February 9, 2012

State Review Framework

Commonwealth of Kentucky
Department for Environmental Protection
Round 2 Report
for Federal Fiscal Year 2009

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I. EXECUTIVE SUMMARY

Major Issues

The State Review Framework (SRF) review of the Commonwealth of Kentucky Department for Environmental Protection (KDEP) identified the following major issues:

- There are continued problems in all three media from Round 1 of the SRF for penalty calculations and documentation. Initial and final penalty calculations are not maintained, so the Environmental Protection Agency (EPA) could not determine if gravity and economic benefit had been calculated and recovered.
- Many of the SRF Round 1 recommendations, particularly for the Clean Water Act (CWA program, were contingent upon the implementation of improvements by KDEP for data management, inspection reports, and timely and appropriate enforcement of violations. The Round 2 review found that many of the problems identified are continuing and resolution by the State has not yet occurred.

Summary of Programs Reviewed

I. Clean Air Act Program

The problems which necessitate state improvement and require recommendations and actions include:

- Inaccurate reporting of Minimum Data Requirements (MDR) data into the Air Facility Subsystem (AFS), including incomplete stack test data and missing results for the Title V annual compliance certification reviews
- Appropriate Compliance Status code is often not reported into AFS.
- Taking longer than 270 days to address High Priority Violation (HPV)
- Penalty documentation does not include gravity and economic benefit calculations
- Penalty documentation does not document the rationale for any differences between the initial and final penalty calculations

Areas meeting SRF program requirements or with minor issues for correction include:

- Date Completeness
- Timeliness of Data Entry
- Completion of Commitments
- Inspection Coverage
- Quality of Inspection or Compliance Evaluation Reports
- Identification of Significant Non-Compliance (SNC) and HPV
- Enforcement Actions Promote Return to Compliance

II. Clean Water Act/National Pollutant Discharge Elimination System Program

The problems which necessitate state improvement and require recommendations and actions include:

- Incomplete MDR data in national data system
- Data reported into national data system is not accurately entered and maintained
- Five program tasks in FY2009 Clean Water Act (CWA) Section §106 Work Plan were not met
- Mining inspection reports were not complete and did not contain the necessary documentation so that proper compliance determinations could be drawn.
- Single event violations (SEVs) are not reported in the national database; however, accurate compliance determinations are made.
- Enforcement actions generally do not include complying or corrective action that will return facilities to compliance in a specified time frame for SNC facilities; however, complying or corrective actions are included for non-SNC facilities.
- Timely or appropriate enforcement actions are not generally taken for SNCs in accordance with the National Pollutant Discharge Elimination System Program Enforcement Management System (NPDES EMS)
- Penalty documentation does not include gravity and economic benefit calculations
- Penalty documentation does not document the rationale for any differences between the initial and final penalty calculations

Areas meeting SRF program requirements or with minor issues for correction include:

- Timeliness of Data Entry
- Inspection Coverage
- Identification of SNC and HPV

III. Resource Conservation and Recovery Act Program

The problems which necessitate state improvement and require recommendations and actions include:

- Penalty documentation does not include gravity and economic benefit calculations
- Penalty documentation does not document the rationale for any differences between the initial and final penalty calculations

Areas meeting SRF program requirements or with minor issues for correction include:

- Data Completeness
- Data Accuracy
- Timeliness of Data Entry

- Completion of Commitments
- Inspection Coverage
- Quality of Inspection or Compliance Evaluation Reports
- Identification of Alleged Violations
- Identification of SNC and HPV
- Enforcement Actions Promote Return to Compliance
- Timely and Appropriate Action

II. BACKGROUND INFORMATION ON STATE PROGRAM AND REVIEW PROCESS

The State Review Framework (SRF) is a program designed to ensure EPA conducts oversight of state and EPA direct implementation compliance and enforcement programs in a nationally consistent and efficient manner. Reviews look at 12 program elements covering data (completeness, timeliness, and quality); inspections (coverage and quality); identification of violations; enforcement actions (appropriateness and timeliness); and penalties (calculation, assessment, and collection).

Reviews are conducted in three phases: analyzing information from the national data systems; reviewing a limited set of state files; and development of findings and recommendations. Considerable consultation is built into the process to ensure EPA and the state understand the causes of issues, and to seek agreement on identifying the actions needed to address problems.

The reports generated by the reviews are designed to capture the information and agreements developed during the review process in order to facilitate program improvements. The reports are designed to provide factual information and do not make determinations of program adequacy. EPA also uses the information in the reports to draw a "national picture" of enforcement and compliance, and to identify any issues that require a national response. Reports are not used to compare or rank state programs.

