STATE REVIEW FRAMEWORK

Alaska

Clean Air Act and Clean Water Act
Implementation in Federal Fiscal Year 2017

U.S. Environmental Protection Agency
Region 10

Final Report
December 16, 2019

I. Introduction

A. Overview of the State Review Framework

The State Review Framework (SRF) is a key mechanism for EPA oversight, providing a nationally consistent process for reviewing the performance of state delegated compliance and enforcement programs under three core federal statutes: Clean Air Act, Clean Water Act, and Resource Conservation and Recovery Act. Through SRF, EPA periodically reviews such programs using a standardized set of metrics to evaluate their performance against performance standards laid out in federal statute, EPA regulations, policy, and guidance. When states do not achieve standards, the EPA will work with them to improve performance.

Established in 2004, the review was developed jointly by EPA and Environmental Council of the States (ECOS) in response to calls both inside and outside the agency for improved, more consistent oversight of state delegated programs. The goals of the review that were agreed upon at its formation remain relevant and unchanged today:

1. Ensure delegated and EPA-run programs meet federal policy and baseline performance standards
2. Promote fair and consistent enforcement necessary to protect human health and the environment
3. Promote equitable treatment and level interstate playing field for business
4. Provide transparency with publicly available data and reports

B. The Review Process

The review is conducted on a rolling five-year cycle such that all programs are reviewed approximately once every five years. The EPA evaluates programs with a primary focus on a one-year period of performance, typically the one-year prior to review, but also evaluating program performance in other time periods that are relevant to overall program performance. The evaluation uses a standard set of metrics to make findings on performance in five areas (elements) around which the report is organized: data, inspections, violations, enforcement, and penalties. Wherever program performance is found to deviate significantly from federal policy or standards, the EPA will issue recommendations for corrective action which are monitored by EPA until completed and program performance improves.

The SRF is currently in its 4th Round (FY2018-2022) of reviews, preceded by Round 3 (FY2012-2017), Round 2 (2008-2011), and Round 1 (FY2004-2007). Additional information and final reports can be found at the EPA website under State Review Framework.

II. Navigating the Report

The final report contains the results and relevant information from the review including EPA and program contact information, metric values, performance findings and explanations, program

responses, and EPA recommendations for corrective action where any significant deficiencies in performance were found.

A. Metrics

There are two general types of metrics used to assess program performance. The first are **data metrics**, which reflect verified inspection and enforcement data from the national data systems of each media, or statute. The second, and generally more significant, are **file metrics**, which are derived from the review of individual facility files in order to determine if the program is performing their compliance and enforcement responsibilities adequately.

Other information considered by EPA to make performance findings in addition to the metrics includes results from previous SRF reviews, data metrics from the years in-between reviews, and multi-year metric trends.

B. Performance Findings

The EPA makes findings on performance in five program areas:

- **Data** - completeness, accuracy, and timeliness of data entry into national data systems
- **Inspections** - meeting inspection and coverage commitments, inspection report quality, and report timeliness
- **Violations** - identification of violations, accuracy of compliance determinations, and determination of significant noncompliance (SNC) or high priority violators (HPV)
- **Enforcement** - timeliness and appropriateness of enforcement, returning facilities to compliance
- **Penalties** - calculation including gravity and economic benefit components, assessment, and collection

Though performance generally varies across a spectrum, for the purposes of conducting a standardized review, SRF categorizes performance into three findings levels:

Meets or Exceeds: No issues are found. Base standards of performance are met or exceeded.

Area for Attention: Minor issues are found. One or more metrics indicates performance issues related to quality, process, or policy. The implementing agency is considered able to correct the issue without additional EPA oversight.

Area for Improvement: Significant issues are found. One or more metrics indicates routine and/or widespread performance issues related to quality, process, or policy. A recommendation for corrective action is issued which contains specific actions and schedule for completion. The EPA monitors implementation until completion.

C. Recommendations for Corrective Action

Whenever the EPA makes a finding on performance of *Area for Improvement*, the EPA will include a recommendation for corrective action, or recommendation, in the report. The purpose of recommendations are to address significant performance issues and bring program performance back in line with federal policy and standards. All recommendations should include specific actions and a schedule for completion, and their implementation is monitored by the EPA until completion.

III. Review Process Information

Clean Air Act (CAA)

Kickoff letter sent: June 4, 2018
Data Metric Analysis and file selections sent to DEC: July 23, 2019
File reviews completed: August 15, 2018
Draft report sent to DEC: June 13, 2019
Comments from DEC received by EPA: July 23, 2019
Report Finalized: December 16, 2019

DEC and EPA key contacts:
Jim Plosay, DEC CAA Program
Pablo Coss, DEC CAA Program
Thomas Turner, DEC CAA Program
Aaron Lambert, EPA CAA file reviewer
John Pavitt, EPA CAA file reviewer
Scott Wilder, EPA SRF Coordinator

Clean Water Act (CWA)

Kickoff letter sent: June 4, 2018
Data Metric Analysis and file selections sent to DEC: October 12, 2018
File reviews completed: April 2019
Draft report sent to DEC: June 13, 2019
Comments from DEC received by EPA: September 30, 2019
Report Finalized: December 16, 2019

DEC and EPA key contacts:
Tiffany Larson, DEC CWA Program
Rick Cool, EPA CWA file reviewer
Scott Wilder, EPA SRF Coordinator

Executive Summary

Introduction

EPA Region 10 enforcement staff conducted a State Review Framework (SRF) oversight review of the Alaska Department of Environmental Conservation's (DEC's) implementation of its compliance and enforcement programs for Clean Air Act (CAA) stationary sources and for Clean Water Act (CWA) National Pollutant Discharge Elimination System (NPDES), known as the Alaska Pollutant Discharge Elimination System (APDES).

EPA Region 10 conducted its first SRF oversight review of DEC's compliance and enforcement program (C&E program) for the Alaska Pollution Discharge Elimination System (APDES) in 2013-2014. This first SRF review was under Round 3 of EPA's SRF reviews and issued in 2014.

The 2014 Report identified significant deficiencies in the APDES C&E program and identified actions that DEC needed to take to address them. Below is a summary of some of the key accomplishments that DEC completed in response to the 2014 Report.

- DEC substantially completed and implemented the 2014 Report's Program Implementation Plan (PIP) which identified priorities and deadlines for DEC's corrective actions. The DEC PIP was DEC's primary, comprehensive response to the 2014 Report and it addressed tasks and related schedules to cover many areas of EPA concern including filling of DEC C&E program staff vacancies, training, standard operating procedures, resource analysis, and performance benchmarks for completion of enforcement cases and inspections.
- DEC completed a resource analysis in October 2015 that was designed to identify the resources needed to meet compliance monitoring requirements, implement timely and effective enforcement, and meet DEC C&E program commitments. The analysis indicated that 12.3 full time equivalents (FTEs) were needed to conduct compliance activities and another 9.1 FTEs were needed to conduct enforcement, for an approximate total of 21.4 FTEs needed for the DEC C&E program. Currently, the DEC C&E program has one program manager and 12 staff.
- DEC completed a state-wide pretreatment survey of approximately 16 communities to identify significant industrial users (SIUs) in publicly owned treatment works (POTWs) that do not have APDES-approved pretreatment programs. Additionally, the DEC APDES permit program is incorporating industrial user survey requirements in new and reissued POTW APDES permits so that the POTW conducts the survey at least once a permit cycle. This survey information can be used by DEC to update potential SIU inventories and assist in determining whether a POTW should be required to develop a formal pretreatment program for DEC review and approval.
- DEC developed and implemented improved standard operating procedures known in the DEC C&E program as Program Operating Guidelines (POGs). DEC developed

approximately 23 POGs that provide detailed and standardized sets of procedures designed to create routine best practices and increase efficiencies of the C&E program's main tasks, such as conducting inspections and preparation of timely inspection reports. The DEC C&E program intends to periodically review the POGs and update them as needed.

- DEC completed some initial C&E performance benchmarks in 2015 for completing formal enforcement actions that were then in DEC's enforcement pipeline to promote more timely and appropriate enforcement, and for completing more inspections on an annual basis. Despite DEC's initial success regarding the 2015 performance benchmarks' completion, this 2019 Report demonstrates continuing EPA concerns related to the timely completion of formal enforcement actions and the ongoing inability of the DEC C&E program to meet EPA compliance monitoring strategy goals and DEC's C&E program commitments due to inadequate program staffing levels.

The DEC APDES C&E program made good faith efforts to respond to the 2014 Report's identified C&E program deficiencies, other related areas of concern, and the report's recommendations, and those DEC efforts for C&E program improvement continue to date despite significant program staff turnover in recent times, and a continuing shortfall in staffing levels needed to complete DEC APDES program commitments. EPA Region 10 will continue to work closely with DEC to implement tasks, recommendations and best practices in response to this 2019 Report in joint efforts to build and maintain a robust APDES C&E program.

Alaska CWA SRF finding comparison of round 3 and round 4:

Metric	Round 3 Finding Level (FY 2012)	Round 4 Finding Level (FY2017)
5a1 Inspection coverage of majors	Area for Improvement	Area for Attention
5b1, 5b2 Inspection coverage of non-majors	Area for Improvement	Area for Improvement
4a1, 4a2, 4a9 Inspection coverage at local pretreatment programs, SIUs, and CGPs	Area for Improvement	Area for Improvement
4a4,4a5 Inspection coverage of CSOs and SSSs	Area for Improvement	Meets or Exceeds Expectations
4a7, 4a8 Inspection coverage of MS4 and industrial stormwater	Area for Improvement	Area for Attention
6b Inspection report timeliness	Area for Improvement	Area for Improvement
9a Enforcement that returns source to compliance	Area for Improvement	Area for Improvement

10b Enforcement that is timely and appropriate	Area for Improvement	Area for Improvement
12a Documentation of the difference between initial and final penalty	Area for Improvement	Area for Improvement

Areas of Strong Performance

The following are aspects of the program that, according to the review, are being implemented at a high level:

Clean Air Act (CAA)

All of the FCEs reviewed met the requirements delineated in EPA's Compliance Monitoring Strategy (CMS) Policy and DEC adequately met its FCE commitments.

Clean Water Act (CWA)

The State meets or exceeds expectations regarding the permit limit entry rate for major and non-major facilities with individual permits (Metric 1b5) and meets or exceeds expectations regarding the discharge monitoring report (DMR) data entry rate for major and non-major facilities with individual permits (Metric 1b6).

The State meets or exceeds expectations regarding the completeness and sufficiency of its inspection reports as means to determine compliance at APDES facilities (Metric 6a).

Priority Issues to Address

The following are aspects of the program that, according to the review, are not meeting federal standards and should be prioritized for management attention:

Clean Air Act (CAA)

Stack test and stack test results are not entered into ICIS in a timely manner.

Clean Water Act (CWA)

The State's inspection coverage rates/frequencies for NPDES non-major facilities (i.e., traditional minors) (Metrics 5b1 and 5b2), pretreatment compliance inspections and audits at approved local pretreatment programs (Metric 4a1), significant industrial user (SIU) inspections, with sampling, for SIUs discharging to non-authorized POTWs (Metric 4a2) and construction stormwater inspections (Metric 4a9) are below the State's APDES commitments and EPA and State compliance monitoring strategy (CMS) goals. EPA is concerned that DEC does not have adequate inspection resources to meet the EPA's 2014 CMS inspection coverage rate/frequency goals across all APDES permit universe sub-sectors on an annual or multi-year commitment basis. DEC's inspection coverage rate performance is an area for State improvement.

The State's accuracy of the identification of violations and the determination of a facility's compliance status (Metric 7e) are areas for State improvement.

The State's percentage of enforcement responses where file documentation demonstrates the non-compliant facility returned, or will return, to compliance (Metric 9a) is significantly low and this is an area for State improvement.

The State does not routinely take enforcement actions that address violations in an appropriate manner. The State does not initiate and complete formal enforcement actions in a timely manner, impeding the State's ability to initiate enforcement actions that address violations using an appropriate formal action and impeding the State's ability to complete more appropriate enforcement actions over time. Metric 10b is an area for State improvement.

Clean Air Act Findings

CAA Element 1 - Data

Finding 1-1
Area for Improvement

Summary:
MDRs are not always correctly entered into ICIS.

Explanation:
2b: 9 of the 29 files had a discrepancy between the data in ICIS and the source file. The discrepancies can be broken into six specific Metric 2b subcategories: 1. Facility identifier - In one source file there was a minor discrepancy in the facility address. a. The address in the DFR was different from the address listed in the facility's source file. 2. Stack Tests - data in five of the source files contained discrepancies: a. Four stack tests located in three of the source files were missing from ICIS and the Detailed Facility Report (DFR). b. Four stack tests from two different source files had documentation indicating the stack tests had a passing result, but the test results in ICIS and the DFR indicated the four tests were still pending. 3. High-priority violations (HPV) - documentation in one of the source files indicates a HPV showing up in ICIS and on the DFR, is incorrect. a. Documentation in the source file from the case synopsis show Alaska DEC made a preliminary determination that the violation in question was only a Potential High Priority Violation (PHPV) not an HPV. DEC said that based on conversations they had with EPA regarding the PHPV designation that when the PHPV was entered into the Alaska DEC data system called Air Tools (AT) under the "PHPV" designation that ICIS would not identified the source as an "HPV". 4. Non-HPV federally reportable violations (FRV) - data in four of the source files contained discrepancies related to FRVs a. One of the source files has 3 FRVs listed on the DFR, but the frozen data count and SRF file selection indicates there are a total of four FRVs. b. Two source files each had documented an FRV but neither of those FRVs were listed in the DFR three-year compliance history by quarter for either source. 5. Informal enforcement actions - data in one source file contained a discrepancy related to informal enforcement actions. a. A warning letter found in the source file was entered ICIS with an incorrect date. 6. Air Program and Subparts - documentation in two of the files had a discrepancy related to source designation. a. The two facilities under ICIS source #209060002 and #212200114 are listed as Major Title V sources in ICIS but the source file indicates they are both minor sources. Alaska DEC said that the discrepancy for ICIS source #212200114 is since the Title V permit for the source was not rescinded until after the SRF data was frozen.

State Response: To the extent possible, DEC has corrected in ICIS-Air and Alaska's AirTools database those identified discrepancies which cover the stack tests, informal enforcement actions, and FRVs. DEC will remind and instruct staff to follow the Standard Operating Procedures for data entry of stack test, FRVs and informal enforcement actions data.

The discrepancy identified under as "Air Program and subparts" relates to source designation. In this case the sources had changed from major to minor in the state files but remained classified as major sources in ICIS. At the time of the audit source #212200114 had undergone the change after the SRF data was frozen but before the onsite audit. The Division notes that he state's database is structured for viewing current source classification and does not readily display past classification. These types of source classification changes can be researched and viewed by using the AirTools database audit trail.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
2b Files reviewed where data are accurately reflected in the national data system [GOAL]	100%	%	20	29	68.97%

CAA Element 1 - Data

Finding 1-2
Meets or Exceeds Expectations

Summary:
MDRs are timely entered into ICIS.

Explanation:
Alaska is below the National Goal of 100% but above the national average of 16.8% with 33.30% for timely reporting of HPV determinations. They are fully meeting the National Goal of 100% for timely reporting of compliance monitoring MDRs. They are below the National Goal of 100% but above the National Average of 77.20% with 78.20% for timely reporting of enforcement MDRs.

State Response: DEC Air Quality will conduct audits on a monthly basis to ensure MDRs (source tests, FRVs, and informal enforcement actions) are properly being transferred from the state's database to ICIS-Air and that they are being entered by staff in a timely manner. Existing SOPs for stack test and FRV data entry were forwarded to staff as a reminder.

Recommendation: As soon as possible after finalizing the report ADEC will contact Region 10 to confirm it has re-entered the 4 stack tests with pending results with a pass or fail result. Within 90 days of the completion of the report, ADEC will provide to Region 10 an updated SOP on MDR data entry.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
3a2 Timely reporting of HPV determinations [GOAL]	100%	16.8%	1	3	33.33%
3b1 Timely reporting of compliance monitoring MDRs [GOAL]	100%	80.9%	301	301	100%
3b3 Timely reporting of enforcement MDRs [GOAL]	100%	77.2%	97	124	78.23%

CAA Element 1 - Data

Finding 1-3
Area for Improvement

Summary:
Stack test and stack test results are not timely entered into ICIS

Explanation:
Alaska is well below the national goal of 100% and the national average of 77.10% with an average of 14.50% for the entry of stack test data and results. During the previous Alaska SRF review for Fiscal Year 2012 the metric was 100% for stack tests and stack test results data entry. Prior to and while onsite conducting the file review the EPA SRF reviewers shared their findings with Alaska DEC staff regarding the stack test data entry timeliness issue. Alaska DEC conducted a root cause analysis and due to; (1) electronic data transfer problems from ADEC database to ICIS-Air, (2) key staff and duties changes, (3) along with lack of key data being entered in a timely manner caused the drop in 3b2 metric percentage. Fixes to the electronic data transfers were completed. Audits have been implemented and expectations communicated to staff to correct the issues related to the entry of stack test data and results.

State Response: EPA accurately described the root causes for the deficiencies in this area and noted that DEC has taken corrective action. DEC Air Quality has an existing, established SOP for stack tests in the state database AirTools User Guide. It states the pollutant results are to be updated in the database in a timely manner. The Division will conduct audits on a monthly basis and a monthly reminder will be sent to staff to update key data fields in a timely manner.

Recommendation: Every 45 days for 180 days after issuance of the final report, ADEC will provide Region 10 a summary report of the percentage of stack tests correctly entered into ICIS, and the results (pass, fail, or a pending) for each of the stack tests entered during that 45 day period to ensure that the identified issues have been addressed and there is sufficient improvement in the entry of stack tests and the results.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
3b2 Timely reporting of stack test dates and results [GOAL]	100%	77.1%	19	131	14.5%

CAA Element 2 - Inspections

Finding 2-1
Meets or Exceeds Expectations

Summary:
All the FCEs reviewed met the requirements delineated in EPA's Compliance Monitoring Strategy (CMS) Policy and DEC adequately met its FCE commitments.

Explanation:
EPA reviewers reviewed 23 files which fully documented FCEs. The reviewers were able to determine the compliance status of all 23 sources. The SRF frozen data indicate that Alaska conducted 78 FCEs at major sources and committed to conduct 79 (98.7%). This percentage is below the National Goal of 100% but well above the National Average of 84.5%. The SRF frozen data indicate that Alaska conducted 15 FCEs at SM80 sources and committed to conduct 17 (88.2%). This percentage is slightly below the National Average of 91.3%. The SRF frozen data indicate that Alaska conducted 137 Title V annual compliance certification reviews and committed to conduct 149 (91.9%). This slightly below the National Goal of 100% but well above the National Average of 69.6%.

State Response: DEC Air Quality will continue to strive to meet its FCE commitments.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
5a FCE coverage: majors and mega-sites [GOAL]	100%	84.5%	78	79	98.73%
5b FCE coverage: SM-80s [GOAL]	100%	91.3%	15	17	88.24%
5e Reviews of Title V annual compliance certifications completed [GOAL]	100%	69.6%	137	149	91.95%
6a Documentation of FCE elements [GOAL]	100%	%	23	23	100%
6b Compliance monitoring reports (CMRs) or facility files reviewed that provide sufficient documentation to determine compliance of the facility [GOAL]	100%	%	24	24	100%

CAA Element 3 - Violations

Finding 3-1
Meets or Exceeds Expectations

Summary:
Alaska makes accurate violation, FRV, and HPV compliance determinations.

Explanation:
Twenty-seven files were reviewed onsite. Based on the Compliance Monitoring Reports other source file documentation, and the case synopses retained in the Air Tools system the State made accurate and reliable compliance determinations for all violations. All but one compliance determination was accurately reported into ICIS. A warning letter dated September 28, 2017 was found in the source file a (FRV) that was not entered into ICIS.

State Response: While the state met expectations, the EPA audit identified a warning letter that had not been entered into ICIS. DEC Air Quality has entered the warning letter dated September 28, 2017 into ICIS.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
7a Accurate compliance determinations [GOAL]	100%	%	26	27	96.3%
7a1 FRV 'discovery rate' based on inspections at active CMS sources	%	5.7%	42	263	15.97%
8a HPV discovery rate at majors	%	2.1%	3	158	1.9%
8c Accuracy of HPV determinations [GOAL]	100%	%	20	20	100%

CAA Element 4 - Enforcement

Finding 4-1
Meets or Exceeds Expectations

Summary:
Alaska makes accurate violation, FRV, and HPV compliance determinations, utilizes appropriate enforcement responses for HPVs, and formal enforcement responses include corrective action that returns facilities to compliance in a specified timeframe.

Explanation:
Metric 10a - Four of the five files reviewed with HPVs were addressed or had a case development and resolution timeline in place as required by EPA HPV policy. One file had an HPV during the review period that was not addressed within 180 days and it did not have a CD&RT in place within 225 days of day zero. Alaska DEC said that the length of time required to resolve this HPV was partially complicated because the facility is located within a remote Alaska Village. Therefore, negotiations, resolution and the final addressing action took much more time to achieve than Alaska DEC had anticipated. Some of the issues causing the delay were related to communication difficulties, in addition to financial issues with the facility that had to be overcome and assessed before the HPV could be addressed and resolved. Although, no record could be found that a CD&RT was in place, it was however, confirmed by the SRF file reviewers that Alaska DEC had consulted with the appropriate EPA staff and that EPA staff agreed with and approved Alaska DEC's final resolution and addressing action for the HPV.

State Response: DEC Air Quality will continue to strive to make accurate violation determinations and utilize appropriate enforcement responses for HPVs including corrective actions to return facilities to compliance.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
10a Timeliness of addressing HPVs or alternatively having a case development and resolution timeline in place	100%	%	4	5	80%
10b Percent of HPVs that have been have been addressed or removed consistent with the HPV Policy [GOAL]	100%	%	3	3	100%
14 HPV case development and resolution timeline in place when required that contains required policy elements [GOAL]	100%	%	4	4	100%
9a Formal enforcement responses that include required corrective action that will return the facility to compliance in a specified time frame or the facility fixed the problem without a compliance schedule [GOAL]	100%	%	8	8	100%

CAA Element 5 - Penalties

Finding 5-1
Area for Attention

Summary:
Alaska generally documents the gravity, economic benefit and any rational for differences in the initial and final penalty assessed. Alaska also includes a copy of the cancelled check for penalties paid.

Explanation:
A total of five files contained actions assessing a penalty. However, in one of the five files (ICIS #218800002) documentation for the penalty calculation and economic benefit could not be located in the Air Tools data base.

State Response: The subject file existed at the time of the audit, but for unknown reasons, DEC staff did not identify and produce it for EPA's review at that time. However, penalty calculations appear to have been discoverable in the database.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
11a Penalty calculations reviewed that document gravity and economic benefit [GOAL]	100%	%	4	5	80%
12a Documentation of rationale for difference between initial penalty calculation and final penalty [GOAL]	100%	%	5	5	100%
12b Penalties collected [GOAL]	100%	%	5	5	100%

Clean Water Act Findings

CWA Element 1 - Data

Finding 1-1
Meets or Exceeds Expectations

Summary:
The State meets or exceeds expectations regarding the permit limit entry rate for major and non-major facilities with individual permits (Metric 1b5) and meets or exceeds expectations regarding the DMR data entry rate for major and non-major facilities with individual permits (Metric 1b6).

Explanation:
Finding 1-1 focuses on Metrics 1b5, the percentage of active individually permitted DMR filers that have permit limits present in the Integrated Compliance Information System (ICIS) national database, and on Metric 1b6, the percentage of expected DMRs that were received during the Fiscal Year 2017 (FY 2017) from all active, individually permitted DMR filers.

According to frozen FY 2017 data, the State performed perfectly (i.e., 100%) for each metric and above the national expectations (i.e., >= 95%), with one minor data entry anomaly.

The Icicle Seafoods, Inc. facility's (M/V Northern Victor) Permit No. AK0052868 had a limit set that was not activated so consequently, this facility was not an active DMR filer and should have been excluded from the Metric 1b5 database (i.e., universe and count) up to through the permit's termination date, October 22, 2017.

The minor data entry anomaly does not detract from the State's strong performance regarding these two data entry metrics. This explanation was revised in response to the State's comments to eliminate discussion about North Tongass Car Wash, Permit No. AK0053635.

State Response: Metrics 1b5 and 1b6 - Permit limit entry rate and DMR data entry rate for major and non-major facilities with individual permits
The state agrees with the rating meets or exceeds expectations. For the period of this review FFY2017, the state maintained 100% entry of active individually permitted DMR filers that have permit limits present in the ICIS database. The anomalies mentioned are superfluous and not applicable to the metric. Individual permit number AK0052868 should have been excluded from the metric as stated. Individual permit number AK0053635 became effective on June 1, 2017; however, the DMR was not due until October 15, 2017 and therefore should have been excluded from the metric.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
1b5 Completeness of data entry on major and non-major permit limits. [GOAL]	95%	88.1%	55	55	100%
1b6 Completeness of data entry on major and non-major discharge monitoring reports. [GOAL]	95%	90.6%	1548	1548	100%

CWA Element 1 - Data

Finding 1-2
Area for Attention

Summary:
The State's mandatory ICIS data entries' completeness and accuracy is an area for attention.

Explanation:
Finding 1-2 focuses on Metric 2b, files reviewed where the data are accurately reflected in the ICIS national data system, and on the FY 2017 frozen, verified data for the universes and counts for Metric 5b1 (inspection coverage for non-major individual permits) and Metric 5b2 (inspection coverage for non-major general permits).

This finding is based on two data completeness and accuracy evaluations: (1) file reviews and (2) a data metrics analysis (DMA) determining there were missing wet weather permit coverages from the ICIS data base.

In regard to Metric 2b, 24 of the 32 files reviewed (i.e., 75%) had accurate and complete mandatory data in the ICIS national data system. Eight files did not have complete or accurate data in ICIS. For example, the legal permittee's name in ICIS was incorrect for three facilities. Enforcement actions were not included in ICIS for four facilities and an inspection was not included in ICIS for another facility. See Attachment A, Element 1 Data, for additional details on missing and inaccurate data entries for the eight identified files.

A data metrics analysis (DMA) was conducted on the ECHO-generated FY 2017 frozen, verified data's metric results for completion and accuracy. The DMA determined that the frozen data for Metric 5b1 (individual permit inspection coverage) included one general permit coverage (i.e., AKR06AE63) and MS4 permits, and that frozen data regarding Metric 5b2 (general permit inspection coverage) included some but not all wet weather permit coverages.

The FY 2017 frozen data for the Metric 5b2's universe included only 161 multi-general sector permit (MSGP) coverages and 208 construction stormwater general permit (CGP) coverages.

However, DEC's 2017 CMS Plan identified a MSGP universe of 335 coverages and a CGP universe of 845 coverages. EPA's revised explanation considers the State's response regarding the CWA Logic Notes and inclusion of wet weather permit coverages in data pulls, and the consequent further evaluation of the ICIS data base showing not all CGP and MSGP coverages had been uploaded into ICIS. A recommendation is included here to facilitate the updating of the ICIS data base to include all wet weather permit coverages.

See Attachment A, Element 1 Data, for additional discussion regarding the evaluation of Metric 2b completeness and accuracy.

By May 1, 2020, DEC shall submit a summary report to EPA describing the corrective actions (i.e., data entry efforts) it will implement to ensure all applicable MSGP and CGP coverages are entered into ICIS in accordance with the NPDES electronic reporting rule requirements with a goal of having complete and accurate metric universes by January 1, 2023. The summary report must include yearly incremental entry goals (e.g., specified goals related to numbers of CGP and MSGP coverages to be entered each calendar year) designed to achieve complete and accurate metric universes by January 1, 2023.

State Response: Metric 2b - Data accurately reflected in the ICIS national data system
The state disagrees with the rating area for improvement. The eight of 32 files reviewed and determined to be inaccurate or incomplete results in approximately 75% of data accurately reflected in ICIS.
Suggested correction: The rating for metric 2b should be changed to area for state attention based on the SRF Round 4 Reviewers Guide.
Recommendation 1: The few inaccuracies or incomplete data entry is attributable to the staff turnover rate, specifically in calendar year 2017, and those areas identified have been corrected.
Recommendation 2: DEC is in the process of updating and standardizing our POGs. Through efforts within DEC to streamline the approval processes, DEC has set a goal that all POGs will be updated in CY 2019. A training will be conducted by April 30, 2020 to allow DEC time to update, reorganize, and finalize the POGs.
Metric 5b1 and 5b2 - Inspection coverage for non-major individual and general permits
The state disagrees with the rating area for improvement. The referenced DMA for metric 5b1 and 5b2 stating "there were inapplicable permit coverages and inspections included in frozen, verified universes and counts…DEC's verified data…inappropriately included wet weather permit coverages in both the Universes and Counts for these two metrics" misrepresents the metric and fails to account for EPA's guidance in which the CWA Logic Notes explain considerations used to develop the select logic for SRF CWA data metrics. The CWA metric specific logic notes for metric 5 state "The counts are combined for traditional wastewater inspections, wet weather inspections, and pretreatment inspections (on direct dischargers only). As of April 2018, ICIS-NPDES doesn't have enough information to reliably identify wet-weather-only permits in order to separate them out, so those permits and their inspections are included in the metrics." It is clear that wet-weather-only permits and inspections are, at this time, inseparable; as a result, the only option available is to include wet weather permits and inspections in metric 5; any other interpretation or manipulation of the data is unreliable. The inclusion of inapplicable facilities in DMA-related metric universes and counts is a recurring SRF review issue and should be corrected throughout this SRF and attachments. Not only is

metric 5 inclusive of wet-weather permits and inspections, it must also be calculated using the state specific CMS plan for the review year as the denominator and the number of non-major individual or general permits as the numerator, neither of which are reflected in the rating. When metric 5 is calculated accurately and in consideration of EPA guidance, it is clear that the rating is inaccurate.
Correction Attachment A: "These six facilities should have been addressed under wet weather metrics, 4a8 and 4a7 respectively, and not included in this Metric 5b1 universe and count." The referenced 4a7 and 4a8 are not data metrics and therefore not part of the data metric analysis report in ECHO or in the CWA Logic Notes. According to the SRF Metric Quick Reference Guide and the CWA Plain Language Guide, 4a7 and 4a8 are CMS metrics that do not have a place in the SRF.
Correction: "The universes and counts were revised and corrected by excluding the wet weather permit coverages and inspections. Accordingly, the Metric 5b1's corrected Alaska percentage result is 11.4% in comparison to the national average of 22% and the Metric 5b2's corrected Alaska percentage result is 4.8% in comparison to the national average of 5.9%." Change to accurately reflect the averages based on the CWA Round 4 Plain Language guide establishing that "The numerator = the number of non-major facilities with general permits inspected; the denominator = the number of facilities with non-major general permits in the state specific CMS Plan for the review year…the denominator that automatically populates in the data metric analysis for Metric 5b2 is not likely to reflect the state's annual inspection commitment that varies from year to year."

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
2b Files reviewed where data are accurately reflected in the national data system [GOAL]	100%	%	24	32	75%

CWA Element 2 - Inspections

Finding 2-1
Meets or Exceeds Expectations

Summary:
The State meets or exceeds expectations regarding the inspection coverage rates/frequencies for facilities with combined sewer overflows (CSO) (Metric 4a4) and for publicly-owned treatment works (POTWs) with sanitary sewer systems (SSSs) (Metric 4a5). The State also meets or exceeds expectations regarding the completeness and sufficiency of its inspection reports as means to determine compliance at APDES facilities (Metric 6a).

Explanation:
Finding 2-1 focuses on the inspection coverage rates/frequencies for CSO-affected facilities and POTWs with SSSs and sanitary sewer overflows (SSO). Finding 2-1 also focuses on the quality of an inspection reports' completeness and sufficiency to determine compliance at a DEC APDES facility. Finally, Finding 2-1 addresses the current non-applicability of Metrics 4a10 and 4a11 to DEC's APDES Compliance Program.

In regard to Metric 4a4, the EPA 2014 CMS has a minimum inspection frequency goal for at least one comprehensive CSO-related inspection every five years. The Juneau-Douglas POTW (AK0023213) is DEC's only identified CSO-related facility. DEC inspected this facility in 2014, 2016 and 2018 and each related inspection report demonstrates the inspector reviewed CSO-related information to assess the POTW's compliance with its APDES permit's CSO provisions. The relevant metrics chart below has a 100% entry indicating DEC is meeting this multi-year based frequency goal even though a CSO-related inspection was not completed in CY 2017 (see asterisk).

In regard to Metric 4a5, the EPA 2014 CMS has a minimum inspection frequency goal for SSSs of at least 5% of SSSs each year, with an inspection priority given to SSSs with chronic SSOs. The EPA 2014 CMS does not have a specific inspection frequency goal for facilities with SSOs, with suggestions that SSO-related inspections be based on information obtained regarding known or suspected overflow events and their frequency.

Metric 4a5 was an area for State improvement in the December 2014 SRF Report (FY 2012).

Subsequent to that 2014 report's issuance, DEC adopted procedures for routinely monitoring their 24-hour compliance hotline as a means to more readily identify SSO events and then evaluate the need for follow-up inspections during the annual CMS inspection plan development process. DEC's 2017 CMS Plan identified a universe of 172 POTWs presumably all with SSSs, and included proposed inspections at 25 facilities or approximately 14.5% of its presumed SSS-based universe. Review of ICIS-generated CY 2017 inspection data shows DEC inspected 24 POTWs in 2017 or an inspection coverage rate of 14%.

A summary review of 2014-2019 CMS plans and applicable inspection results generally shows that DEC plans to inspect and completes inspections of POTWs with SSSs at least at the CMS goal rate of 5% routinely. Additionally, the DEC 2017 CMS Plan identified five SSO events from the hotline reviews, with two SSO events at EPA-regulated facilities. In 2017, DEC proposed to inspect and did inspect the major POTW that had an SSO event.

In regard to Metric 6a, DEC adopted numerous program operating guidelines (POGs) in response to the December 2014 SRF Report (FY 2012) including an APDES inspection report template which is used by inspectors routinely.

Except with regard to the inspection evaluation period addressed under findings related to Metric 7e, 34 inspection reports were reviewed for quality needed to make accurate compliance determinations, and only one file lacked adequate complete and sufficient records to determine

compliance at the facility; that file lacked copies of an inspection report and resulting compliance letter.

In regard to Metric 4a10, DEC has consistently reported in their annual CMS inspection plans that there are no large or medium confined animal feeding operations (CAFOs) in Alaska. The relevant metrics chart below has an NA for currently non-applicable based DEC-provided information in its CY 2017 CMS Plan. EPA will work with DEC in CY 2020 to update and verify the existence or non-existence of CAFOs in Alaska based on EPA headquarters comments regarding U.S. Department of Agriculture data on Alaska cattle feeding operations herd sizes.

In regard to Metric 4a11, the State does not have an EPA-authorized biosolids program for major POTWs. The relevant metrics chart below has an NA for non-applicable.

Finding 2-1 (Meets or Exceeds Expectations) regarding Metrics 4a4 and 4a5 inspection coverage rates/frequencies has to be considered in context with Finding 2-2 (area for State attention) and Findings 2-3 and 2-4 (areas for State improvement) because DEC's ability to meet the CMS inspection frequency/coverage goals for any one metric sub-sector competes for the DEC's limited inspection resources which are currently not adequate to meet EPA CMS goals for DEC's entire APDES inspection universe.

State Response: Metrics 4a4 and 4a5 - Inspection rates/frequencies for facilities with CSOs and POTWs with SSSs

The state agrees with the rating meets or exceeds expectations.

Metric 6a - Completeness and sufficiency of inspection reports as a means to determine compliance

The state agrees with the rating meets or exceeds expectations.

The state has worked diligently to draft and implement program operating guidelines (POGs) to improve performance in and execution of metrics 4a4, 4a5, and 6a.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
4a10 Number of comprehensive inspections of large and medium concentrated animal feeding operations (CAFOs) [GOAL]	100% of commitments	%	0	NA	0
4a11 Number of sludge/biosolids inspections at each major POTW. [GOAL]	100% of commitments	%	0	NA	0
4a4 Number of CSO inspections. [GOAL]	100% of commitments*	%	1	1	100%
4a5 Number of SSO/SSS inspections. [GOAL]	100% of commitments	%	24	25	96%
6a Inspection reports complete and sufficient to determine compliance at the facility. [GOAL]	100%	%	33	34	97.1%

CWA Element 2 - Inspections

Finding 2-2
Area for Attention

Summary:
The inspection coverage rates/frequencies for major facilities (Metric 5a1), Phase I and II MS4 audits or inspections (Metric 4a7) and industrial stormwater inspections (Metric 4a8) are areas for State attention in the context of DEC's entire APDES inspection universe because DEC does not have adequate inspection resources to meet the EPA's 2014 CMS inspection coverage rate/frequency goals across all sub-sectors on an annual or multi-year commitment basis. However, DEC did meet or exceed its 2017 CMS Plan goals for these three metrics in 2017.

