make the slightest effort to identify any work that was actually affected by this incident other than the fill and vent activity. Its "intuitive" knowledge that this outage would somehow have been shortened by 41 days if this incident had not occurred cannot sustain its finding on this point.

CONCLUSION

Contrary to this Court's decision, the Commission has again relied on hindsight in seeking to hold management responsible for on-the-job decisions and actions of plant workers performing a single, small task in the course of a massive and unique repair effort. The Commission has again relied heavily upon post-accident evaluations of safety-related procedures and concerns. In sum, the Commission has simply re-cast its original order in different language, and its findings on remand are defective for the same reasons enunciated in this Court's decision.

The Commission has also failed to support its finding that this incident delayed start-up by 41 days over and above the acknowledged 14-day delay in commencing the fill and vent activity. In fact, there is no evidence at all showing 55 days of delay, and the evidence is instead uncontroverted that this incident prolonged the outage by only 14 days. As a matter of law, the Commission's rejection of the Company's unrebutted evidence is insufficient to support its finding of a 55-day delay.

Commission Order No. 12240 should be reversed to the extent that it requires Florida Power to refund $11,056,000 in fuel costs, plus interest, to its customers.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by U.S. mail this 13 day of October, 1983, to all counsel of record.

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Attorney