A. GENERAL PROGRAM OVERVIEW

The information contained in this section, including agency structure, resources, data reporting systems, and accomplishments and priorities was provided by KDEP and was not verified by EPA for the SRF Report.

Agency Structure

The Kentucky Department for Environmental Protection (KDEP) is one of the three departments in the Commonwealth of Kentucky Energy & Environment Cabinet (EEC). Kentucky is one of four states of the United States that designates itself as a Commonwealth. For purposes of this report, the word "state" means "commonwealth." The EEC was formed in June 2008, combining the environmental and mineral functions of the former Environmental & Public Protection Cabinet (EPPC) with the Governor's Office of Energy Policy. The other two EEC departments

are the Department for Natural Resources (KYDNR) and the Department of Energy Development & Independence.

Within KDEP, there are six divisions responsible for carrying out compliance and enforcement activities:

- Division for Air Quality (DAQ) – With the exception of one county, the DAQ regulates state and federal air pollution standards through technical assistance to industries, and inspection of sources and enforcement of violations. The Louisville Metro Air Pollution Control District (LMAPCD) is responsible for implementing the local air program in Jefferson County, Kentucky.
- Division of Water (DOW) – This Division is the primary agency responsible for implementing and enforcing most of the state and federal drinking water and CWA programs in Kentucky. At coal operations, KDEP shares the responsibility of regulatory oversight with the KYDNR (see "Roles and Responsibilities" section below).
- Division of Waste Management (DWM) – DWM regulates the management of hazardous and solid wastes in Kentucky.
- Division of Enforcement (DENF) - The DENF is the centralized organization for compliance and enforcement activities. DENF is a multimedia division and addresses issues in the air, waste, and water programs.
- Division of Compliance Assistance (DCA) - DCA provides assistance to individuals and businesses in their efforts to comply with Kentucky's environmental requirements. The DCA's current programs include: KY EXCEL; Brownfields; Compliance Assistance; Operator Certification; and Small Business Air Quality.
- Division of Environmental Program Support (DEPS) – The responsibilities of this division include centralized laboratory testing for the Kentucky EEC, emergency response, data management, and administrative/facility support.

Compliance/Enforcement Program Structure

KDEP's central office is located in Frankfort, Kentucky. The Air Quality, Waste Management and Water divisions each have regional offices which perform the department's duties on a local level, including inspections, complaints, and informal enforcement actions. KDEP has a centralized multi-media enforcement division, the DENF, which is responsible for formal civil actions for all KDEP programs. DENF also manages strategic enforcement planning, budget, and compliance activities for violations referred from the central Frankfort office.

Roles and Responsibilities

Violation discovery may be through an inspection of the regulated site by a regional office inspector, or it may come from routine monitoring reports that the regulated entity is required to submit on a schedule. The regional offices also respond to citizen complaints. Informal enforcement responses resulting from inspections and complaints are typically handled by the regional offices. Formal enforcement cases are referred to DENF, and primarily originate from the regional offices, but may also originate from the central KDEP office.

After a case has been researched, and the basis and scope of the enforcement action has been

fully developed, a Case Resolution Proposal is prepared. The proposal outlines the merits of the case, proposes the necessary remedial actions, proposes penalties for settlement discussions, and discusses the factors considered in developing the proposed penalties. During the course of a case negotiation, it may be necessary to revise the proposed settlement in the Case Resolution Proposal. A memorandum discussing the changes from the original Case Resolution Proposal is prepared that describes the reasons for the settlement changes. This memorandum is filed with the original Case Resolution Proposal.

DENF takes all reasonable steps to resolve an enforcement case prior to seeking litigation. Case actions are executed through either a Demand Letter or an Agreed Order.
The appropriate document is selected based on the following criteria:

- Demand Letters are unilateral orders and are appropriate to use for cases where the assessment of civil penalty is the primary issue, and remedial measures are general or very simple.
- Agreed Orders (AO) are used if any of the following apply:
  - The responsible party wishes to have the settlement executed in an AO;
  - Any of the remedial measures have a required deadline that extends more than 90 days from the effective date of the resolution document;
  - The DENF is allowing installment payments of a civil penalty;
  - The DENF is imposing performance or probated penalties; or
  - SEPs are part of the settlement.