Explanation:
Finding 2-2 focuses on the inspection coverage rates/frequencies for major facilities, Phase I and II MS4 stormwater facilities and industrial stormwater facilities (i.e., MSGP).

In regard to Metric 5a1's major facility inspection coverage, it was an area for State improvement in the previous December 2014 SRF Report (FY 2012).

Since 2014, DEC has made a concerted effort to ensure major facilities are inspected once every two years, consistent with the EPA 2014 CMS goals. DEC's 2017 CMS Plan proposed 27 major inspections with EPA contributing 3 inspections of that total number. DEC's 2018 CMS Plan indicates that 27 major inspections were completed in 2017 with EPA contributing 3 inspections to that total number. The relevant metrics chart below reflects this 2017 DEC effort but DEC's meeting of 2017 expectations for this one discrete Metric 5a1 must be considered and factored into context of the totality of inspection coverage circumstances over time as discussed below.

EPA has assisted DEC's inspection efforts by inspecting APDES facilities, including major facilities. For example, in the most recent two year period 2017-2018, EPA inspected 9 major facilities out of a two-year total of 56 inspections (i.e., 16%) in comparison with a major facility universe of 57 facilities. Attachment C includes a summary of major facility inspection coverage rates for CYs 2014-2017 showing overall performance met or exceeded the Metric 5a goals.

In regard to Metric 4a7, this metric was also an area for State improvement in the December 2014 SRF Report (FY 2012).

DEC has six MS4 facilities and its 2017 CMS Plan projected an inspection at one MS4 facility which was completed as planned. However, in the context of the EPA CMS multi-year commitment goals, DEC missed initial frequency deadlines and then had extended delays in completing initial compliance monitoring activities at three MS4 facilities; thus, the basis for the determination that additional attention should be directed to this sub-sector in terms of planning and scheduling inspections and audits to meet CMS goals.

In regard to Metric 4a8, DEC's inspection coverage for this MSGP-based sub-sector met or exceeded expectations during the last review period covered by the December 2014 SRF Report (FY 2012).

The EPA 2014 CMS has a goal of inspecting 10% of the universe yearly. In 2017, DEC inspected about 8.7% of the MSGP universe but in the period 2015-2018, the average annual coverage is 7.7%. However, in 2017, DEC exceeded its 2017 MSGP inspection goal. DEC proposed to complete 23 MSGP inspections but it completed 29 inspections (126% of its goal).

DEC's 2017 performance for these three metrics and this Finding 2-2 (area for State attention) regarding Metrics 4a7, 4a8 and 5a1 inspection coverage rates/frequencies over time (i.e., multi-year) has to be considered in context with Finding 2-1 (meets or exceeds expectations) and Findings 2-3 and 2-4 (areas for State improvement) because DEC's ability to meet the CMS inspection frequency/coverage goals for any one metric sub-sector competes for the DEC's limited inspection resources which are currently not adequate to meet EPA CMS goals for DEC's entire APDES inspection universe.

DEC continues to have significant, recurring performance limitations and deficiencies regarding achievement of EPA CMS inspection coverage goals on a consistent basis across all metric sub-sectors. Accordingly, the corrective action recommendations for Findings 2-3 and 2-4 are equally applicable for Findings 2-1 and 2-2 because of the DEC's zero sum situation regarding inspection resources that must be allocated across all APDES permit universes and subsectors.

See Attachment C for further details regarding the evaluation of Metrics 4a7, 4a8 and 5a1.

State Response: Metric 5a1 - Major facility inspection coverage
The state disagrees with the rating area for state attention. In the most recent two-year period 2017-2018, EPA inspected nine major facilities out of a two-year total of 57 inspections while the state conducted 24 inspections each year for a two-year total of 48 inspections. The summation over the two-year period 2017-2018 of the EPA and state inspections is 57 in comparison with a major facility universe of 57 facilities results in 100% coverage. The rating for metric 5a1 should be changed to meets or exceeds expectations. EPA conducted inspections are part of the performance partnership agreement and it would be a duplication of effort, misuse of resources, and an unnecessary interruption of business to re-inspect a facility that EPA had inspected outside of the CMS inspection intervals. The inspection numbers are only reflective of state inspections and not inclusive of those led by EPA leading the reader to conclude that the major facility universe has not been inspected in accordance with the CMS goals, an erroneous conclusion as previously demonstrated, and the major facilities universe has 100% inspection coverage.

The untitled table below, metric 5a1, appears to indicate that 57 major facility inspections should have been conducted during FFY2017 and represents the state as having completed 40.4% of the inspection goal. The goal for CY2017 was to inspect one-half of the major facility universe (57/2) or approximately 29 inspections. Since 2010, DEC CMS planning has adopted the national goal of an inspection of a major facility once every two years. It is inconsistent data presentation to report the goals on a two-year interval yet only indicate a single year of inspection totals.

Correction: Update the table to either increase column “State N” to a two-year total or decrease column “State D” to a single year goal and correct column “State %” accordingly.

Metric 4a7 - Phase I and II MS4 audits or inspection
The state disagrees with the rating area for state attention. The state inspected one MS4 in the CY2017 CMS as planned. In the context of the EPA CMS multi-year commitment goals, DEC has inspected the remaining five MS4s between CY2016-2018 thus fully satisfying the CMS commitment goals. Given both the scope of the single federal fiscal year SRF and in consideration of the mentioned, although outside of the scope of metric 4a7, multi-year commitment goals, this rating should be changed as it has 100% coverage.

Suggested correction: The rating for metric 4a7 should be changed to meets or exceeds expectations.

Metric 4a8 - Industrial stormwater inspections
The state agrees with the rating area for state attention. For CY2019 CMS that state has proposed to conduct 38 MSGP inspections of the total 364 MSGP authorizations constituting 10.4% of the sector, thus satisfying the 52% of the nationwide CMS inspection goal.

Correction: Change "DEC has five MS4 facilities" to correctly reflect the number of MS4 facilities. DEC has five non-major MS4 facilities and one major MS4 facility for a total of six MS4 facilities.
Correction: "Finding 2-2 (area for State attention) regarding Metrics 4a7, 4a8 and 5a1 inspection coverage rates/frequencies has to be considered in context with Finding 2-1 (area for State attention)…" Change to correctly reflect the finding of 2-1 to meets or exceeds expectations.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
4a7 Number of Phase I and II MS4 audits or inspections. [GOAL]	100% of commitments	%	1	1	100%
4a8 Number of industrial stormwater inspections. [GOAL]	100% of commitments	%	29	23	126.1%
5a1 Inspection coverage of NPDES majors. [GOAL]	100%	%	24	24	100%

CWA Element 2 - Inspections

Finding 2-3
Area for Improvement

Summary:
The State's inspection coverage rates/frequencies for pretreatment compliance inspections and audits at approved local pretreatment programs (Metric 4a1), significant industrial user (SIU) inspections, with sampling, for SIUs discharging to non-authorized POTWs (Metric 4a2) and construction stormwater inspections (CGP) (Metric 4a9) are substantially below the State's APDES commitments and EPA and State compliance monitoring strategy (CMS) goals. The primary root cause is that DEC does not have adequate inspection resources to meet the EPA's 2014 CMS inspection coverage rate/frequency goals across all APDES universe sub-sectors on an annual or multi-year commitment basis.

The State's performance regarding the timeliness of inspection report completion (Metric 6b) is also an area for State improvement.

Explanation:
Finding 2-3 focuses on the inspection coverage rates/frequencies for pretreatment compliance inspections and audits at approved local pretreatment programs, SIU sampling inspections for SIUs

discharging to non-authorized POTWs and construction stormwater inspections (CGP). Finding 2-3 also focuses on Metric 6b, timeliness of inspection report completion.

Metric 4a1 was an area for State improvement in the December 2014 SRF Report (FY 2012).

DEC has had pretreatment sector authority and jurisdiction since the APDES Phase II transfer, October 31, 2009. Initially, the Fairbanks/GHU POTW (AK0023451) was the only approved pretreatment program. The North Pole POTW (AK0021393) pretreatment program was approved on May 15, 2012.

The DEC Program Description, Section 9.1.4, indicates that DEC will conduct an annual pretreatment compliance inspection (PCI), and a pretreatment compliance audit (PCA) at least every five years. Subsequent to DEC initiating pretreatment program implementation oversight, DEC CMS plans generally include PCI coverage rate goals in accord with EPA CMS goals.

The DEC PCI/PCA commitments, as summarized in their 2017 CMS Plan, are to conduct at least one PCA every five years and at least two PCIs every five years which is in accord with EPA's 2014 CMS.

The DEC's 2017 CMS Plan proposed to conduct a pretreatment compliance inspection (PCI) of the Fairbanks/GHU program. The PCI was not completed as planned. The DEC's 2018 CMS Plan proposed to conduct a PCI at the North Pole POTW in the fall 2018. The PCI was not completed as planned. In December 2018, DEC confirmed that it has not conducted any PCIs at either approved pretreatment program.

A December 2018 draft DEC 2019 CMS Plan and a March 2019 final draft DEC 2019 CMS Plan indicate DEC's intentions to conduct PCIs in 2019 at each of the approved programs.

As of October 31, 2019, DEC will have had authority to implement pretreatment programs (including oversight) for ten years. Assuming DEC completes its 2019 CMS Plan as proposed in draft in December 2018 and March 2019, DEC will have completed one documented PCA and one PCI of the Fairbanks/GHU program in comparison with the EPA CMS multi-year commitment goals of at least two PCAs and four PCIs in that same ten year time frame.

As of October 31, 2019, North Pole's pretreatment program is in its eighth year of implementation. DEC completed one PCA and no PCIs within the first five years of North Pole's Program (i.e. August 2012 - August 2017). Assuming DEC completes its 2019 CMS Plan as proposed in draft in December 2018 and March 2019, DEC will have completed one PCI in the approximate two and one-half years of North Pole's second five-year implementation period.

Regarding Metric 4a2, the metric was an area for State improvement in the December 2014 SRF Report (FY 2012) based on DEC's underperformance in conducting SIU sampling inspections of the three SIUs in North Pole prior to the 2012 authorization of a North Pole pretreatment program.

The DEC Program Description, Section 9.1.4, states in part that DEC will inspect and sample significant industrial users (SIUs) in non-delegated POTWs at least once per year, which is consistent with the EPA 2014 CMS.

As part of DEC's 2015-2016 SIU state survey, DEC determined that the Alaskan Brewing Company (ABC) was a SIU with reasonable potential to adversely affect operations at the Juneau Mendenhall POTW. DEC conducted a SIU inspection (non-sampling) of the ABC facility in February 2016 but no SIU sampling inspections were conducted at the ABC facility in 2017 or 2018.

A December 2018 draft 2019 CMS Plan did not include any SIU sampling inspection of the ABC facility in 2019. A March 2019 final draft 2019 CMS Plan indicates ABC will be inspected in 2019. Assuming DEC completes an ABC sampling inspection as proposed in the final draft 2019 CMS plan, DEC will have conducted a partial inspection of ABC in 2016 (i.e., inspection lacked sampling), no SIU sampling inspections of ABC in 2017 and 2018 and a SIU sampling inspection in 2019.

Metric 4a9 was identified as an area for State improvement in the December 2014 final SRF Report (FY 2012) for CGP facilities.

The EPA 2014 CMS's inspection frequency goal for CGP permittees is to inspect at least 10% of the regulated construction sites annually. For CY 2017, DEC proposed to complete 32 CGP inspection within a universe of 845 coverages or a projected coverage rate of 3.8%. DEC completed 39 inspections for an actual coverage rate of 4.6%.

From an overall APDES program inspection coverage rate perspective, it is important to consider each subject sub-sector (e.g., CGP, MSGP, etc.) within the totality of DEC's entire ADPES universe and to consider the variability of inspection coverage rates year to year to more accurately assess program performance over multi-year commitments.

Attachment B contains an evaluation of the first four calendar years of DEC's CGP coverage rate performance under the EPA 2014 CMS. The evaluation indicates that DEC's projected and estimated average inspection coverage rate over these four years is less than 5% per year, substantially below the EPA CMS coverage rate goal of 10%.

Regarding Metric 6b, the State's performance regarding the timeliness of inspection report completion was an area for improvement in the December 2014 SRF Report (FY 2012).

The DEC Program Description, Section 9.1.5, states in part DEC's intent to transmit the final inspection report to the inspected facility's responsible party within 30 days of a compliance evaluation inspection (CEI) or within 45 days of a compliance sampling inspection (CSI). In the previous SRF review, 4 of 17 inspection reports were completed within DEC's prescribed timeframe goal (23.5%) with an average time for completion of reports of 86 days.

DEC created an inspection report template POG in response to the 2014 SRF Report's timing improvement status which template is now routinely used by DEC inspectors. In this current SRF

review, 11 of 35 inspection reports were completed within the prescribed timeframe goal (31.4%). Completion/submission time averages were 58 days for CEI reports and 32 days for a CSI report.

See Recommendation Nos. 1 - 7 under Element 2, Inspections, Finding 2-4 for corrective actions related to inspection frequency/coverage rates for all APDES permit universe sub-sectors, including construction stormwater general permit (CGP) sub-sector inspections.

State Response: Metrics 4a1 and 4a2 - Pretreatment compliance inspections and audits and SIU inspections with sampling and SIUs discharging to non-authorized POTWs
The state agrees with the rating area for state improvement. The state did not unilaterally eliminate PCIs and has included PCIs in the CY2019 CMS goal; however, due to the resource intensive nature of inspecting and auditing facilities with approved pretreatment programs and inspecting significant industrial users with sampling, the state has allocated funding in state fiscal year 2020 to contract inspections of both the approved programs and significant industrial users without an approved program.

Recommendation 1 and 2: In consideration of this effort, DEC will be working with a contractor to establish timelines as identified in recommendations 1 and 2 and hope to provide the resulting timeline by April 30, 2020 and have completed two PCIs and one SIU inspection with sampling by June 30, 2020.

Metric 4a9 - Phase I and II construction stormwater inspection
The state agrees with the rating area for state improvement. The CMS goal of 10% inspections each year of the approximately 845 authorizations is unachievable at the current staffing levels, short inspection season, and in consideration of the geographical magnitude of the state. As a means of prioritization, the state has set a goal to inspecting 10% of the total new authorizations each year

Metric 6b - Timeliness of inspection report completion
The state disagrees with the rating area for state improvement. Upon request, EPA provided the data used to identify which inspection reports were reviewed and which of those were determined to exceed the report completion timeline to assert that nine of 34 reports were timely. The data provided demonstrates that 35 inspection reports were reviewed for timeliness. Of the 35 inspection reports reviewed: EPA failed to account for those with sampling events, which have an inspection timeliness goal of 45 days, amounting to an additional five timely inspection reports; EPA misidentified the number of days to complete one inspection report; EPA included two inspection reports from 2015 and one from 2018 all of which are outside the timeframe of this SRF; and, EPA included one inspection report from 2013, the year before the state received the previous SRF in 2014.

Correction: The Program Description part 9.1.5 states a compliance inspection report will be transmitted within 30 days while a compliance sampling inspection report will be transmitted within 45 days. Given the inaccurate description of the state's completion and transmittal goals in conjunction with multiple errors in the supporting evidence and documentation provided by EPA the state questions the accuracy of the rating.

Correction: EPA's documentation demonstrates that 35 inspection reports were reviewed; of those, EPA stipulated that nine were timely, four of those were outside of the SRF review year, and six were misidentified as untimely. Correcting these errors results in 15 of 31 inspection reports completed timely.

Correction: EPA states that "the time for inspection reports was reduced significantly to an average of 57 days," Correcting for the errors identified above results in a combined average of 52 days. This observation fails to account for the Program Description establishing goals of compliance inspection reports transmitted within 30 days while a compliance sampling inspection reports transmitted within 45 days. A more holistic and accurate representation of the program goals based on the data EPA selected and provided follows: compliance inspection reports with a transmittal goal of 30 days has an average completion time of 66 days; while a compliance sampling inspection report with a transmittal goal of 45 days has an average completion time of 30 days.

Recommendation 3: Beginning in December 2018 the state has placed concerted effort on timeliness of inspection report completion and communicated this effort through staff training, despite the short inspection season and limited personnel; as of September 9 for CY2019, 95% of inspection reports have been completed on time with an average completion time of 22 days. Training of staff and focusing efforts on timeliness of inspection report completion has already transpired and is unnecessary as demonstrated by the state's current timeliness of inspection reports.

Recommendation:

Rec #	Due Date	Recommendation
1	12/31/2019	By December 31, 2019, DEC shall submit the CY 2020 CMS Inspection Plan with a proposed SIU sampling inspection of the Alaskan Brewing Company (ABC) (Juneau) to be conducted in CY 2020, along with a multi-year planned pretreatment inspection/audit schedule consistent with the EPA 2014 CMS that proposes actual 2020 date(s) and tentative dates in future specified years covering 2021-2024 for the Fairbanks/GHU and North Pole pretreatment programs. The proposed schedule shall include the specific type of compliance monitoring activity (e.g., audit, inspection) projected for implementation at each program and the projected schedule (e.g., targeted calendar quarter/year) for each activity.
2	12/30/2020	By December 31, 2020, DEC shall complete a SIU sampling inspection of the Alaskan Brewing Company (ABC) (Juneau). DEC shall develop a sampling plan in conjunction with the POTW to ensure the sampling is conducted on all pollutant parameters that have the potential to cause or contribute to pass-through at or interference of the POTW's treatment trains. DEC shall submit a completed sampling plan to the EPA at least 30 days prior to the planned sampling inspection.
3	04/30/2020	The DEC Compliance Program shall conduct a training course for all Program staff regarding POG revisions made in response to this SRF Report or for any other reasons, and address and review the 30-day and 45-day time frame goals for completing and conveying completed comprehensive evaluation inspection and comprehensive sampling inspection reports, respectively, to the applicable facility.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
4a1 Number of pretreatment compliance inspections and audits at approved local pretreatment programs. [GOAL]	100% of commitments	%	0	1	0%
4a2 Number of inspections at EPA or state Significant Industrial Users that are discharging to non-authorized POTWs. [GOAL]	100% of commitments	%	0	1	0%
4a9 Number of Phase I and Phase II construction stormwater inspections. [GOAL]	100% of commitments	%	39	32	121.9%
6b Timeliness of inspection report completion [GOAL]	100%	%	11	35	31.4%

CWA Element 2 - Inspections

Finding 2-4
Area for Improvement

Summary:
The State's multi-year inspection coverage rates/frequencies for NPDES non-major facilities (i.e., traditional minors) (Metrics 5b1 and 5b2) are below the State's multi-year APDES commitments and EPA and State multi-year compliance monitoring strategy (CMS) goals.

Explanation:
Finding 2-4 focuses on the multi-year inspection coverage rate/frequency goals for NPDES non-major facilities often referred to as traditional non-major facilities or traditional minor facilities (i.e., excluding facilities covered under Metrics 4a1 - 4a11). However in terms of a single year performance (CY 2017 only), DEC data indicates DEC exceeded their CY 2017 Plan commitments for traditional minor inspections by approximately 7% (completing 74 inspections when 69 inspections were scheduled).

DEC's Amended Final APDES Program Application (approved 2008) committed to inspect all minor facilities at least once every five years. DEC's CMS inspection plans generally adopt the EPA CMS goal of inspecting traditional minor facilities at least once every five years (i.e., 20% per year) but typically acknowledge that meeting those multi-year inspection goals will be

challenging, especially for the log transfer facilities sub-sector which has a universe of significant numbers of inactive sites, and the placer mining facilities sub-sector covered by general permits.

Metrics 5b1 and 5b2 were identified as areas for State improvement in the December 2014 final SRF Report for FY 2012.

In the last 10 years, DEC has had a continuing significant challenge meeting the EPA 2014 CMS multi-year inspection goals for traditional minor permits, primarily because of insufficient inspection staff resources.

DEC's inspection performance for these two traditional minor facility subsets illustrates the effect of insufficient inspection staff resources. Attachment A describes the corrections made to the frozen FY 2017 universes and counts for Metrics 5b1 and 5b2 to focus on traditional minor permittees. This discussion uses the corrected Metric 5b1 universe of 35 individual permits and corrected count of 4 inspections and the corrected Metric 5b2 universe of 1115 general permit coverages and corrected count of 54 inspections.

Regarding Metric 5b1, a review was conducted of the 35 individual permits that were in effect at least some time during any of the five calendar years 2013 - 2017. The review showed that 18 of the 35 permits had at least one inspection during that five-year period (51%) and 17 permits (49%) had not been inspected in that five-year period. In response to the State's responses, the metrics chart was revised to include DEC's five-year 51% coverage rate to date in comparison with the five-year, 100% CMS coverage goal.

Of the 17 not-inspected permits, 7 permits were issued within the last 2.5 years of that 5-year time period and were awaiting a first inspection.

Of the remaining 10 not-inspected permits, two permits have had no ICIS-recorded inspections for at least 13 years. Two other permits did not have any ICIS-recorded inspections for about 7.4 years and 8.5 years prior to January 1, 2018. Four permits are exceeding five years without any ICIS-recorded inspection activity. Finally, two permits terminated in October and November 2016 had no prior inspection history within that 2013 - 2017 time frame. These remaining 10 not-inspected permits represent 29% of the 35 permit universe.

Regarding Metric 5b2 and using corrected frozen FY 2017 data, the Metric 5b2 inspection coverage rate was 4.8%, in comparison with a CMS goal of 20% per year. In response to the State's responses, the metrics chart was revised to reflect the 4.8% comparison with the 20% per year goal.

Attachment C contains an evaluation regarding CY 2018 projections and CYs 2015 and 2016 inspection results for combined universes of Metrics 5b1 and 5b2.

The DEC CY 2018 CMS Plan's EOY 2017 Chart indicates that DEC inspected 74 traditional minors in CY 2017. Using the DEC CY 2017 CMS Plan's traditional minor universe of 1329 permits, the CY 2017 inspection coverage rate would be 5.6 % for the traditional minor facility

sub-sector (i.e., 74/1329). Using DEC's traditional minors universe from its CY 2018 CMS Plan of 1070 permits, the calculated inspection coverage rate is 6.9% (i.e., 74/1070).

In terms of single year CMS Plan performance, the DEC CY 2018 CMS Plan's EOY 2017 Chart indicates that DEC inspected 74 traditional minors in CY 2017 and that 69 minors were scheduled to be inspected. Using these DEC figures, DEC exceeded their CY 2017 Plan commitments for traditional minor inspections by approximately 7% for that single calendar year.

The DEC's EOY charts for CY 2015 and CY 2016 show inspection coverage rates of 5.6 % and 3.4 %, respectively, for the traditional minor facility sub-sector.

The primary root cause of DEC's inability to meet EPA CMS inspection goals across all APDES universe sub-sectors on a consistent annual or multi-year commitment basis is the lack of adequate inspector resources (i.e., insufficient inspector FTEs). This root cause was also identified in the December 2014 SRF Report (FY 2012).

The 2014 SRF Report required DEC to conduct a resource analysis of the DEC APDES Compliance Program to determine, in part, the number of staff positions (FTEs) necessary to meet APDES commitments, EPA CMS goals and conduct a vigorous compliance and enforcement program (with timely and appropriate enforcement that included formal actions).

The DEC's Resource Analysis (October 30, 2015) indicated that 12.3 FTEs were needed to conduct compliance monitoring activities and another 9.1 FTEs were needed to conduct enforcement, for an approximate total of 21.4 FTE needed for the DEC Compliance Program. The 21.4 FTE total also included some management, administrative and data support.

The draft DEC CY 2019 CMS Plan (December 2018) indicates that the DEC APDES Compliance Program's fully allocated FTE base consists of one program manager and 12 staff. The program was recently reorganized into three distinct teams: (1) Inspection team with five positions and one working supervisor; (2) Enforcement team with two positions and one working supervisor; and (3) Data Management team with two positions and one working supervisor.

The draft CY 2019 Plan projects the completion of 169 inspection in CY 2019 for all APDES universe sub-sectors or approximately 29 inspections per inspector position (i.e., 169 inspections divided by 5.8 FTE inspectors in the inspection team taking into account supervisor duties).

The proposed 29-inspections-per-year-per-inspector FTE was used in a resource needs demonstration to illustrate inspector FTE needs to meet EPA CMS goals with DEC's current ADPES permit universe and a hypothetically reduced APDES permit universe. See Attachment C for these illustration demonstrations.

The resource needs demonstration indicates DEC would need 10 - 12 inspector FTEs each accomplishing an average 29 inspections per year to meet EPA CMS goals for the hypothetically reduced APDES permit universe.

DEC's team reorganization may produce the efficiencies (i.e., more inspections per inspector position), needed to meet the projected CY 2019 169 inspection level. If completed as projected, DEC's annual average inspection level for 2015-2019 (completed and projected) would be approximately 141 inspections.

The Attachment C demonstration is limited in scope. The illustrative demonstration projects needed FTEs levels only for the compliance monitoring activities (i.e., inspections, etc.) needed to meet EPA 2014 CMS inspection frequency/coverage goals. The demonstration was not a program-wide FTE resource needs analysis for the entire Compliance Program like DEC's 2015 Resource Analysis; i.e., this demonstration did not factor in the additional enforcement resources needed to evaluate these additional inspection reports, and develop, initiate and finalize the appropriate and timely enforcement actions as part of the additional post-inspection follow-up work load.

The State's response that the Metrics 5b1/5b2 evaluation and findings should be limited to DEC's CY 2017 CMS Plan does not take into account that other factors (e.g., multi-year performance trends) may be considered in EPA's evaluations and in choosing an appropriate finding level. *See e.g.,* SRF Reviewer's Guide, Round 4 (2018-2022), Appendix J. The totality of circumstances of DEC's inspection coverage rate performance over multi-years (i.e., not solely CY 2017) has to be evaluated for a more accurate, reliable overall inspection program performance determination and the selection of appropriate finding level determinations for Metrics 5a1, 5b1, 5b2 and the Metric 4 series. Adherence to DEC's narrow interpretations and resulting applications of the CWA Metrics Plain Language Guide's provisions would lead to an incomplete and inaccurate evaluation of DEC's inspection program performance over time, and absurd and unreasonable results regarding finding levels.

State Response: Metric 5b1 - Inspection rates/frequencies for non-major facilities with individual permits

The state disagrees with the rating area for improvement. Metric 5b1 examined the number of non-major individual permitted facilities that were inspected over the period of 2013 – 2017. The calculation used in the SRF resulted in 29% goal attainment. While this number is not shown in the relevant metrics table (5b1 score is 12.2%) it is shown that the national goal is 100%. Using the CWA Plain Language Guide, metric 5b1 is calculated on an annual basis, not over a period of time. Using 2017 as the basis for this calculation, there were 29 minor individual permitted facilities operating in 2017, the 2017 state specific CMS listed 38 in error. Of those 29, three were not authorized in 2017 and would not have been included in the CMS or inspection planning for CY 2017. Therefore, 26 non-major individual permits were considered. The state goal is to inspect 20% of the sector authorizations annually. During CY 2017, the state would have set the goal to inspect five non-major individual permitted facilities. The state was able to inspect three, resulting in a 5b1 score of 60% of the state goal being achieved, higher than 29% reflected in the SRF. The state does not believe this is 'substantially below' its APDES commitments.

Metric 5b2 - Inspection rates/frequencies for non-major facilities with general permits

The state disagrees with the rating area for improvement. Metric 5b2 was calculated in error to show that the state is substantially below the state goals. The national goal of 100% would reflect that the state was able to inspect facilities as outlined in the CMS. Using the CWA Plain

Language Guide, metric 5b2 is calculated on an annual basis. In the 2017 CMS, the state proposed inspecting 134 facilities. In actuality, the state was able to inspect 128 facilities in 2017. This represents 96% of the state commitment, which results in a rating of meets or exceeds based on the SRF Round 4 Reviewers Guide, substantially higher than the miscalculated SRF value of 4.8%.

The state is concerned with the varied and inaccurate calculations presented in the SRF calculation methodology and its inconsistency with the CWA Plain Language Guide. In addition to the errors addressed above, metric 5b1 was calculated over a five year period while 5b2 was calculated on a single year period. Neither calculation considered the 2017 CMS as required. The state makes earnest effort to meet or exceed the commitment goals outlined in the state specific CMS. The state believes the SRF should reflect the correct calculation of these metrics and include the accurate state percentages provided here.

Recommendations 1 and 3: DEC will submit the 2020 CMS by December 31, 2019 or sooner and DEC will submit the 2021 CMS by December 31, 2020 or sooner.

Recommendations 2 and 4: The 2020 CMS will include 30 inspections per staff member and 20 inspections for the section lead, totaling 170 inspections. The viability of increasing the inspection numbers is dependent upon the CY2019 completion and timeliness results. The previous year's completion and timeliness results will inform the inspection numbers for staff members and section lead for each subsequent year with the lowest limit being 30 inspections per staff member and 20 inspections for the section lead. Any additional staff members added to the team would hold the same inspection requirements. The proposed 290 inspections is unlikely to be met in FY2020 due to staffing, as outlined above, however the Department is currently reprioritizing programs to reorganize and increase staffing levels for the inspection section. Due to the changes happening mid-year, we will continue to struggle to meet the goals as outlined for FY2020, with the anticipation of accomplishing the goals for FY2021.

Recommendations 5 and 6: DEC conducted an analysis of AKG375000 Small Sized Suction Dredge in CY2017 in recognition of the findings of the 2012 SRF. The 2,700 authorizations identified in the CY2017 CMS was inaccurate. Beginning in January 2018 DEC reissued AKG375000 and implemented an online registration system to accurately account for the number of registrations, based on the primary waterbody listed, each year. The small sized suction dredge process is a permit by rule and as such has an annual registration requirement, registrations under this permit expire December 31 of the year the authorization was issued and must be renewed prior to the start of operation each year. In CY2018, there were 169 registrations and as of July 10, 2019 for CY2019, there are 131 registrations. It is not possible to account for AKG375000 registrations in the yearly CMS plan, due December 31 of each year given that the registration process is not required until prior to the start of operation the following year. DEC considers registrations in this sector to be of low environmental risk and largely comprised of recreational miners operating for less than a week at a time. The limited resources and geographical magnitude of the state in conjunction with the prioritization process for inspections in the program description results in these facilities being excluded from the CMS and inspected as resources allow and on an "in the area" basis which has been discussed with EPA in prior years and during this SRF review process.

Recommendation 7: When drafting the annual CMS DEC consistently uses targeted prioritization, and deprioritizes those facilities which are authorized but not in operation, to project inspection numbers by sector. The prioritization method is guided by our program description and includes, but is not limited to, the following factors: classification as a major or minor facility, time since last inspection, type of receiving environment, cumulative effects from other discharges, discharge into an impaired waterbody, health effects from potential wastewater treatment process failure, failure to submit DMR, and post inspection compliance.

Recommendation:

Rec #	Due Date	Recommendation
1	12/31/2019	By December 31, 2019, DEC shall submit its CY 2020 CMS Inspection Plan that includes DEC's plans for conducting at least 232 compliance evaluation inspections of APDES permitted facilities in CY 2020.
2	12/31/2020	By December 31, 2020, DEC shall complete at least 232 compliance evaluation inspections of APDES permitted facilities in CY 2020.
3	11/30/2020	By November 30, 2020, DEC shall submit its CY 2021 CMS Inspection Plan that includes DEC's plans for conducting at least 290 compliance evaluation inspections of APDES permitted facilities in CY 2021.
4	12/31/2021	By December 31, 2021, DEC shall complete at least 290 compliance evaluation inspections of APDES permitted facilities in CY 2021.
5	06/01/2021	By December 31, 2020, DEC shall complete the draft revision and re-development of methods to accurately project the number of active placer mining operations (i.e., permit coverages) covered by APDES permits on a year-to-year basis. The active projection methods shall be developed for each general permit used within DEC's placer mining sector (e.g., AKG370000, AKG371000, AKG374000, AKG375000, etc.). The methods shall be developed and documented for use in preparing annual CMS Inspection Plans and shall include procedures for updating the methods and projections to account for new information developed about this sector over time. The documented draft methods shall be submitted to EPA by December 31, 2020 for review and comment. The documented final active projection methods taking into account EPA's review and comments shall be submitted to EPA by June 1, 2021.
6	11/30/2021	By November 30, 2021, DEC shall submit its CY 2022 CMS Inspection Plan that includes DEC's plans for conducting compliance evaluation inspections of APDES permitted facilities at the inspection frequency/coverage rates in EPA's 2014 CMS, and including at least 20% of the projected active placer mine general permit coverages (except AKG375000) using the final projection methods developed and finalized under Recommendations Nos. 5-6. The CMS Inspection Plan shall describe in detail how the active projection methods were used to develop and determine the active coverages and proposed inspection numbers, and the Plan shall describe the projected number

		of active placer mining operations under each general permit. The Plan must describe a robust CY 2022 field-based compliance monitoring strategy for the AKG375000 subsector.
7	12/31/2022	By December 31, 2022, DEC shall complete the number of compliance evaluation inspections of APDES permitted facilities in CY 2022 at the inspection frequency/coverage rates in EPA's 2014 CMS and including at least 20% of the projected active placer mine general permit coverages (except AKG375000 with its CY 2022 field-based CMS) using the final active projection methods developed and finalized under Recommendations Nos. 5-6.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
5b1 Inspections coverage of NPDES non-majors with individual permits [GOAL] State five year results to date	100%/5-year goal	%	18/5-yr	35	51%
5b1 Inspections coverage of NPDES non-majors with individual permits [GOAL] Corrected FY 2017 Frozen Data – one year only (5 year 100% goal = average of 20%/yr)	100%/5-year goal	22%	4	35	11.4%
5b2 Inspections coverage of NPDES non-majors with general permits [GOAL] Corrected FY 2017 Frozen Data – one year only (5 year 100% goal = average of 20%/yr)	100%/5-year goal	5.9%	54	1115	4.8%

CWA Element 3 - Violations

Finding 3-1
Area for Improvement

Summary:
The State's accuracy of the identification of violations and the determination of a facility's compliance status (Metric 7e) is an area for State improvement.

Explanation:

Metric 7e assesses whether facility violations and the facility's compliance status are accurately identified, assessed and determined based on the documentation obtained by the regulatory agency and contained in agency files.

Metric 7e was identified as areas for State attention in the December 2014 final SRF Report (FY 2012).

In this SRF review, 34 inspection reports and related files were reviewed. The facility's violations and compliance status were accurately identified, assessed and determined in 20 facility situations (58.8%).

The EPA 2014 compliance monitoring strategy (CMS) generally attempts to ensure inspection frequencies of once-every-two-years for major facilities, and once-every-five-years for minor facilities with exceptions for large stormwater permit universes. The strategy promotes a seamless, unbroken time period for regulatory agencies' knowledge regarding a facility's compliance status; in effect, the regulatory agency should know the compliance status continuously and for any one time without periods of not knowing compliance status.

In situations where frequency goals cannot be achieved routinely, it becomes even more important that an inspection's compliance evaluation accurately assesses that facility's compliance status for the period between extended inspection periods.

In regard to DEC's compliance evaluation procedures, the Inspection Preparation/Process (IP/P) POG No. 14.15 specifies procedures DEC inspectors are supposed to use to prepare for, conduct and document in an inspection and to determine a facility's compliance status.

The primary key component of the IP/P POG's pre-inspection preparation is the requirement that the DEC inspector perform a Compliance Evaluation (CE) of the facility using the Compliance Evaluation POG, POG No. 14.09. As the IP/P POG notes, the CE allows the inspector to become familiar with the permittee, the facility and the compliance history.

The IP/P POG highlights an important on-site inspection task in terms of assessing compliance status and history by instructing the inspector to conduct an on-site records review and to provide the facility official with the date range that is requested. This will typically be from the date of the last APDES inspection through the current date. See IP/P POG No. 14.15, Facility Inspection, Para. 4 (p. 5).

The Compliance Evaluation POG No. 14.09 contains the operating procedures to conduct a CE (file review) as a part of the inspection process, prior to an inspection. The POG's operating guideline in terms of file review scope is that the evaluation period will be from the date of the last review to the present day. In accord with the IP/P POG instructions, this scope would typically be back to the date of the last inspection, if applicable, through the current date.

The CE POG identifies various DEC and EPA databases for the inspector's use to conduct a file review and establish a clear picture of a permittee's compliance history, and requires the inspector to review six (6) specific databases. Finally, the POG instructs the inspector to use the

"Compliance Evaluation Checklist" (identified in the CE POG as an attachment) to document the review and to save the Checklist in the Inspection folder in the WPC file.

