

**REDACTED**

Rocky Mountain Power

Docket No. 21-035-01

Witness: Brad Richards

BEFORE THE PUBLIC SERVICE COMMISSION  
OF THE STATE OF UTAH

ROCKY MOUNTAIN POWER

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**REDACTED**

Response Testimony of Brad Richards

December 2021

1 **Q. Please state your name, business address, and present position with PacifiCorp**  
2 **d/b/a Rocky Mountain Power (the “Company”).**

3 A. My name is Brad Richards. My business address is 1407 West North Temple, Suite  
4 210, Salt Lake City, Utah 84116. My title is Vice President of Thermal Generation.

### 5 **QUALIFICATIONS**

6 **Q. Briefly describe your education and professional experience.**

7 A. I have 21 years of power plant commissioning, operations, and maintenance  
8 experience. I was previously the Managing Director of Gas and Geothermal Generation  
9 from January 2018 to September 2021. For 17 years before that, I held a number of  
10 positions of increasing responsibility within PacifiCorp’s generation organization and  
11 with Calpine Corporation in power plant commissioning and operations. In my current  
12 role, I am responsible for operating and maintaining PacifiCorp’s coal, natural gas-  
13 fired, and geothermal generation fleet.

14 **Q. Have you testified in previous regulatory proceedings?**

15 A. No.

### 16 **PURPOSE OF TESTIMONY**

17 **Q. What is the purpose of your testimony in this case?**

18 A. My testimony responds to the direct testimonies of Mr. Philip DiDomenico and  
19 Mr. Dan F. Koehler of Daymark Energy Advisors, Inc. (“Daymark”) who submitted  
20 testimony and exhibits on behalf of the Division of Public Utilities (“DPU” or  
21 “Division”).

22 **Q. To what issues raised by Daymark in its testimony do you wish to respond?**

23 A. My testimony addresses the recommendations contained in DPU Confidential Exhibit

24 2.3 to disallow recovery of replacement power costs related to two separate outages in  
25 2020 from the deferred EBA costs.

26 **Q. Please list the specific generating units and 2020 outages being discussed.**

27 A. The outages in question occurred at:

- 28 1. Hunter Unit 3, on June 28, 2020
- 29 2. Gadsby Unit 2, on July 5, 2020

30 **HUNTER UNIT 3 (June 28, 2020)**

31 **Q. Please describe the outage at Hunter Unit 3.**

32 A. On June 28, Hunter Unit 3 was removed from service due to high superheater (“SH”)  
33 differential pressure and high exit gas temperature. The high differential pressure and  
34 exit gas temperature were a result of slag build up on the superheater section of the  
35 boiler, which was first observed on June 23, 2020. Attempts to remove the slag from  
36 the superheater section with the unit in service were unsuccessful, therefore an outage  
37 was necessary to access the boiler for cleaning.

38 **Q. What is Daymark's rationale for the proposed disallowance related to this outage?**

39 A. On page 28 of DPU Confidential Exhibit 2.3, Daymark concludes that:

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45 **Q. Can you please explain the slag build up?**

46 A. On June 23, 2020, plant personnel observed high superheater differential pressure,

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<sup>1</sup> DPU Confidential Exhibit 2.3 - Daymark Energy Advisors EBA Audit Report for Calendar Year 2020, page 28.

47 which is indicative of slag build up on the superheater section of the boiler. Typically,  
48 problems associated with slagging are a result of changes in coal quality. Coal quality  
49 is measured routinely on belts feeding storage silos; however, there is a delay between  
50 the time the measurement is taken and the time the coal enters the boiler. In addition, a  
51 particular batch of poor-quality coal, when identified, cannot reasonably be tracked  
52 through the coal feeding system relative to the time that it is consumed in the boiler.  
53 Because Hunter 3 is considered a flexible load unit, as opposed to a base loaded unit,  
54 coal may reside in a silo for greater than eight hours, which results in varying coal  
55 quality entering the boiler at any one time and makes it difficult to track poor quality  
56 fuel and preemptively apply corrective action in time to compensate for poor-quality  
57 fuel.

58 The Company believes a batch of high calcium coal, which can cause slag, entered the  
59 boiler on or around June 23, 2020. Once the slag was identified, attempts to remove it  
60 were unsuccessful. Specifically, changes in unit operating parameters to reduce slag  
61 such as unit load, air portions, and increased soot blower operations, did not decrease  
62 the build up of slag during this event. The slagging continued to build up until June 28,  
63 2020, when the unit entered a forced outage to clean the superheater section of the  
64 boiler.

65 **Q. What procedures did the Company have in place at the time of the outage to**  
66 **prevent the type of slag build up that occurred?**

67 A. Plant operators routinely walk the unit down to assess slag/ash fouling relative to soot  
68 blowing effectiveness. When a noticeable increase in slag/ash fouling occurs,  
69 additional soot blowing is typically the first response. If soot blowing operation is

70 ineffective, the boiler load can be reduced to aid in combatting pervasive fouling. In  
71 this instance, the slagging occurred in an area of the boiler without observation ports,  
72 which would allow for direct observation of the effected region. The indicators that are  
73 available, primarily the duct pressure differential across superheat elements, provide  
74 post-fouling indication. Due to the aggressive nature of this fouling event, by the time  
75 the indicative parameters represented a problem slagging controls were ineffective.