The EEC has the option to file petitions for a direct referral for administrative hearing without issuing prior Letters of Warning or Notices of Violation (NOVs), and without referring the violations for civil enforcement negotiations through DENF. Direct referrals are used only with the approval of upper KDEP management. Once the complaint has been filed with the Office of Administrative Hearings, the Hearing Officer may decide to send the matter to mediation. The intent of mediation is for the regulated entity and the Cabinet to resolve the issue and develop an Agreed Order without going through the formal hearing process.

If the case proceeds to administrative hearing, at the conclusion of the hearing, the Hearing Officer is required to produce a report and recommended order for the Cabinet Secretary. Both documents are required to contain a finding of fact and a conclusion of law. The Cabinet Secretary may remand the matter to the Hearing Officer, adopt the report and recommended order as the final order, or issue the Secretary's own final order. Appeals and judicial reviews of final orders of the Cabinet are filed in Franklin Circuit Court. The Cabinet can also seek an injunction, file a civil suit, or file penalty-only actions in Franklin Circuit Court.

The EEC Secretary may also issue Abate and Alleviate Orders in situations that present conditions or activities that constitute a danger to public health or welfare or are likely to result in substantial damage to natural resources. The Cabinet Secretary is required to immediately notify the Governor when an Abate and Alleviate Order is issued. An administrative hearing must be scheduled within ten days of the issuance of an Abate and Alleviate Order.

For coal operations, KDEP shares regulatory responsibilities with KYDNR for the oversight of CWA NPDES permits. Since 1983, KYDNR or its precursor, the Department for Surface Mine

Reclamation and Enforcement, has been designated as the primary agency responsible for inspection and enforcement of Kentucky Pollutant Discharge Elimination System (KPDES) general and individual permits on coal operations by a *Memorandum of Understanding* (MOU) between what is now KYDNR and KDEP. The MOU covers Coal General KDPES Permits and individual KPDES permits on coal operations with the exception of sanitary wastewater discharges which are still inspected and enforced by KDEP. The most recent revision of the MOU, signed in March 2007, set out the responsibilities of the respective departments and specified procedures to bring more consistency to the handling and enforcement of discharge monitoring reports in the two departments. KYDNR conducts reviews of DMRs for the KPDES Coal General Permit and the KPDES Individual Permits for coal facilities and notifies the regulated entities of KPDES permit violations through its Coal DMR Letters. These letters function as letters of warning. When a regulated entity has received three Coal DMR Letters, these letters are referred to the KDEP's DENF. An NOV is issued by DENF citing the violations under KRS 224, and a formal enforcement action is initiated.

Local Agencies Included/Excluded from Review

LMAPCD is the responsible agency for implementing the local air program in Jefferson County, Kentucky. This agency was also evaluated under the SRF Round 2 in 2010, and the final report is available on EPA's website: http://www.epa.gov/oecaerth/state/srf/index.html. The report can be found under the "Kentucky" section of the website in the SRF Round 2 column.

Resources / Staffing / Training

The resource information represents the Full Time Equivalent (FTE) positions for the implementation of the state's compliance and enforcement programs reviewed under the SRF.

CAA Resources – There are approximately 61.6 FTEs available to implement the state's CAA compliance monitoring and enforcement program, which includes 7.6 positions in the central office and 54 positions in the eight regional offices. As of December 2010, there were two vacant source inspector positions in the Paducah regional office.

KDEP - CAA Compliance & Enforcement FTE	
Field Offices	FTE
Ashland	8
Bowling Green	6
Florence	6
Frankfort	9
Hazard	6
London	4
Owensboro	6
Paducah	9
Subtotal	**54**
Central Office	
Division for Air Quality	3
Division of Enforcement	4.6

Total	**61.6**

NPDES Resources - KDEP has approximately 59.9 FTEs that are directly involved in CWA compliance monitoring and enforcement activities, including regional field office efforts, and main office efforts, including regional field office management and administration, wet weather and pretreatment program implementation, compliance data review and management, and supervisory/management. Of these resources, 37.2 are located in the ten regional offices.

KDEP – CWA NPDES Compliance & Enforcement FTE	
Field Offices	FTE
Bowling Green	4.0
Columbia	4.0
Florence	3.7
Frankfort	3.5
Hazard	4.2
London	3.5
Louisville	3.7
Madisonville	4.2
Morehead	3.8
Paducah	2.6
Subtotal	**37.2**
Central Office	
Division of Water	15
Division of Enforcement	7.7
Total	**59.9**

DOW's general fund annual allotment has been reduced by 20% ($2.1 million) over the last five years. DOW general fund reductions are disproportionally realized on the permitting programs, monitoring programs and inspections as these programs are significantly more dependent on general funds than other programs.