DEC also created an APDEC Inspection Report template, POG No. 14.02. This POG, Section 3 Findings, requires the inspector to include concise information on various topics including previous inspections, enforcement actions and compliance history.

During this SRF's file reviews, it was discovered that DEC inspection files did not contain any completed Compliance Evaluation Checklists that were supposed to be completed in accord with the CE POG and saved in the Inspection folder in the WPC file. In late 2018, the DEC Compliance Program manager indicated that a CE checklist template had not been created and attached to the CE POG.

Consequently, DEC's inspection files lacked the POG-required CE documentation demonstrating that an inspector completed the CE following the CE POG's procedures and ensuring all six (6) databases were reviewed as required within the CE POG's evaluation period scope, as a means to determine the facility's compliance status and history.

In 14 inspection report evaluations, there were significant inaccuracies regarding facility compliance status and history, and violation determinations. Attachment D, Element 3 Violations, contains the evaluation details for these 14 facilities.

In at least 11 inspection report situations, the compliance evaluation period was not in accord with DEC POGs, EPA CMS or best practices. Of these 11 facilities, the reviews were able to identify permit effluent limit violations in at least 7 facility inspection evaluations that were not accounted for due to the truncated or shortened evaluation periods.

In 8 inspection reports and related documents (e.g. follow-up enforcement action), there were situations where violations were not correctly determined, evidence existed for citing violations that were not cited, or other inaccuracies.

Regarding Metric 7e, root causes for these situations include the lack of a CE checklist to ensure proper evaluation periods are assessed, failure to adhere to the POG and EPA CMS procedures that promote a seamless knowledge, based on time, of a facility's compliance status and POGs that do not discuss in detail, promote or require expressly the documentation of an inspector's evaluation period determination.

The State's response asserts, in effect, that a truncated or shortened compliance evaluation period (e.g., short than a period going back to the last inspection) is merely an administrative error in establishing and determining the compliance status of a facility. A facility's compliance status cannot be accurately assessed if all applicable violations are not accurately identified as an integral first step in gathering complete compliance-related information. The appropriate and accurate compliance evaluation period is a fundamental and integral part of accurately evaluating and determining the compliance status of the facility.

State Response: Metric 7e - Accurate identification of facility violations and the facility's compliance status
The state disagrees with the rating of area for improvement.

Metric 7e, specifically addresses the accuracy 34 minor GP, or minor IP, inspection reports. Of those 34 inspection reports, the SRF claims that 20 accurately reflected the compliance status of the facility and the remaining 14 facilities were called out in Attachment D. Of the 14 facilities, seven facilities were flagged, in Attachment D, for state administrative errors, such as: referencing the most recently conducted inspection incorrectly or the coverage length of the inspection cited as the only improper factor, or that the inspection report did not cover the time period since the last inspection. Administrative errors do not affect the compliance status of the facility represented in the report, which is the objective of metric 7e. According to POG language, and as outlined below, it is not a requirement for non-major inspections to go back to the date of the last completed inspection and instead states that inspections will 'typically' go back to the date of the last completed inspection. It is the case that given the size of the permit universe combined with the specific records retention conditions in permits that the inspections do 'typically' go back to the date of last inspection unless the record retention requirement is less stringent than the date of the last inspection. With this consideration, these seven inspection reports accurately represented the compliance status consistent with policy for the duration of the compliance review. Considering these seven inspections complete and accurate brings the total number of inspections complete to 27, representing 79% of examined inspection reports, higher than the 58% calculated in the SRF and according to the SRF Round 4 Reviewers Guide warrants a rating of area for state attention.

The APDES program, as designed, is largely reliant on self-reporting at multiple intervals for the regulated community; therefore, not all permitted facilities are required to submit the same level of detail, monthly or annually, to the state to determine facility compliance. The state does however attempt to inspect facilities as outlined in Element 2-1, and as demonstrated there, has met or exceeded expectations in identifying the compliance status of a facility.

DEC has made efforts, and will continue to do so, to educate and inform new and current compliance and enforcement staff on the proper regulatory citation for observed and documented violations. Additional emphasis will be put on checking ICIS for effluent violations.

Correction: The assertion that the state should have knowledge of the 'compliance status continuously' dismisses the reporting intervals and suggest a level of oversight inconsistent with the NPDES program.

Correction: The SRF incorrectly references POG No. 14.09 as being applicable to all inspections. This POG is specifically used to address inspections of major facilities. The assertion that the inspection must go back to the date of the last completed inspection is incorrect. The language used in the POG, and as referenced in the SRF, is that inspections will 'typically' go back to date of the last completed inspection.

Correction: The Compliance Checklists are paper forms that the inspectors use during the inspection and as a tool in drafting the inspection report; they are not to be appended to the

inspection report. They are not required to be saved in the WPC as the inspection report should be a standalone document and contain all the relevant information and observations recorded onsite and during the file review to determine compliance.

Recommendations 1: DEC is in the process of updating and standardizing our POGs. Through efforts within DEC to streamline the approval processes, DEC has set a goal that all POGs will be updated in CY 2019. If the compliance evaluation checklist is retained within the revised POG, it will be reflected in the final version of the POG that is expected to be completed in CY 2019.

Recommendation 2: Proposes that staff be trained on all the newly developed POGs by September 6, 2019. This is not in agreement with other sections of the SRF. For example, Recommendation 1 (addressed above) requires the POG to be submitted for review by October 31 (comments incorporated by December 31). A training will be conducted by April 30, 2020 to allow DEC time to update, reorganize, and finalize the POGs.

Recommendation:

Rec #	Due Date	Recommendation
1	04/30/2020	By January 31, 2020, DEC shall provide to EPA, for review and comment, a draft Compliance Evaluation (CE) Checklist, a revised draft Compliance Evaluation POG (CE POG), POG No. 14.09, and a revised draft APDES Inspection Report template, POG No. 14.02. DEC's revisions to these three documents shall address this report's issues related to the inspection evaluation period determination and documentation. During the revision process, DEC shall consider these suggested revisions to: (1) the CE POG to include clarification and additional narrative on establishing appropriate evaluation periods, including instructions when a facility has had no prior inspections; (2) the CE POG that instruct the inspector to enter the inspection evaluation period determination into the revised CE Checklist and revised APDES Inspection Report template; (3) the CE Checklist to include entries where the inspector will identify the inspection's evaluation period and explain the basis for that evaluation period determination; and (4) the APDES Inspection Report template to include a data entry location for documenting the inspection's evaluation period determined by the inspector using the revised CE POG procedures and documented in the revised CE Checklist. If DEC does not adopt any suggested revision(s), DEC shall provide a summary written explanation and reasons to EPA with its draft documents that are initially submitted for EPA's review and comment. By April 30, 2020, DEC shall incorporate EPA's comments into a final CE Checklist, the final CE POG, POG No. 14.09, and the final Inspection Report template, POG No. 14.02.
2	04/30/2020	By April 30, 2020, the DEC Compliance Program shall conduct a training course for all Program staff regarding POG revisions made in response to this SRF Report or for any other reasons, and address and review the procedures for determining and documenting the appropriate evaluation period time using the revised CE POG, CE Checklist and revised APDES Inspection Report template POG.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
7e Accuracy of compliance determinations [GOAL]	100%	%	20	34	58.8%

CWA Element 3 - Violations

Finding 3-2
Area for Attention

Summary:
Finding 3-2 is based on the levels of noncompliance associated with Element 3 Violation Metrics 7j1, 7k1 and 8a3. The levels of noncompliance in these three review indicators demonstrates the need for the State to assess noncompliance universes for root causes and assess whether appropriate enforcement tools are being applied, and in a timely manner, that result in actual facility compliance. An evaluation of these metrics provides an important foundation context for Finding 4-2, regarding Metric 10b and whether enforcement responses address violations in an appropriate manner. The recommendations in Finding 4-2 should help improve these review indicator metrics.

Explanation:
Element 3 Violation Metrics 7j1, 7k1 and 8a3 generally measure levels of noncompliance determined in inspections recorded for the review year, noncompliance levels of major and minor facilities, and percentages of major/minor facility significant noncompliance. These review indicators reflect in part the effectiveness of the state's compliance and enforcement efforts and whether appropriate enforcement responses are being taken and have lasting compliance effect.

As stated in the SRF Plain Language Guide, high non-compliance rates under these 3 metrics may indicate a lack of timely and appropriate enforcement. The Metric 10b findings related to whether enforcement responses address violations in an appropriate manner are related to and intertwined with these 3 metrics' outcomes and accordingly, an evaluation of these metrics provides important, foundational context for the Metric 10b enforcement explanation.

Attachment D contains additional details regarding the evaluation of these 3 metrics which evaluation is summarized here.

Metric 7j1 is a review indicator regarding single-event violations (SEVs) reported and tracked in ICIS for the review year. DEC's frozen FY 2017 data showed 108 facilities with reported SEVs under Metric 7j1.

The DEC frozen FY 2017 data for inspection-related Metrics 5a1, 5b2 and 5b2 showed a total of 147 inspections. Accordingly, the frozen FY 2017 data shows SEVs being reported in approximately 73.5% of inspections (i.e., 108/147). This SRF Report's Inspection Coverage Data Table showed that violations were found at 121 facilities from the approximate 153 inspections conducted in CY 2017, or approximately 79.1% of inspections resulted in reported violations (i.e., 121/153).

The national average for Metric 7k1, Major and Non-Major Facilities in Noncompliance, was 18.5%.

Metric 7k1 is a review indicator showing the percentage of major and non-major facilities with violations reported in the ICIS-NPDES system. Violations factored into the Metric 7k1 evaluation include SNC/Category 1, RNC/Category 2 or effluent, SEVs, compliance schedule and permit schedule violations.

DEC's frozen FY 2017 data for Metric 7k1, Major and Non-Major Facilities in Noncompliance, showed a level of 67.7% compared to a national average of 18.6%. Even excluding inapplicable frozen FY 2017 data (i.e., terminated permit coverages), the non-compliance level for Metric 7k1 is still approximately 56.7% compared to a national average of 18.6%. Attachment D also contains an evaluation of the frequency that facilities are in a status reportable non-compliance (RNC).

Metric 8a3 is a review indicator that identifies the percentage of major facilities in significant non-compliance and non-major (minor) facilities in Category I non-compliance during the review fiscal year. DEC's frozen FY 2017 data for Metric 8a3 showed a level of SNC/Category I noncompliance of 9.2%, compared to the national average of 7.5%.

The level of facility noncompliance associated with these 3 metrics demonstrates a significant need for DEC to take steps to identify the root causes of these violations and implement measures to reduce noncompliance rates with some consideration to be given to focus initial efforts on DEC's domestic sub-sector.

A potential root cause for these high levels of non-compliance is DEC's failure to use the proper enforcement tool for the particular underlying violations. The SRF reviews and evaluations associated with Metric 10b (e.g., Finding 4-2) show DEC's heavy reliance on compliance letters in situations where the DEC Enforcement Response Guide (ERG) does not have a compliance letter as an appropriate response. Additionally, DEC uses notices of violations in many situations where the ERG indicates a formal action is the appropriate response.

DEC's assessment should evaluate whether it is utilizing the most appropriate enforcement tools to address violations and whether the content and requirements of any tool use is correcting the underlying facility conditions leading to these metrics' noncompliance rates. Additionally, DEC should determine whether it is completing each enforcement action in a manner that documents the facility's return to compliance. Finally, the DEC's assessment should also review the timing of any post-compliance monitoring activity to ensure it is being done in a timely manner and in a means that leads to a compliant facility.

See the recommendations under Element 4, Enforcement, Finding 4-2, for corrective actions regarding Metric 10b evaluations and for a related assessment of the root causes for the high non-compliance rates of DEC's domestic sub-sector that might be reflected in the frozen FY 2017 data for Metrics 7j1, 7k1 and 8a3.

State Response: Metric 10b – Enforcement responses reviewed that address violations in an appropriate manner

The state agrees with the rating area for attention.

Metric 10b is given two ratings in this SRF under both Element 3-2 (area for attention) and Element 4-2 (area for improvement). The state acknowledges in the discussion of Finding 4-2 that additional attention is warranted in enforcement responses that address violations in an appropriate manner. The state would also point out that the goal is facility compliance and not enforcement, a facility achieving compliance with the lowest level of enforcement possible is a successful outcome.

Metric 7j1 - Review of major and non-major APDES facilities with single-event violations reported in the review year
Review indicator for metric 10b. The SRF inaccurately compares the number of facilities with SEVs to the number of inspections completed during the review year and misrepresents this metric as the violation rate within the state. This is inconsistent with the CWA Plain Language Guide and inaccurately inflates the violation rate within the state. The CWA Round 4 Plain Language Guide, states metric 7j1 is a comparison of the number of facilities with SEVs identified during file review and the reflection of those specific SEVs in ICIS.

Correction: Based on numbers provided metric 7j1 should be; the number of facilities with SEVs identified in file review ~ 108 facilities compared to the SEVs in ICIS for those same facilities ~ 121. An accurate approximation of metric 7j1 is 108/121, or 89% of violations accurately reported in the review year. The state has not adjusted for those SEVs generated automatically (e.g., effluent limit violations from a DMR, or permit compliance schedule violations). A percentage of 89% violations accurately reported warrants a rating of meets or exceeds expectations in accordance with the SRF Round 4 Reviewers Guide.

Metric 7k1 - Major and non-major facilities in noncompliance
Review indicator for metric 10b. The reviewer failed to omit the 636 terminated authorizations from the count. Discussions the EPA was present for and participated in identified terminated authorizations inclusion, specifically in metric 7k1, inflates the reported percentages. Eliminating the 636 terminated authorizations provides an accurate count of 667 compared to the universe of 2,067 yields a percentage of 32.2%, markedly closer to the national average of 18.5%, than the overstated 67.7%.

Metrics 7j1 and 7k1 shows that Alaska has a higher level of reported noncompliance than the national average. Alaska is unique in many respects which may explain some of this discrepancy, although, likely not all. As opposed to cities in the contiguous United States, many villages in Alaska are off transportation grids, making delivery of goods, equipment, and personnel difficult. While transportation of a wastewater treatment facility elsewhere may only involve a flatbed trailer, getting the same treatment facility to a remote facility in Alaska drastically increases the cost and logistics of installing and operating the same system. Additionally, in many rural Alaska communities, access to the professional services available in many other cities may not be available. Other compounding factors include the availability of transportation systems for effluent samples to be analyzed, the proximity of certified testing labs, remoteness, geography (depth to bedrock), abundance of water, availability of trained operators, and lack of infrastructure in many areas.

Metric 8a3 – Percentage of major facilities in SNC and non-major facilities in Category I noncompliance during the reporting year

Review indicator for metric 10b. The national average is 7.5%, while Alaska is higher at 9.2% constituting an increase of 1.7%. The discrepancy between Alaska and the national percentage is overstated in the SRF as being 23% above the national average, a misleading way to calculate the higher rate in Alaska. This metric is meant to be compared to the national average not expressed as a percentage of the national average. A noncompliance rate near the national average is an indicator of an effective compliance program. EPA CWA Plain Language Guide states, "If significant noncompliance at majors or non-major facilities in Category 1 noncompliance is significantly above the national average, timely and appropriate action may not be promoting return to compliance. If the percentage of major facilities in SNC or non-major facilities in Category I noncompliance is significantly lower than the national average, reviewers should carefully review files for inspected facilities without violations, and those with non-SNC violations, to determine whether SNC or Category I violation determinations are accurately identified in files reviewed." For this reason, the state believes the rating should be meets or exceeds expectations.

Correction: Change "The significant level of DEC noncompliance associated with these 3 metrics" to correctly reflect that it is the facilities noncompliance and not DEC noncompliance.

The state agrees that using the proper enforcement tool when responding to noncompliance is important in implementing a compliance program. Identifying and utilizing the proper enforcement tool (e.g. compliance letter, notice of violation, settlement agreement, compliance order…etc.) at each step in the process is currently an area of substantial attention.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
7j1 Number of major and non-major facilities with single-event violations reported in the review year	%	%	108		
7j1 Number of major and non-major facilities with single-event violations reported in the review year.	%	%	108		
7k1 Major and non-major facilities in noncompliance [Frozen FY 2017 data].	%	18.5%	1400	2067	67.7%
8a3 Percentage of major facilities in SNC and non-major facilities Category I noncompliance during the reporting year.	%	7.5%	146	1585	9.2%

CWA Element 4 - Enforcement

Finding 4-1
Area for Improvement

Summary:
The State's percentage of enforcement responses where file documentation demonstrates the non-compliant facility returned, or will return, to compliance (Metric 9a) is significantly low and this is an area for State improvement.

Explanation:
Metric 9a is a file-review based goal metric designed to assess whether the enforcement actions in reviewed files returned or will return a facility in violation to compliance. Actions that indicate return to compliance include injunctive relief, documentation of return to compliance and enforceable requirements with date-certain schedules for major facility non-compliance.

In this SRF review, 37 enforcement actions and related files were reviewed. The enforcement actions and file documentation were adequate to determine that 20 of 37 actions (i.e., 54.1%) returned or will return the facility to compliance. In the other 17 actions, file reviews and evaluations did not demonstrate the action returned or will return the facility to compliance.

This Metric 9a was also identified as an area for State improvement (8 of 18 actions or 44.4%) in the December 2014 final SRF Report (FY 2012).

The details of the Metric 9a evaluation and file reviews are located in Attachment E of this SRF Report.

DEC's 2005 Enforcement Manual states that the importance of tracking enforcement actions and corrective actions necessary to come into compliance cannot be stressed enough. The 2005 Manual dictates that all DEC enforcement actions must be logged and tracked in DEC's Complaint Automated Tracking System (CATS) database, along with an enforcement tracking number (ETN) which should be placed on the first page of each enforcement action.

The 2005 Manual also states that it is equally important to determine when a facility returns to compliance or has satisfied the conditions of the enforcement action. The 2005 Manual requires that the enforcement action in CATS be closed out once the case officer determines all terms and conditions of the enforcement action have been met, and that an Enforcement Closeout Letter (ECL) be drafted and issued.

DEC's 2015 Enforcement Manual includes an ECL template for enforcement action close-out so presumably, the intent and instructions of the 2005 Manual are still controlling.

Consistent with the 2005 Manual's directives, the Compliance Letter (CL) and the Notice of Violation (NOV) POGs require the case officer to enter the enforcement case into CATS where the CATS' ETN is generated.

The Compliance Evaluation (CE) POG provides that the CL and NOV deliverables are to be added to the facility's Schedule of Compliance (SOC) tab within the Discharge Results and Online Permit System (DROPS) database.

The Inspection Preparation/Process (IP/P) POG (#10, p. 7) also provides that if the inspection results in an enforcement action, it must be entered into DROPS and requested deliverables must be entered into the DROPS' Enforcement Action's Schedule of Compliance (SOC). The IP/P POG provides that as each deliverable is received and accepted, the inspector must update the DROPS SOC. The POG provides that once all deliverables are received and accepted, the inspector must close out the Enforcement Action SOC.

The Tracking Facility Compliance (TFC) POG, No. 14.23, is applicable to tracking schedules of compliance in DROPS associated with enforcement actions that have deliverables. The POG has detailed procedures for creating DROPS entries for deliverables/submissions, e.g. receipt date, accepted/not-accepted, close out, etc.

Noticeably absent from the IP/P and TFC POGs is any reference to the requirement that the case officer issue an ECL in accord with the DEC Enforcement Manuals when completing the enforcement action closeout procedures.

A review of several compliance tracking POGs (e.g. CE, TFC, IP/P) and enforcement tool POGs (e.g. CL, NOV, COBC, etc) identified inconsistencies regarding (1) establishment and use of a CATS' ETN; (2) identified tasks for tracking enforcement tool-required deliverables; (3) retention

of deliverables in the WPC folders; (4) closing out the enforcement action in CATS and DROPS; and (5) issuance of a final case Closeout Letter.

Attachment E discusses in detail various inconsistencies (e.g. lack of same or similar tasks) within several POGs.

Of the17 enforcement actions reviewed that did not return the facility to compliance, 12 DEC files lacked documentation demonstrating the respondent complied completely with the enforcement tool's deliverable/submission requirements.

In four of these 17 actions, the chosen enforcement tool did not adequately address all identified violations. Two of these four actions are a subset of the 12 actions where deliverables documentation was also lacking.

In eight of these 17 actions, there was current information demonstrating continuing violations after the apparent close out of the enforcement action. Three of these eight actions are a subset of the 12 actions with inadequate documentation. Also, three of these eight actions are a subset of the four actions where the enforcement tool did not adequately address all identified violations.

Of the 17 actions, 16 DEC files did not have any Closeout Letter. One file had an email exchange acknowledging receipt of deliverables and for purposes here, was construed as somewhat equivalent to a Closeout Letter.

Out of the 17 actions, 12 actions used NOVs that had CATS' ETNs displayed on the NOV itself but as noted, except for one equivalent email, none of the other 11 NOV files had any Closeout Letter as provided for in DEC's enforcement manuals.

Attachment E, Table A, summarizes the file review results conducted on the 17 enforcement actions, and the attachment provides a summary response to the State's responses to the draft SRF report.

Root causes include the failure to adhere to the Enforcement Manuals and POG procedures which would ensure the case officer has verified and accepted all deliverables, that the deliverables were saved to the WPC folder for purposes of documentation and that a Closeout Letter was issued.

Additionally, the enforcement actions issued in eight situations did not return the facility to compliance so DEC should evaluate what enforcement tool is appropriate.

State Response: Metric 9a – Percentage of enforcement responses that returned, or will return, a source in violation to compliance

The state disagrees with the rating area for improvement.

As outlined in the CWA Plain Language Guide, metric 9a examined the "percentage of enforcement responses that returned, or will return, a source in violation to compliance." A total of 37 enforcement actions were examined, of which, 20 actions were considered sufficient to bring the facility into compliance. Of the remaining 17 facilities, six were in compliance at the

close of the enforcement action and only demonstrated noncompliance after the close of the enforcement case. In error, the SRF examined the completeness of the enforcement packet and compliance with state POGs as a measure considered in metric 9a totaling five additional facilities that were brought into compliance at the close of the enforcement case. As stated in the SRF, this metric examines only the compliance status of the facility after state enforcement. When metric 9a is calculated correctly, the number of facilities that did not come into compliance, or will not come into compliance in the future, is six of the 37 enforcement cases. This resulted in state intervention returning 84% of facilities to compliance.

Correction: The state requests that unrelated information in the SRF be removed to include only those parameters considered by metric 9a.

Since the 2014 SRF, DEC has made efforts to increase the number of facilities that will return to compliance because of enforcement actions. DEC has replaced the DROPS data management tool with a web-based gateway called Water Solution. This will increase accountability in tracking deliverables. The DROPS database was identified as inadequately addressing the needs of the Division of Water and an alternative was implemented. Currently, a long-term solution to the needs of the Division is being examined by the Data Section for inspection and enforcement tracking. Based on the SRF Round 4 Reviewers Guide the rating should be area for state attention.

While the records provided may not have included a closeout letter, many inspectors send emails, such as the one that was included, to the facilities outlining outstanding deliverables or submission and acceptance of all required submittals. This email is not often saved within the inspection folder, as has been demonstrated here. Additional attention will be given to the retention of this correspondence in the future.

Recommendation 1: As addressed in the recommendation section of Element 3 Section 1, DEC is in the process of updating and standardizing POGs and more accurately reflect the enforcement manual and current practice. Through efforts within DEC to streamline the approval processes, DEC has set a goal that all POGs will be updated in CY 2019 and training provided by April 30, 2020. The recommendations given in the SRF will be taken into consideration.

Recommendation:

Rec #	Due Date	Recommendation
1	04/30/2020	By January 31, 2020, DEC shall provide to EPA, for review and comment, draft revisions and updates to the DEC enforcement action POGs (e.g., at least CL, NOV, CO, COBC) and as applicable, compliance evaluation and tracking POGs (e.g., CE, IP/P and TFC) to improve facility compliance tracking and promote task consistency within POGs. During the revision process, DEC shall consider these suggested revisions: (1) Add an editable block to the CL POG and CL template for the entry of the CATS ETN; (2) Revise the IP/P POG, page 6, #5.a.i. to include the same generate-CATS-ETN text for the CL that is in the NOV POG provision, #5.a.ii; (3) Instruct the case officer/inspector to enter each CL and NOV into CATS to generate a CATS ETN; (4) Require CATS ETN to be placed on the first page of all enforcement tools; (5) Include or reference procedures for tracking deliverables by the case officer/inspector and include instructions on how to track deliverables in DROPS by opening a DROPS SOC; (6) Add tasks to the CL POG and NOV POG, similar to the CO and COBC POGs, for tracking deliverables and closing out the enforcement action; (7) Include or reference procedures for closing out the enforcement action in DROPS and CATS when all deliverables have been received and accepted, and all other elements of the enforcement action are completed; (8) Include in all enforcement tool POGs' Record Management provisions, the saving of the deliverables into the WPC sub-folder; and (9) Include or reference in all enforcement tool POGs the procedures to draft and issue a Closeout Letter and to save a copy of the issued Closeout Letter to the WPC folder's Correspondent sub-folder. If DEC does not adopt any suggested revision(s), DEC shall provide a summary written explanation and reasons to EPA with its draft documents that are initially submitted for EPA’s review and comment. By April 30, 2020, DEC shall incorporate EPA’s comments into final editions of the DEC enforcement action POGs (e.g., at least CL, NOV, CO, COBC) and applicable compliance evaluation and tracking POGs (e.g., CE, IP/P and TFC) regarding facility compliance tracking improvements, and task consistency within POGs.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
9a Percentage of enforcement responses that returned, or will return, a source in violation to compliance [GOAL]	100%	%	20	37	54.1%

CWA Element 4 - Enforcement

Finding 4-2
Area for Improvement

Summary:
The State does not routinely take enforcement actions that address violations in an appropriate manner. The State does not initiate and complete formal enforcement actions in a timely manner, impeding the State's ability to initiate enforcement actions that address violations using an appropriate formal action and impeding the State's ability to complete more appropriate enforcement actions over time. Metric 10b is an area for State improvement.

Explanation:
Metric 10b is a file metric that assesses whether enforcement responses address violations in an appropriate manner.

In this SRF review, 39 enforcement actions were reviewed. The review determined that DEC enforcement responses addressed violations in an appropriate manner in 11 of 39 situations (i.e., 28.2%).

This Metric 10b was also identified as an area for State improvement in the 2014 SRF Report (FY 2012). In that review, 9 of 17 actions were found to have addressed violations in an appropriate manner (i.e., 52.9%).

Attachment F has a summary of some key DEC POGs and its APDES Enforcement Response Guide (ERG, May 2008) to highlight some key elements that were considered significant during the enforcement action reviews. Refer to Attachment F for details about the ERG's application of appropriate enforcement tools.

Generally, an appropriate enforcement response is one that results in the violator returning to compliance as quickly as possible, promotes deterrence and is equitable. DEC's ERG notes that the effectiveness of an enforcement response includes whether the response establishes the appropriate deterrent effect for the particular violator and for other potential violators, and the response promotes fairness among comparable violators.

The Metric 10b file review determined that the enforcement responses taken in 28 situations were not appropriate. The 28 actions used either a compliance letter (CL) or notice of violation (NOV).

CLs were the primary action in 12 situations and the NOV was the primary enforcement action in 16 situations.

For context, the CL POG, No. 14.04, states that a CL is an informal enforcement action used to address *minor* noncompliance. The DEC 2008 APDES Application's Program Description (Final October 29, 2008), Section 9.4.3 stated that DEC would use a less formal action like a CL when the respondent had a few or no previous violations during the previous six months. DEC's 2015 Enforcement Manual, p. 1-7, states that informal actions like a CL are used for a "lower priority violations."

The NOV POG, No. 14.05, notes that an NOV documents significant compliance issues (e.g., repeat violations, violations of permit conditions).

In 8 situations, a CL was used to address permit effluent limit (PEL) violations. A CL is not an ERG option for PEL violations.

In 9 situations, a CL was used as the response action to violations identified in a compliance inspection in situations where the ERG options for these compliance inspection-based violation situations do not provide a CL as an enforcement response option (e.g., violations of permit conditions like BMP, O&M, record detention, record availability, etc.).

In 5 of these 9 situations, the CL also addressed PEL violations. In two, CLs were used to respond to SNC-level PEL violations for two major facilities instead of SNC-related formal actions. DEC files did not include any written record justifying why an informal action was the more appropriate response in these SNC situations; however, in accord with the ERG, the use of a CL could not be justified as an appropriate response for PEL violations.

The file review also included four other major facilities with SNC-level PEL violations where the response was an NOV instead of a SNC-related formal action response. In these four situations, the DEC files did not include any written record justifying why the NOVs were the more appropriate enforcement response.

Eight other NOV situations had some major or gross sampling, monitoring or reporting deficiencies that were frequent or continued violations (i.e., not minor, and not isolated or infrequent) that, in accordance with the ERG, excluded the use of an NOV as an appropriate enforcement response option. At least two of these 8 situations also had frequent PEL violations which is a separate, independent basis requiring the selection of an ERG formal action instead of an NOV.

Attachment F summarizes the factual basis for the determinations made regarding the 28 situations where CLs and NOVs were used.

Attachment F also evaluates DEC's performance in initiating and completing timely formal enforcement actions to identify root causes for this Metric 10b situation.

Timely enforcement has been a consistent deficiency for DEC performance. The 2014 SRF Report found that DEC did not consistently take timely enforcement actions, and that the failure to initiate and complete formal enforcement actions in a timely manner impeded DEC's ability to initiate and complete more enforcement actions over time. The 2014 Report noted that delays in timely completion of formal actions resulted in fewer actions being completed overall as staff prioritize limited time and resources for pending actions and delay development of new appropriate actions.

The Attachment F evaluation shows that DEC initiated and completed 8 formal actions in the approximate 2 years it has been operating under the time frame goals of its Enforcement Action Timelines POG. Six of the 8 actions did not meet the POG's aspirational goals and of those six actions, four actions exceeded the POG's time frame goals by substantially more than 6 months.

Selecting an appropriate enforcement tool can also affect whether the enforcement action is taken and completed in a timely manner. In response to Metric 9b determinations based primarily on lack of enforcement action deliverables in DEC files, Attachment E evaluates the implementation of the DEC's Tracking Facility Compliance (TFC) POG in terms of tracking the submission of enforcement action deliverables and closing out an enforcement action in DROPS. It also addresses the time frames or timeliness for completing enforcement action deliverables which presumably, returns the facility to compliance.

Attachment E shows DEC's heavy reliance on informal actions (e.g., NOVs) with extended, lengthy non-enforceable deliverable due dates and extensions often exceeding 1-2 years in length. The evaluation of deliverable time frames in late 2017 and mid-2018 showed substantial lengthy deliverable due dates and extension deadlines often exceeding one year with large numbers of actions exceeding two years for submissions of deliverables. These extended, non-enforceable schedules are beyond what EPA Region 10 deems appropriate for the use of informal actions or timely regarding schedules that exceed one year response times, except in unusual, limited circumstances.

The root causes of this issue include the following: (a) lack of adequate staff resources to meet DEC commitments, EPA CMS inspection goals and conduct a robust enforcement program that applies appropriate enforcement tools; (b) the current inability to meet aspirational time frame goals for formal actions creating impediments for inspectors to routinely and consistently apply accurate and appropriate ERG-based response actions because the formal enforcement system is backlogged with existing cases; and (3) the mis-application of appropriate ERG enforcement options to underlying violation fact situations.

The recommendations below include a recommendation that was in the 2014 SRF Report to insure DEC reports on enforcement case progress on a routine basis (e.g. monthly or quarterly check-in conference calls between EPA and the DEC Compliance Program). If at any time EPA determines there is a potential that an action will not be completed using an appropriate enforcement tool or that an action will not be completed in a timely manner, EPA will discuss with DEC the need for a change in agency lead for the case. In addition to these recommendations, the EPA enforcement

director and DEC's Division of Water director will include the discussion of enforcement case progress as part of their monthly telephone check-ins.

EPA will continue to conduct compliance evaluation inspections of APDES-permitted facilities to supplement DEC annual inspection efforts. In addition, EPA will continue to initiate and complete EPA-lead enforcement cases in Alaska.

State Response: Metric 10b – Enforcement responses reviewed that address violations in an appropriate manner

The state agrees with the rating area for improvement. As addressed in Element 3 Section 2, specifically the issuance of Compliance Letters for violations which are more appropriately addressed through the issuance of a NOV, the first step in the state's formal enforcement process. The NOV serves to notify the permittee that the state identified violations and that the state may pursue a compliance order by consent (COBC) or compliance order (CO) as appropriate. In December 2018, the state restructured the compliance and enforcement program into two distinct sections, compliance (dedicated inspection staff) and enforcement (dedicated enforcement staff). This change is expected to expedite formal enforcement proceedings and facilitate case elevation where required. The POGs related to the enforcement section have been updated in 2019, and will continue to be updated as processes change. POGs related to the formal enforcement process will be finalized in CY 2019.

A possible root cause identified in the SRF for the inappropriateness of enforcement actions is the limitations placed on staff. The state acknowledges that current staffing levels impose limitations on meeting the CMS established aspirational goals. DEC is confident that with the allocation of dedicated enforcement staff progress will be made in this area. The addition of supplementary positions is being pursued with the intent that EPA inspections conducted in Alaska are not supplementary to those conducted by the state and instead are solely motivated by EPA's oversight obligations.

Recommendation 1: Requests DEC to examine, among other things, the high level of noncompliance among the domestic sub-sector. Possible rationalizations for this discrepancy were addressed in Element 3 Section 2 comments. DEC is in the process of updating and standardizing POGs to more accurately reflect the enforcement manual and current practice. Through efforts within DEC to streamline the approval processes, DEC has set a goal that all POGs will be updated in CY 2019 and training provided by April 30, 2020. It is premature to conduct a root cause analysis without first implementing the self-identified proactive program reorganization and procedural guidance updates addressing the concerns listed in recommendation 1.

Recommendation 2: The state acknowledged the lengthy formal enforcement process and in early 2019 taken steps to expedite this process. It is premature to evaluate enforcement tools and procedures identified in 2017 without first implementing the self-identified proactive program reorganization and procedural guidance initiatives of 2019.

Recommendation 3: It is the state's intention that staff will evaluate the ICIS Violations report in advance of each inspection. This will be memorialized in the appropriate POG and the update completed by December 31, 2019.

Recommendation 4: Notification procedures for facilities with SNC conditions will be memorialized in the appropriate POG and the update completed by December 31, 2019.

Recommendation 5: Training on the updated POGs and procedures will be completed by April 30, 2020. The POGs and procedural changes will reference the APDES ERG and SNC criteria as appropriate.

Recommendation 6: Requests that DEC submit to the EPA, on a quarterly basis, justification for not pursuing formal enforcement with facilities in SNC and to retrospectively include the first three quarters of 2019. DEC currently meets with EPA quarterly to discuss and provide updates on the disposition of facilities within the state in SNC status, at which time DEC has provided EPA with all requested information. DEC will continue to provide information upon request regarding facilities in SNC.

Recommendation 7: Requests that DEC complete 12 formal actions by May 2020. This goal is aspirational and cannot be used as a performance metric. DEC will pursue enforcement action in accordance with departmental guidance and the current and to-be revised POGs for the purposes of ensuring compliance and not achieving an arbitrary enforcement recommendation.

Recommendation 8: By December 31, 2019, DEC will include EPA on the distribution list for compliance letters, this change will be in conjunction with finalization of the updated POGs. A copy of all updated POGs will be provided to EPA by January 31, 2020 for opportunity to comment no later than February 28, 2020 for consideration in the final version.

