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%