The total number of KDEP staff identified as working on compliance monitoring and enforcement program activities is 59.9 FTEs spread over 79 personnel positions (whole or partial FTE). This number includes 37.2 FTEs in the DOW Regional Field Offices, and 15 FTEs in the Pre-treatment and Wet Weather programs in the central office as well as supervisory and management staff. DOW anticipates that over the next biennium the program will be funded to keep personnel at this level. Some vacancies generally occur (approximately 6-8%), but the funded effort is anticipate to remain at this level for at least the next biennium.

In addition, KYDNR has approximately 23.7 FTEs supporting oversight of NPDES compliance of coal operations in the Division of Mine Reclamation and Enforcement, primarily in five regional office locations in the state.

RCRA Resources – There are approximately 51.1 FTEs dedicated to implement the RCRA hazardous waste program. This includes 47 FTEs in ten field offices and 4.1 FTEs in the Frankfort central office.

KDEP – RCRA Compliance & Enforcement FTE	
Field Offices	FTE
Bowling Green	4
Columbia	4
Florence	6
Frankfort	6
Hazard	4
London	2
Louisville	7
Madisonville	5
Morehead	4
Paducah	5
Subtotal	**47**
Central Office	
Division of Waste Management	3
Division of Enforcement	1.1
Total	**51.1**

The DWM general fund budget has been cut by over 30% since July 1, 2008. Over the same time period there has been no increase in the RCRA grant. This has eliminated the Field Operations Branch's budget for training and the associated travel to attend training made available by EPA. The Field Operations Branch has developed an in-house training program for new inspectors, providing the basic knowledge required to conduct RCRA inspections; however, without the additional training made available by EPA it would not be unexpected to see a decline in the quality of future inspections. Another factor that may be influenced by the funding cuts is inspector turnover. Pay has been frozen for state employees during FY2011 and 2012. This may cause inspectors to seek promotion opportunities and higher pay outside the Field Operations Branch. The funding cuts have reduced the total number of RCRA inspections conducted between FY2009 and FY2010. This trend is expected to continue if further cuts are made in subsequent state budgets.

In January 2010, a RCRA inspector in the Frankfort Regional Office transferred to an inspector position with the Blue Grass Army Depot (DOD) section. The RCRA position has remained unfilled since that time. KDEP anticipates hiring a replacement during the second quarter of FY2011. It will be a year before an inspector will be fully trained to conduct all inspections that constitute the RCRA universe found in the Frankfort Regional Office. This is important to note because the Frankfort Region is second only to the Louisville Region in the number of registered RCRA facilities. In the interim, Field Operations has detailed inspectors from Louisville to

conduct inspections in the Frankfort Region. This should provide minimum coverage of the LQG and SQG universe in the region. The delay in hiring a replacement will put the branch in a position of playing catch up through 2013.

Data Reporting Systems/Architecture

CAA - In TEMPO, "flagged" data is automatically uploaded to an interim flat file. One central office employee implements EPA's Universal Interface (UI) on at least a monthly basis (now generally weekly) and uploads data from the TEMPO flat file to the UI that uploads quality controlled data to AFS. The central office employee also routinely compares data in AFS to TEMPO data on a periodic basis to identify and correct discrepancies. This person also accesses AFS to manually complete certain tasks such as linking HPVs to AFS enforcement data.

CWA – KDEP converted from EPA's CWA Permit Compliance System (PCS) to the Integrated Compliance Information System (ICIS-NPDES) in February 2011. Kentucky is a pilot state, and will partially flow data via the exchange. Kentucky is currently working to implement Net DMR contingent on acceptance of KDEP's CROMERR application.

The following data is entered directly into EPA's national database:

Permit Facility Data (excluding General Stormwater Construction permits)
Permit Tracking Data (excluding General Stormwater Construction permits)
Permit Limits
Discharge Monitoring Reports (DMRs)
Inspections
Pretreatment Inspections (received from the Pretreatment Coordinator approximately two times a year)
Enforcement Actions
Informal enforcement actions from DOW Regional Field Offices
Compliance Schedules
The remaining data elements are reported through the following processes:

General Stormwater Construction Permits Facility Data and Permit Tracking Data (TEMPO-state data system) – A data extract is pulled weekly from the TEMPO data system using ASCII Delimited and uploaded into the Federal database.

The following data is entered directly into EPA's national database:

RCRA - RCRAInfo compliance is updated by the DWM Hazardous Waste Branch's Administrative Section. After inspectors from the DWM Field Operations Branch conduct an inspection, a data input form is completed in the Hazardous Waste Compliance and Enforcement Log. This is forwarded electronically to the Hazardous Waste Branch within five days of the completion of the inspection for input into RCRAInfo.