Recommendation:

Rec #	Due Date	Recommendation
1	12/01/2020	By December 1, 2020, DEC will submit a summary report to EPA describing its compliance and enforcement strategy for addressing the high non-compliance rates in DEC's domestic sub-sector (e.g. POTWs, WWTFs treating sewage, etc.). The report must discuss DEC's evaluation of the root causes and performance limiting factors of that sub-sector's compliance rate issues and of DEC's compliance and enforcement procedures, processes and enforcement tools affecting these compliance rate issues. The report must discuss DEC's evaluation of and recommendations for substantive and procedural changes to address the root causes and performance limiting factors.
2	06/01/2020	By June 1, 2020, DEC will complete an analysis of their enforcement procedures and enforcement tools to determine the causes and performance limiting factors for: (1) DEC's 2016-2018 timeliness performance discussed herein regarding the implementation of their Enforcement Action Timelines POG; and (2) DEC's heavy reliance on informal actions with the lengthy, non-enforceable deliverable due dates and extension deadlines that exceed one year. The analysis must evaluate and recommend substantive and procedural changes to address the root causes and performance limiting factors. By June 1, 2020, DEC shall submit a summary report to EPA of its analysis and substantive and procedural changes made or proposed to be made to address root causes and performance limiting factors.
3	08/01/2020	By June 1, 2020, DEC, in concert with the Department of Law (DOL), shall complete an evaluation of DEC enforcement tools and their use to promote timely compliance, including timely submission of enforcement action deliverables. Areas of focus will include whether enforcement tools can be used in other ways to promote more timely compliance, and whether an expanded use of settlement agreements and expedited settlement agreements within appropriate sectors has the potential to promote more timely and effective enforcement actions. As part of the evaluation, DEC will consider implementing a pilot program to test the use of any new or revised enforcement tools and related procedures to determine effectiveness. By August 1, 2020, DEC shall submit a summary report to EPA describing the evaluation, outcomes and anticipated implementation schedule if applicable.
4	4/30/2020	See Element 3, Violations, Finding 3-1, Recommendation No. 1 regarding creating a Compliance Evaluation Checklist and revised Compliance Evaluation POG. The CE checklist and revised CE POG

		should also require the inspector to evaluate the ICIS Violations Report for significant noncompliance (SNC) conditions as provided for in 40 CFR Part 123.45, including chronic effluent limit violation conditions and effluent limit violations above the technical review criteria. The POG revisions should clarify data entry and internal notification requirements.
5	04/30/2020	Provide to EPA revised versions of the Compliance Letter POG, No. 14.04, and Notice of Violation POG, No. 14.05, to instruct the inspector to notify the DEC Compliance Program manager and Enforcement Team supervisor of any significant noncompliance (SNC) conditions identified for any facility during a compliance evaluation or inspection for which one of these informal enforcement tools is being considered as an enforcement response. The instruction must address the timely notice so that the manager and supervisor can evaluate the facility's SNC conditions and the proposed basis and justification for use of any informal enforcement tool and allow adequate time for consideration of, if appropriate, a formal enforcement action. Consistent with EPA SNC Policy, the POGs must be revised to instruct the inspector to prepare a written record that clearly justifies the reasons a formal action was not taken and to save the written record to the facility's WPC folders. The Compliance Evaluation POG will also be revised to include an instruction that the inspector notify the DEC Compliance Program manager and Enforcement Team supervisor of any SNC conditions identified during a compliance evaluation and any inspection. See Finding 3-1, Recommendation No. 1 regarding other related Compliance Evaluation POG and CE Checklist recommendations.
6	04/30/2020	Conduct a training course for all Program staff regarding the application of the APDES Enforcement Response Guide (ERG) and EPA's NPDES Significant Noncompliance (SNC) criteria and any related, updated and revised POGs, program procedures, etc. The training will also address procedures for how inspectors and case officers will document and notify the Program manager and Enforcement and Inspection teams' supervisors of SNC situations, and the application of the ERG that deems a formal action to be the most appropriate response but where the inspector or case officer is making a recommendation for an informal action (e.g. compliance letter, notice of violation).
7	02/01/2020	Starting on February 1, 2020 and on a calendar quarterly basis, DEC shall submit a written report (e.g., table, chart, spreadsheet) to EPA that identifies facilities with SNC conditions (e.g. chronic effluent violations, TRC level effluent violations, etc.) and any application of

		the DEC ERG that designates a formal action as the appropriate response but where DEC has selected to take no action or an informal enforcement action (e.g. compliance letter, notice of violation). The report must include the permittee name, facility name, APDES permit number, summary of the violation situation, selected action and justification/reasons for the selected action. The first report, due February 1, 2020, must cover these situations/actions/no-actions concluded in the first three calendar quarters of CY 2019.
8	06/01/2020	Complete at least eleven (11) formal enforcement actions.
9	01/01/2021	Complete at least an additional eight (8) formal enforcement actions.
10	01/01/2021	By January 1, 2020, DEC shall submit copies of all inspection reports and related enforcement actions (ranging from compliance letters, NOVs, etc. to administrative and judicial actions for any applicable APDES-permitted or unpermitted facility) to EPA and continue submissions for 1 year. After a year, EPA will reassess to determine if further compliance letter submissions are necessary. This is an existing, on-going procedure regarding NOVs and formal actions but will now also include compliance letters.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
10b Enforcement responses reviewed that address violations in an appropriate manner [GOAL]	100%	%	11	39	28.2%

CWA Element 5 - Penalties

Finding 5-1
Area for Improvement

Summary:
The State's formal penalty action files routinely do not contain documentation that explains the justification and rationale for the reduction of the penalty amount from the initial value calculated and proposed/assessed to the final penalty amount assessed and paid. The State's performance regarding Metric 12a is an area for State improvement.

Explanation:
Metric 12a is a file-review based goal metric designed to assess whether DEC creates an adequate written record explaining and justifying the reasons for any reduction from the penalty amount originally calculated and proposed/assessed to the final penalty assessed and paid.

In this SRF review, 6 penalty actions were reviewed. The file reviews determined that DEC files contained the requisite justification document in only 2 of the 6 actions (i.e., 33.3%).

This Metric 12a was also identified as an area for State improvement in the December 2014 final SRF Report (FY 2012). During that SRF review, 1 of 2 penalty actions were found to have adequate justification documentation (i.e., 50%).

In response to the December 2014 final SRF Report (FY 2012), DEC drafted a Penalty Calculations and Settlement Procedures POG, No. 14.22, which includes an attachment 'Final Penalty Adjustment Memo.' The POG, Task #8, directs the case officer to document and justify the difference from the original proposed penalty to the final penalty amount using the Final Penalty Adjustment Memo.

In terms of the POG's Record Management provisions, the POG also instructs the case officer to save all penalty related documents into the DEC WPC folders and various specific sub-folders.

In this SRF review, only one of six penalty action files contained the requisite Final Penalty Action Memo identifying some justification for the penalty reductions, but a second file contained other adequate documentation. In four of six penalty actions, there was no written justification documentation in the DEC files.

More detailed file comments for these four penalty actions can be found in Attachment G of this SRF Report.

State Response: Metric 12a – Documentation of rationale for difference between initial penalty calculation and final penalty
The state agrees with the rating area for improvement. DEC is in the process of updating and standardizing POGs to more accurately reflect the enforcement manual and current practice. These efforts within DEC will likely streamline the approval processes and penalty calculations, and include documenting the justification for the final penalty adjustments.

Recommendation 1: DEC has set a goal that all POGs will be updated in CY 2019 and training provided by April 30, 2020. A copy of all updated POGs will be provided to EPA by January 31, 2020 for opportunity to comment no later than February 28, 2020 for consideration in the final version.

Recommendation 2: DEC has set a goal that all POGs will be updated in CY 2019 and training provided by April 30, 2020.

Recommendation:

Rec #	Due Date	Recommendation
1	04/30/2020	DEC will revise enforcement tool POGs (e.g., settlement agreement, compliance order by consent, etc.) that have the potential to include a negotiated penalty to incorporate and discuss DEC's Penalty Calculations and Settlement Procedures POG, No. 14.22, to highlight the need to prepare and save to the WPC folders a Final Penalty Adjustment Memo in applicable situations. DEC will provide the EPA the opportunity to review and comment before the revisions are final.
2	04/30/2020	The DEC Compliance Program shall conduct a training course for all Program staff regarding the DEC Penalty Calculations and Settlement Procedures, POG No. 14.22, and specifically the tasks for documenting final penalty amounts and any differences that must be documented and justified using the Final Penalty Adjustment Memo. The training should also cover related record management tasks and revisions to other enforcement tool POGs that refer to POG No. 14.22 procedures related to the documentation of penalty differences (i.e. differences from original proposed penalty in comparison to final penalty amount assessed).

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
12a Documentation of rationale for difference between initial penalty calculation and final penalty [GOAL]	100%	%	2	6	33.3%

CWA Element 5 - Penalties

Finding 5-2
Area for Attention

Summary:

The State's procedures for assessing and documenting gravity and economic benefit during the penalty development stage (Metric 11a) and for collecting and documenting penalty collection (Metric 12b) are areas for State attention.

Explanation:
Metric 11a is a file-review based goal metric designed to assess whether the penalty calculations have appropriately calculated and documented gravity and economic benefit determinations.

Metric 12b is a file-review based goal metric designed to assess whether the final penalty in any formal penalty-related action was collected. This assessment relies on documentation in the DEC files that might include canceled check, correspondence documenting transmittal of the check or some official agency document showing acceptance of payment.

In this SRF review, 5 penalty actions were reviewed for each metric. The file reviews determined that DEC files contained the requisite Metric 11a gravity/economic benefit documentation in 4 of the 5 penalty determination situations (i.e., 80%), and that the DEC files contained the requisite Metric 12b penalty collection documentation in 4 of 5 completed penalty actions (i.e., 80%).

Metrics 11a and 12b documentation was also assessed in the December 2014 final SRF Report (FY 2012). During that SRF review, 2 of 2 penalty actions were found to have adequate documentation for both metrics (i.e., 100%).

The root cause underlying the Metric 11a situation appears to be a lack of express tasks within the DEC Penalty Calculations and Settlement Procedures POG, No. 14.22, instructing the case officer to expressly record and document how the gravity component is derived (in addition to the final determination) and on the documentation of the economic benefit calculations (e.g., underlying key facts, reasons for mitigating, rationale, etc.).

POG No. 14.22 indicates it contains steps to document the final decision (penalty determination decision) but the tasks are general in nature and do not contain explicit instructions on the nature of documentation needed to show the actual interim steps in making final gravity and economic benefit determinations.

The root cause underlying the Metric 12b situation appears to be a lack of express tasks within the DEC Penalty Calculations and Settlement Procedures POG for collecting and documenting penalty payment and ensuring such documentation is saved into the WPC folders. POG No. 14.22 indicates it covers settlement procedures through to the end-point of receiving payments. The POG's records management provisions allude to how the Department of Law (DOL) receives payments and notifies DEC of such payments; however, the POG's tasks do not expressly instruct the case officer to create and save appropriate documentation of payment received.

The POG's record management provisions do not clearly state or indicate that penalty payment collection documentation should be saved to the WPC folders.

A potential remedy to the Metric 11a situation is to revise POG No. 14.22 to include specific instructions within existing numbered tasks for creating appropriate interim step documentation of

how the final determination was calculated and derived, including discussion of key underlying facts, reasons, rationale, etc. The POG could identify and stress in some additional detail that the documentation should show how the final decision was derived so that the reader can have a more comprehensive understanding of what steps and reasons were used to make the final conclusion/determination.

A potential remedy to the Metric 12b situation is to revise POG No. 14.22 to include specific numbered tasks for creating appropriate payment-received documentation and saving this documentation to the WPC folders. The POG could also identify in detail what types of documentation are required or preferred for this documentation and records management task.

EPA strongly recommends that DEC consider these potential POG revision remedies, with additional staff training, as one means to address the areas of State attention for Metrics 11a and 12b.

State Response: Metric 11a – Penalty calculations reviewed that document and include gravity and economic benefit
The state agrees with the rating area for attention.

Metric 12b – Penalties collected
The state agrees with the rating area for attention.

Metric 11a and 12b examined the documentation and completeness of penalty calculations, BEN calculations, and gravity components. DEC has set a goal that all POGs will be updated in CY 2019 and training provided by April 30, 2020. A copy of all updated POGs will be provided to EPA by January 31, 2020 for opportunity to comment no later than February 28, 2020 for consideration in the final version.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State %
11a Penalty calculations reviewed that document and include gravity and economic benefit [GOAL]	100%	%	4	5	80%
12b Penalties collected [GOAL]	100%	%	4	5	80%

ATTACHMENT A – Element 1 Data

File Review – Metric 2b Overview. Metric 2b is a file review metric that compares data in the ECHO Detailed Facility Report (DFR) or the national database ICIS-NPDES to information in facility files. If the information in the facility files is missing from, or inaccurately entered into, the national database ICIS-NPDES, the data for that file is not complete or accurate.

Permit No.	Facility Name	File Review Comments
AKR06AB22	Sawmill Cove Industrial Park Recycling Center	The latitude/longitude from the notice-of-intent (decimal) was entered into ICIS in the degree/minute/second boxes so the resulting DFR lat/long (decimal) is not accurate. ICIS has two compliance monitoring entries for the same September 26, 2017 inspection. One entry is marked incorrectly as a "base" program and the second entry is marked correctly as a stormwater non-construction program.
AKG370754	Olson Ketchem Creek Mine Site	The facility site name is entered into ICIS as the legal permittee. The permittee is Steve Olson, not the facility name.
AKR06AD87	North Park Fuels	The May 8, 2017 compliance letter has not been entered into the ICIS compliance monitoring tab.
AKG520402	Alaska Omega Nutrition, Inc. (AONI)	ICIS still shows Ocean Beauty Seafoods, Inc. as legal permittee but DEC 2017 inspection report indicates the APDES permit was transferred to Alaska Omega Nutrition, Inc. in March 2016. Files contain a March 2016 DEC Permit Transfer Form supporting the inspection report entry. The FRS program's latitude/longitude in ICIS and on the DFR is neither a key current AONI building site or end-of-pipe discharge location. The ICP program latitude/longitude is accurate.

AK0023213	Juneau Douglas WWTP	ICIS does not contain applicable entries for the February 14, 2016 inspection, the related SEV, and the March 24, 2016 compliance letter.
AK0022951	Mendenhall Valley WWTP	ICIS does not contain an enforcement action entry for the May 5, 2016 Notice of Violation.
AK0053384	Ward Cove Industrial WWTF	DEC permit identifies Full Cycle, LLC as the named permittee (issuance date October 1, 2014; effective date November 1, 2014) but the ICIS permittee entry reflects a prior legal entity. SIC code in ICIS is incorrect (currently 2421 = sawmill). Inspection report includes SIC code of 4952, sewage system.
AK0053333	Chena Power Plant	ICIS does not contain an enforcement action entry for the August 2016 interim compliance-order-by-consent.

Data Metrics Verification – Overview. As part of the SRF process, a data metric analysis (DMA) is conducted of the ECHO-generated FY 2017 frozen, verified data's metric results for completion and accuracy. This overview discussion considers the State's response regarding the CWA Logic Notes and inclusion of wet weather permit coverages in ICIS data pulls.

The DMA showed that frozen data for Metric 5b1 (individual permit inspection coverage) included one general permit coverage (i.e., AKR06AE63) and five MS4 permits. The DMA also showed that frozen data regarding the universe for Metric 5b2 (general permit inspection coverage) included some wet weather permit coverages, and that evaluation determined not all wet weather general permit coverages have been uploaded into the ICIS data base.

The FY 2017 frozen data for the Metric 5b2's universe included only 161 multi-general sector permit (MSGP) coverages and 208 construction stormwater general permit (CGP) coverages. However, DEC's 2017 CMS Plan identified a MSGP universe of 335 coverages and a CGP universe of 845 coverages. Consequently, EPA's further evaluation after receiving the State's response indicated that not all wet weather permit coverages had been uploaded into the ICIS data base. A recommendation will be included in the SRF

report to facilitate DEC uploading wet weather permit coverages into the ICIS data base to ensure comprehensive data is available in ICIS.

However, in accordance with the Clean Water Act Metrics Plain Language Guide, the Metric 5b1/5b2 frozen data must be corrected to focus on traditional minor facilities (that is, those minor facilities subject to the EPA 2014 CMS goal of one inspection at least every five years). Metrics 5b1 and 5b2 address inspection coverage rate goals for traditional minor permittees; that is, a CMS goal of an inspection at least once every five years. *See* Clean Water Act Metrics Plain Language Guide (State Review Framework Round 4), Guidance, pp. 11-12.

Metric 5b1 – Inspection Coverage of Non-Majors with Individual Permits. The FY 2017 frozen, verified data showed a Universe of 41 permits and a Count of 5 permits inspected. Based on this data, the Alaska result was reported as 12.2% in comparison with the National Average of 22%.

The FY 2017 frozen data's Universe of 41 coverages included one MSGP coverage and 5 MS4 coverages. The Count included one MS4 permit. These six facilities should have been addressed under wet weather metrics, 4a8 and 4a7 respectively, and not included in this Metric 5b1 universe and count.

Correcting the Metric 5b1 universe and count by excluding these six wet weather permit coverage, the corrected Universe is 35 individual permits and the corrected Count is 4 inspections. The corrected Alaska percentage result is 11.4% in comparison to the National Average of 22%.

Metric 5b2 – Inspection Coverage of Non-Majors with General Permits. The FY 2017 frozen, verified data showed a Universe of 1484 permit coverages and a Count of 120 permit coverages inspected. Based on this data, the Alaska result was reported as 8.1% in comparison with the National Average of 5.9%.

The FY 2017 frozen data's Universe of 1484 coverages included 161 MSGP covers and 208 CGP coverages. The Count of 120 inspections included 26 MSGP inspections and 40 CGP inspections. However, DEC's 2017 CMS Plan identified a MSGP universe of 335 coverages and a CGP universe of 845 coverages. Consequently, EPA's further evaluation (post-State responses) determined that not all wet weather permit coverages had been uploaded into the ICIS data base so that the universe did not accurately reflect the entire universe of applicable coverages for wet weather permits.

Even if it were appropriate to include all wet weather coverages in this metric's counts and universe, adding in the additional 174 MSGP coverages (i.e., 335 – 161 = 174) and the additional 637 CGP coverages (i.e., 845 – 208 = 637) into this metric's universe

results in a universe of 2295 coverages. Using the FY 2017 count of 120 coverages, the overall FY 2017 coverage rate would be 5.2%.

Correcting the universe and the count by excluding these wet weather permit coverages so as to focus only on traditional minor facilities, the corrected Universe is 1115 general permit coverages and the corrected Count is 54 inspections. The corrected Alaska percentage result is 4.8% in comparison to the National Average of 5.9%.

ATTACHMENT B – Element 2 Inspections, Metrics 4a1 – 4a10

Overview. DEC made some specific inspection and related compliance monitoring commitments in the State's October 2008 Amended Final [APDES] Program Application (approved October 31, 2008) which includes an APDES Program Description (Final October 29, 2008). If applicable, those inspection and related compliance monitoring commitments are identified below in the applicable metric discussion.

Metric 4a1 – Pretreatment Compliance Inspections and Audits. This Metric 4a1 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012.

DEC has had pretreatment sector authority and jurisdiction since the APDES Phase II transfer, October 31, 2009. Initially, the Fairbanks/GHU POTW (AK0023451) was the only approved pretreatment program. The North Pole POTW (AK0021393) pretreatment program was approved May 15, 2012. DEC's May 15, 2012 approval letter indicated that North Pole must implement and enforce the approved program within 90 days of the approval letter (e.g., August 13, 2012).

2017 & 2018 CMS Plan Performance. The DEC's 2017 CMS Plan indicated its intention to conduct a pretreatment compliance inspection (PCI) of the Fairbanks/GHU program. The PCI was not completed as planned. The DEC's 2018 CMS Plan indicated its intention to conduct a PCI at the North Pole POTW in the fall 2018. The PCI was not completed as planned.

In December 2018, DEC confirmed that it has not conducted any PCIs at either approved pretreatment program.

A December 2018 draft DEC 2019 CMS Plan indicates DEC's intentions to conduct PCIs in 2019 at each of the approved programs. A final draft DEC 2019 CMS (March 27, 2019) indicates two PCIs are planned in CY 2019.

Multi-Year Commitment Performance. The DEC Program Description, Section 9.1.4, indicates that DEC will conduct an annual PCI, and pretreatment compliance audit (PCA) at least every five years. Subsequent to initiating pretreatment program implementation, DEC eliminated its annual PCI commitment unilaterally. The DEC PCI/PCA commitments, as summarized in their 2017 CMS Plan, are to conduct at least one PCA every five years and at least two PCIs every five years which is in accord with EPA's 2014 CMS.

Fairbanks/GHU POTW Pretreatment Program. In terms of PCAs, DEC reported that a PCA was completed at this facility by Tetra Tech on May 11, 2010 but there are no ICIS entries to corroborate that such an audit was completed and documented. DEC has not produced any PCA report documentation. ICIS indicates a PCA was completed in January 2015.

North Pole POTW Pretreatment Program. In terms of PCAs, ICIS indicates a PCA was completed in December 2016.

Summary. As of October 31, 2019, DEC will have had authority to implement pretreatment programs (including oversight) for ten years. DEC will have completed one documented PCA

and one PCI of the Fairbanks/GHU program in comparison with the EPA CMS multi-year commitment goals of at least two PCAs and four PCIs in that same ten year time frame.

As of October 31, 2019, North Pole's pretreatment program will be in it's eighth year of implementation. DEC completed one PCA and no PCIs within the first five years of North Pole's Program (i.e. August 2012 – August 2017). Assuming DEC completes its 2019 CMS Plan as proposed in draft in December 2018 and in final draft in March 2019, DEC will have completed one PCI in the approximate two and one-half years of North Pole's second five-year implementation period.

This Metric 4a1 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012. Based on actual performance to date, DEC's multi-year performance under Metric 4a1 remains an area for improvement.

Metric 4a2 – Significant Industrial User Inspections at Non-Authorized POTWs. This Metric 4a2 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012.

The DEC Program Description, Section 9.1.4, states in part that DEC will inspect and sample significant industrial users (SIUs) in non-delegated POTWs at least once per year.

In accordance with the DEC Program Description, Section 8.3.1, DEC committed that, prior to assuming authority to implement the pretreatment program (i.e. prior to October 31, 2009), it would develop a plan to complete a state-wide industrial survey of all industrial users (IUs) in non-delegated POTWs that might be subject to pretreatment requirements in an effort to identify all facilities meeting the definition of categorical or significant non-categorical industrial users (SIUs). DEC committed to periodically reviewing and updating the DEC SIU inventory. During the FY 2012 SRF, DEC confirmed that this state-wide survey was not completed. Consequently, one post-SRF corrective action required DEC to complete the SIU survey in non-delegated (non-authorized) POTWs which it completed during the 2015-2016 period.

EPA's 2016 permit quality review identified the existence of three SIU/CIUs in the North Pole POTW jurisdiction. The DEC Program Description, Section 8.13.3, also identified the three IUs in North Pole: Petro Star refinery, Golden Valley Energy Association and Flint Hills refinery. As noted previously, North Pole's approved pretreatment program was effective on August 13, 2012.

DEC's CMS inspection plan submittals for CYs 2010-2013 did not identify proposals for conducting SIU sampling inspections in non-authorized POTWs. DEC reported that an SIU inspection (non-sampling) of the Flint Hills refinery was done in 2010. DEC reports no SIU sampling inspections were done in 2011 or 2012. ICIS only showed evidence of the 2010 Flint Hills refinery inspection. In accordance with the DEC Program Description and the EPA 2007 CMS, DEC should have conducted annual pretreatment sampling inspections at the three SIUs in North Pole from October 31, 2009 through North Pole's pretreatment program approval, May 5, 2012. DEC partially completed one SIU pretreatment/sampling inspection (a non-sampling

event) within the first three years of its authority and jurisdiction over the pretreatment sector. At a minimum, DEC should have completed at least six complete SIU pretreatment/sampling inspections over that time period. These findings were the basis for the December 2014 SRF Report's determination that completion of SIU pretreatment inspections was an area for State improvement.

As part of the 2015-2016 SIU state survey, DEC determined that the Alaskan Brewing Company (ABC) is an SIU with reasonable potential to adversely affect operations at the Juneau Mendenhall POTW. DEC conducted a SIU inspection (non-sampling) of the ABC facility in February 2016.

In December 2018, DEC confirmed that it did not conducted any SIU sampling inspections at the ABC facility in 2017 or 2018.

Summary. This Metric 4a2 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012, based on DEC's underperformance in conducting sampling SIU inspections of the three SIUs in North Pole.

A December 2018 draft DEC 2019 CMS Plan did not include any SIU sampling inspection of the ABC facility in 2019. A final draft March 2019 DEC CMS Plan indicates an intent to conduct one SIU sampling inspection in 2019.

Assuming DEC completes its 2019 CMS Plan as proposed in final draft in March 2019 (i.e., one SIU sampling inspection presumably of the ABC facility), DEC will have completed a partial inspection of ABC in 2016 (i.e., inspection lacked sampling), no SIU sampling inspections of the ABC facility in 2017 and 2018, and a current intent to conduct one SIU sampling inspection in 2019. Based on actual performance in the 2016-2018 period, DEC's performance under Metric 4a2 remains an area for improvement.

Metric 4a4 – Combined Sewer Overflow Inspections. This Metric 4a4 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012. This determination was based on an EPA 2007 CMS goal providing for a combined sewer overflow (CSO) inspection once every three years and DEC had not inspected their only CSO facility, Juneau-Douglas POTW (AK0023213), in the three years 2011-2013.

The EPA 2014 CMS now has a minimum inspection frequency goal for at least one comprehensive CSO-related inspection every five years.

The Juneau-Douglas POTW is a major facility; accordingly, it is subject to the DEC Program Description commitment of an annual inspection and the EPA CMS goal of one comprehensive evaluation inspection (CEI) every two years. DEC inspected this POTW in 2014, 2016 and 2018 and each of the inspection reports demonstrates that the DEC inspector is reviewing CSO-related information to assess the POTW's compliance with the CSO provisions of its APDES permit.

Summary. Since the last SRF review for FY 2012, DEC has conducted CEIs at the POTW every two years (i.e., 2014, 2016, 2018) that included CSO-related compliance determinations. The State meets or exceeds expectations regarding Metric 4a4 performance on CSO inspections.

Metric 4a5 – Sanitary Sewer Systems (SSSs) and Sanitary Sewer Overflow (SSO) Inspections. This Metric 4a5 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012. This SRF finding was based on the DEC's lack of a historic or existing strategy and implementation that demonstrated DEC's ability to identify and evaluate SSO-related information which would have been used to devise and implement an applicable follow-up SSO inspection strategy. As of August 2013, DEC did not have a written strategy that identified and evaluated potential SSO information for the purposes of devising follow-up SSO inspections.

Additionally, the 2007 EPA CMS has no set inspection frequency of goal for SSO inspections. Instead, SSO inspections were to be scheduled on an as needed basis based on information about overflow occurrences reviewed by the approved state program. The CMS provided that SSO inspections could be conducted in conjunction with compliance evaluation inspections at the POTWs.

In August 2013, DEC indicated that a strategy would be considered as part of their CY 2014 CMS effort. DEC's December 24, 2013 letter (i.e., draft CY 2014 CMS) indicated that the 24-hour compliance hotline tracking spreadsheet is now being evaluated for reports of sewer system overflows. DEC's August 12, 2014 Letter (i.e. final CY 2014 CMS) indicates that the 24-hour compliance hotline tracking spreadsheet was reviewed to identify reports of sewer overflows and that no inspections were planned in CY 2014 based on this review. DEC has carried this same procedure forward in all subsequent annual CMS plans using the 24-hour compliance hotline as the source to identify SSO incidents and inspection follow-up strategies.

The EPA 2014 CMS now has a minimum inspection coverage goal for SSSs of at least 5% of SSSs each year, with an inspection priority given to SSSs with chronic overflows.

The 2017 DEC CMS Plan identified five SSO events from reviews of the 24-hour compliance hotline with two SSO events occurring at EPA-regulated Section 301(h) POTWs. An SSO event occurred at the Juneau Mendenhall POTW (AK0022951) and DEC proposed to inspect that facility in 2017. DEC inspected this POTW on December 11, 2017.

The 2017 DEC CMS Plan also identifies a universe of 172 POTWs which presumably all have SSSs. This CMS Plan included proposed inspections at five major POTWs and 20 minor POTWs or approximately 14.5% of its SSS-based universe.

Review of ICIS-generated CY 2017 inspection data shows DEC inspected five major POTWs and 19 minor POTWs, or a 2017 inspection coverage rate of 14%.

A summary review of 2014-2019 DEC CMS Plans and inspection results generally shows that DEC typically plans to inspect more than 5% of its POTW/SSS universe each calendar year and accomplishes inspection coverage rates of at least 5% routinely.

Summary. The State meets or exceeds expectations regarding Metric 4a5 performance for SSS and SSO inspections.

Metric 4a7 – Phase I & II MS4 Audits and Inspections. This Metric 4a7 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012 for the Phase I MS4 facilities primarily because the Port of Anchorage MS4 had not been inspected within the five years after the initial February 2008 audit.

For context in this SRF process, the MS4 sector has multi-year inspection/audit coverage goals and resulting anticipated inspection commitments which span both EPA 2007 and 2014 CMSs. In regard to the EPA 2007 CMS, refer to the Clean Water Act Metrics Plain Language Guide (State Review Framework Round 3), Appendix D. For Phase I and Phase II MS4s, after the initial audit or inspection conducted within five or seven years of the 2007 NPDES CMS issuance, respectively, the goal is for the state to conduct another audit or inspection with the follow timeframes:

If initial audit/inspection leads to determination of . . .	*Then another audit/inspection should be conducted within . . .*
Full compliance or only minor violations	Five years
Violation(s) requiring enforcement order	One year

The EPA 2014 CMS includes a minimum compliance monitoring goal for MS4s that at least once every five years, the approved state program conducts one or more of the following compliance monitoring activities: on-site audit, MS4 inspection, or off-site desk audit. In addition, and as part of this CMS goal, each MS4 permittee should receive an *on-site* audit or inspection at least every seven years.

The following discussion is based on ICIS compliance monitoring entries existing under each of these permitted facilities as of March 13, 2019. Additionally, and in regard to Fairbanks (AKS053406) and Fairbanks/NB (AKS053414), DEC reported during the last SRF process that the January 8, 2010 inspections identified in ICIS for these two facilities were not MS4-based programmatic inspections but instead were follow-up responses to complaints received by DEC about illicit discharges to the MS4 systems with a focus on compliance assistance. Accordingly, those January 2010 ICIS inspection entries are not considered MS4 inspections for purposes of evaluating MS4 audit/inspection coverages under the EPA frequency goals.

The DEC's 2017 CMS Plan proposed to complete one MS4 inspection in 2017 of the City of Anchorage. ICIS data indicates that inspection was completed in November 2017.

Port of Anchorage (AKS052426). This MS4 Phase I facility was audited in February 2008. It was not subsequently inspected until December 2016, 4 years after the projected February 2013 5-year interval deadline and over 8.5 years after the initial compliance monitoring activity.

City of Anchorage/ADOT (AKS052558). This MS4 Phase I facility was initially inspected in June/July 2012 and subsequently audited and inspected in June 2015 and November 2017, respectively.

Fairbanks (AKS053406). This MS4 Phase II facility was inspected initially in June 2016, over 1.5 years after the October 2014 deadline for an initial MS4 audit/inspection (i.e., within seven years after the October 2007 issuance of the EPA 2007 CMS). The facility was inspected again in November 2018.

Fairbanks/North Star Borough (AKS053414). This MS4 Phase II facility was inspected initially in June 2016, over 1.5 years after the October 2014 deadline for an initial MS4 audit/inspection (i.e., within seven years after the October 2007 issuance of the EPA 2007 CMS). The facility has not been inspected or audited since the June 2016 inspection.

Fort Wainwright (AKS055859). This MS4 Phase II facility was first permitted in September 2016. An MS4 inspection was conducted in August 2018.

Summary. The State's performance and adherence to EPA-generated MS4 inspection/audit deadlines and frequency goals under Metric 4a7 is an area for State attention. This finding is based primarily on the DEC missing initial frequency deadlines and then extended delays in completing initial compliance monitoring activities for the Port of Anchorage, Fairbanks and Fairbanks/North Star Borough facilities.

Metric 4a8 – Industrial Stormwater (MSGP) Inspections. The EPA 2014 CMS's inspection goal for MSGP permittees is to inspect at least 10% of the universe each year.

For CY 2017, DEC proposed to complete 23 MSGP inspection within a universe of 335 coverages or a projected coverage rate of 6.9%. DEC completed 29 inspections for an actual coverage rate of 8.7%. However, looking at a one-year performance effort, DEC completed 126% of its CY 2017 goal (i.e., 29/23 = 126%).

From an overall APDES program inspection coverage rate perspective, it is important to consider each subject sub-sector (e.g., MSGP) within the totality of DEC's entire ADPES universe and to consider the variability of inspection coverage rates year to year. For that perspective, here is data from the first four calendar years of DEC's MSGP coverage rate performance under the EPA 2014 CMS.

Calendar Year	Universe	Inspections Completed	Coverage Rate
2015	279	24	8.6%

2016	344	22	6.4%
2017	335	29	8.7%
2018	341	26	7.6%

Based on this four year period, DEC has been inspecting on average about 7.7% of the MSGP universe on an annual basis.

Summary. The State's performance regarding Metric 4a8 coverage rates is an area for State attention.

Metric 4a9 – Construction Stormwater (CGP) Inspections. This Metric 4a9 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012 for CGP facilities.

The EPA 2014 CMS's inspection frequency goal for CGP permittees is to inspect at least 10% of the regulated construction sites annually.

For CY 2017, DEC proposed to complete 32 CGP inspection within a universe of 845 coverages or a projected coverage rate of 3.8%. DEC completed 39 inspections for an actual coverage rate of 4.6%.

From an overall APDES program inspection coverage rate perspective, it is important to consider each subject sub-sector (e.g., CGP) within the totality of DEC's entire ADPES universe and to consider the variability of inspection coverage rates year to year. For that perspective, here is data from the first four calendar years of DEC's CGP coverage rate performance under the EPA 2014 CMS.

Calendar Year	Universe	Inspections Completed	Coverage Rate
2015	1155	34	2.9%
2016	1305	33	2.5%
2017	845	39	4.6%
2018	699	13	1.9%

Even adjusting for any potential anomalies that might exist in the 2015-2016 universes (assume in effect that the 2017 and 2018 universe levels may be more reflective of coverages in effect),

DEC's projected/estimated average inspection coverage rate over these four years would still be less than 5% per year, substantially below the EPA CMS coverage rate goal of 10%.

Summary. The State's performance regarding Metric 4a9 coverage rates is an area for State improvement.

Metric 4a10 – Large and Medium NPDES-Permitted CAFOS Inspections. Metric 4a10 addressed the number of comprehensive inspections conducted of large and medium concentrated animal feeding operations (CAFOs). The EPA's target CMS goal is one CEI of each NPDES-permitted CAFO every five years.

In regard to Metric 4a10, DEC has consistently reported in their annual CMS inspection plans that there are no large or medium confined animal feeding operations (CAFOs) in Alaska. For example, the DEC CY 2017 CMS Plan (Dec. 23, 2016) stated that Kirk Brown, AK Department of Natural Resources-Division of Agriculture, state there were no concentrated animal feeding operations in Alaska. The same DEC representation citing the same DNR staff person was made in DEC's CY 2016 CMS Plan (Dec. 22, 2015) and in DEC's CY 2017 CMS Plan (Dec. 23, 2016).

EPA-OECA raised questions regarding the draft SRF Report's statements on this metric that there were no large or medium CAFOs in Alaska. EPA-OECA asked if all CAFO/AFOs in the state had been identified and evaluated to determine whether the facility would require a NPDES permit or has the potential to discharge. EPA-OECA noted that recent agricultural census data from USDA suggested that medium/large CAFOs may exist for beef cattle.

The USDA-National Agricultural Statistics Service (NASS) 2017 Census of Agriculture (Alaska State and Area Data, Vol. 1, Geographic Area Series, Part 2, AC-17-A-2) (issued April 2019) and specifically, Table 12, Cattle and Calves Inventory, p. 20, provides statistics on herd size per farm. The Table's herd size differentiations (e.g., 200 to 499, 500 to 999) do not exactly match EPA's regulatory definition thresholds for medium CAFOs (i.e., 300 – 999 animal units) and the Table has no information on whether these inventories are related to *confined* operations.

The NASS data is not conclusive and determinative on the actual existence of EPA-defined medium and large beef cattle CAFOs; however, the NASS data is a reasonable basis upon which Region 10 intends to bring this CAFO data to DEC's attention for discussion and to request an additional, more comprehensive evaluation between DEC and DNR on existence of AFOs and CAFOs that should then be addressed in accordance with the EPA 2014 CMS in an upcoming DEC annual CMS Plan.

Summary. Region 10 did not further delay the issuance of the draft SRF report to DEC for review and comment to definitively address EPA-OECA comments on Metric 4a10. Region 10 sent an email to DEC on November 11, 2019 submitting the NASS data for their review and consideration and requesting that DEC evaluate this CAFO issue with the ADNR-Division of Agriculture in an effort to include updated information in DEC's draft CY 2020 CMS plan.

Region 10 will continue to work with DEC in CY 2020 to update and verify the existence or non-existence of CAFOs in Alaska based on the EPA-OECA comments regarding U.S. Department of Agriculture (NASS) data on Alaska cattle feeding operations herd sizes.

