**To: Bill Gase, Acting Operations Manager**

**From: Marlene Baker, Chief Treatment Technician**

**Re: Oral Reprimand Response**

**Date: April 30, 2012**

In response to the charges of Dereliction of Duty leveled against me regarding the March 25th, 2012 TCEQ violation event, I would like to point out that many decisions lead up to the circumstances which precipitated the event. The original plans for the plant shut down included a start date after the first of the month and primarily the decision to push up the date of the startup was responsible for the violation. During the 11 days that the plant ran following the startup, only 3 Combined Filter Effluent turbidity exceedances were necessary to put us in a state of violation. It is often the case that starting a plant after an extended shut down can lead to high turbidities, particularly considering the limited supply of backwash water available to us at Pierce Burch when the plant is shut down. The manner in which the plant had been shut down, suddenly one afternoon rather than on the planned schedule, also contributed to being ill prepared for the early startup.

Furthermore, it is the duty of the Operations Services Administrator to be aware of matters like the number of allowable exceedances and to make those kinds of facts known to the operations staff, which was also not the case. It would have been a more prudent decision by management to wait until the original planned date before starting the plant.

When I arrived for my shift, I was made aware of the rising turbidities in the plant by the previous shift’s chief, and that Bill Gase, the manager, had been contacted in regard to this event. No instructions were given at this time regarding how to proceed to handle the growing crisis. During the night, as the turbidities rose, I cleaned turbidimeters as they spiked, flushed the lines to the turbidimeters to ensure the cleanest sample possible was reaching the instrument and washed filters as their turbidities spiked, but I did not have the option to change which filters were in use because of existing instructions to always run the filters involved in the filter study. I raised the dosages of the coagulation chemicals in response however, when changes are made to the these chemicals, the results are not seen at the filters or combined filter effluent for 8 to 10 hours due to long detention times in the sedimentation basins. Therefore, none of the changes I made to the chemical feeds would have an effect on the water I was producing during my shift.

During this event, I was acting on my own best judgment, as there were no Standard Operating Procedures in place for how to handle such a series of exceedances. Given that I had been assured that management was fully aware of the emerging situation, I feel that I acted appropriately, making use of all the tools available to me as an operator. With such a narrow window of time before the number of exceedances reached a critical level, more care should have been taken to keep the operations staff aware of the point when the only remaining option would have been to shut down the plant and discard the water that had been produced in the clearwell. Even if we had shut down after the initial exceedance, the low number of turbidity readings for the month would have left us in violation because of the late start date. The manner of the plant startup in late March left operations in a position that was not designed for our success.

Marlene Baker, Chief Treatment Technician