The state's data system is TEMPO. The inspector conducting the inspection is responsible for inputting all appropriate inspection information into TEMPO. Under the Field Operations Branch's business rules the inspector has 20 days from the completion of the inspection to

complete his/her inspection report. RCRA Info and TEMPO are two complete and separate systems that do not interface in any manner.

As enforcement cases progress, DENF staff complete CMEL data forms. These forms are forwarded to the Hazardous Waste Branch's Administrative Section for data entry.

B. Major State Priorities and Accomplishments

The SRF is designed to evaluate specific compliance and enforcement elements, and there may be state priorities and accomplishments that are not captured in the SRF findings. EPA acknowledges the efforts by Kentucky that contribute to the mutual goals of ensuring compliance and promoting environmental stewardship. The following Kentucky priorities and accomplishments were provided by the state. However, the information has not been verified by EPA and may reflect activities that were not ongoing during the time period of the SRF review (FY2009):

CAA Priorities - Inspection priorities are dictated by EPA Compliance Monitoring Strategy (CMS) and Division goals. Field staff completes a Full Compliance Evaluation (FCE) at all major sources (including conditional majors that take a limit to avoid Title V) every two calendar years. The inspector conducting the inspection is responsible for inputting all appropriate inspection information into TEMPO. Under the Field Operations Branch's business rules the inspector has 20 days from the completion of the inspection to complete their inspection report.

The following measures are used to track the level of success in meeting the DAQ's CMS goals;
Number of major stationary source inspections conducted
Number of minor stationary source inspections conducted
Number of routine (non-complaint) asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP) and Asbestos Hazard Emergency Response Act (AHERA) inspections conducted
Number of asbestos NESHAP and AHERA complaint investigations conducted
Number of asbestos NESHAP notification investigations for existing Agency Interests (AIs)
Number of asbestos NESHAP notification investigations for non-Agency Interests
Number of routine non-asbestos complaint investigations conducted
Compliance rate of stationary source inspections
Compliance rate of all incident investigations
Compliance rate with 401 KAR 63:005 (open burning), 63:010 (fugitive emissions) and 401 KAR 53:010 (odor) rules
Compliance rate of NESHAP and AHERA-related inspections and investigations
Initiate appropriate enforcement action on 100% of high-priority violations (HPV as defined by EPA) within 60 days of discovery
Resolve 100% all violations within 90 days or refer to the Division of Enforcement
Complete inspection of 50% of NESHAP-regulated asbestos activities within the current fiscal year for which the division has received a required notification
Complete inspection of 20% of selected AHERA local education agencies (i.e. school districts) for the current fiscal year

CWA Priorities - Kentucky annually prepares a Compliance Monitoring Strategy (CMS), based on the federal CWA §106 Workplan, to ensure systematic determination of compliance and deterrence from violations within the regulated community. The CMS breaks down facilities by type and a certain percentage of each type is inspected yearly. The percentages are based on national, regional and state priorities. The following criteria are used to determine the facilities chosen each year:

PCS non-compliance report and enforcement history
305b report
303d list
Historical knowledge
Trends
Complaints
Date and type of last inspection
50% of Majors receive a Compliance Evaluation Inspection (CEI) annually with a Compliance Sampling Inspection (CSI) once every three years, and a Performance Audit Inspection (PAI) once every five years
20% of Minor municipals receive a CEI annually with a CSI once every 5 years
Potential for regionalization
KDEP Enforcement Management System (EMS).

RCRA Priorities - Hospitals and healthcare facilities were a priority for Region 4 compliance assistance from 2005 to 2008. Kentucky targeted these facilities in FY 2009. During the first half of the year the compliance rate for hospitals and healthcare facilities was less than 10%. The RCRA compliance rate for all facilities in Kentucky has averaged about 75%. Based on the low compliance rate a strategy for education was developed to increase compliance. The Field Operations Branch in cooperation with the Kentucky Division for Compliance Assistance conducted a one day workshop for hospitals and healthcare facilities. Over 50 participants attended. This industry segment had a compliance rate of less than 50% during FY 2010 but this was to be expected because facilities that had not attended the state work shop in 2009 or the Region 4 workshop in 2007 were targeted.

CAA Accomplishments – In calendar year 2009, FOB staff completed 3,734 compliance inspections of various types at either non-permitted or permitted sources (Title V, synthetic minor or minor). Types of inspections included full compliance evaluations, partial compliance evaluations, records reviews, compliance demonstrations (stack tests), asbestos, follow-up inspections of documented violations, and self-initiated inspections of suspected violators.