ATTACHMENT C – Element 2 Inspections, Metrics 5a1, 5b1 and 5b2

Overview. DEC made some specific inspection and related compliance monitoring commitments in the State's October 2008 Amended Final [APDES] Program Application (approved October 31, 2008) which includes an APDES Program Description (Final October 29, 2008). If applicable, those inspection and related compliance monitoring commitments are identified below in the applicable metric discussion.

Metric 5a1 – NPDES Majors. This Metric 5a1 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012.

In 2008, the State committed to inspect *annually* all facilities classified as a major discharger, whether covered under an individual or general permit. *See* State's Amended Final [APDES] Program Application (approved 2008), APDES Program Description (Final Oct. 29, 2008), Section 9.1.3.

EPA's 2007 and 2014 CMS include an inspection coverage rate goal for major facilities of at least one comprehensive inspection every two years. Since 2010, DEC's CMS Plans have adopted the national goal of an inspection of a major facility once every two years.

Since 2014, DEC has made a concerted effort to adhere to the EPA CMS majors' frequency of once-every-two-years. Despite not meeting this frequency exactly using only DEC inspectors, the joint DEC/EPA inspection effort has produced results that closely adhered to the EPA CMS multi-year goal and DEC's CMS Plans.

DEC has approximately 57 active major permit coverages (Agrium is counted in DEC's major universe but it is an inactive industrial facility with an active, effective major IP). The summary bullets below for CYs 2014-2017 shows that any two-year combined total is very close or at the 57 active Majors level:

- 2014 – 2015 = 49
- 2015 – 2016 = 56
- 2016 – 2017 = 57*

(*) Ocean Beauty Petersburg Plant was inspected by EPA and DEC for three years in a row.

Using DEC data (CMS Plan, Appendix B charts), EPA conducted approximately 5 major inspections in CYs 2016 and 2017 or about 9% of the major facility inspections were done by EPA. EPA's continuing inspection investment in Alaska supplements DEC's major inspection efforts and provides DEC an ability to divert inspection resources to other non-major inspection priorities. In CY 2018, EPA conducted 6 major facility inspections.

DEC 2017 CMS Plan (Dec. 23, 2016), Appendix B, predicted a total of 27 Major inspections with EPA contributing 3 inspections to that total. DEC 2018 CMS Plan (Feb. 26, 2018), Appendix B, shows that 27 Major inspections were completed in 2017 with EPA contributing 3 inspections to that total. Consequently, DEC met or exceeded its projected inspection coverage level for the CY 2017.

The following major facility inspection information was derived from the DEC 2018 CMS Plan (Feb. 26, 2018), Appendix B, Majors Inspections Planned (includes Major Inspections completed for CYs 2014-2017).

CY	2014	2015	2016	2017	2018
Total Combined DEC & EPA	23	26	30	27	29
EPA Contribution	1	5	2	3	6

Over the CY 2014-2018 period, EPA conducted about 13% of all major facility inspections completed in that five-year period. During the latest two year period, 2017-2018, EPC conducted 16% of all major facility inspections.

Summary. From an overall APDES program inspection coverage rate perspective, it is important to consider each subject sub-sector (e.g., series for 5a, 5b and 4a1-4a9) within the totality of DEC's entire ADPES inspection universe and to consider the effects of trying to meet the CMS inspection coverage rate goals in each subject sub-sector. Accordingly, the finding for any one metric must consider and be tempered by that finding's potential impact on other metrics' findings.

Consequently, the DEC performance for Metric 5a1, in context with the performance over the entire APDES inspection universe, is an area for State attention. This "state attention" finding acknowledges DEC's significant turn-around in coverage of major facilities since the last SRF review, but also takes into account the DEC's continuing, prolonged lack-of-adequate-resources which affects the DEC compliance and enforcement program's overall performance in meeting CMS goals.

However, it is also important to acknowledge DEC's concerted effort to meet the EPA CMS majors' frequency goals and their accomplishments of these efforts, including their meeting or exceeding their CY 2017 goals for this metric.

Metrics 5b1 & 5b2 NPDES Non-Majors Overview. Metrics 5b1 and 5b2 cover the inspection coverage rates for NPDES non-major facilities often referred to as traditional non-major facilities or traditional minor facilities (i.e., excluding non-major facilities covered under Metrics 4a1 – 4a11).

Under SRF Element 1, Attachment A discusses the revisions that had to be made to the frozen FY 2017 universes and counts for these two metrics to eliminate coverages that were not traditional minor facilities. Please refer to Attachment A for that data correction discussion.

As part of the State's Amended Final [APDES] Program Application (approved 2008), the State committed to inspect all facilities classified as a traditional minor discharger with an individual or general permit at least once every five years. DEC's annual CMS inspection plans adopt the national goal of inspecting traditional minor facilities at least once every five years (i.e., 20% per year reflecting the once-every-five-year cumulative or multi-year goal) but acknowledge that meeting those multi-year inspection coverage rate goals will be challenging.

Metric 5b1 – NPDES Non-Majors with Individual Permit Coverage. This Metric 5b1 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012.

For context, DEC has had the APDES program since November 1, 2008 or just over 10 years. Over that 10 year period, DEC has had a continuing significant challenge meeting the EPA 2014 CMS frequency goals for traditional non-major (minor) permits because of insufficient inspection personnel. This subset of non-majors with individual permits is illustrative of that continuing resource insufficiency issue.

In contrast, the following evaluation and bullets do not appear to support a conclusion of the existence of a "minor problem" in inspection coverage frequency which is the conclusion and determination that must be made for a "Area for State Attention" finding.

- Of the total corrected 35 permit universe, 18 permits were inspected during a five-year period of 2013 – 2017 or 51% coverage in comparison with the 100% CMS goal.
- Excluding the 7 permits issued within the last 2.5 years of that five-year period, the coverage rises to just 18/28 or 64% in comparison to the 100% CMS goal.
- Two industrial individual permits have had no on-site recorded compliance monitoring for at least 13 years.
- Two other permits (Juneau and Air Force) did not have any on-site recorded compliance monitoring for about 7.4 years and 8.5 years up to January 1, 2018.
- At least 4 permits (excluding the two terminated permits) are now exceeding five years without any on-site recorded compliance monitoring activity.

Last Five Years – CYs 2013 through 2017. Using the EPA's 2014 CMS goals for traditional non-majors at a general goal of once-per-five-years, a review of the 35 permits with individual permits that were in effect at least some time during any of the five calendar years 2013 – 2017, is illustrative of the DEC's inspection resource issue that affects DEC's overall inspection coverage rate/frequency deficiency.

This illustrative evaluation showed that 18 of the 35 permits had at least one inspection during that five-year period (51%).

Below, a summary of the other 17 permits with permit issuance dates identified for permits with no ICIS-reported compliance monitoring activity during the five year period, 2013-2017.

Permit No.	Name	Last Inspection before 1/1/2018	Permit Issuance Date	Comments
AK0000370	CPD Alaska	9/17/2012		
AK0001341	Air Force DOD	7/29/2010		Inspected 5/16/2018
AK0026603	Chugach Elec Assoc.	NA	1/15/2016	
AK0029441	Petro Star	5/9/2012		
AK0045675	Vigor AK	6/30/2004		
AK0049514	Juneau, City & Borough	6/11/2009		
AK0050563	Alyeska Pipeline	10/10/2012		Multiple Pump Stations
AK0053236	Ted Stevens Marine – NOAA NMFS	NA	1/9/2013	
AK0053392	Ketchikan Pulp Co.	6/29/2004		
AK0053635	North Tongass Car Wash	NA	4/7/2017	
AK0053708	Niblack Project	NA	7/31/2015	
AK0053724	City of Seward	NA	8/26/2016	
AK0053732	Aurora Energy	NA	3/2/2016	
AK0053741	Usibelli Coal	NA*	3/8/2017	Inspected 6/20/2018
AK0053767	ENI Operating Co.	NA	10/25/2012	
AK0062278	ExxonMobil Alaska LNG	NA	2/19/16	Terminated 11/17/16

Permit No.	Name	Last Inspection before 1/1/2018	Permit Issuance Date	Comments
AK0053660	Pt. Thompson Central Pad CC2	NA	9/28/12	Terminated 10/24/16

Of the 17 permits in this chart, 7 permits for which no inspection occurred within the targeted time period (i.e., CYs 2013-2017) were issued within the last 2.5 years of that 5-year targeted time period. For illustrative purposes, even if these 7 permits issued in last 2.5 years of the targeted time period are excluded from the Universe, the inspection coverage rate/frequency percentage only increases to 18/28 or 64%.

Of the remaining 10 permits from the chart, two permits (i.e., Vigor and Ketchikan Pulp) have had no on-site ICIS-recorded compliance monitoring for at least 13 years. Two other permits (i.e., Juneau and Air Force) did not have any on-site ICIS-recorded compliance monitoring for about 7.4 years and 8.5 years up to January 1, 2018. The remaining 4 permits (excluding the two terminated permits) are now exceeding five years without any on-site ICIS-recorded compliance monitoring activity.

In summary:

- Of the total corrected 35 permit universe, 18 permits were inspected during a five-year period of 2013 – 2017 or 51% coverage in comparison with the 100% CMS goal.
- Excluding the 7 permits issued within the last 2.5 years of that five-year period, the coverage rises to just 18/28 or 64% in comparison to the 100% CMS goal.
- Two industrial individual permits have had no on-site ICIS-recorded compliance monitoring for at least 13 years.
- Two other permits (Juneau and Air Force) did not have any on-site ICIS-recorded compliance monitoring for about 7.4 years and 8.5 years up to January 1, 2018.
- At least 4 permits (excluding the two terminated permits) are now exceeding five years without any on-site recorded compliance monitoring activity.

Summary. This evaluation demonstrates the existence of something more than a "minor problem" in accomplishing CMS-based inspection coverage rate/frequency goals, which is the conclusion and determination that must be made for a "Area for State Attention" finding. Consequently, the DEC performance for Metric 5b1, in context with the performance over the entire APDES inspection universe, continues to be an area for State improvement.

Metric 5b2 – NPDES Non-Majors with General Permit Coverage. This Metric 5b2 was identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012.

For context, DEC has had the APDES program since November 1, 2008 or just over 10 years. Over that 10 year period, DEC has had a continuing significant challenge meeting the EPA 2014

CMS frequency goals for traditional non-major (minor) permits because of insufficient inspection personnel. This subset of non-majors with general permit coverages is illustrative of that continuing resource insufficiency issue.

As noted above, the SRF Element 1's Attachment A discusses the revisions that had to be made to the frozen FY 2017 universes and counts for Metrics 5b1 and 5b2 to eliminate coverages that were not traditional minor facilities. Based on those corrections, the Metric 5b2 inspection coverage rate based on FY 2017 frozen data was 4.8%, in comparison with a CMS goal of 20% per year.

Additionally and as background, DEC's annual calendar year CMS plans do not separate out the total universe of traditional non-majors into individual and general permit sub-sectors. As noted above, DEC's subsector of traditional non-majors with individual permits (IPs) is very small (e.g. corrected Metric 5b1 universe of 35 permits) in comparison to the DEC CY 2018 universe for traditional non-majors covered by general permits (GP) of 1070 permits, or approximately 3% of a total combined universe of GP and IP coverages (i.e., 31/1101 or 2.8 %). Accordingly, the following evaluation does not attempt to separate these differing sub-sectors and instead, treats DEC's information as a combined universe of IPs and GPs coverages.

The following information covers the first four calendar years' DEC CMS Plans that were submitted subsequent to the issuance of the EPA's 2014 CMS.

CY 2018 Projection. The DEC's CY 2018 CMS Plan projected a goal to inspect a total of 71 traditional non-majors in CY 2018. The Plan notes that the Universe for traditional non-majors is 1070 facilities. Accordingly, the projected inspection coverage rate = 71/1070 or 6.6 %.

CY 2017. The DEC's CY 2018 CMS Plan included the EOY 2017 Chart indicating that DEC had inspected 74 traditional non-majors in CY 2017. Using the DEC's traditional non-majors' Universe of 1329 permits from its CY 2017 CMS Plan, the inspection coverage rate = 74/1329 or 5.6 %.

Using DEC's traditional non-majors' Universe from its CY 2018 CMS Plan of 1070 permits, the inspection coverage rate = 74/1070 or 6.9 %.

As background, the DEC's CY 2018 CMS Plan submittal (Feb. 26, 2018) reported that DEC conducted a total of 139 inspections in CY 2017. The submittal's EOY Chart for CY 2017 generally divided the completed 139 inspections as follows:

Majors	22
Traditional Non-Majors (excluding MSGP & CGP) (derived)	74
MSGP	24
CGP	39
Misc Others	2

CY 2016. The evaluation of the DEC's CY 2017 CMS Plan for CY 2016 indicates DEC inspected a total of 45 traditional non-majors in CY 2016.

For CY 2016 illustration purposes and using the DEC's traditional non-majors' Universe of 1329 permits from its CY 2017 CMS Plan, the CY 2016 inspection coverage rate for traditional non-majors = 45/1329 or 3.4 %.

For CY 2016 illustration purposes and using DEC's traditional non-majors' Universe from its CY 2018 CMS Plan of 1070 permits, the CY 2016 inspection coverage rate for traditional non-majors = 45/1070 or 4.2 %.

As background, the DEC's CY 2017 CMS Plan submittal (Dec. 23, 2016) reported that DEC had conducted a total of 130 inspections in CY 2016. The submittal's EOY Chart information was evaluated for CY 2016 and the evaluation generally divided the completed 130 inspections as follows:

Majors	28
Traditional Non-Majors (excluding MSGP & CGP) (derived)	45
MSGP	22
CGP	33
Misc Others	2

CY 2015. The DEC's CY 2016 CMS Plan submittal (Jan. 25, 2016) reported that DEC had conducted a total of 130 inspections in CY 2015. The DEC's CY 2018 CMS Plan included the EOY 2017 Chart indicating that DEC had inspected 74 traditional non-majors in CY 2017.

Using the DEC's traditional non-majors' Universe of 1329 permits from its CY 2017 CMS Plan, the inspection coverage rate = 74/1329 or 5.6 %.

For CY 2015 illustration purposes and using DEC's traditional non-majors' Universe from its CY 2018 CMS Plan of 1070 permits, the CY 2015 inspection coverage rate for traditional non-majors = 74/1070 or 6.9 %.

In summary:

- The corrected Alaska inspection coverage rate percentage for Metric 5b2 is 4.8 % for the FY 2017 frozen data.
- The DEC CY 2018 CMS Plan's EOY 2017 Chart shows an inspection coverage rate of 5.6 %.
- The DEC's EOY charts for CY 2015 and CY 2016 show inspection coverage rates of 5.6 % and 3.4 %, respectively.

Summary. This evaluation demonstrates the existence of something more than a "minor problem" in accomplishing CMS-based inspection coverage rate/frequency goals (e.g., 20% per year to meet a once-in-five-years frequency), which is the conclusion and determination that must be made for a "Area for State Attention" finding.

Regardless of the count/universe comparisons made for this four year period of 2015-2018, the range of coverage rates of 3.4% to 5.6% is significantly below the CMS goal of 20% per year average that would be needed to meet the EPA CMS goal of once-in-five-years frequency. Consequently, the DEC performance for Metric 5b2, in context with the performance over the entire APDES inspection universe, continues to be an area for State improvement.

However, it is also important to acknowledge DEC's concerted efforts to meet their annual CMS Plan inspection commitments even though the DEC's overall, multi-year inspection coverage rates may not be meeting the EPA 2014 CMS goals. In terms of single year CMS Plan performance, the DEC CY 2018 CMS Plan's EOY 2017 Chart indicates that DEC inspected 74 traditional minors in CY 2017 and that 69 minors were scheduled to be inspected. Using these DEC figures, DEC exceeded their CY 2017 Plan commitments for traditional minor inspections by approximately 7% for that single 2017 calendar year.

Inspector FTE Resource Needs Demonstration

The purpose of this demonstration is to identify the number of inspector FTEs that would be needed to achieve the inspection coverage rate/frequency goals in the EPA 2014 CMS based on DEC's APDES universe levels in their draft CY 2019 CMS Plans.

This demonstration has two scenarios: (1) FTE inspector needs based on the application of the EPA 2014 CMS to DEC's APDES permit universe levels in their draft CY 2019 CMS Plans; and (2) FTE inspector needs based on the application of the EPA 2014 CMS to DEC's APDES permit universe levels in their draft CY 2019 CMS Plans with some modifications to the Placer Mine and Log Transfer facility sub-sectors based on assumptions for "active" facilities as discussed below.

Current DEC FTE Level. This demonstration will also be used to show what current DEC inspection FTE allocations will be able to accomplish under these illustrative scenarios. As noted above, the draft DEC CY 2019 CMS Plans indicate that the DEC APDES Compliance Program's fully allocated FTE base consists of one program manager and 12 staff. The program is reorganized into three distinct teams:

- Inspection team: five positions plus one working supervisor
- Enforcement team: two positions plus one working supervisor
- Date Management team: two positions plus one working supervisor

The working supervisors have programmatic responsibilities and approximately 20% of their time is allocated to supervisory responsibilities. The draft Plan projects the completion of 169 inspection in CY 2019 for all APDES permit universes or approximately 29 inspections per

inspector position (i.e., 169 inspections divided by an estimated 5.8 FTE inspectors in the inspection team).

The proposed 29-inspections-per-inspector FTE will be a factor used in this demonstration.

Scenario No. 1. Application of the EPA 2014 CMS to DEC's APDES permit universe levels in their draft CY 2019 CMS Plans with the exception that no facilities are included for inspections for this scenario from the Small Sized Suction Dredge GP, AKG375000.

Sub-Sector	Universe	CMS Reqt	Comment, Assumptions	Required Inspections
Majors	58	Once every two years	50% of universe per year	29
Traditional Minors	Total = 969	Once every five years	20% of universe per year	194
a. Domestic	159			
b. Seafood	154			
c. Mining	474 under three GPs & 5 under IPs Total: 479 [excludes all facilities under Small Sized GP, AKG375000]			
d. Oil & Gas	71			
e. Misc Minor Facilities with IPs	15			
f. Log Transfer	91			
MS4s	6	I – every 5 yrs II – every 7 yrs	Assume an average of 1 per year	1
Misc: Non-Contact Cooling Water	7	Once every five years	20% of universe per year	2

Sub-Sector	Universe	CMS Reqt	Comment, Assumptions	Required Inspections
Misc: Drinking Water Treatment Plants	12	Once every five years	20% of universe per year	2
Pesticides	3	TBD	Complaint Driven	0
Storm Water				
a. MSGP	345	10% of universe per year		35
b. CGP	781	10% of universe per year		78
SIUs Under DEC Authority	1	Annual sampling inspection		1
Misc: Excavation Disch	70	TBD	Complaint Driven	1
Misc: Hydrostatic Testing	9	TBD	Complaint Driven	1
TOTAL				**344**

Assuming 29 inspections per year per inspector FTE, DEC would need approximately 12 inspector FTEs in order to meet the EPA CMS goals under this Scenario No. 1, which would not have allocated any inspections in any year for the facilities covered under the Small Sized Suction Dredge GP, AKG375000.

Scenario No. 2. Application of the EPA 2014 CMS to DEC's APDES permit universe levels in their draft CY 2019 Plans with modifications based on some assumptions of "active" facilities (permit coverages) under the three main GPs for the placer mining sub-sector (with the exception that no facilities are included for inspections for this scenario for the Small Sized Suction Dredge GP, No. AKG 375000), and under the two Log Transfer Facilities (LTF) GPs.

Placer Mine Sub-Sector. DEC's allocation of inspection resources for inspections of placer mine facilities have resulted in extremely low levels of inspection coverage rates/frequencies percentages since DEC was authorized in 2008. For example, the previous SRF Report (FY 2012) noted that DEC inspected approximately 27 placer mine facilities over a three year period, CYs 2011-2013, and based on DEC's estimated universe of active facilities for this time period, the annual average coverage rate is less than 1%.

DEC CMS plans for 2015-2019 have projected proposed minimum placer mine inspections (i.e., at least this number) of 12, 6, 15, 15 and 15, respectively, or an average of 13 inspections per year.

In their 2011 and 2012 CMS plan submissions, DEC indicated there are approximately 1000 active placer mining facilities active in any one year.

In their CY 2017 CMS Plan, DEC reported that its Small Sized Suction Dredge GP (AKG375000) has approximately 2700 authorizations (November 2016 data) but DEC has not included any of this information in their CY 2018 and 2019 draft CMS Plans and the current information indicates DEC does not invest any inspection resources for facilities covered by this GP.

The May 2012 DEC fact sheet for the Small Sized Suction Dredge GP (AKG375000) developed and report some information on the number of estimated small suction dredges operational in any one year. The DEC fact sheet indicated that as of January 1, 2012, the 2007 GP had about 4000 authorizations, with an estimate that each single "facility" had an average of four GP coverages so actual number of permitted facilities was only 1000 under this particular GP. Using ADF&G permitting data for fish habitat permits (i.e., 1000 fish habitat permits issued in 2011) and an average of four ADF&G permits per facility, DEC estimated there were approximately 250 operations active in 2011.

DEC's Resource Analysis (Oct. 30, 2015) also estimated there were approximately 250 active small placer mining operations under the Small Sized Suction Dredge GP.

Using the November 2016 data of 2700 authorizations and other factors from the 2012 DEC fact sheet (e.g., four coverages per facility), an assumption could be made, for sole purposes of this demonstration, that the GP now covers approximately 675 facilities. Assuming a similar proportion of ADF&G active operations per DEC permitted facilities (e.g., 250 of 1000 or 25%), an assumption could be made that this Small Sized Suction Dredge GP could have an estimated 169 GP-covered facilities active in any one year (i.e., 25% of 675).

This Small Sized Suction Dredge GP discussion illustrates there is a potential substantially large sub-set of active discharging facilities (i.e., 169 – 250 facilities) that are not getting any affirmative inspection attention from DEC on any planned basis. For purposes of this demonstration, this particular GP universe will not be included in the scenario.

The following assumptions are applied in an effort to focus on a potentially *active* yearly sub-set of the remaining entire Placer Mining universe covered by three main GPs as discussed below.

The annual active facility estimates were made in August 2012 by EPA's senior NPDES placer mining permit writer for the following two GPs:

- Mechanical Placer Miners, AKG370000: 50%-67% active on yearly basis
- Medium Size Suction Dredge, AKG371000: 50% active on a yearly basis

The evaluation assumes the 10 facilities currently under the Norton Sound Large Dredge GP are all active on an annual basis.

Sub-Sector	GP Universe Authorizations per Draft 2019 CMS Plan	Active Factor Assumption	Estimated Active Facilities Each Year
Mech Placer AKG370000	339	50% - 67%	170-228
Medium Size AKG371000	125	50%	63
Norton Sound Large Dredge AKG374000	10	100%	10
		TOTAL	243 - 301

Log Transfer Sub-Sector. DEC's CY 2009-2013 CMS Plan submissions typically indicated that there were approximately six LFTs active each year. Recent CMS Plans have not included information about active sites but generally DEC has planned to inspect one active site per year. For purposes of this demonstration, an active universe of six LTFs will be used.

100% of CMS Goals Using Est. Active Universes for Placer Mine and LTF Sub-Sectors

Sub-Sector	Universe	CMS Reqt	Comment, Assumptions	Required Inspections
Majors	58	Once every two years	50% of universe per year	29
Traditional Minors	Total = 648-706	Once every five years	20% of universe per year with assumptions about active universes for LTF and Placer Mine sub-sectors as noted above.	130-142
g. Domestic	159			
h. Seafood	154			
i. Mining	474 under GPs 5 under IPs Total: 479			

Sub-Sector	Universe	CMS Reqt	Comment, Assumptions	Required Inspections
	Active Universe = 243-301			
j. Oil & Gas	71			
k. Misc Minor Facilities with IPs	15			
l. Log Transfer	91 Active Universe = 6			
MS4s	6	I – every 5 yrs II – every 7 yrs	Assume an average of 1 per year	1
Misc: Non-Contact Cooling Water	7	Once every five years	20% of universe per year	2
Misc: Drinking Water Treatment Plants	12	Once every five years	20% of universe per year	2
Pesticides	3	TBD	Complaint Driven	0
Storm Water				
c. MSGP	345	10% of universe per year		35
d. CGP	781	10% of universe per year		78
SIUs Under DEC Authority	1	Annual sampling inspection		1
Misc: Excavation Disch	70	TBD	Complaint Driven	1

Sub-Sector	Universe	CMS Reqt	Comment, Assumptions	Required Inspections
Misc: Hydrostatic Testing	9	TBD	Complaint Driven	1
TOTAL				**281 - 292**

Assuming 29 inspections per year per inspector FTE, DEC would need between 9.7 – 10.1 inspector FTEs in order to meet 100% of the CMS goals.

Note, this demonstration is limited in scope in terms of projecting needed FTE compliment. The demonstrations was focused solely on compliance monitoring activities needed to meet EPA 2014 CMS goals. This demonstration does not factor in the additional enforcement team resources that would be needed to process these additional inspection reports, develop, initiate and finalize the appropriate and timely enforcement actions as part of the additional post-inspection follow-up work load.

ATTACHMENT D – Element 3 Violations

Violation Metrics 7j1, 7k1 and 8a3

Metrics 7j1, 7k1 and 8a3 generally measure levels of noncompliance determined in inspections recorded for the review year, noncompliance levels of major and minor facilities, and percentages of major/minor facility significant noncompliance. These review indicators reflect in part the effectiveness of the state's compliance and enforcement efforts and whether appropriate enforcement responses are being taken and have lasting compliance effect. As stated in the SRF Plain Language Guide, high non-compliance rates under these 3 metrics may indicate a lack of timely and appropriate enforcement.

The Metric 10b findings related to whether enforcement responses address violations in an appropriate manner are reflected, in part, in Element 3 Violation Metrics 7j1, 7k1 and 8a3. The levels of noncompliance in these three review indicators demonstrates the need for the State to assess noncompliance universes for root causes and assess whether appropriate enforcement tools are being applied, and in a timely manner, that result in actual facility compliance.

Metric 7j1 – Number of Major and Non-Major Facilities with Single-Event Violations Reported in FY 2017.

Metric 7j1 is a review indicator regarding single-event violations (SEVs). SEVs are violations of the CWA's NPDES requirements that are documented during a compliance inspection, reported by the facility or determined through some other compliance monitoring method by the NPDES regulatory authority. SEVs do not include violations generated automatically (e.g., effluent limit violation from a DMR, or permit compliance schedule violations) by the ICIS-NPDES system.

DEC's frozen FY 2017 data showed 108 facilities under Metric 7j1. The DEC frozen FY 2017 data for inspection-related Metrics 5a1, 5b2 and 5b2 showed inspections levels conducted during the review year of 23, 5 and 120 respectively for a total of 147 inspections. Accordingly, the frozen FY 2017 data shows a violation rate of approximately 73.5% (i.e., 108/147).

This SRF Report's Inspection Coverage Data Table showed that violations were found at 121 facilities from the approximate 153 inspections conducted in CY 2017, or a violation rate of approximately 79.1% (i.e., 121/153).

In comparison, the national average for Metric 7k1, Major and Non-Major Facilities in Noncompliance, was 18.6%.

The Alaska 73.5% - 79.1% levels of SEV-related noncompliance for FY/CY 2017 and their contrast to the national average noncompliance level of 18.6 %, in combination with the Metrics 7k1 and 8a3 data and discussion below, indicates the need for DEC to take steps to identify the causes of these noncompliance rates and implement measures to reduce noncompliance rates.

High non-compliance reported under Metric 7j1 may indicate a lack of timely and appropriate enforcement. *See* EPA CWA Metrics Plain Language Guide (SRF Round 4), p. 18.

Metric 7k1 - Major and Non-Major Facilities in Noncompliance.

Metric 7k1 is a review indicator showing the percentage of major and non-major facilities with violations reported in the ICIS-NPDES system. Violations factored into the Metric 7k1 evaluation include SNC/Category 1, RNC/Category 2 or effluent, SEVs, compliance schedule and permit schedule violations.

DEC's frozen FY 2017 data for Metric 7k1, Major and Non-Major Facilities in Noncompliance, showed a level of 67.7% compared to a national average of 18.6%.

During EPA review of the associated universe and count, issues were identified regarding higher levels of permit coverages in each area that should be resolved and eliminated. These items were discussed with DEC and initial efforts were taken in later 2018/early 2019 by DEC and EPA to address terminated placer mining general permit coverages that were in this metric's universe/count due to failure to submit annual reports. EPA R10 also discussed with DEC the need to connect completed enforcement actions to the underlying violations that exist in ICIS as a means to resolve ICIS-based violations.

The underlying FY 2017 Metric 7k1 universe and count need to be reviewed routinely and in detail by DEC to ensure that inapplicable permit coverages are identified and removed during the annual data verification process prior to the data set being frozen. DEC should also initiate their procedures to resolve and close out terminating permits when appropriate by resolving violations and begin routinely connecting completed compliance actions to the appropriate, underlying ICIS violations addressed in those actions.

DEC and EPA efforts to clean up the Metric 7k1 universe/count eliminated about 529 placer mining general permit coverages that were related to schedule violations (i.e., failure to submit an annual report).

However, even excluding these 529 coverages from the frozen FY 2017 Metric 7k1 data's count and universe, the non-compliance level for Metric 7k1 is still approximately 56.7% (i.e., 871/1538) compared to a national average of 18.6%.

The DEC frozen FY 2017 data, as is, showed a count of 1400 facilities and of that count, 824 facilities had at least one quarter of RNC, and 451 facilities had at least 3 or more quarters of RNC.

Even when 529 terminated AKG37s are eliminated from the original 1400 count, 53 terminated AKG37s are eliminated from the RNC counts from the original 451 facilities (3 or more quarters) and the 275 terminated AKG37s are eliminated from the entire original 824 RNC group, the RNC noncompliance levels are still significant.

At least 398 facilities have 3 or more quarters of RNC out of 549 facilities (3 or more quarters) (72.5%) and at least 549 facilities with at least on quarter of RNC out of 871 facilities in a corrected count (63%).

These noncompliance levels, compared to a national average of 18.6% along with the Metrics 7j1 and 8a3 data, indicates the need for DEC to identify the causes of these violations and implement measures to reduce noncompliance rates, and implement data verification procedures designed to identify resolvable noncompliance conditions (e.g., connecting completed enforcement actions with ICIS violations) to ensure the ICIS database is updated and accurate.

High non-compliance reported under Metric 7k1 may indicate a lack of timely and appropriate enforcement. *See* EPA CWA Metrics Plain Language Guide (SRF Round 4), p. 18.

In response to the State's comments on the draft SRF report: The State incorrectly states that the Metric 7k1 discussion failed to take into consideration terminated place mine authorizations (see evaluation above). Even when the 529 terminated placer coverages are eliminated from the metric's count and universe, the noncompliance level is reduced from 67.7% to 56.7% (still compared to the national average of 18.6%).

The State's comments assert that 636 terminated authorizations should have been deleted from consideration but then argues that doing so provides an accurate count of 667, then compares that 667 to the universe of 2067 to yield a percentage of 32.2% (i.e., 667/2067) which DEC asserts is markedly closer to the national average of 18.5%. The State's comments do not explain why the terminated coverages should only be eliminated from the numerator but not also from the denominator. If the State's 667 terminated coverage number is eliminated from both the count of 1400 and the universe of 2067, the result is a noncompliance level of 52.4% (i.e., 733/1400) (still compared to the national average of 18.6%). In summary, the State's comments do not explain why 32.2% is a valid, reliable determination for comparison purposes with the national average.

Metric 8a3 - Percentage of Major Facilities in SNC and Non-Major Facilities in Category I Noncompliance.

Metric 8a3 is a review indicator that identifies the percentage of major facilities in significant non-compliance and non-major (minor) facilities in Category I non-compliance during the review fiscal year.

DEC's frozen FY 2017 data for Metric 8a3 showed a level of SNC/Category I noncompliance of 9.2% in comparison with the national average of 7.5%.

Of the 146 facilities in the Metric 8a3 count, 109 facilities were in the domestic sub-sector (e.g., POTWs and WWTFs that treat sanitary sewage), or approximately 75% of the entire 146 facility count. Using *domestic* counts from the DEC's draft CY 2019 CMS Plan (Appendix A), the metric's 109 domestic facilities present about 63% of DEC's entire domestic universe of 173 facilities.

A drilldown of the Metric 8a3 count of 146 facilities shows the following information:

- 127 of 146 facilities (87%) ended the review year in a reportable non-compliant status.
- 111 facilities (76%) had 3 or more quarters of reportable non-compliance.
- 107 facilities (73%) had at least three consecutive quarters of reportable non-compliance in the last three quarters of the review year.

A drilldown of the Metric 8a3's 109 domestic facilities shows the following information:

- 102 of 109 facilities (94%) ended the review year in a reportable non-compliant status.
- 90 facilities (83%) had 3 or more quarters of reportable non-compliance.
- 86 facilities (79%) had at least three consecutive quarters of reportable non-compliance in the last three quarters of the review year.

DEC's SNC/Category I noncompliance rate is higher than the national average. The length of noncompliance status during the review year for the metric's entire count as well as the metric's *domestic* sub-set is substantial. Domestic facilities make up 75% of this metric's entire count, and noncompliant domestic facilities represent upwards of 63% of the DEC's domestic sub-sector, demonstrating high levels of noncompliance in this sub-sector.

The significant level of DEC noncompliance, along with the totality of information and noncompliance data under Metrics 7j1 and 7k1, demonstrate a significant need for DEC to take steps to identify the causes of the violations underlying these noncompliance rates, and implement measures to reduce noncompliance rates with some consideration to be given to focus initial efforts on DEC's domestic sub-sector.

High non-compliance reported under Metric 8a3 may indicate a lack of timely and appropriate enforcement. *See* EPA CWA Metrics Plain Language Guide (SRF Round 4), p. 18.

DEC's assessment should evaluate whether it is utilizing the most appropriate enforcement tools to address violations and whether the content and requirements of any tool use is correcting the underlying facility conditions leading to these metrics' noncompliance rates.

Additionally, the DEC's assessment should review the timing of any post-compliance monitoring activity to ensure it is being done in a timely manner and in a means that leads to a reliably compliant facility.

The DEC's assessment should also review the timing of any post-compliance monitoring activity to ensure it is being done in a timely manner and in a means that leads to a compliant facility.

No specific numbered SRF Report recommendations are made for this evaluation of Metrics 7j1, 7k1 and 8a3. Readers should refer to this SRF Report's findings under Metric 10b for related recommendations.

Metric 7e - Accuracy of Compliance Determinations.

Metric 7e is a file review-based goal metric designed to assess whether facility violations and the facility's compliance status are accurately identified, assessed and determined based on the documentation obtained by the regulatory agency and contained in its files. The Metric 7e is determined using a numerator that is the number of files containing inspection reports reviewed with sufficient, accurate documentation leading to an accurate compliance assessment and determination, and using a denominator that is the number of inspection reports reviewed.

In this SRF review, 34 inspection reports and related files were reviewed. The facility's violations and compliance status were accurately identified, assessed and determined in 20 facility situations (58.8%).

DEC Compliance Evaluation Procedure Summary

In response to the previous December 2014 SRF Report (FY 2012 review year), DEC developed program operating guidelines (POGs) to promote procedural and substantive consistency and uniformity, and to promote resource staff and time efficiencies.

POG No. 14.15, Inspection Preparation/Process (IP/P), outlines the procedures DEC inspectors are supposed to use to prepare for, conduct and document in an inspection. The POG notes that it is the DEC Compliance Program's policy to conduct inspections to determine a facility's *compliance status*. The IP/P POG also notes DEC's intent to inspect major discharges biannually and minor facilities at least once every five (5) years.

The primary key component of this POG's pre-inspection preparation is the DEC inspector's performance of a Compliance Evaluation (CE) using the Compliance Evaluation POG, POG No.14.09. As the IP/P POG notes, the CE allows the inspector to become familiar with the permittee, the facility and the *compliance history*.

In the context of Metric 7e, the IP/P POG highlights an important on-site inspection task in terms of assessing compliance status and history by instructing the inspector to conduct an on-site records review and to provide the facility official "with the date range that is requested. *This will typically be from the date of the last APDES inspection through the current date." See* IP/P POG No. 14.15, Facility Inspection, Para. 4 (p. 5) (italics added for emphasis).

POG No. 14.09, Compliance Evaluation, contains the operating procedures to conduct a CE (file review) as a part of the inspection process, prior to an inspection. The POG's operating guideline in terms of file review scope is that the evaluation period will be from the date of the last review to the present day. In accord with the IP/P POG instructions, this scope would typically be back to the date of the last inspection through the current date.