76 **Q. What steps has the Company taken since the forced outage to respond to the**  
77 **event?**

78 A. In review of the event, the Company identified several process and procedure changes  
79 that may enhance its response to future fuel quality issues. When the boiler was  
80 designed there were no observation ports installed where the slag build-up for this event  
81 occurred. The Company determined several projects to reduce the likelihood of  
82 reoccurrence, which are scheduled to occur at the next planned overhaul: 1) enhancing  
83 the soot blowing capacity in the affected region, and 2) creating additional observation  
84 ports to enhance visibility to impacted section of the boiler. Additionally, a slag-specific  
85 operational procedure was developed to include lowering the differential pressure  
86 alarm across the superheat assemblies and specific action item relative to differential  
87 pressure indications.

88 **Q. How do you respond to the recommended disallowance for this outage?**

89 A. I recommend that the Commission reject the adjustment proposed by Daymark.  
90 Daymark's suggestion that the Company did not have plans for routine slag build up in  
91 place at the time of the outage is inaccurate. The Company routinely monitors for slag  
92 in the boiler and clears it while the unit is online. During this event, the standard

93 practice for clearing the slag build up was ineffective due to unusually poor coal quality  
94 and gaps in the observation points for slag build up, not because of any problem with  
95 the Company's procedures. The Company has since identified an opportunity to  
96 improve operating practices to minimize chances of the event recurring.

97 **GADSBY UNIT 2 (July 5, 2020)**

98 **Q. Please describe the background of the Gadsby Unit 2 outage.**

99 A. On July 5, 2020, Gadsby Unit 2 was brought offline due to a generator hydrogen seal  
100 failure. Prior to the event, a mechanical float failed in a generator seal oil vacuum tank,  
101 requiring repairs to ensure proper tank level could be maintained. When draining the  
102 tank to repair the float, a backup oil regulator failed to maintain the necessary system  
103 pressure. The lack of adequate system oil pressure caused a generator hydrogen seal to  
104 overheat and fail, which required a unit outage to repair.

105 **Q. Please explain how the Company's actions were appropriate during the event.**

106 A. The Company followed the Original Equipment Manufacturer ("OEM") procedures for  
107 bypassing the vacuum tank when the unit is in operation. There was no indication that  
108 the backup oil regulator would not function as designed; therefore, there was no reason  
109 to believe verifying functionality was necessary prior to performing maintenance.

110 **Q. What steps has the Company taken to ensure that this situation does not recur?**

111 A. The Company conducted a root cause analysis to determine how it could prevent  
112 recurrence. In review of the event, the Company determined revisions to the operating  
113 procedure would minimize the potential of reoccurrence. Specifically, the Company  
114 found the OEM operating procedure for removing the vacuum tank from service did  
115 not identify the verification of the backup regulator as part of the process. As a

116 corrective action identified in review of the event, the Company added regulator  
 117 functional testing to its normal operating procedure, ensuring the performance of the  
 118 regulator is tested on a routine basis. The Company’s significant event report identifies  
 119 [REDACTED] as the root cause of the outage. Although  
 120 it was not recommended by the OEM, the Company has added a backup regulator  
 121 functional test to its operating procedures. It would penalize the Company for seeking  
 122 to improve OEM or plant procedures if that served as evidence of a [REDACTED]  
 123 [REDACTED]<sup>2</sup>

124 **Q. What is your recommendation to the Commission with respect to the Gadsby Unit**  
 125 **2 adjustment proposed by Daymark?**

126 A. I recommend that the Commission reject the adjustment proposed by Daymark. The  
 127 Company utilized the best available OEM procedures for this system. Daymark’s  
 128 assertion that the Company has shown [REDACTED]  
 129 [REDACTED] does not consider the operating procedures that  
 130 were in place and looks at the situation with the advantage of hindsight. The  
 131 expectation that the Company be held to a standard of perfection is unreasonable. The  
 132 Company acted prudently by following the OEM procedure during an abnormal repair  
 133 event with no indication the backup regulator would not function as designed.

**FLEET-WIDE SHARING OF LESSONS LEARNED**

135 **Q. Did Daymark raise any other issues that you wish to address?**

136 A. Daymark makes a general assessment [REDACTED]  
 137 [REDACTED]

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<sup>2</sup> DPU Confidential Exhibit 2.3 - Daymark Energy Advisors EBA Audit Report for Calendar Year 2020 page 29.

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139 **Q. How do you respond?**

140 A. Daymark's assessment is inaccurate. The Company shares significant event details  
141 with all generating facilities for the purposes of minimizing future outages. Root  
142 causes and corrective actions from an event are reviewed by subject matter experts at  
143 each plant for applicability. The Company's generation fleet consists of equipment  
144 diverse in geographic location, style, OEM, date of installation, and usage; therefore,  
145 corrective actions for an equipment or process failure at one facility do not necessary  
146 apply at others. Subject matter experts identify and implement pertinent corrective  
147 actions when appropriate.

148 **Q. What is your recommendation to the Commission?**

149 A. I recommend that the Commission reject the calculated disallowances for the two  
150 outages addressed above. My testimony demonstrates the Company was prudent in its  
151 actions.

152 **Q. Does this conclude your testimony?**

153 A. Yes.