In calendar year 2010, FOB staff completed 3,795 compliance inspections of various types at either non-permitted or permitted sources (major Title V, synthetic minor, minor). An FCE was completed at about 92% of the major sources.

CWA Accomplishments - Over the reporting period, DOW had an average of only 37 inspectors. Notably, 30% of these inspectors had only 0-3 years of experience. Despite low staffing numbers and inexperience, DOW met its CWA §106 workplan commitments, while also responding to 2,195 complaints, environmental emergencies and natural disasters, including a

major ice storm, a wind storm/hurricane, and other issues that otherwise diverted limited resources.

In the 2009 state fiscal year, the DOW Wet Weather Section reviewed and commented on submittals from Kentucky's 17 CSO communities, addressing the following consent agreement issues:

- Approximately 13 of the 15 remaining Nine Minimum Controls compliance reports during the fiscal year ending June 30, 2009;
- Four (4) Sanitary Sewer Overflow Plans, which DOW has reviewed and offered comments regarding three of those plans;
- More than 30 Capacity, Management, Operations and Maintenance **(**CMOM) self-assessments;
- Approximately six of the interim long-term control plans in Kentucky's CSO consent agreements.

RCRA Accomplishments - In FY2009 the Field Operations Branch inspected 94% of the permitted TSDs, 62% of the LQG universe and 51% of the SQG universe.

C. Process for SRF Review

The Kentucky SRF Round 2 was initiated with a July 16, 2010, kick-off letter to the KDEP Commissioner from the EPA Region 4 Regional Counsel and Director of the Office of Environmental Accountability (OEA). On October 12, 2010, the Preliminary Data Analysis (PDA) and File Selections for all three media were sent to the state. The onsite file reviews for each media took place during December 2010 and January 2011, at the KDEP offices in Frankfort, Kentucky. The fiscal year of the KDEP SRF review was FY2009.

State and EPA Region 4 contacts:

	Kentucky	**EPA Region 4**
SRF Coordinators	Jeff Cummins, Acting Director Division of Enforcement Mark Cleland, Branch Manager Compliance & Operations Branch, Division of Enforcement	Shannon Maher – OEA, SRF Coordinator Steve Hitte – Chief, Analysis Section, OEA
CAA	Kevin Flowers, Branch Manager Field Operations Branch Division for Air Quality	Mark Fite – OEA Nicole Radford & Todd Groendyke - Air, Pesticides & Toxics Management Division
CWA	Tom Gabbard, Branch Manager Compliance & Technical Assistance Branch Division of Water	Shelia Hollimon - OEA Amanda Driskell- Water Protection Division
RCRA	Duke York, Division of Waste Management	Connie Raines - OEA Brian Gross – RCRA Division

III. STATUS OF OUTSTANDING RECOMMENDATIONS FROM PREVIOUS REVIEWS

During the first SRF review of KDEP's compliance and enforcement programs, Region 4 and KDEP identified a number of actions to be taken to address issues found during the review. The table below shows the actions that have not been completed at the time of the current SRF review. (Appendix A contains a comprehensive list of completed and outstanding actions for reference.). The findings from Round 1 may not reflect current status.

State	Status	Due Date	Media	Element	Finding
KY - Round 1	Not Completed in Round 1 - Identified in Round 2	9/30/2010	CAA	E8 Penalties Collected	None of the case resolution proposals reviewed clearly denoted consideration of gravity or economic benefit penalty components. KDEP should continue use of clearly denoting consideration of the gravity and economic benefit components in their penalty documentation and retain this documentation for a period of time to be determined by KDEP.
KY - Round 1	Not Completed in Round 1 - Identified in Round 2	9/30/2010	CWA	E7 Penalty Calculations	KDEP has no written penalty policies. KDEP generally attempts to follow EPA's penalty guidelines, however, penalty worksheets are not included in the compliance and enforcement files nor are they formally maintained elsewhere, due to the statutory prohibition. KDEP should adopt a singular form/format for documenting penalty rationale. Additionally, Kentucky should utilize EPA's BEN model or other similar methodology as a useful tool in calculating economic benefit.
KY - Round 1	Not Completed in Round 1 - Identified in Round 2	9/30/2010	CWA	E8 Penalties Collected	Of the formal enforcement actions reviewed that had associated penalties, payment acknowledgement documentation (i.e. closure letter, copy of check/payment) was not consistently found in the files reviewed, nor was documentation provided by KDEP that supported that such information was maintained elsewhere. Additionally, KDEP has/does not enter penalty collected information into PCS (see Elements 9, 10 and 12). The KDEP should pursue collection of assessed penalties and provide better documentation.