The CE POG identifies various DEC and EPA databases for the inspector's use to conduct a file review and "establish a clear picture of a permittee's compliance history" and requires the inspector to review six (6) specific databases. Finally, the POG instructs the inspector to use the "Compliance Evaluation Checklist" (identified in the CE POG as an attachment) to document the review and to save the Checklist in the Inspection folder in the WPC file.

Finally, DEC also created an APDEC Inspection Report template, POG No. 14.02. This POG, Section 3 Findings, requires the inspector to include concise information on various topics including previous inspections, enforcement actions and compliance history.

SRF File Review. During the file reviews for facilities with inspection reports, the reviewer was not able to locate any completed Compliance Evaluation Checklists in DEC files. In discussions with the previous DEC Compliance Program manager, the manager indicated that a checklist template had not been created and attached to the CE POG as noted in the CE POG. The prior manager also confirmed that DEC was not conducting annual compliance evaluations of major facilities as specified in this CE POG should be done.

Consequently, DEC's inspection files lacked the required CE documentation demonstrating that an inspector completed the CE following the CE POG's procedures and ensuring all six (6) databases were reviewed as required within the CE POG's evaluation period scope, as a means to determine the facility's pre-inspection compliance status and history.

Accuracy Review

Permit No.	Facility Name	Inspection Date Under Review	Last Review - Inspection Date	File Review Comments
AK0031429	USCG Kodiak	3/15/17	5/9/13	IR incorrectly states that this is first inspection of this facility. IR says evaluation period is 8/1/14 – 3/15/17 (i.e., approx. 33 months) but not back to last inspection. IR and NOV refer to a March 2017 TOC exceedance but no file or ICIS evidence exists for that exceedance. DMR & ICIS show TOC exceedance in January 2017 but that violation is not cited in IR or NOV. File evidence of permit effluent limit violations (pH) in May and July 2013 that are not identified and cited in the IR or NOV. Evidence of permit effluent limit exceedances for January, February and March 2017 in identified in IR are not expressly cited as violations in IR or NOV.
AK0050571	Kensington Gold Mine	8/30/17	6/8/14	IR is silent in re evaluation period but IR text appears consistent with ICIS violation report period of 11/15/14 – 8/23/17 but not covering period since 6/8/14. Neither IR or 10/13/17 Compliance Letter address or cite June and July 2014 WET effluent limit violations or June 2014 turbidity violation that would have likely been identified if the ICIS violation report was run with a starting date of the last inspection.

Permit No.	Facility Name	Inspection Date Under Review	Last Review - Inspection Date	File Review Comments
				IR indicates an area of concern (AOC) is that pH and turbidity standards were expired (photos show expiration dates of August, September and October 2016). Expired solutions should have been cited as violation of Permit Standard Conditions, 1.6.1 (lack of adequate laboratory controls and QA procedures) and 1.11.4 (reqt to use approved Part 136 test procedures). IR & Compliance Letter (CL) allege violation of Permit Part 2.2.1. asserting as part of the violation that an updated QAPP was not received within 60 days of permit effective date. Permit, Part 2.2.1 only requires permittee to update the QAPP and submit written notification to DEC that an updated QAPP has been implemented. The Permit does not require submission of updated QAPP. IR & CL alleges a violation that the 2014 QAPP did not have required signature. Permittee's 10/31/17 submission contains permittee's 7/29/17 letter to DEC with notice of QAPP revision and submission of a completed August-September 2014 QAPP signature page with green postal card showing DEC's receipt of letter and signature page prior to the inspection. File evidence appears to negate alleged violation with regard to 2014 QAPP signature page.
AKG573004	Dillingham POTW	5/25/17	8/27/13	IR acknowledges prior 2013 inspection and resulting NOV (i.e., 2/20/14); however, IR evaluation period is 4/2/15 – 5/8/17 (25 months), but not back to August 2013.

Permit No.	Facility Name	Inspection Date Under Review	Last Review - Inspection Date	File Review Comments
				IR and NOV do not assess or cite violations regarding failure to submit DMRs (June & Oct 2014, and March 2015) and effluent limit violations that occurred in following months since 2013 inspection and Feb 2014: Feb – May 2014; July-Sept 2014; Nov 2014; and Jan 2015.
AKR06AB73	Ketchikan Ready-Mix Quarry	8/7/2017	5/9/12	IR acknowledges that DEC inspected facility in 2012 (i.e., May 9, 2012) and issued NOV; however, inspection only covers period of AKR06 effectiveness to facility (8/3/15) (i.e., approx. 24 months) and excludes 5/9/12 – 8/3/15) (approx. 39 months).
AKR06AA08	Raibow Fiberglass	9/1/17	NA	MSGP coverage was effective 2015 with no prior AKR05 coverage. IR states evaluation period was Feb-August 2017.
AKR06AD78	Signature Flight Support	8/3/17		Facility obtained AKR06 coverage on 12/17/15. IR acknowledges prior AKR05 coverage (EPA eNOI indicates 10/25/09 AKR05 coverage date). IR says no prior AKR05/AKR06 related inspections; however, IR evaluation is only three years, 8/3/14-8/3/17. IR states that no quarterly visual monitoring has been conducted but neither IR or Compliance Letter (CL) allege violation of MSGP Part 6.2.1 (i.e., must collect sample and conduct a visual assessment). Alleged violation of MSGP Part 6.2.2 is moot or not applicable if there are no visual assessments conducted to be then subsequently documented.

Permit No.	Facility Name	Inspection Date Under Review	Last Review - Inspection Date	File Review Comments
				MSGP Part 6.3.1 required permittee to conduct comprehensive site inspection in 2015 and 2016. IR states that no comprehensive site inspections were conducted since AKR06 authorization. Neither IR or CL contain violation of Part 6.3.1 for failure to conduct 2015 and 2016 comprehensive site inspections. Alleged violation of MSGP Part 6.3.2 (documentation of comp. insp.) is moot or not applicable if there are no comp. site inspections were conducted to then be subsequently documented.
AK0023213	Juneau-Douglas POTW	2/24/16	9/15/14	DEC file does not contain an ICIS violation report for this 2016 inspection and IR is silent in regard to evaluation period. IR cites 2014 inspection and indicates DMRs from 2013 to present were reviewed. IR and Compliance Letter (CL) only cite reporting violations related to permit effluent limit exceedance events for January, July and August 2015. Neither IR or CL cite actual permit effluent limit violations for the three year DMR review that should have identified the following months of permit effluent limit violations: April, Aug-Sept 2013; Jan, May-June 2014; and Jan, Jul and Aug 2015. Note: DEC files also contained 9/15/14 IR which indicated that three (3) years of DMRs were reviewed. For purposes here it is assumed latest three years, i.e., Aug. 2011 – Aug. 2014. DEC inspection file does not contain an ICIS violations report. IR does not cite as violations the ICIS-based permit effluent limits in the following months: April 2013; Aug-Sept 2013; Jan 2014; and May-June 2014. DEC 10/14/14 letter to permittee declared that

Permit No.	Facility Name	Inspection Date Under Review	Last Review - Inspection Date	File Review Comments
				DEC's inspection found plant in compliance with all terms and conditions of its permit.
AK0023451	Fairbanks/GHU POTW	7/25/17	9/19/14	IR observation indicated that pH buffer solution in the lab expired March 2017. Permit requires daily pH readings and inspection photos of pH calibration book appear to indicate calibrations are done daily. Failure to have unexpired pH lab solution was not cited in IR or Compliance Letter as a violation. IR did not even cite this issue as area of concern. Expired pH solution should have been cited as violation of Permit Standard Conditions, 1.6.1 (lack of adequate laboratory controls and QA procedures) and 1.11.4 (reqt to use approved Part 136 test procedures).
AK0036994	Shoreside Petroleum	9/29/15	Review in re CAFO	IR acknowledged EPA CAFO (April 2012) covered failure-to-sample violations from April 2009 – May 2011 with CAFO indicating that sampling initiated June 2011. IR states inspection evaluation period is 6/30/14 – 10/1/15 (15 months); however, IR ICIS violation report only covered 8/31/14 – 6/30/15 (10 months). IR and NOV do not assess or cite effluent limit violations that occurred in following months since June 2011: Sept 2011; May & June 2012; Feb, May, July & Nov 2013; and June 2014.
AK0022951	Mendenhall POTW	11/17/15	10/21/13	IR says evaluation period is August 1, 2014 (date of permit issuance) to present (about 16.5 months). IR does not acknowledge file's ICIS violation report covering 10/31/13 –

Permit No.	Facility Name	Inspection Date Under Review	Last Review - Inspection Date	File Review Comments
				8/31/15. Consequently, IR and Compliance Letter do not cite effluent limit violations in following months: Nov 2013 and Jan, March and Aug 2014.
AK0053384	Ward Cove Ind. WWTF	7/18/18	6/13/13	IR incorrectly states last inspection was in 2005; last inspection was in June 2013 with Dec. 2013 NOV. IR says evaluation period is January 2015 – June 2018 (i.e., 42 months). Consequently, IR and Sept. 2018 NOV do not cite effluent limit violations in the following months: Dec. 2013; and Jan, Feb, Mar, April, June, Oct. 2014.
AK0040380	Usibelli Coal Mine	11/3/16	Recon 9/22/14	IR attached an ICIS violations report showing settleable solids daily maximum effluent limit violations above technical review criteria levels (e.g., 900%, 1500% & 1940%) but these effluent limit violations are not cited in the IR or in the 11/17/16 NOV. IR's Area of Concern (AOC) section states that QAPP annual certification statement has not been submitted per Permit, Part II.6.b. (i.e., none have been received to date). The permit was issued August 1998. Repeated failure to submit permit-required annual certification (more than 15 years) should have been cited as violations in IR and NOV.
AKG315001	Hilcorp Granite Pt. Tank Farm	4/2/15	8/17/11	IR evaluation period was Jan 2012-April 2015, not back to prior inspection of Aug. 2011 to assess compliance status. Accordingly, IR did not assess facility compliance with permit requirements back to August 2011, including Aug 2011 effluent violation.

Permit No.	Facility Name	Inspection Date Under Review	Last Review - Inspection Date	File Review Comments
AKG572047	Vallenar View MHP	11/20/15	5/30/08	IR acknowledges last inspection was in 2008 but IR evaluation period appears to be 11/30/12 – 8/31/15 (i.e., 33 months) based on ICIS violation report. IR contains adequate evidence to cite violations of improper O&M (e.g., Permit Standard Conditions 1.6.1) and failure to create, retain and make available O&M records (e.g., Permit Standard Conditions 1.6.2) further back in time in accord with POGs 14.09 and 14.15 (e.g. records review). These violations were not cited in IR or NOV.

IR = inspection report

ATTACHMENT E – Element 4 Enforcement – Metric 9a

Metric 9a is a file-review based goal metric designed to assess whether the enforcement actions in reviewed files returned or will return a facility in violation to compliance. Actions that indicate return to compliance include injunctive relief, documentation of return-to-compliance and enforceable requirements with date-certain schedules for major facility non-compliance (e.g. SNC).

In this SRF review, 37 enforcement actions and related files were reviewed. The enforcement actions and file documentation were adequate to determine that 20 of 37 actions (i.e., 54.1%) returned or will return the facility to compliance.

This Metric 9a was also identified as an area for State improvement (8 of 18 actions or 44.4%) in the December 1, 2014 final SRF Report for FY 2012.

EPA Response to State Response

Metric 9a information and data was correctly evaluated. The SRF report/attachment's discussion of the DEC compliance tracking provisions is provided for context and background so there is an understanding of what procedures are to be followed by DEC staff and what expectations exist on DEC C&E folder and file content with regard to relevant information and data regarding a facility's return-to-compliance (RTC) status. DEC relies heavily on informal enforcement tools (e.g., compliance letters, notices of violation) that typically request that the respondent provide submissions (e.g., DMRs, SWPPP, etc.) and written explanations (i.e., deliverables). Reviewing enforcement files to determine whether all required deliverables have been submitted and adequately address the underlying enforcement tool's requirements/requests is one factor and method used in determining what relevant file evidence exists that a facility has been reliably returned to compliance with certainty or there is a reasonable expectation that an RTC status will occur based on file review evidence.

The State's responses asserted that an additional 11 enforcement cases (i.e., 11 of the EPA-identified 17 cases finding file inadequacies) returned the facility to compliance. The State's responses appear to be based on DEC's review of electronic entries made in either or both of DEC's Complaint Automated Tracking System (CATS) database and its Discharge Results and Online Permit System (DROPS) database. DEC did not comment on directly or contest EPA's determination, where applicable, that files lacked adequate documentation of expected deliverables received and determined adequate. EPA cannot independently corroborate the correctness of the database entries (e.g., are entries correctly supported by received and acceptable deliverables) for these 11 cases given the lack of some or all expected and required deliverables in the DEC files reviewed, where applicable. While a database entry is not alone conclusive evidence that a facility was returned to compliance, the existence of database entries closing out an informal enforcement action without adequate, expected and required documentation in DEC files (e.g., missing deliverables) does appear to indicate that procedures for retaining and filing deliverables per POG provisions may not be adhered to as expected. If that is an

accurate assessment, DEC should consider additional training to emphasize adherence to POG provisions that adequately populate DEC C&E files with required deliverables demonstrating the enforcement action was adhered to by the respondent.

DEC Compliance Tracking Procedure Summary

The DEC 2008 APDES Application's Program Description (Final, October 29, 2008), Section 9.5.1, stated that all inspections and enforcement actions will be logged in the Discharge Results and Online Permit System (DROPS) database. It also stated that actions resulting in a Notice of Violation (NOV) or higher level of enforcement response will be tracked in DEC's Complaint Automated Tracking System (CATS) database.

DEC's Enforcement Manual (6th Edition, October 2005) states in relevant part "The importance of tracking enforcement actions and corrective actions necessary to come into compliance cannot be stressed enough." 2005 Manual, p. 3-3. The 2005 Manual dictates that all DEC enforcement actions must be logged and tracked in DEC's CATS database. Id., pp. 3-1 and 3-3. CATS provides the means to track each enforcement action with a unique enforcement tracking number (ETN) which should be placed on the first page of each enforcement action. Id., pp. 3-3 and 4-7.

The 2005 Manual also states that it is equally important to determine when a facility returns to compliance or has satisfied the conditions of the enforcement action. 2005 Manual, p. 4-14. The 2005 Manual requires that the enforcement action in CATS be closed out once the enforcement officer verifies and determines that all terms and conditions of the administrative enforcement action have been met, and that an Enforcement Closeout Letter (ECL) be drafted and issued. See 2005 Manual, pp. 4-14 – 4-15, Figure 4-7. The sample ECL, Figure 4-7, indicates the ECL can be signed by the enforcement officer. 2005 Manual, p. 4-34.

DEC has subsequently published a revised Enforcement Manual (7th Edition, 2015; pages dated 05/2016). The 2015 Manual includes a template for an enforcement action close letter using an NOV as an example for the letter's close-out decision. See 2015 Manual, Attachment 1-5, p. 1-33. The 2015 Manual is less descriptive than the 2005 Manual on enforcement tracking and the use of the ECL; however, presumably the 2015 Manual intends that an enforcement action in CATS be closed out once the enforcement officer verifies and determines that all terms and conditions of the administrative enforcement action have been met and that an ECL be drafted and issued to accomplish that close out.

In response to the previous December 2014 SRF Report (FY 2012 review year), DEC developed program operating guidelines (POGs) to promote procedural and substantive consistency and uniformity, and to promote resource staff and time efficiencies. Several POGs contain provisions that are key components in tracking enforcement actions.

Consistent with the 2005 Manual's directives, the Compliance Letter POG, No. 14.04 (effective date 12/4/14), and the Notice of Violation POG, No. 14.05 (effective date 12/4/14), require the case officer to enter the enforcement case into CATS where the CATS' ETN is generated.

The Compliance Evaluation (CE) POG, No. 14.09 (effective date 12/4/14), contains the operating procedures to conduct a CE (file review) as a part of the inspection process, prior to an inspection, which if applicable includes follow-up using compliance letters (CLs), notices of violation (NOVs) or other actions. The POG provides that the CL and NOV deliverables are to be added to the facility's Schedule of Compliance (SOC) tab within the DROPS database.

The Inspection Preparation/Process (IP/P), POG No. 14.15 (effective date 8/20/15), outlines the procedures DEC inspectors are supposed to use to prepare for, conduct and document in an inspection and the POG includes post inspection documentation procedures. The IP/P POG (#10, p. 7) provides that if the inspection results in an enforcement action, the inspector must open an enforcement action in DROPS and the requested deliverables must be entered into the DROPS' Enforcement Action's Schedule of Compliance (SOC).

The IP/P POG (#10, p. 7) provides that as each deliverable is received and accepted, the inspector must update the DROPS SOC. Finally, the POG provides that once all deliverables are received and accepted, the inspector must close out the Enforcement Action SOC. Noticeably absent from this POG's No. 10 task, is any reference to the requirement that the case officer draft and issue a Closeout Letter in accord with the DEC 2005 Enforcement Manual.

The Tracking Facility Compliance (TFC) POG, No. 14.23 (effective date 1/19/16), contains procedures for tracking facility/permittee compliance and specifically, the POG is applicable to tracking schedules of compliance in DROPS associated with enforcement actions that have deliverables. The POG has detailed, step-by-step procedures for creating DROPS entries for deliverables/submissions, e.g. receipt date, accepted/not-accepted, close out, etc. Also noticeably absent from this POG's enforcement action closeout procedures is any reference to the requirement that the case officer draft and issue a Closeout Letter in accord with the DEC 2005 Enforcement Manual.

A review of several compliance tracking POGs (e.g. CE, TFC, IP/P) and enforcement tool POGs (e.g. CL, NOV, COBC, etc) identified inconsistencies regarding (1) establishment and use of a CATS' ETN; (2) identified tasks for tracking enforcement tool-required deliverables; (3) retention of deliverables in the WPC folders; (4) closing out the enforcement action in CATS and DROPS; and (5) issuance of a final case Closeout Letter. This review focused on the four enforcement tool POGs that had the most likelihood of requiring a respondent's reply to alleged violations with some required deliverables: (1) CL POG No. 14.04; (2) NOV POG No.

14.05; (3) Compliance Order by Consent (COBC) POG No. 14.08 (effective date 3/3/15); and (4) Compliance Order (CO) POG No. 14.16 (effective date 8/28/15). Some of these key inconsistencies are summarized below.

- NOV POG has an express directive to enter the CATS' ETN on the NOV using an editable block. The CL, COBC and CO POGs do not have similar express directives and the CL POG does not have a similar editable block for the letter form.

- The IP/P POG, post inspection documentation provisions (p. 7), instructs the inspector or case officer to generate a CATS's ETN for an NOV but the POG does not include the same or similar directive for issuance of a CL even though the CL POG requires the case officer to enter the CL enforcement case into CATS where the CATS' ETN is generated.

- The COBC POG (Task No. 18) and CO POG (Task No. 10) expressly require the case officer to track receipt of deliverables. The CL and NOV POGs do not have this same tracking deliverables task.

- None of the four POGs cites or references the TFC POG which has the detailed procedures for tracking deliverables or the IP/P POG (#10, p. 7) for tracking deliverables in DROPS.

- The "Record Management" provisions of the COBC and CO POGs expressly direct the case officer to save the enforcement tool's deliverables in the WPC folder under the Deliverables sub-folder. The CL and NOV POGs do not have this same save-deliverables-to-WPC-folder task in their respective Records Management provisions. Neither the CL or NOV POG provides instructions on what to do with deliverables; however, the TFC POG has detailed procedures for what should be done with deliverables (e.g. accepted/not-accepted, etc.).

- The COBC POG (Task No. 19) and CO POG (Task No. 11) expressly require the case officer to close out the file and enforcement action in CATS after all elements of the enforcement tool are complete. The CL and NOV POGs do not have this same CATS close out task even though both CL and NOV POGs require the case officer to enter the CL or NOV enforcement case into CATS.

- None of the four POGs expressly requires the case officer to close out the enforcement action in DROPS in accordance with the close-out procedures in the TFC POG or in the IP/P POG (#10, p. 7) after all deliverables have been made and been deemed accepted.

- In accord with the DEC 2005 Enforcement Manual, Part 4.A.11, the CO POG (effective date 8/28/15), Task No. 11expressly requires that a final case Closure [Closeout] Letter be mailed to the respondent acknowledging the case has been closed. The CL, NOV and COBC POGs do not have this same Closeout Letter task and none of the three POGS even references use and issuance of a Closeout Letter.

- Neither the TFC POG or the IP/P POG contain an express task that the case officer draft and issue a Closeout Letter in accord with the DEC 2005 and 2015 Enforcement Manuals once all deliverables have been received and accepted and the case officer closes out the DROPS SOC.

File Review Summary

Of the17 enforcement actions reviewed at 14 facilities, 12 DEC actions lacked documentation demonstrating the respondent complied completely with the enforcement tool's deliverable/submission requirements.

In four of these 17 actions, the chosen enforcement tool did not adequately address all identified violations. Two of these four actions are also a subset of the 12 actions where deliverables documentation was lacking.

In eight of these 17 actions, there was current information demonstrating that a reliable and certain return-to-compliance (RTC) status had not been achieved and documented, and that there were continuing violations after the apparent close out of the enforcement action. Three of these eight actions are also a subset of the 12 actions where deliverables documentation was lacking. Additionally, three of these eight actions are also a subset of the four actions where the chosen enforcement tool did not adequately address all identified violations.

Of the 17 enforcement actions, 16 DEC files did not have any Closeout Letter. One file had an email exchange acknowledging receipt of deliverables and for purposes here, was construed as somewhat equivalent to a Closeout Letter.

Out of the 17 actions, 12 actions used NOVs that had CATS' ETNs displayed on the NOV itself but as noted, except for one equivalent email, none of the other 11 NOV files had any Closeout Letter.

Table A below summarizes the file reviews conducted on the 17 enforcement actions.

Table A*

Facility Name	Enf Tool	ET Iss Date	ETN Y/N	Cl Ltr or Equiv. Y/N	File Review Comments
Sawmill Cove Industrial Park	NOV	3/22/18	Y	N	DEC file does not contain respondent documents (i.e., NOV deliverables) in response to NOV (e.g., NOV corrective actions a, b, e, f, h and i).
McKenzie Inlet LTF	NOV	7/24/17	Y	N	DEC file does not contain respondent documents (i.e., NOV deliverables) in response to NOV.
Kensington Gold Mine	CL	10/13/17	N	N	CL did not include any corrective actions for cited permit effluent limit violations (ELVs). CL only requests QAPP submission. CL did not request a written report explaining why ELVs and other violations occurred, what corrective actions have been taken and steps that will be taken to prevent similar compliance problems in future. ICIS indicates pH ELV in Nov 2017 and copper ELV in Mar & Oct. 2018.
Dillingham POTW	NOV	6/26/17	Y	N	Since May 25, 2017 CEI and NOV, POTW has continued to have routine effluent limit violations (ELVs). For example and not all inclusive since 6/26/17 NOV, ICIS indicates ELVs in every month from Nov. 2017 through February 2019 (date of last ICIS pull for this evaluation. May 2017 IR indicates DEC inspected this facility in 2009 and 2013 and found ELVs that resulted in NOVs. DEC was pursuing a compliance order on consent (COBC) with an enforceable corrective action schedule in mid-2014 but it was never finalized.

Facility Name	Enf Tool	ET Iss Date	ETN Y/N	Cl Ltr or Equiv. Y/N	File Review Comments
					Inspection evaluation period was 25 months (April 2015-May 2017) and ICIS indicates that ELVs occurred in 21 of those 25 months. The evaluation period did not cover period since last inspection (August 2013). Since that August 2013 inspection, ELVs occurred in 13 of 19 months during period September 2013-May 2015.
King Salmon Lagoon	NOV	8/16/17	Y	N	NOV includes various corrective actions including submission on 11/15/17 of design report/preliminary engr plans and specs for facility upgrade and by 2/15/18, engineered plans. NOV has 12/31/17 deadline for other corrective action responses and submissions. Feb. 15, 2018 , Borough requests extension for NOV deadlines which was granted but correspondence does not demonstrate what new deadlines were created. DEC file does not contain documentation that NOV deliverables were made or that a new extension deadline was made and complied with. ICIS indicates permit effluent limit violations continued (e.g. Sept-Oct 2017; Jan. May-Nov 2018).
Alaska Logistics, LLC	NOV	7/28/17	Y	N	Except as noted, DEC file does not contain respondent documents (i.e., NOV deliverables) in response to NOV (e.g., NOV corrective actions a, b, c, d, e, and f). DEC file did include 2017 annual report (i.e. NOV corrective action g.).
Raibow Fiberglass	NOV	10/30/17	Y	N	DEC file does not contain respondent documents (i.e., NOV deliverables) in response to NOV (e.g. NOV deliverables #1-10).

Facility Name	Enf Tool	ET Iss Date	ETN Y/N	Cl Ltr or Equiv. Y/N	File Review Comments
					DEC file has email granting 30-day extension to NOV deadlines and email indicating non-receipt on that deadline of the deliverables.
D&A Gold LLC Walker Fork Mine Site	CL	9/14/17	N	N	DEC file does not appear to contain respondent documents (i.e., CL deliverables) in response to CL's 10/27/17 deadline which appears to explain why NOV was issued with exact same corrective actions.
	NOV	11/30/17	Y	N	DEC file contains some NOV deliverables but does not contain NOV deliverables b. (2017 daily inspection logs) and d. (2017 discharge monitoring logs).
Trident Akutan	NOV	5/11/16	Y	N	DEC files did not contain NOV-requested respondent submission related to approval of outfall relocation. Violations continued regarding effluent limitations, spills, and invalid sampling procedures and were subsequently re-cited in 4/3/18 NOV. For example, ELVs were cited for February, March and December 2016 and September 2017; 29 spills occurred from 2016 to 2018, and many weeks in 2016/2017 of invalid sampling results.
Juneau-Douglas POTW	CL for 2/24/16 insp.	3/24/16	N	N	DEC file does not contain respondent documents (i.e., CL deliverables) in response to CL (i.e. explanation for failure to conduct non-compliance reporting and a plan to correct notification for future). CL did not address ongoing permit effluent limit violations (ELVs).

Facility Name	Enf Tool	ET Iss Date	ETN Y/N	Cl Ltr or Equiv. Y/N	File Review Comments
					ICIS indicates that ELVs continued routinely through 2017. For historical context, DEC entered into a settlement agreement in August 2015 for $62,000 for violations that included 990 ELVs occurring January 2009 through April 2011. In August 2018, DEC made a referral to the Department of Law for issuance and negotiation of a compliance order on consent (COBC).
	NOV for 4/20/18 insp.	5/17/18	Y	N	DEC file does not contain respondent documents (i.e., NOV deliverables) in response to NOV (e.g. NOV deliverables a.-e.).
Haxby Tract	NOV	4/11/14	Y	Y - Email Equiv.	DEC file, April 2015 inspection and 5/12/15 NOV show compliance was not achieved with prior inspection and 4/11/14 NOV. DEC eventually entered into an expedited settlement agreement for a $15,100 penalty in April 2017.
North Pacific Seafoods	CL	3/21/17	N	N	DEC file does not contain respondent documents (i.e., CL deliverable) in response to CL.
Mendenhall POTW	CL for 11/17/15 insp	12/1/15	N	N	ICIS Violation Report covered 10/13/2013 – 08/31/2015. IR cited ELVs noting numerous ELVs between August 2014 to current and identified it as repeat violations.

Facility Name	Enf Tool	ET Iss Date	ETN Y/N	Cl Ltr or Equiv. Y/N	File Review Comments
					CL requested narrative describing conditions leading to permit effluent limit violations but the request covered a more limited time period than cited in the IR regarding ELVs. CL only requested causes for ELVs occurring in date range 1/1/2015 – 3/31/2015. CL did not ask about ELVs that occurred in August, October and November 2015. POTW response indicated cause was uncertain but noted excessive COD issues. Permit effluent limit violations continued in 2016-2018. ICIS identified continued ELVs in Dec-2015, Feb & Oct-2016, and 6 months in 2017.
	NOV for 12/11/17 insp.	2/28/18	Y	N	Permit effluent limit violations continued through 2018 into 2019 (e.g., March, May, June, Sept, Oct, Nov. Dec, 2018; and Jan-Feb 2019). In June 2018, DEC made a referral to the Department of Law for the issuance and negotiation of a compliance order on consent (COBC).
Usibelli Coal Mine	NOV	11/17/16	Y	N	DEC file does not contain respondent documents (i.e., NOV deliverables) in response to NOV (e.g. no updated BMP plan submission and no documents addressing corrective action related to sediment/debris removal from ponds and outfall extension or armoring). .

- "ET Iss Date" means Enforcement Tool Issuance Date.
- "ETN" means the CATS' Enforcement Tracking Number.

- "Cl Ltr" means the Closeout Letter referenced by the DEC 2005 Enforcement Manual, Part 4.A.11., and the DEC 2015 Enforcement Manual, Attachment 1-5.

Tracking Facility Compliance – Deliverables & Submission Timing

The purpose of the following discussion is to summarize findings related to a more in-depth inquiry into the implementation of the Tracking Facility Compliance (TFC) POG, No. 14.23 (effective date 1/19/16) in terms of tracking the submission of enforcement action deliverables and closing out an enforcement action in DROPS. In addition, this discussion also addresses the time frames or timeliness for completing enforcement action deliverables which presumably, returns the facility to compliance.

As discussed previously, the TFC POG contains procedures applicable to tracking schedules of compliance (SOC) in DROPS associated with enforcement actions that have deliverables. The POG has detailed, step-by-step procedures for creating DROPS entries for deliverables/submissions, e.g. receipt date, accepted/not-accepted, close out, etc. The SOC entries include deliverable due dates, and if necessary, "extended" entries with new due dates.

In March 2019, EPA made an inquiry to DEC about the 14 facilities (i.e., 17 enforcement actions) discussed above where deliverables were not part of the DEC files. The inquiry focus was on the CATS and DROPS databases and whether those databases reflected the inspector/case lead's entries of receipt and acceptance of deliverables (despite the absence of deliverables in the files) and the close-out or closure of the enforcement action within those databases.

DEC's April 2019 response provided the following information the TFC POG's Task #13, the SOC Deliverables Tracking Report, which POG indicated was usually generated once a week and sent to the compliance group. DEC reported that the report was generally generated weekly during the CYs 2016-2018 and that if the frequency varied, it was one-to-two-weeks depending on staff outages. The resolution of any outstanding deliverables on the SOC Deliverables Tracking Report was the responsibility of the inspector/case lead with the section leads generally making inquiry with inspectors/case leads on deliverables that were not closed out and were overdue.

DEC's April 2019 response also provided the following information of special interest on 7 of the 14 facilities in EPA's initial inquiry:

Facility Name & Permit No.	Enf Tool	Issued Date	EA Opened in CATS? Y/N & CATS ETN	EA Closed in CATS? Y/N & Closed Date	EA Opened in DROPS SOC? Y/N	All Deliverables Rec'd & Accepted? Y/N	EA Closed in DROPS SOC? Y/N & Closed Date	If EA Not Closed, Still Active & Waiting for Deliverables? Y/N & Due Date for Deliverables
Kensington Gold Mine (Major) AK0050571	CL	10/13/17	N	N/A	Y	N	Y 12/31/17	N
Dillingham POTW AKG573004	NOV	6/26/17	Y 2017-R0703	N	Y	N	N	Y Waiting on Deliverables 8/1/19
King Salmon Lagoon AKG573029	NOV	8/16/17	Y 2017-R0769	N	Y	N	N	Y Waiting on Deliverables 11/30/18, 3/15/19 5/15/19
Rainbow Fiberglass AKR06AA08	NOV	10/30/17	Y 2017-R0932	N	Y	N	N	Y 9/15/2018

Juneau-Douglas POTW (Major) AK0023213	CL for 2/24/16 insp.	3/24/16	N	N/A	Y No SOC listed	Y No SOC listed	Y 3/24/16	N
	NOV for 4/20/18 insp.	5/17/18	Y 2018-R0586	N	Y	N	N	Y Waiting for Deliverables/Elevated to negotiations Due 6/30/18
Haxby Tract AKR10FM71	NOV	4/11/14	Y 14-0236-40-0001	Y 6/09/2014	N	N	N	N
Usibelli Coal Mine (Major) AK0040380	NOV	11/17/16	Y 2016-R0972	N	Y	N	N	Y Waiting for Deliverables 2/28/17

The following observations are based on the above entries. DEC indicated that the Compliance Letters (CLs) for Kensington Mine and Juneau-Douglas POTW were not entered into CATS (i.e., N/A) despite the Enforcement Manual discussion and the CL POG indicating the case officer should enter the case into CATS where a CATS enforcement tracking number is generated.

Kensington Gold Mine (Major). The EA was closed out even though all deliverables had not been received and/or accepted.

Dillingham POTW. This NOV has current deliverables due approximately 25 months after NOV issuance.

King Salmon Lagoon. This NOV has current deliverables due approximately 15.5 – 22 months after NOV issuance.

Raibow Fiberglass. The NOV deliverable due dates were extended to September 15, 2018 – 10.5 months after NOV issuance. As of April, 2019, the deliverables are approximately 6.5 months overdue.

Juneau-Douglas POTW (Major). The CL deliverable was not listed in the DROPS SOC database and the action was closed out on the same date of CL issuance. For context, SNC conditions occurred in 2017. The May 17, 2018 NOV's six deliverables were due on June 30, 2018. As of April 2019, the deliverables are approximately 9 months overdue since the NOV's original submission due date.

Haxby Tract. The April 2014 NOV deliverables were not received for an August 2013 inspection. A subsequent April 2015 inspection was conducted with a resulting May 2015 NOV. DEC eventually took a formal action (ESA) that was completed in April 2017.

Usibelli Coal Mine (Major). The November 2016 NOV's deliverables were due in February 2017 but DEC is still waiting for the deliverables. As of mid-April 2019, approximately 29 months have passed since NOV issuance.

Summary. DEC relies heavily on informal actions with very extended, non-enforceable lengthy schedules for deliverables that are expected to help return the facility to compliance (e.g., Dillingham at 25 months; King Salmon at 15.5-22 months; Raibow at 10.5 months and now, overdue since issuance at 17 months; Usibelli at 29 months). These extended, non-enforceable schedules are beyond what EPA Region 10 deems appropriate for the use of informal actions or timely regarding schedules that exceed one year response times, except in unusual, limited circumstances. Note, this SRF review determined that something more than an NOV was the appropriate action for Dillingham, King Salmon, Raibow and Usibelli under the Metric 10b evaluation.

SOC Deliverables Tracking Reports. Based on EPA's review of the preceding April 2019 DEC response for the 14 facilities, a review was conducted of two SOC Deliverable Tracking Reports that were generated by DEC on November 8, 2017 and July 26, 2018 to further evaluate the time frames or timeliness for completing enforcement action deliverables which presumably, returns the facility to compliance.

For context, the Tracking Reports are real time reviews of current deliverable status subject to potential updating delays because the inspectors/case leads have other priority work which might delay DROPS updates and DEC's ability to timely respond to overdue deliverables.

The following table summarizes some data from the two Tracking Reports:

Tracking Report Date	# Enf Actions in Report	# Enf Actions with Overdue Deliverables	# Overdue by < 6 months	# Overdue by 6-12 months	# Overdue by > 12 months with comments
Nov. 8, 2017	76	47	20	10	17 7 @ > 2 years 10 @ > 1 year
July 26, 2018	52	29	15	5	9 5 @ > 2 years 3 @ approx.15 months 1 @ 19 months

The 2017 Tracking Report indicates that deliverables overdue by 6 months or more are 57% (i.e., 27/47) of all overdue deliverables, and those deliverables overdue by more than 12 months are 36% (i.e., 17/47) of all overdue deliverables.

The 2018 Tracking Report indicates that deliverables overdue by 6 months or more are 48% (i.e., 14/29) of all overdue deliverables, and those deliverables overdue by more than 12 months are 31% (i.e., 9/29) of all overdue deliverables.

Summary. The primary observation of this Tracking Report review is the substantial number of overdue deliverables exceeding one year overdue and of that sub-set, the large number of overdue deliverables exceeding two years overdue.

Legacy cases (i.e., cases with extended, lengthy deliverable due dates or substantially overdue deliverables) have the potential to require already burdened inspectors/case leads to expend additional, ongoing oversight time and resources, affecting their ability to focus on new or prospective inspections and timely follow-up enforcement actions.

Consistent with the prior determinations and based solely on the time frames summarized here, these extended, non-enforceable deliverable schedules are beyond what EPA Region 10 deems timely enforcement regarding schedules that exceed one year response times, except in unusual, limited circumstances.

ATTACHMENT F – Element 4 Enforcement – Metric 10b

Metric 10b is a file-review based goal metric designed to assess whether the reviewed enforcement responses addressed the violations in an appropriate manner.