KY - Round 1	Not Completed in Round 1 - Identified in Round 2	9/30/2010	RCRA	E7 Penalty Calculations	No penalty documentation or penalty calculations are permanently maintained in the case files after the cases are fully resolved. KDEP does not utilize the RCRA Civil Penalty Policy because of a statutory prohibition against the use of guidance or policies in setting penalties. KDEP does have factors they consider when determining a penalty amount. These factors do contain a gravity component (designed to reflect the seriousness of the violation) and economic benefit component (designed to calculate the economic advantage of noncompliance). The KDEP documents these factors in its case resolution proposals. KDEP considers the factors of gravity and economic benefit, among other factors, in determining the penalties in the enforcement cases, but does not maintain this calculation in the file after the case is fully resolved. KDEP should consider options to permanently document the penalty calculations in the enforcement files.
KY - Round 1	Not Completed in Round 1 - Identified in Round 2	9/30/2010	RCRA	E8 Penalties Collected	KDEP does not maintain penalty calculations in the enforcement files. The final penalties were reflected in RCRAInfo, but the penalty calculations were not formally documented in the files. KDEP should maintain both initial and final penalty documentation, including economic benefit and gravity - based calculations.

IV. FINDINGS

Findings represent Region 4's conclusions regarding the issue identified. Findings are based on initial findings identified during the data or file review, as well as from follow-up conversations or additional information collected to determine the severity and root causes of the issue. There are four types of findings:

Finding	Description
Good Practices	This describes activities, processes, or policies that the SRF data metrics and/or the file reviews show are being implemented exceptionally well and which the state is expected to maintain at a high level of performance. Additionally, the report may single out specific innovative and noteworthy activities, processes, or policies that have the potential to be replicated by other states and can be highlighted as a practice for other states to emulate. No further action is required by either EPA or the state.
Meets SRF Program Requirements	This indicates that no issues were identified under this element.
Areas for State* Attention ***Or, EPA Region's attention where program is directly implemented.**	This describes activities, processes, or policies that the SRF data metrics and/or file reviews show are being implemented with minor deficiencies. The state needs to pay attention to these issues in order to strengthen performance, but they are not significant enough to require the region to identify and track state actions to correct. This can describe a situation where a state is implementing either EPA or state policy in a manner that requires self-correction to resolve concerns identified during the review. These are single or infrequent instances that do not constitute a pattern of deficiencies or a significant problem. These are minor issues that the state should self correct without additional EPA oversight. However, the state is expected to improve and maintain a high level of performance.
Areas for State * Improvement – Recommendations Required ***Or, EPA Region's attention where program is directly implemented.**	This describes activities, processes, or policies that the metrics and/or the file reviews show are being implemented by the state that have significant problems that need to be addressed and that require follow-up EPA oversight. This can describe a situation where a state is implementing either EPA or state policy in a manner requiring EPA attention. For example, these would be areas where the metrics indicate that the state is not meeting its commitments, there is a pattern of incorrect implementation in updating compliance data in the data systems, there are incomplete or incorrect inspection reports, and/or there is ineffective enforcement response. These would be significant issues and not merely random occurrences. Recommendations are required for these problems, and they must have well-defined timelines and milestones for completion. Recommendations will be monitored in the SRF Tracker.

CAA Program

CAA Element 1 – Data Completeness: Degree to which the Minimum Data Requirements are complete.	
This finding is a(n)	❒ Meets SRF Program Requirements ☑ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	In general, Kentucky has ensured that all minimum data requirements (MDRs) were entered into the AFS, with a few exceptions that have been corrected.
Explanation	Element 1 of the SRF is designed to evaluate the degree to which the State enters MDRs into the national data system. In the Preliminary Data Analysis (PDA), KDEP was at or near the national goal of 100% for Data Metrics 1c5, 1c6, and 1h2 (100%, 98.4%, and 100%, respectively). These metrics measure the degree to which various MDRs for National Emissions Standards for Hazardous Air Pollutants (NESHAP) and Maximum Achievable Control Technology) (MACT) sources and HPV actions are complete in AFS. For Data Metric 1c4, the official data set (ODS) indicated that only 77.1% of the State's New Source Performance Standards (NSPS) sources (148 out of 192) had the applicable subpart coded into AFS. However, in their response to the ODS, the State provided a corrected metric value of 98.9%, advising that 27 sources were erroneously identified as being subject to NSPS. These have been corrected in AFS. The State explained that another 15 sources are natural gas transmission facilities that are subject to a general permit with many NSPS subparts potentially applicable, but not specifically identified in the permit. Since sources in this sector are potentially subject to one of EPA's National Enforcement Initiatives, two supplemental files were selected for further evaluation. Both files indicated a discrepancy between the permit and the information in AFS. Although this suggests that some minor "cleanup" of the information in AFS is warranted, it does not indicate a significant issue. Data Metrics 1h1 and 1h3 measure the percentage of HPVs with a discovery date and violation type code entered into AFS. Metric 1h1 indicates only 6.7% of HPVs (1 of 15) had a discovery date reported, and Metric 1h3 shows that 73.3% of HPVs (11 of 15) had a violation type code in AFS. KDEP advised that these HPV data elements have to be manually linked or entered in AFS, and due to personnel changes, this was not done consistently in FY2009. However, the State reports that new procedures have been established to address this issue. The