In this SRF review, 39 enforcement actions were reviewed. The reviews determined that the DEC enforcement responses addressed the violations in an appropriate manner in 11 situations (i.e., 28.2%).

This Metric 10b was also identified as an area for State improvement in the December 1, 2014 final SRF Report for FY 2012. During that SRF review, 9 of 17 actions were found to have addressed violations in an appropriate manner (i.e., 52.9%).

DEC Enforcement Response Summary

The following discussion is not intended to be an exhaustive, comprehensive summary of the DEC POGs or its APDES Enforcement Response Guide (ERG, May 2008). It is intended to highlight some key elements that were considered significant during the enforcement action reviews. The summary does not repeat or discuss the entirety of EPA's SNC procedures and policies.

Note: The appropriateness of an enforcement response is dependent, in part, on an accurate compliance evaluation and resulting determination. For example, if the inspector does not use the appropriate evaluation period for a compliance evaluation or fails to accurately assess a facility's compliance history, then those inaccuracies will affect the inspector's current evaluation of the quantity and frequency of violations and effects, in any, of prior enforcement responses' effectiveness in returning a facility to compliance. Accordingly, the file review results for Metric 7e should be considered and factored into these Metric 10b reviews and determinations.

Generally, an appropriate initial response is one that effectively results in the violator returning to compliance as expeditiously as possible, promotes deterrence and is equitable. DEC's ERG notes that the effectiveness of an enforcement response includes whether the enforcement response establishes the appropriate deterrent effect for the particular violator and for other potential violators, and the enforcement response promotes fairness among comparable violators.

As discussed below, the Metric 10b reviews determined that the selected enforcement responses taken in 28 situations were not appropriate. The 28 enforcement actions used either a compliance letter (CL) or notice of violation (NOV). CLs were the primary enforcement action in 12 situations and the NOV was the primary enforcement action in 16 situations.

For context, the CL POG, No. 14.04, states that a compliance letter is an informal enforcement action used to address *minor noncompliance.* The DEC 2008 APDES Application's Program Description (Final October 29, 2008), Section 9.4.3 stated that DEC

would use a less formal action like a CL when the respondent had a few or no previous violations during the previous six months. DEC's 2015 Enforcement Manual, p. 1-7, states that informal actions like a CL are used for "lower priority violations."

The NOV POG, No. 14.05, notes that an NOV documents significant compliance issues (e.g., repeat violations, violations of permit conditions).

EPA's noncompliance reporting regulation, 40 CFR Part 123.45(a)(iii), provides in relevant part that Category II noncompliance includes violations of permit conditions which are of "substantial concern" including violations of permit effluent limits, unpermitted discharges and delayed DMR filings.

Some key elements of the DEC ERG were implicated frequently during the evaluation process and are summarized here for additional context and background.

A CL is not an ERG enforcement response option for violations of permit effluent limits (PELs). An NOV is the lowest enforcement tool available for infrequent and isolated minor violations of PELs, and for infrequent or isolated major violations of a single PEL.

ERG options for frequent PEL violations is a formal action (i.e., something more than an NOV).

A CL is not an ERG enforcement response option for minor sampling, monitoring or reporting deficiencies that are frequent or continued violations (i.e., not isolated or infrequent). A CL is not an ERG option for major or gross sampling, monitoring or reporting deficiencies regardless of the frequency (i.e., something more than a CL is needed for major or gross deficiencies that are isolated, infrequent, frequent or continued violations).

In contrast, a CL *is* an ERG option for the failure to sample, monitor or report (routine reports) if isolated or infrequent depending on the circumstances.

An informal enforcement response (e.g., CL or NOV) are not an ERG enforcement response options for discharge without a permit.

In the context of a compliance inspection, a CL is not an ERG enforcement response option for minor or major violations of sampling or analytical procedures, and a CL is also not an ERG enforcement response option for violations of permit conditions (e.g., BMP, O&M, unauthorized discharge or bypass, record detention, or record availability).

An NOV is not an ERG enforcement response option for major or gross sampling, monitoring or reporting deficiencies that are frequent or continued violations (i.e., not minor, and not isolated or infrequent).

File Review Summary

Metric 10b reviews determined that the selected enforcement responses taken to address violations in 28 situations were not appropriate. Of these 28 enforcement actions, a CL was the selected enforcement tool in 12 situations and an NOV was the selected enforcement tool in 16 situations.

In 8 situations, a CL was used to address PEL violations – a CL is not an ERG options for PEL violations. Additionally and as noted previously, EPA noncompliance regulations designate PEL violations as a *substantial concern*. Clearly, EPA does not view PEL violations as low priority violations. Compare that EPA substantial designation to the DEC CL POG's reference that CLs are for *minor* noncompliance or the DEC 2015 Enforcement Manual's indication that CLs are used for low priority violations.

In 9 situations, a CL was used as the follow-up response action to violations identified in a compliance inspection in situations where the ERG options for these particular violation situations, in a compliance inspection context, do not provide a CL as an enforcement response option (e.g., violations of permit conditions like BMP, O&M, record detention, record availability, etc.).

In 5 of these 9 situations, a CL was also used to address PEL violations as described in the previous paragraph.

In two situations, CLs were used to respond to SNC-level PEL violations for two major facilities instead of SNC-related formal actions. In addition, the DEC files for these two Major Facility-CL situations did not include any written record clearly justifying why an informal action was the more appropriate enforcement response. Of course, in accord with the DEC ERG, the use of a CL could not be clearly justified as an appropriate response for PEL violations.

The file reviews also included four other major facilities with SNC-level PEL violations where the response action was an NOV instead of a SNC-related formal action as the appropriate enforcement response to the SNC status. In these four situations, the DEC files did not include any written record clearly justifying why the NOVs were the more appropriate enforcement response.

The file reviews included a minor facility with an individual permit (IP) that was designated Category I noncompliance status. The inspection report overlooked a prior DEC 2013 inspection and related 2013 NOV, and consequently, PEL violations that occurred in 10 of the 17 months prior to the inspector's evaluation period were not factored into the enforcement tool selection process. Even with the inappropriately shortened evaluation period, the inspection report acknowledged that since 2015, only 4 months of DMRs did not have effluent violations and that the other 38 monthly DMRs had effluent violations. The SNC-level TRC related PEL violations, the chronic PEL violations and other major permit condition violations indicated that a formal action was the appropriate enforcement response to this Category I noncompliance situation.

Excluding the 4 major facility SNC situations and the minor IP facility's Category 1 situation, 8 other NOV situations had some major or gross sampling, monitoring or reporting deficiencies that were frequent or continued violations (i.e., not minor, and not isolated or infrequent) that, in accordance with the ERG, excluded the use of an NOV as an appropriate enforcement response. At least two of these 8 situations also had frequent PEL violations which is a separate, independent basis requiring the selection of an ERG formal action instead of an NOV.

The summaries of the factual bases, and their ERG-based application, for determining that CLs and NOVs were not the appropriate enforcement response for the identified violations are included in the table at the end of this Attachment F. Note, the listing of permit condition violations are not routinely exhaustive but attempt to accurately identify some key violating conditions.

DEC Formal Enforcement Actions & Timing

An evaluation into the root causes of this Metric 10b situation (i.e., only 11 of 39 actions were determined to be appropriate response actions) requires at least some review and evaluation of DEC's recent performance regarding the initiation and completion of formal enforcement actions (FEAs) and related lapsed time for completing any FEAs.

Timely enforcement has been a consistent problem area for DEC. The December 1, 2014 final SRF Report for FY 2012 found that DEC did not consistently take timely enforcement actions, and that the failure to initiate and complete formal enforcement actions in a timely manner impeded DEC's ability to initiate and complete more enforcement actions over time. The 2014 SRF Report noted that delays in timely completion of formal actions resulted in fewer actions being completed overall as staff prioritize limited time and resources for pending actions and delay development of new appropriate actions.

The 2014 SRF Report identified numerous factors that contributed to or caused DEC performance issues, including timely enforcement, which factors included the following: (1) DEC appears to lack an adequate complement of trained inspectors to implement a vigorous compliance and enforcement program that meets DEC commitments and EPA CMS inspection goals; and (2) DEC's APDES Enforcement Response Guide (ERG) did not contain specific time frames or goals for initiating and completing enforcement actions.

In regard to the lack-of-adequate-resources factor, the 2014 final SRF Report required DEC to conduct a resource analysis of the DEC APDES Compliance Program to determine, in part, the number of staff positions (FTEs) necessary to meet APDES commitments, EPA CMS goals and conduct a vigorous compliance and enforcement program (with timely and appropriate enforcement that included formal actions). DEC's Resource Analysis (October 30, 2015) indicated that 12.3 FTEs were needed to conduct compliance activities and another 9.1 FTEs were needed to conduct enforcement, for an approximate total of 21.4 FTE needed for the Compliance Program. The 21.4 FTE total included some management, administrative and data support also.

In regard to the lack-of-time-goals factor for initiation and completion of enforcement actions, the 2014 final SRF Report required DEC to develop and implement program operating guidelines (POGs) that included timelines and time frame goals for completion of each type of enforcement action. In response, DEC developed and implemented the Enforcement Action Timelines POG (EAT POG_, No. 14.29 (effective January 25, 2016) which included aspirational time frame goals for completing three types of formal enforcement actions: compliance orders by consent (COBC), expedited settlement agreements (ESA) and settlement agreements (SA).

In addition, the 2014 SRF Report also included specific deadlines for completing various levels of formal actions as a means to promptly address a backlog of unfinished formal enforcement cases that had been languishing in DEC's enforcement pipeline. This included a deadline of January 1, 2015 to complete three formal actions, by March 31, 2015, complete an additional three actions and by March 2015, EPA and DEC were to identify other cases that were then targeted for completion by December 2015 and in calendar year 2016. In preparation of this current SRF review, the most recent prior DEC program manager indicated that CY 2015 was not a representative year for completion of formal actions because so many developed and already initiated actions were in the pipeline that their completions in 2015 were not representative of typical operating conditions.

Since 2015, DEC has completed a total of 21 formal enforcement actions in three calendar years as follows: 2016 = 8; 2017 = 6 and 2018 = 7.

For purposes of this SRF review, an evaluation was also conducted on the three types of formal enforcement tools (i.e., COBC, ESA and SA) for formal enforcement actions that were initiated after the EAT POG's January 25, 2016 effective date, and completed by February 2019. The results of the evaluation are found in the table below.

Permit Number	Entity	Enf Tool	Inspection Date (2)	DOL Referral Date (3)	Date of Action	Days to Complete	# Days Beyond POG Goal
AKU000311	City of Nome	ESA	June 30, 2016	NA	Jan. 20, 2017	204	94-109
AK0036994	Shoreside Petroleum	SA	NA	Jan. 25, 2016	June 27, 2017	519	355
AKG315002	Hilcorp Alaska	SA	NA	Oct. 6, 2017	May 3, 2018	209	45
AKG370B90	CCR Mining,	COBC	NA	June 22, 2016	June 27, 2018	735	511-571

Permit Number	Entity	Enf Tool	Inspection Date (2)	DOL Referral Date (3)	Date of Action	Days to Complete	# Days Beyond POG Goal
AKG370137	R&M Mining	ESA	Sept. 19, 2017	NA	July 18, 2018	302	192-207
AKU000312	Haines Packing	COBC	NA	March 20, 2017 (4)	August 6, 2018	504	280-340
AKG315015	Hilcorp Alaska	COBC	April 20, 2018 (5)	April 24, 2018	Sept. 14, 2018	143	Met Goal
AKG370443	Hope Mining Co.	ESA	Sept. 5, 2018	NA	Nov. 18, 2018	74	Met Goal

Table Footnotes:

1. This chart is based on the DEC Program Operating Guideline (POG) No. 14.29, Enforcement Action Timelines (Effective Date January 25, 2016). The enforcement cases listed in this chart are based on an inspection dates (except as noted) or a Department of Law (DOL) referral dates, as applicable to the enforcement tool, that occurred on or after the POG's effective date of January 25, 2016.
2. The POG provides that for a compliance-order-by-consent (COBC) or a settlement agreement (SA), the "days-to-complete" aspirational goal range of 164 – 224 days and 164 days, respectively, which begins to run from the completed DOL referral date.
3. The POG provides that for an expedited settlement agreement (ESA), the "days-to-complete" aspirational goal range of 95 – 110 days which runs from the facility inspection completion date.
4. DEC Enforcement Tracker indicates a March 20, 2017 DOL referral date with a caveat of no record, then October 6, 2017. March 23, 2017 check-in meeting notes indicate manager said DOL referral was made previous week. June 23, 2017 check-in meeting notes indicate DEC had briefing packet and was ready to meet with DOL. Subsequent trackers indicate DOL meeting did not occur until March 14, 2018. For purposes of this chart, the initial referral date of March 20, 2017 is used.

5. This enforcement action was prompted by Hilcorp's April 20, 2018 letter to DEC acknowledging DMR-related effluent violations for period of 2012-2018 so DEC's enforcement tracker uses this April 20, 2018 date as the date of initial violation or discovery. The enforcement case was not the result of a DEC inspection.

In summary, this chart shows that DEC initiated and completed 8 formal actions in the approximate two years it has been operating under the aspirational time frame goals of the EAT POG. Six of the 8 actions did not meet the POG's aspirational goals and of those 6 actions, four actions exceeded the POG's time frame goals by substantially more than 6 months.

Of the two actions that met time frame goals, the Hilcorp action is not a typical enforcement action resulting from a DEC inspection or a solely DEC-initiated compliance evaluation. The Hilcorp action was prompted by Hilcorp's self reporting of the noncompliance situation on which the DEC penalty action was taken and completed.

The current SRF review also shows that DEC has not adhered to the EPA SNC policy on timely formal actions in response to initial SNC conditions at major facilities, and has instead, relied almost exclusively on informal actions for which no records have been created or retained which clearly justify the use of an informal action. These practices raise concerns both about the lack of timely enforcement for significant noncompliance but also appropriate enforcement tool selection and use to achieve compliance as expeditiously as possible.

File Review Summary Table

The summaries of the factual bases, and their ERG-based application, for determining that CLs and NOVs were not the appropriate enforcement response for the identified violations are included in the table below. "ET Iss Date" means Enforcement Tool Issuance Date.

As noted before, the listing of permit condition violations are not routinely exhaustive of the totality of noncompliance that can be found in the IR or accompanying CL/NOV, but an attempt was made to accurately identify some key violating conditions supporting the determinations.

Table: Metric 10b – Enforcement Responses Not Addressing Violations in an Appropriate Manner

Facility Name	Enf Tool	ET Iss Date	File Review Comments
Sawmill Cove Industrial Park	NOV	3/22/18	More than NOV. Major sampling, monitoring and reporting deficiencies (frequent and continued violations) (i.e., not minor, and not isolated and infrequent). Other major permit conditions violations. For example:

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			8 consecutive quarters of no benchmark sampling 7/2015 – 6/2017; No effluent samples collected for 7/2015 – 6/2017; Five quarters of lack of site inspections; No comprehensive inspections done in 2015 and 2016; No annual reports filed for 2015 and 2016; No SWPPP training records; No signed and certified SWPPP and not maintained up to date; Multiple failures to implement BMPs; Lack of corrective action log.
Merrill Field Airport	NOV		More than NOV. Evaluation period covered Nov 2011 – Nov 2016. Major monitoring and permit condition-required documentation deficiencies – frequent or continued violations (i.e., not minor, or isolated and infrequent). Other major permit condition violations. For example: Routine inspection required monthly during deicing season are not being done – none in 2012-2013; 2 in 2014 and 2016; 4 in 2015; Comprehensive Insp Rpts not available for 2012, 2013 and 2016; Repeat deficiencies noted in quarterly consultant reports for multiple quarters without being addressed; Employee training records not available for 2012, 2013 and 2014; Monthly quantities of deicing chemicals not being maintained; Maintenance and repair of control measures not documented in SWPPP; Deicing chemical application rate is unknown to facility officials and not being analyzed to minimize contamination of storm water; No snow melt control measures are documented in SWPPP; 2012, 2013 and 2014 SWPPPs not signed/certified; and Other miscellaneous documentation and control measure violations.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
Kensington Gold Mine	CL	10/13/17	CL is not an ERG option for permit effluent limit violations, and ERG requires, at minimum, an NOV or more for WET limit violations. See file review comments for Metrics 7e and 9a. For compliance inspections, a CL is not an ERG option for either minor or major sampling violations or for other violations of permit conditions (e.g., BMP, O&M, unauthorized discharge or bypass, record detention or record availability, etc.). Neither IR or 10/13/17 Compliance Letter address or cite June and July 2014 WET effluent limit violations or June 2014 turbidity violation that should have been identified, considered and factored in if the ICIS violation report was run with a starting date of the last inspection. If appropriate evaluation was considered with resulting identified violations cited, at least an NOV was required to address WET limit violations, and other final permit effleunt limit violations. Inspection also identified other permit condition violations. For example: IR indicates an area of concern (AOC) is that pH and turbidity standards were expired (photos show expiration dates of August, September and October 2016). Expired solutions should have been cited as violation of Permit Standard Conditions, 1.6.1 (lack of adequate laboratory controls and QA procedures) and 1.11.4 (reqt to use approved Part 136 test procedures).
Dillingham POTW	NOV	6/26/17	More than NOV. Permit effluent limit exceedances are frequent and almost continuous in some long periods and some at significant levels. ERG provides at least some formal action for frequent effluent limit violations. Here, ERG criteria for NOV (i.e. infrequent or isolated minor exceedances) is not applicable. See also file comments on Metrics 7e and 9a for more background.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			IR acknowledges prior 2013 inspection and resulting 2014 NOV (i.e., 2/20/14); however, IR evaluation period is only 4/2/15 – 5/8/17 (25 months), but not back to August 2013, prior inspection date. Current IR and 2017 NOV do not assess or cite violations regarding failure to submit DMRs (June & Oct 2014, and March 2015) and effluent limit violations that occurred in following months since 2013 inspection and Feb 2014 NOV: Feb – May 2014; July-Sept 2014; Nov 2014; and Jan 2015. IR does not appear to acknowledge significant noncompliance (SNC) related to July-August 2016 BOD monthly effluent limit violations exceeding TRC levels. Of the 25 month evaluation period for this inspection, 21 of 25 months had effluent violations. The POTW does not have disinfection but instead relies on fecal coliform limits with a mixing zone. Of the 25 month evaluation period for this inspection, the fecal coliform monthly average effluent limits were violated in 12 of 25 months with significant levels of exceedances. Since the 2013 inspection and for 2014-2018, here is a summary of the number of months per year in which fecal coliform limits were exceeded: 2014 – 4; 2015 – 5; 2016 – 4; 2017 – 5; and 2018 – 6. Since May 25, 2017 CEI and 2017 NOV, POTW has continued to have routine effluent limit violations (ELVs). For example and not all inclusive since 6/26/17 NOV, ICIS indicates ELVs in every month from Nov. 2017 through February 2019 with most recent ELVs being significant noncompliance (i.e., substantially exceeding TRC trigger levels). For example, BOD weekly average effluent violations for April – October and December 2018 have been substantially above TRC trigger levels. BOD weekly average and TSS weekly average effluent violations for January-February 2019 are also significantly above TRC trigger levels. An appropriate evaluation period assessment in June 2017 would have demonstrated that 2014 NOV did not get facility compliance and that significant noncompliance

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			(e.g. duration/frequency as wells as 2016 SNC levels) was continuing. Permit effluent limit exceedances are frequent and almost continuous in some time periods and some at significant levels. ERG provides at least some formal action for frequent effluent limit violations. Given totality of IR results (e.g., only one blower operational, no working aeration system in Cell 2, no disinfection system, etc.) and ERG provision, a formal action would have been the appropriate enf tool.
King Salmon Lagoon	NOV	8/16/17	More than NOV. Major sampling, monitoring and reporting deficiencies (frequent and continued violations) (i.e., not minor, and not isolated and infrequent). Other major permit conditions violations. Evaluation period was 2014 – May 2017. For example: Failure to sample/submit DMRs – no DMRs from permit effective date of Nov. 2013 – June 2015; Aug. 2015-May 2016 and July 2016; Failure to perform weekly lagoon inspection and maintain inspection documentation; Failure to report noncompliance events; Failure to meet compliance schedules in 2013 authorization; Failure to monitor flows 5 days a week; Failure to maintain lagoon maintenance program plan; Failure to obtain operator certification; Failure to maintain leaking lagoon evaluation; Failure to develop and implement a QAPP. Inspector observed that the two aerators in the secondary lagoon were non-operational and aeration is currently operation in primary lagoon only. Of the 11 months of available sampling/DMRs as of June 2017 inspection, permit effluent violations (e.g., TSS, BOD, fecal coliform, pH) were identified in 9 months. Monthly BOD effluent limit violations became SNC-based chronic in June 2017.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			ERG provides for formal action (more than NOV) for frequent violations of effluent limits (here, effluent violations were not infrequent or isolated minor violations).
Ketchikan Ready-Mix	NOV	11/15/17	Context: DEC last inspected in May 2012 and issued NOV. Current inspection only covered July 2015- August 2017 (i.e., approx. 24 months) and excludes 5/9/12 – 8/3/15) (approx. 39 months). Here, determination below for something more than an NOV is justified even on basis of the shorter 24 month period covered by the 2017 inspection and Nov. 2017 NOV. More than NOV. Major sampling, monitoring and reporting deficiencies (frequent and continued violations) (i.e., not minor, and not isolated and infrequent). Other major permit conditions violations and high pollution risk site conditions. For example: Failure to sample each outfall for quarterly visual assessments (missed one of two outfalls); Failure to submit benchmark monitoring to DEC; Discharge effluent exceeding Alaska water quality standards without corrective action; Failed to follow-up benchmark exceedances with additional sampling and corrective actions; Failure to do 24-hour non-compliance notices and submit 5-day non-compl reports; No up-to-date copies of training logs in SWPPP (repeat violation); Disposal of trash and stored fluids in unapproved locations (repeat violation). Inspector observation: very little attention has been given to control runoff; oil observed under a majority of equipment; large storage area had significant oil under equipment.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
Alaska Logistics, LLC	NOV	7/28/17	Context: Inspection covered April 2015 – June 2017 (approx. 26 months). In effect, there does not appear to be any implementation of major MSGP/SWPPP provisions for this approximate 2-year time frame. More than NOV. Major sampling, monitoring and reporting deficiencies (frequent and continued violations) (i.e., not minor, and not isolated and infrequent). Other major permit conditions violations. For example: No quarterly routine facility inspections and quarterly visual sampling/assessments were being done; No comprehensive inspections being done and no Annual Reports submitted; Copies of SWPPP and MSGP permit were not available on site; Copies of NOI and DEC authorization letter were not available on site; No records of employee training, SWPPP modifications, spill incidents, inspection reports.
Raibow Fiberglass	NOV	10/30/17	Context: MSGP coverage was effective February 2015 with no prior AKR05 coverage. IR states evaluation period was Feb-August 2017 (7 months); not the approximate 31 months beginning on coverage date. Here, determination below for something more than an NOV is justified even on basis of the shorter 7-month period covered by the 2017 inspection and Oct. 2017 NOV. More than NOV. Major sampling, monitoring and reporting deficiencies (frequent and continued violations) (i.e., not minor, and not isolated and infrequent). Other major permit conditions violations. For example: Routine quarterly facility inspections have not been completed and inspection reports are not available; Quarterly visual sampling/assessments have not been complete and reports are not available;

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			Comprehensive inspection reports were not available and annual reports were not submitted to DEC; SWPPP did not address required Sector R training requirements and there were no training records available; MSGP-prohibited pressure washing (also SWPPP said no pressure washing is conduced on-site) was being done on site; No SWPPP and DEC authorization on site.
D&A Gold LLC Walker Fork Mine Site [Note: Due to proximity in time of CL then NOV issuance, these two enf. actions are being evaluated together and treated as one Metric 10b evaluation.]	CL	9/14/17	Context: Mine in operation June-October 2016, then again June-October 2017 with a DEC August 30, 2017 inspection. CL is not an ERG option for permit effluent limit violations. For compliance inspections, a CL is not an ERG option for either minor or major sampling violations or for other violations of permit conditions (e.g., BMP, O&M, unauthorized discharge or bypass, record detention or record availability, etc.). Also, major sampling, monitoring and reporting deficiencies (frequent and continued violations) (i.e., not minor, and not isolated and infrequent). Other major permit conditions violations and WQBEL were being exceeded in receiving water. For example: Turbidity readings of wastewater discharge are not in compliance with effluent limits or WQSs; Daily inspection records were not available; Discharge monitoring records not available; 2016 annual report not submitted; No oral or written non-compliance submissions made in regard to non-complying turbid water discharges; Permit and DEC authorization not available.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
	NOV	11/30/17	More than NOV. Major sampling, monitoring and reporting deficiencies (frequent and continued violations) (i.e., not minor, and not isolated and infrequent). Other major permit conditions violations and WQBEL were being exceeded in receiving water. NOV was sent after permittee failed to respond to prior CL.
Signature Flight	CL	10/5/17	Context: Facility obtained AKR06 coverage on 12/17/15. IR acknowledges prior AKR05 coverage (EPA eNOI indicates 10/25/09 AKR05 coverage date). IR says no prior AKR05/AKR06 related inspections; however, IR evaluation is only three years, 8/3/14-8/3/17. More than CL. For compliance inspections, a CL is not an ERG option for either minor or major sampling violations or for other violations of permit conditions (e.g., BMP, O&M, unauthorized discharge or bypass, record detention or record availability, etc.). Major sampling and monitoring deficiencies (frequent and continued violations) (i.e., not minor, and not isolated and infrequent). Other major permit reporting condition violated. For example: No quarterly sampling/visual monitoring has been done (at least six consecutive quarters since Dec. 2015 authorization); No annual comprehensive site inspections conducted since current Dec. 2015 authorization (at least two consecutive years); No annual reports submitted since current Dec. 2015 authorization;
North Park Fuels	CL	5/8/17	Context: MSGP coverage effective January 26, 2016. Inspection on April 19, 2017. More than CL. For compliance inspections, a CL is not an ERG option for either minor or major sampling violations or for other violations of permit conditions (e.g.,

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			BMP, O&M, unauthorized discharge or bypass, record detention or record availability, etc.). Major sampling and monitoring deficiencies (frequent and continued violations) (i.e., not minor, and not isolated and infrequent). Other permit condition violations. For example: No quarterly sampling/visual assessment and reports for main facility and Lot B; No routine facility inspection reports available at time of inspection for Lot 6B; Comprehensive site inspection records were not available; No employee training records; SWPPP was not signed and dated; Permittee did not have copy of the MSGP; 2016 annual report was not submitted to DEC.
Alaska Omega Nutrition	CL	12/5/17	Context: Evaluation period is March 2016 – June 2017. More than CL. For compliance inspections, a CL is not an ERG option for either minor or major sampling violations or for other violations of permit conditions (e.g., BMP, O&M, unauthorized discharge or bypass, record detention or record availability, etc.). ERG option for discharge without a permit is a formal action. Here, major monitoring deficiency (i.e., not minor). Other significant permit condition violations. For example: Permittee failed to complete a seafloor survey; Permit does not authorize observed stormwater discharges to processing waste discharges (i.e., discharge without a permit); Employee training records not available;

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			Non-compliance notifications not available; Clogged outfall line with unplanned discharge from main sump indicates likely O&M violation.
Trident Akutan	NOV	5/11/16	Context: Evaluation period was 2013 – May 2016. SNC conditions - facility appears in multiple QNCRs beginning with Jan-March 2016 and April-June 2016 TRC trigger level effluent violations for TSS (Oct 2015 and Feb 2016). More than NOV. EPA SNC policy requires formal action or written justification for any informal action. Here, DEC file did not contain written justification for NOV which was issued 2.5 months after first QNCR conditions. ERG also provides that major or gross sampling and monitoring deficiencies (frequent or continued violations) should have formal action. Invalid sampling/monitoring issues giving rise to violations below are major and gross in both length of time that violations are occurring as well as the numbers of invalid samples. These are not minor deficiencies, and certainly not isolated or infrequent. Other major permit condition violations indicate something more than NOV is the appropriate response given totality with SNC effluent limit violations. Before listing examples – here is an IR excerpt of invalid samples that could not be used in DMR determinations: IR Excerpt [Note; inspector's evaluation of this invalid sample issue only convered 2013-2015; not Jan-May 2016. Trident's August 2016 NOV response indicated this invalid sampling problem existed prior to January 2014 but was not being reported as invalid, and that this problem continues into mid-2016 as of time of their response.]: Numerous required samples for BOD_5, fecal coliform (FC) and total suspended solids (TSS) for Outfalls 001 and 006 were deemed invalid due to exceedances in hold time and thus could not be used in DMR

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			calculations and submission. Trident Akutan was unable to obtain valid results as summarized below from facility Annual Reports: **2015** 12 weeks with no valid BOD5 test results for Outfall 001. Permit required weekly monitoring. 24 weeks with no valid BOD5 test results for Outfall 006. Permit requires weekly monitoring. 2 weeks with no valid TSS test result for both Outfalls 001 and 006. Permit requires weekly monitoring. Zero valid results for FC in January, April and May. Permit requires monitoring 5 days per month. One valid result for FC in March. Permit requires monitoring 5 days per month. Two valid results for FC in June, July and August. Permit requires monitoring 5 days per month. Four valid results for FC in December. Permit requires monitoring 5 days per month. **2014** 9 valid results out of an annually required 60 (5 per month) for FC from Outfall 006 were obtained. 31 weeks with no valid BOD5 test results for Outfall 006. Permit requires weekly monitoring. 16 weeks with no valid BOD5 test results for Outfall 001. Permit required weekly monitoring. 7 weeks with no valid TSS test results for Outfall 006. Permit requires weekly monitoring. 4 weeks with no valid TSS test results for Outfall 001. Permit requires weekly monitoring. **2013** One hold time exceedance for the entire year was noted on 7/9/2013 for BOD5 Major permit condition violation examples include: There was no QAPP (blank 2013 QAPP word document was presented); Failure to conduct daily sea surface monitoring 28 days between 4/16/15-12/19/15; Two outfalls were relocated without prior approval; No sign that sewage is being discharged; Seven oil spills in three years; Invalid sampling/monitoring as summarized above (appears persistent pre-2014 through summer 2016) (IR identifies this as a repeat violation); WWTF is being operated by two uncertified operators; Outfall 006 discovered broken in January 2016 and continues to discharge secondary sewage effluent at unauthorized location; 17 reported incidents between 2013-2016 of foam/sheen/discoloration at dock.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			The totality of effluent limit violations (valid) with SNC conditions, the major/gross sampling/monitoring violations, and other listed major permit condition violations (including monitoring) indicates a formal action is the appropriate enforcement response.
Juneau-Douglas POTW	CL for 2/24/16 insp.	3/24/16	Context: DEC file does not contain an ICIS violation report for this 2016 inspection and IR is silent in regard to evaluation period. IR cites 2014 inspection and indicates DMRs from 2013 to present were reviewed. IR and CL only cite reporting violations related to permit effluent limit exceedance event for January 2015 and other noncompliance event reporting violations in July and August 2015. IR also acknowledges prior formal SA action in 2015 for 990 effluent violations occuring in period of Jan. 1, 2009 – April 30, 2011. Neither IR or CL cite actual permit effluent limit violations for the three year DMR review that should have identified the following months of permit effluent limit violations: April, Aug-Sept 2013; Jan, May-June 2014; and Jan, Jul and Aug 2015. More than CL. CL is not an ERG option for permit effluent limit violations. Also major reporting violations – failure to report effluent limit violation (verbal and written 5-day report) and other written noncompliance report failures related to non-compliance events regarding treatment unit impacts due to hydraulic surge events.
	NOV for 4/20/18 insp.	5/17/18	Context: DEC file's ICIS violation report covered February 2016 – April 20, 2018. SNC conditions - facility appears in July-September & October-December 2017 QNCRs for chronic ammonia monthly effluent limit violations (i.e., June-Sept violations) and TRC trigger levels for TSS (July-August).

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			More than NOV. EPA SNC policy requires formal action or written justification for any informal action. Here, DEC file did not contain written justification for NOV which was issued over one-half year after first QNCR conditions. Other major permit condition violations indicate something more than NOV is the appropriate response given totality with effluent limit violations (IR identified this as repeat violations). For example: Failed to have an up-to-date QAPP – most recent was May 2014 and not representative of current POTW activities; Failed to have an up-to-date O&M Plan – most recent was November 2015 and it did not represent current POTW and permittee failed to conduct and document annual O&M Plan review (IR noted this as repeat violation); Permittee failed to implement appropriate BMPs (IR noted this as repeat violation).
Haxby Tract	NOV	4/11/14	More than NOV. Major monitoring deficiencies – frequent or continued violations (i.e., not minor, or isolated and infrequent). Other significant permit condition violations also. CGP authorization April 2012; August 2013 inspection. Grading log not being maintained and site is not tracking dates of grading activities; Stabilization log not being maintained and site is not tracking dates of stabilization measures when initiated; Corrective action log not being maintained; No rain records being maintained onsite; DEC enforcement file says 32 inspections missed between 1/1/13 – 8/16/13; SWPPP was not signed or certified; Large piles of uncovered fill material (e.g., not stabilized); No maps included in SWPPP;

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			No records documenting dates of temporarily or permanent cessation of construction activities; No training records onsite with SWPPP; No documentation of control measure maintenance and repairs; No logs found documenting SWPPP modifications; SWPPP did not contain any certificates indicating inspectors were CESCL certified.
North Pacific Seafoods	CL	3/21/17	Context: Applicable general permit identifies size limit as an effluent limit and fact sheet indicates it is a TBEL. CL is not an ERG option for permit effluent limit violations. Here, CL identified 40 events of grind size exceedances from 2015 – August 2016. More than CL.
Mendenhall POTW	CL for 11/17/15 insp	12/1/15	Context: IR says evaluation period is August 1, 2014 (date of permit issuance) to present (about 16.5 months). IR does not acknowledge file's ICIS violation report covering 10/31/13 – 8/31/15 (22 months). Consequently, IR and Compliance Letter do not cite effluent limit violations in following months: Nov 2013 and Jan, March and Aug 2014. CL is not an ERG option for permit effluent limit violations. Additionally, of the 22 month ICIC violation report period, effluent limit violations occurred in 8 months. Jan-March 2015 included monthly average violations for TSS and BOD at 94% and 132% TRC trigger level. Here, frequent violations of permit effluent limits; not infrequent or isolated minor violations. Appropriate action would be a formal enforcement action.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
	NOV for 2/24/16 site visit	5/5/16	Context: This NOV was based on a site visit. The NOV cited pretreatment requirement noncompliance related to two activities: (1) POTW's failure to sample/monitoring for all pollutant parameters related to the industrial user discharges in the August 2014 POTW Permit, Part 2.4.2; and (2) POTW's failure to obligate SIU (Alaska Brewing Company) to conduct wastewater sampling (no less than once every six months) per SIU monitoring requirements in the Permit, Part 2.4.7. By May 2016, POTW had failed to adequately monitor all pollutants since 8/1/14, an approximate 22 month period, and at least three consecutive sampling events of the SIU had not occurred. More than NOV. The POTW's two sets of violations of the permit conditions were not minor or infrequent. The POTW's failure to establish and enforce the SIU's monitoring requirement was not isolated or infrequent but time period shows it was continued until enforcement action prompted attention.
	NOV for 12/11/17 insp.	2/28/18	Context: DEC file's ICIS violation report covered Dec 2015 – Dec 2017 (25 months). SNC conditions - facility appears in October-December 2017 and January-March 2018 QNCRs for above TRC trigger levels for BOD and TSS in Oct-Nov. Also, of the 25 month period, 9 months had effluent violations. More than NOV. EPA SNC policy requires formal action or written justification for any informal action. Here, DEC file did not contain written justification for NOV which was issued three months after first QNCR conditions. In addition, Dec. 2015 CL (informal) was not effective in achieving compliance. Another informal action given the frequent effluent violations is not an appropriate response. ERG provides for a formal action for frequent violations of effluent limits; here, effluent limit violations were not infrequent, or isolated minor.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
Usibelli Coal Mine [Note: These three informal actions are intertwined and integrated regarding violating conditions over an approximate two year period.]	CL	11/19/14	CL is not an ERG option for permit effluent limit violations. For compliance inspections, a CL is not an ERG option for either minor or major sampling violations or for other violations of permit conditions (e.g., BMP, O&M, unauthorized discharge or bypass, record detention or record availability, etc.). Here, CL cited failure to maintain sediment ponds (e.g. BMP deficiencies or O&M violations) and failure to update BMP Plan and QAPP. ICIS and the 11/3/16 IR indicates the Nov. 19 CL was associated with Recon Inspection (Sept. 22, 2014). ICIS shows this inspection identified an effluent limit violation (i.e., failed toxicity test or WET failure) in addition to BMP deficiencies & O&M violations regarding failure to maintain sediment ponds. ICIS also shows a settleable solids effluent violation in September 2014 exceeding TRC levels (1940%). CL is not an ERG option for permit effluent limit violations (Or WET limit violations) so this 2014 CL should have at least been something more than a CL. ERG also requires at least NOV or more for the WET failure.
Usibelli Coal Mine	NOV	10/2/15	More than NOV – SNC level effluent limit violations in August & Sept 2015 require formal action per EPA SNC policy for Major facilities, and if no formal action, written justification for why informal action is justified. NOV also cites permit condition violations related to multiple bypass events. ICIS entries show no inspections between inspections of 9/22/14 and 11/3/16. NOV cites permit effluent limit violations for August & September 2015 which ICIS indicates exceeded TRC levels (i.e., 900% & 1500% respectively). Major facility was then cited in FY 2015 Q4 and FY 2016 Q1 QNCRs for SNC-based TRC-level permit effluent limit violations.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			NOV also noted violating conditions here were similar to those in Nov. 2014 CL (i.e., repeat). In sum, enf action should have been a formal action. DEC file did not contain written justification for NOV per EPA EMS and EPA May 2008 memo in regard to timely and appropriate responses to SNC violations.
Usibelli Coal Mine	NOV	11/17/16	More than NOV – IR acknowledged 2014 CL for failure to update BMP plan and O&M violations for failure to maintain sediment ponds. November 2016 inspection and IR cite same violations as repeat violations. 2015 NOV should have been a formal action. Here, repeat violations show prior CL and NOV are not achieving sustained compliance. In totality of what occurred in last two years, something more than an NOV should have been the appropriate enf tool at this time.
Fairbanks/GHU POTW	CL	8/23/17	Context: 7/25/17 inspection had a compliance evaluation period of 10/1/14-7/26/17. POTW was SNC with initial appearances on QNCRs for July-Sept 2015 and Oct-Dec 2015. POTW had TRC level BOD mo. ave. violations in July, Aug, Sept, Oct and Nov 2015. POTW had chronic TSS mo. ave. violations in July, Aug, Sept, Oct and Nov 2015. IR acknowledges 2015 SNC status. DEC file contains a May 23, 2016 referral recommendation to Department of Law for a Settlement Agreement (SA) for the SNC conditions. The recommended SA was never issued or completed. Even absent SNC conditions, a CL is not an ERG option for permit effluent limit violations. Here, effluent violations were SNC (e.g. both TRC and chronic). For compliance inspections, a CL is not an ERG option for either minor or major sampling violations or for other violations of permit conditions (e.g., BMP, O&M, unauthorized discharge or bypass, record detention or record availability, etc.). Here, other permit condition violations cited.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			More than CL – SNC level effluent limit violations in 2015 require formal action per EPA SNC policy for Major facilities, and if no formal action, written justification for why informal action is justified. DEC file did not contain written justification for the CL or written explanation why SA was not pursued to completion as proposed in May 2016 (at that time, approximately one-half year since SNC conditions). CL also cited O&M violations of influent pumps and that required maintenance records were not available (i.e., other permit condition violations during a CEI for which a CL is not an ERG option).
Ward Cove Ind. Site WWTF	NOV	9/19/18	Context: Inspector overlooked June 2013 inspection and related NOV (i.e., IR incorrectly stated that last inspection was in 2005 – no IR acknowledgement of6/13/13 inspection or Dec 2013 NOV). That DEC 2013 informal action did not achieve facility compliance. Frequent effluent violations occurred after June 2013 inspection (e.g., June, Aug, Sept, Dec 2013; Jan-April, June, Oct 2014. Here, evaluation period was Jan 2015 – Jan 2018. IR reports that since 2015, only 4 monthly DMRs did not have effluent violations; the 38 other monthly DMRs had effluent violations. This minor IP facility is being flagged in ICIS FY 2017 frozen data as a SNC/Category 1 violation status. There were above TRC trigger level effluent violations in 2016 (3 qtrs), 2017 (3 qtrs) and 2018 at a frequency at times that were SNC-level chronic violations. ICIS shows effluent limit violations occuring routinely during the three year inspection evaluation period on a monthly count basis as follows: 2015 = 7 months; 2016 = 7 months and 2017 = 11 months. More than NOV. ERG provides that frequent violations of permit effluent limitations should get a formal action. Here, even failure to consider 2013-2014 violations, the 3-year evaluation period had effluent violations in 25 of 36 months or approx. 70% of

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			the months. The Category 1 status with TRC level violations and chronic-level frequencies of effluent limit violations should have received a formal action in accordance with the ERG. Here, NOV was silent in regard to expectations on when compliance should be achieved.c ERG provides that major or gross sampling deficiencies (frequent or continued violations) should get formal action. Failure to complete copper sampling after notice as summarized below is a frequent, continued violation of major parameter. Other major permit condition violations exist. For example: Lack of sampling - Permittee was notified in May 2016 that required copper sampling was not being done – even after notice, copper sampling was not done in 2016 Q2, Q4 and not in 2017, Q1, Q3 and Q4; Effluent flow was not being continuously monitored; QAPP was not updated to reflect new staff or procedures; Many months of noncompliance without verbal or written reporting. Totality of violations (e.g., effluent limit violations, Cat 1 status, and permit condition violations) indicates an appropriate enf tool should be more than NOV.
Hilcorp Granite Point Tank Farm	CL	5/12/15	Context: 4/2/15 inspection with an evaluation period of Jan 2012 – April 2015. Tank farm was SNC with initial appearances on QNCRs for Jan-Mar 2014 and Apr-June 2014 for oil and grease effluent limit violations exceeding TRC trigger level occurring during the period of Dec 2013-March 2014. IR did not acknowledge SNC status but it did evaluate in detail the various effluent limit violations. May 2015 CL contained detailed summary of effluent limit violations.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			DEC file shows formal case development activity in February 2016 that eventually led to a final Settlement Agreement (SA) completed in June 2016 covering these SNC level and other effluent violations. Even absent SNC conditions, a CL is not an ERG option for permit effluent limit violations. Here, effluent violations were SNC (i.e., exceeded TRC trigger level). More than CL – SNC level effluent limit violations during period of Dec 2013 – March 2014 require formal action per EPA SNC policy for Major facilities, and if no formal action, written justification for why informal action is justified. DEC file did not contain written justification for the CL issued in May 2015, approximately 15 months since prior SNC-related TRC exceedances. The June 2016 SA covers effluent violations for Dec 2012; Dec 2013; Feb-March 2014; and May 2015, over two years since last SNC-related TRC exceedance. Also, a CL is not an ERG option for major or gross sampling or monitoring deficiencies (e.g. , frequent or continued), or for either minor or major sampling procedure violations identified during a compliance inspection. Here, Aromatic Hydrocarbon limit violations (then only quarterly sampling required) in Dec 2012 and Feb 2014 triggered requirement for additional consecutive monthly monitoring until at least three consecutive months of compliance were demonstrated. Here, no additional sampling/monitoring was done. This is a major/gross sampling and monitoring violation that is frequent and continued for a WQS-based effluent limit. In accord with ERG, something more than CL was the appropriate enf. tool even in the absence of the SNC conditions and related effluent limit violations.n
	CL	4/3/17	Context: 3/23/17 inspection with evaluation period of 1/15-3/17.

Facility Name	Enf Tool	ET Iss Date	File Review Comments
			More than CL. CL is not an ERG option for the permit condition violations identified in this compliance inspection. For compliance inspections, a CL is not an ERG option for either minor or major sampling violations or for other violations of permit conditions (e.g., BMP, O&M, unauthorized discharge or bypass, record detention or record availability, etc.). Here, pH calibration log not being created/retained is a sampling and/or monitoring procedure that is frequent and was ongoing (not isolated or infrequent. In addition, IR says no employee training records being kept and BMP plan was not complete. Based on these violations, the CL was not an appropriate enf. tool.
US Coast Guard Kodiak	NOV	4/17/17	IR/NOV cite violation that permittee has an unauthorized discharge from pump house discharges to an oil water separator (OWS), into culvert then into bay. ERG does not have NOV as option for discharge without a permit (only COBC or CO in unintentional). Additionally, see Metric 7e comments. File evidence of permit effluent limit violations (pH) in May and July 2013 that are not identified and cited in the IR or NOV. Evidence of permit effluent limit exceedances for January, February and March 2017 in identified in IR are not expressly cited as violations in IR or NOV. Totality of other violations (e.g., effluent limit violations and permit condition violations) in addition to discharge-without-permit violation indicate an appropriate enf tool should be more than NOV.

"ET Iss Date" means Enforcement Tool Issuance Date.

ATTACHMENT G – Element 5 Penalties – Metrics 11a, 12a & 12b

RE: File Review Comments

Element 5 Penalties – Metric 11a

Nome Port Dock Expansion. DEC originally proposed to use an ESA as the formal enforcement tool. The ESA procedure uses a worksheet that has pre-determined penalties for specific violations, but the worksheet is not designed to include economic benefit considerations or calculations. Accordingly, the DEC file does not include any documentation related to economic benefit estimations/determinations. DEC pivoted to a SA as the final agreed-to formal enforcement document to address a legal dispute, which SA then included the designated ESA penalty amount. On this basis, this metric provision regarding economic benefit documentation is moot and not applicable.

Hilcorp Granite Point Tank Farm. Penalty memo only states a conclusion that facility did not gain any significant economic benefit from noncompliance without any explanation, discussion of relevant facts, reasons, etc. The statement regarding significant economic benefit indicates some benefit was derived which begs the question of how much benefit was estimated in order to make this significance determination/conclusion. In sum, memo does not explain the basis for the memo's conclusory statement.

Element 5 Penalties – Metric 12a

Trident Naknek. The DEC file had at least three different penalty determination reports with various penalty amounts (i.e., $269,000, $98,000, $76,000). There was no written documentation with any explanation or rationale on the final settled penalty of $35,000 and how DEC rationalized the penalty amount differences from the other determination reports.

Vallenar View MHP. DEC file does not contain any documentation of an apparent DEC ability-to-pay evaluation and determination. There was no written documentation explaining the penalty amount difference between initial settlement penalty calculation and the final COBC's $20,000 penalty.

Haxby Tract. January 11, 2017 memo acknowledges original penalty at $24,600 and final penalty at $15,100 without any written documentation explaining how the difference was derived (i.e., no reasons or rationale). Memo cites "negotiation with permittee" that that is a procedural statement, not a justification or reasoned discussion of the basis for the lower penalty amount. Revised penalty worksheet eliminated number of deficiencies/violations so there was no file basis from which the reviewer could derive DEC's rationale or justification.

Aurora Energy Chena Power Plant. There was no written record in DEC file showing the rationale or justification for the reduction of the original penalty memo's $23,685 settlement proposal to the final SA's $17,823. Without any written explanation, it appears the final settlement of $17,823 does not contain the economic benefit of $5862. In sum, the DEC file does not document the reasons/rationale for the reduction from the initial value calculated.

Element 5 Penalties – Metric 12b

Nome Port Dock Expansion. The City (Port owner/operator) challenged DEC's proposed ESA on the legal basis that the City was not obligated to get construction stormwater general permit coverage. DEC pivoted to a settlement agreement (SA) that expressly acknowledged this legal dispute and deferred any agreed-to-penalty payment of $6500 to future City violations for not getting CGP coverage. Consequently, no penalty was paid under this SA so the issue of Metric 12b application is moot and not applicable.

Hilcorp Granite Point Tank Farm. DEC file had not documentation showing the penalty was paid or collected. There is no documentation of any attempt to collect the penalty if payment was not made or made timely.

STATE REVIEW FRAMEWORK

Alaska

Resource Conservation and Recovery Act
Implementation in Federal Fiscal Year 2019

U.S. Environmental Protection Agency
Region 10

Final Report
August 16, 2021

I. Introduction

A. Overview of the State Review Framework

The State Review Framework (SRF) is a key mechanism for EPA oversight, providing a nationally consistent process for reviewing the performance of state delegated compliance and enforcement programs under three core federal statutes: Clean Air Act, Clean Water Act, and Resource Conservation and Recovery Act. Through SRF, EPA periodically reviews such programs using a standardized set of metrics to evaluate their performance against performance standards laid out in federal statute, EPA regulations, policy, and guidance. When states do not achieve standards, the EPA will work with them to improve performance.

Established in 2004, the review was developed jointly by EPA and Environmental Council of the States (ECOS) in response to calls both inside and outside the agency for improved, more consistent oversight of state delegated programs. The goals of the review that were agreed upon at its formation remain relevant and unchanged today:

1. Ensure delegated and EPA-run programs meet federal policy and baseline performance standards
2. Promote fair and consistent enforcement necessary to protect human health and the environment
3. Promote equitable treatment and level interstate playing field for business
4. Provide transparency with publicly available data and reports

B. The Review Process

The review is conducted on a rolling five-year cycle such that all programs are reviewed approximately once every five years. The EPA evaluates programs on a one-year period of performance, typically the one-year prior to review, using a standard set of metrics to make findings on performance in five areas (elements) around which the report is organized: data, inspections, violations, enforcement, and penalties. Wherever program performance is found to deviate significantly from federal policy or standards, the EPA will issue recommendations for corrective action which are monitored by EPA until completed and program performance improves.

The SRF is currently in its 4th Round (FY2018-2022) of reviews, preceded by Round 3 (FY2012-2017), Round 2 (2008-2011), and Round 1 (FY2004-2007). Additional

information and final reports can be found at the EPA website under State Review Framework.

II. Navigating the Report

The final report contains the results and relevant information from the review including EPA and program contact information, metric values, performance findings and explanations, program responses, and EPA recommendations for corrective action where any significant deficiencies in performance were found.

A. Metrics

There are two general types of metrics used to assess program performance. The first are **data metrics**, which reflect verified inspection and enforcement data from the national data systems of each media, or statute. The second, and generally more significant, are **file metrics**, which are derived from the review of individual facility files in order to determine if the program is performing their compliance and enforcement responsibilities adequately.

Other information considered by EPA to make performance findings in addition to the metrics includes results from previous SRF reviews, data metrics from the years in-between reviews, multi-year metric trends.

B. Performance Findings

The EPA makes findings on performance in five program areas:

- **Data** - completeness, accuracy, and timeliness of data entry into national data systems
- **Inspections** - meeting inspection and coverage commitments, inspection report quality, and report timeliness
- **Violations** - identification of violations, accuracy of compliance determinations, and determination of significant noncompliance (SNC) or high priority violators (HPV)
- **Enforcement** - timeliness and appropriateness of enforcement, returning facilities to compliance
- **Penalties** - calculation including gravity and economic benefit components, assessment, and collection

Though performance generally varies across a spectrum, for the purposes of conducting a standardized review, SRF categorizes performance into three findings levels:

Meets or Exceeds: No issues are found. Base standards of performance are met or exceeded.

Area for Attention: Minor issues are found. One or more metrics indicates performance issues related to quality, process, or policy. The implementing agency is considered able to correct the issue without additional EPA oversight.

Area for Improvement: Significant issues are found. One or more metrics indicates routine and/or widespread performance issues related to quality, process, or policy. A recommendation for corrective action is issued which contains specific actions and schedule for completion. The EPA monitors implementation until completion.

C. Recommendations for Corrective Action

Whenever the EPA makes a finding on performance of *Area for Improvement*, the EPA will include a recommendation for corrective action, or recommendation, in the report. The purpose of recommendations is to address significant performance issues and bring program performance back in line with federal policy and standards. All recommendations should include specific actions and a schedule for completion, and their implementation is monitored by the EPA until completion.

III. Review Process Information

Resource Conservation and Recovery Act (RCRA)

Due to the COVID-19 related travel restrictions, the SRF file review of Region 10's implementation of the RCRA Subtitle C program in Alaska was conducted remotely as an electronic file review during the period between June 2020 and February 2021. The key EPA review contacts were Elizabeth Walsh, Adam Klinger, Rachel Mirro and Fran Jonesi (lead Headquarters contact) Jonesi.Fran@epa.gov. The key Region 10 contacts were Jennifer Sullivan, Scott Wilder and Cheryl Williams (lead Regional contact) Williams.CherylB@epa.gov.

Executive Summary

Areas of Strong Performance

Region 10 implements the following aspects of the RCRA Subtitle C Program at a high level:

- Comprehensive evaluation inspection (CEI) reports are complete and contain sufficient documentation to allow compliance team to make compliance determinations.
- Compliance determinations, including findings that the facility is in significant noncompliance (SNC), are consistently accurate.
- One hundred percent of enforcement responses reviewed are appropriate to the identified violations and have returned sites to compliance.
- While there were few penalties for which gravity and economic benefit were required to be calculated, each of them was appropriately documented. Similarly, all files documented the rationale for the difference in the initial and the final penalty when the final value was lower than the initial calculated value.

- All penalty files documented the collection of the penalty.

Priority Issues to Address

The following are aspects of the RCRA Subtitle C program that, according to the review, are not meeting federal guidance and should be prioritized for management attention:

- Inspection reports are not completed in a timely manner.

Executive Summary

The sole Area for Improvement in the SRF Round 4 Alaska RCRA Program concerns Metric 6b, which measures the percentage of inspection reports reviewed that are completed in a timely manner. OECA found this metric to be an Area for Attention in the SRF Round 3 report.

In both SRF Round 3 and for part of SRF Round 4, OECA used 150 days as the applicable time frame for regions to complete inspection reports. In response to the Round 3 SRF review, Region 10 updated its Inspection Template with the 150-day timeframe and OECA notes that their inspection reports are generally now finalized in less than 150 days. In June 2018, however, OECA reduced the timeframe from 150 days to 60 days for EPA to finalize its own inspection reports when directly implementing a federal environmental program. This is the situation in Alaska, which does not have an authorized RCRA Subtitle C program, and where EPA, therefore, directly implements the RCRA Subtitle C program, including conducting inspections and developing inspection reports.

For purposes of this SRF review, OECA used 150 days as the applicable timeframe for those inspections conducted by Region 10 prior to the effective date of the new 60-day timeframe and used 60 days as the applicable timeframe for those inspections conducted afterward. Region 10 finalized its inspection reports within the applicable timeframe 3 out of 14 times, which despite the improvement, results in a finding of Area for Improvement.

Comparison between Round 3 and Round 4 Areas of Improvement Metric Findings

Metric	Round 3 Finding Level FY 2012	Round 4 Finding Level FY 2019
6b Inspection reports were not completed in a timely manner	Area for State Attention	Area of Improvement

Resource Conservation and Recovery Act Findings

RCRA Element 1 - Data

Finding 1-1
Meets or Exceeds Expectations

Recurring Issue:
No

Summary:

Region 10 completely and accurately entered the mandatory data into RCRAInfo 90% of the time.

Explanation:

OECA uses the SRF as the primary tool for evaluating a region's performance of how the region directly implements RCRA Subtitle C; therefore, it is essential that enforcement and compliance activities conducted by the Region be entered into RCRAInfo in a complete and accurate manner. The SRF process involves selecting a one-year period of performance and using the enforcement and compliance data from that review year to investigate a varied range of activities conducted by the region. If the data from that review year does not contain enough examples from a range of categories of facilities, i.e., facilities with informal or formal enforcement actions, significant noncompliance (SNC), or penalty actions, then activities from a prior fiscal year are selected to ensure the evaluation and findings are based on a sufficient number of activities.

The review year for this SRF review is FY2019. Because there were insufficient examples of facilities with formal enforcement actions, penalties, and facilities that were in SNC in FY2019, it was necessary to select 3 facilities from FY2017 and one facility from FY2018 in addition to the 20 facilities from FY2019. SRF policy is to review the additional 4 facilities from outside the review year by evaluating them exclusively for the metric they were selected for. Thus, for Metric 2b, which is the complete and accurate entry of mandatory data, OECA evaluated all of the RCRA data and file metrics for the twenty facilities with enforcement and compliance activities in FY2019. The supplemental 4 facilities were only evaluated for SNC, formal enforcement actions, and/or penalties. In 4 cases, it was necessary to select the same facility for FY2019 and for a prior year.

OECA compared file documentation from each of the 20 facilities evaluated for Metric 2b with data from the ECHO Detailed Facility Report and RCRAInfo to determine whether minimum data requirements (MDRs) are completely and accurately reflected in RCRAInfo. The MDRs include such facility information as facility identifying information, inspections and compliance evaluations, noncompliance and significant noncompliance (SNC), informal and formal enforcement actions, and penalty documentation. In 18 out of 20 facilities, or 90% of the files reviewed, Region 10 accurately entered all required minimum data requirements associated with

each of the 20 facilities into RCRAInfo. There were 2 facilities where one or more minimum data requirements was either missing or inaccurate.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State Total
2b Accurate entry of mandatory data [GOAL]	100%		18	20	90.0%

Region 10 Response

The Region disagrees with the finding for two of the facilities. The data in RCRAInfo accurately reflected the documentation in the file. In these two instances the Reviewers believed that not all areas of concern articulated in the inspection reports were documented in RCRAInfo as violations. As explained to the Reviewers, the Region believes it is the inspector's job to document his/her observations and highlight areas of concern which may or may not be a violation. It is up to a case officer to make violation determinations. The data in RCRAInfo accurately documented the inspection documentation as well as the violation documentation that was present in the files. The Region, however, agrees with the Reviewers, that the case officer did not include some violations in the follow-up enforcement that should have been identified and therefore accurate compliance determinations were not made.

OECA Clarification Regarding Region 10 Response

OECA agrees with Region 10's position that for two of the four facilities originally found by OECA to be inaccurately reflected in RCRAInfo, the issue instead is an inaccuracy in compliance determination. OECA, therefore, changed the number of files reviewed which accurately reflects the national data system from 16 out of 20 to 18 out of 20, as now indicated in the metric table 2b above.

RCRA Element 2 - Inspections

Finding 2-1

Meets or Exceeds Expectations

Recurring Issue:
No

Summary:

Inspection reports are complete and sufficient to determine compliance. Region 10 met its goals for inspection coverage, meeting or exceeding the national goals for all inspection coverage areas.

Explanation:
Metric 6a requires inspection reports to include a narrative discussion that explains the facility's activities, its manufacturing and waste management operations at the facility, the generation and handling of wastes, and observations from the inspection which may be violations along with supporting evidence supporting such a finding of noncompliance by the compliance team. Inspection reports should also include all documentation which provide evidence of potential violations such as statements, photographs, maps, copies of permits and records. OECA selected a total of 24 facilities for this review. There were 12 LQGs, 5 of which also were TSDFs, 5 VSQGs (formerly CESQGs), 3 SQGs, and 4 facilities listed as "other."

Region 10 utilizes a standardized format for each inspection report, organizing the report into 4 sections: Section A includes basic facility and inspection information, Section B describes the general facility information and gives information about the owner/operator and background and history of the facility, Section C provides relevant regulatory information including the compliance history, regulatory status, and Section D provides a complete description of the unannounced inspection, including description of the inspector's presentation of credentials, date and time of arrival, and a list of the personnel with whom the inspector met with. Section D also contains the details about the opening and closing conference and contains the most detailed information in a summary of the inspection. Each inspection report includes attachments containing the photo log and a CD containing all photos taken during the inspection.

During the selected review year of FY2019, Region 10 conducted inspections at 14 out of the 24 facilities selected to be evaluated for this review. Each of the 14 inspection reports contained an explanation of the facility’s activities and a description of all areas of the facility, along with extensive photographs. At 13 out of 14 inspections, or 92.9% of the time, Region 10 prepared detailed reports which contained sufficient documentation and thorough observations about potential violations to determine the compliance status of the facility. For one out of 14 facilities, there was an omission of the potential violation and correspondence subsequent to inspection, as well as an omission of the subsequent NOV identifying another waste of concern.

Regarding inspection coverage, Metric 5a addresses the two-year inspection coverage of operating TSDFs. In FY2019, there were three operating TSDFs in Alaska. Region 10 conducted CEIs at all 3 facilities in Alaska over the two-year period (2 of the operating TSDFs were inspected in 2019).

Metric 5b addresses the annual inspection coverage of LQGs using the Biennial Report universe. Region 10 does not have an alternative compliance monitoring strategy (CMS) and follows EPA’s 2015 CMS which requires that the Region must annually inspect at least 20% of the LGQ universe, so that the entire universe is inspected every five years. Region 10 met the national goal of 20% by conducting inspections at 22.9 % of the active RCRA BR LQGs (8 out of 35 facilities).

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State Total
6a Inspection reports complete and sufficient to determine compliance [GOAL]	100%		13	14	92.9%
5a Two-year inspection coverage of operating TSDFs [GOAL]	100%	95.5%	3	3	100%
5b Annual inspection of LQGs using BR universe [GOAL]	20%	16%	8	35	22.9%

RCRA Element 2 – Inspections

Finding 2-2

Area for Improvement

Recurring Issue:
Recurring from Round 3

Summary:

Conducting inspections in Alaska poses somewhat unique challenges. Low seasonal temperatures and shorter daylight hours create a limited timeframe to conduct inspections and the ability to group several inspections together is not always possible due to the vast distances between facilities. Region 10 has been thoughtful about scheduling and conducting inspections for Subtitle C facilities to meet these challenges and seeks to maximize the time in the field for inspectors when circumstances are conducive, This review has identified a deficiency in the inspection process in that inspection reports are not completed in a timely manner, as established in national guidance. This was the case in the SRF Round 3 review and although improved, remains the case in Round 4.

During the Round 3 SRF review in 2013, OECA found this area to be an Area for Attention because Region 10 finalized inspection reports within the applicable 150-day timeframe 66.6% of

the time. While Region 10 has made progress in reducing the time for finalizing inspection reports since Round 3, the Round 4 SRF review finds that only 21.4% of inspection reports were finalized within the applicable timeframe, which for most of the inspections reports reviewed in this report is now 60 days.

Explanation:

Metric 6b evaluates the timeliness of inspection report completion. EPA's 2003 Hazardous Waste Civil Enforcement Response Policy requires that determinations of a violation are made within 150 days from the first day of the first inspection (Day Zero). For Metric 6b, EPA used 150 days as the applicable time frame for regions to complete inspection reports during SRF Round 3 and for Round 4. During the Round 3 SRF review, OECA found that Region 10 took longer than 150 days to finalize one third of their inspection reports, took longer than 200 days for 5 of those reports and took longer than 300 days for 3 of those reports. One report remained incomplete 711 days after Day Zero at the time of issuance of the SRF Review. As a result, OECA issued a finding of Area of Attention during the 2013 Round 3 SRF review for this metric.

Since 2013, Region 10 has adopted several practices which have resulted in better inspection report timeliness. Shortly after the Round 3 review, Region 10 updated its Inspection Template to include timeframes and OECA reviewed the template and found it to be complete. Reviewers noted and appreciate the progress Region 10 has made to improve the timeliness of their inspection reports such that, according to the Round 4 SRF review, they are generally finalized in less than 150 days (the average is 99 days).

On June 29, 2018, OECA issued the final Interim Policy on Inspection Report Timeliness and Standardization (Interim Inspection Report Policy), which reduced the timeframe for finalizing RCRA inspection reports from 150 days to 60 days. The effective date of the Interim Inspection Report Policy was based on a phased-in approach, depending on the region and the media program. The 60-day timeframe became effective for Region 10 for RCRA Subpart C facilities beginning January 2019. Because this Round 4 SRF Report reviewed data from FY2019, which began October 1, 2018, for purposes of this SRF review, OECA used the inspection report completion timeframe of 150 days for any facilities reviewed with inspections occurring during the first quarter of FY2019, from October 1, 2018 until December 31, 2018. OECA used the inspection report completion timeframe of 60 days for facilities reviewed with inspections occurring between January 1, 2019 and September 30, 2019.

Out of the 14 inspections occurring during FY2019, 4 of them occurred during the first quarter of FY2019 (October 1, 2018 thru December 31, 2018) and 10 of them occurred during the next three quarters of FY2019 (January 1, 2019 through September 30, 2019). Out of the 4 inspections conducted by Region 10 in the first quarter of 2019, Region 10 finalized inspection reports within 150 days in 2 out of 4 inspections. Out of the remaining 10 inspections occurring during the next three quarters of FY2019, between January 1, 2019 and September 30, 2019, Region 10 finalized inspection reports within 60 days only one out of 10 times. Thus, out of 14

inspection reports finalized by Region 10 during the FY 2019 review year, Region 10 finalized its inspection reports within the applicable timeframe 3 out of 14 times, or 21.4%.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State Total
6b Timeliness of inspection report completion [GOAL]	100%		3	14	21.4%

Rec #	Due Date	Recommendation
1	June 30, 2022	Region 10 will complete its inspection reports within 60 days of the last date of the inspection. Region 10 will send 10 consecutive completed inspection reports for inspections conducted since October 1, 2019 to reviewers for evaluation. Reviewers will measure success and close this recommendation by evaluating the 10 consecutive inspection reports to determine that the reports are finalized within 60 days of the last date of the inspection at least 75% of the time. Due date: September 30, 2022

Region 10 Response

While the Region appreciates the Reviewers taking into account the changing requirement for timeliness of inspection reports that occurred during the review year by calculating both inspection report completion goals, we are disappointed that the Reviewers didn't give credit for the significant decrease in the amount of time in which that our inspection reports were finalized during the review year. As the file review spreadsheet indicates, the Region averaged 99 days to complete all inspection reports reviewed. We suggest that the finding should show that we meet national expectation of completing inspection reports within 150 days 80% of the time (12/14 files) but that we were unable to meet the new EPA goals of completing the inspection report within 60 days and sending it to the facility in 70 days during the review year.

The Region rejects the recommendation as unnecessary work and asks that the Reviewers rely on data that is already being collected and reported in ICIS be used to measure our improvement from the 2019 data. We also ask, if using the new timeliness goal that the policy that set that goal be used in whole. In that document, the goal is for 75% of inspection reports to be completed within 60 days and sent to the facility within 70 days: not 100% .

RCRA Element 3 - Violations

Finding 3-1
Meets or Exceeds Expectations

Recurring Issue:
No

Summary: Region 10 makes accurate compliance determinations based on observations in the inspection reports which describe potential violations. Region 10 accurately determined compliance 85.7% of the time.

Explanation:
Metric 7a evaluates the percentage of inspection reports reviewed that lead to accurate compliance determinations. In 12 out of 14 facilities, Region 10 made accurate compliance determinations after reviewing the observations listed in the inspection reports. At both facilities, the inspection report described observations that would have been expected to result in an identified violation. For example, the inspection report describes undocumented inspection logs and the failure to demonstrate universal waste accumulation time.

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State Total
7a Accurate compliance determinations [GOAL]	100%		12	14	85.7%

RCRA Element 3 - Violations

Finding 3-2
Meets or Exceeds Expectations

Recurring Issue:
No

Summary: Region 10 identified the facility in SNC during FY2019 within the applicable timeframe of 150 days. For Metric 8c, Region 10 made appropriate SNC determinations 86.7% of the time (13 out of 15 times).

Explanation:
For Metric 7b, Region 10 found 8 facilities out of 14 (57.1%) had violations as determined by the case officer based on observations made during CEI and FCI compliance evaluations.

For Metric 2a, there were 6 longstanding secondary violators.

Metric 8b evaluates the percentage of SNC determinations made within 150 days of Day Zero. Region 10 made the SNC determination at the one facility evaluated during the review year of 2019 which was in significant noncompliance within the 150-day timeframe.

Metric 8c: The Hazardous Waste Civil Enforcement Response Policy (ERP) defines SNC as "those violators that have caused actual exposure or a substantial likelihood of exposure to hazardous waste or hazardous waste constituents, are chronic or recalcitrant violators, or deviate substantially from the terms of a permit, order, agreement or from RCRA statutory or regulatory requirements." In the event of a secondary violation, if the facility does not come into compliance within 240 days, then the implementing agency should reclassify the site as an SNC. Metric 8c evaluates the percentage of files reviewed in which significant noncompliance (SNC) status was appropriately determined during the review year. Out of the files that were reviewed in FY2019, there was only one facility that was in SNC; therefore, OECA selected 4 additional files which contained facilities in SNC, which were evaluated exclusively for Metric 8c. Out of the 15 facilities which were determined to have violations, Region 10 correctly determined the SNC status in 13 out of those 15 facilities, resulting in a rate of 86.7%. At 2 facilities, Region 10 failed to correctly characterize the facility as being in SNC. One of these instances was due to the recalcitrant nature of the facility.

Relevant Metrics

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State Total
7b Violations found during CEI or FCI inspections	N/A		8	14	57.10%
8a SNC identification rate (for CEIs and FCIs)	N/A		1	33	3%
8b Timeliness of SNC determinations[GOAL]	100%	39.6%	1	1	100%
2a Longstanding secondary violations	N/A				6
8c Appropriate SNC determinations [GOAL]	100%		13	15	86.7%

Region 10 Response

The Region disagrees with the Reviewers determination that either of the facilities indicated should have been identified as a SNC. In the case that the Reviewers highlight as a recalcitrant facility, three years prior the Region did find violations (that resulted in a SNC determination and formal enforcement). Those violations included the failure to conduct weekly inspections, incomplete manifests, and failure to make hazardous waste determinations on waste streams at two different locations of the facility. There were also some less significant violations of the universal waste regulations. For the inspection in question that the Reviewers indicate should have led to a SNC determination, the violations included four drip pans that contained lead contaminated antifreeze (but no evidence that the lead failed TCLP), some mismanaged aerosol cans, and some mismanaged universal waste. Although the universal waste was a repeat violation, taken on whole, the violations found in 2019 involved a limited amount of waste, didn't result in significant deviation from the regulations and were unlikely to result in the exposure or a release. The facility should not have been determined a SNC based solely on the fact that the facility appeared to be recalcitrant.

For the second case, although there were multiple violations, the violations were minor and involved the mismanagement of aerosol cans and leather gloves that were no longer wearable. None of the violations caused the likelihood of a release, did not represent a significant deviation

from the regulations and did not indicate the facility was recalcitrant. All violations were easily corrected.

The Region requests this metric be amended to show 100% appropriate SNC determinations were made for the files reviewed.

RCRA Element 4 - Enforcement

Finding 4-1

Meets or Exceeds Expectations

Recurring Issue: No

Summary:
Region 10 takes timely enforcement actions to address identified violations. Appropriate enforcement actions were taken to address violations, and all of the formal and informal enforcement actions resulted in the facilities' return to compliance.

Explanation:
Metric 9a evaluates the percentage of enforcement responses that have returned or will return sites in significant noncompliance or secondary violation to compliance. 100% (11 of 11) of Region 10's formal and informal enforcement actions have resulted in a return to compliance, meeting the national goal of 100%. For Metric 10b, 12 out of 12 enforcement actions taken by Region 10 were determined to be appropriate, resulting in a rate of 100% and meeting the national goal of 100%. At the only facility in SNC, during the review year, Region 10 took timely enforcement to address the SNC in accordance with Metric 10a, which measures the percentage of SNC violations addressed with a formal enforcement action.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State Total
9a Enforcement that returns sites to compliance [GOAL]	100%		11	11	100%
10b Appropriate enforcement taken to address violations [GOAL]	100%		12	12	100%
10a Timely enforcement taken to address SNC [GOAL]	100%	28%	1	1	100%

RCRA Element 5 - Penalties

Finding 5-1

Meets or Exceeds Expectations

Recurring Issue:
No

Summary:
Three out of three penalty actions for which economic benefit and gravity were required to be considered in their penalty calculations, included the documentation for economic benefit and gravity. All files reviewed for penalties contained the documentation of the rationale for the difference between initial penalty calculation and final penalty when it is lower than the initial calculated value, along with documentation that the penalty had been collected.

Explanation:
Metric 11a evaluates the percentage of penalty calculations reviewed that document, where appropriate, gravity and economic benefit. Three out of the three penalties reviewed which required the consideration of gravity and economic benefit, included the gravity and economic penalty components. One additional penalty was reviewed which did not require consideration of economic benefit and gravity because it was an Expedited Settlement Agreement, which, pursuant to the EPA RCRA Expedited Settlement Policy, uses a different method of penalty calculation.

For Metric 12a, OECA evaluated four penalty actions to determine the percentage of penalties that document the rationale for the final value when it is lower than the initial calculated value. All four

penalty actions included a final penalty value which was lower than the initial calculated value. In all four of those cases, the file contained the documentation for the rationale for the difference between the initial and final penalty.

For Metric 12b, four out of four files contained documentation showing that penalties were collected, including copies of the cancelled checks.

Relevant metrics:

Metric ID Number and Description	Natl Goal	Natl Avg	State N	State D	State Total
11a Gravity and economic benefit [GOAL]	100%		3	3	100%
12a Documentation of rationale for difference between initial penalty calculation and final penalty [GOAL]	100%		4	4	100%
12b Penalty calculation [GOAL]	100%		4	4	100%