	FY2010 data shows improvements for Metrics 1h1 and 1h3 (50% & 100%, respectively), and the FY2011 data to date is at 100% for both metrics, suggesting that the State's new procedures have been effective. Since these are minor issues that KDEP has already self corrected without additional EPA oversight, this element is designated as an area for state attention. However, the State is expected to improve and maintain a high level of performance.
Metric(s) and Quantitative Value(s)	Data Metric — Goal — State 1c4 - % NSPS Facilities with subprogram designation: — 100% — 98.9% 1c5 -% NESHAP facilities with subprogram designation — 100% — 100% 1c6 - % MACT facilities with subprogram designation — 100% — 98.4% 1h1 - HPV Day Zero (DZ) Pathway Discovery date: Percent DZs reported after 10/1/05 with discovery — 100% — 6.7% 1h2 - HPV DZ Pathway Violating Pollutants: Percent DZs reported after 10/1/05 — 100% — 100% 1h3 - Percent DZs reported after 10/1/05 with HPV Violation Type Code — 100% — 73.3% 1k - Major Sources Missing CMS Policy Applicability — 0 — 1
State Response	Current KDEP procedures ensure that these MDRs for new HPVs are entered into AFS, as demonstrated by the 100% success percentages in FY2011. The NSPS subpart issue for natural gas transmission facilities needs further review by KDEP to develop a satisfactory resolution.
Recommendation(s)	No formal recommendations are being tracked for this element.

CAA Element 2 – Data Accuracy: Degree to which data reported into the national system is accurately entered and maintained	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	The accuracy of MDR data reported by the KDEP into AFS needs improvement. In particular, stack test data was incomplete, results for the Title V annual compliance certification reviews were missing, and a variety of discrepancies between the files and AFS were identified in most files reviewed.
Explanation	Data Metric 2a compares the number of HPVs identified in AFS during the review year to the number of major sources listed in AFS as "in violation" or "meeting compliance schedule." All HPVs are to be assigned a Compliance Status code that represents the source as either in violation or meeting a schedule until all penalties are paid and all injunctive relief is completed. Because HPV facilities are only a subset

	of violating facilities, this metric provides a strong indication of whether Compliance Status is being accurately reported. Typically, a State may find two, three, or more violators for every HPV, so the ratio of HPVs to all violating sources should be well below 50%. That is why the national goal for this metric is set at ≤ 50%. Since KDEP's value of 53.8% did not meet the national goal, supplemental files were reviewed and additional analysis of the Metric 2a data was performed to further evaluate this issue. This investigation confirmed that the State was not accurately reporting the Compliance Status of HPVs. In other words, the Compliance Status code for some sources with an HPV was not changed to "in violation." A similar conclusion was drawn for the Compliance Status of non-HPV violations under Element 7 (Metric 7b), so the recommendation outlined under Element 7 will address this issue for both HPV and non-HPV sources. Data Metric 2b1 measures the percentage of stack tests without a results code reported into AFS. KDEP's value of 0% meets the national goal. However, whereas the frozen data indicates that only 5 stack tests were conducted in FY2009, the production data shows that at least 62 stack tests were conducted, suggesting that the reporting of stack test information into AFS is not timely, complete, or accurate. KDEP acknowledges that they have a significant backlog in reviewing and approving stack test reports, and entering data into their database (TEMPO), which is then uploaded to AFS. KDEP advises that management and staff level vacancies which contributed to the backlog have now been filled. Since the new manager came on board, they have eliminated the backlog of reviews prior to FY2009 and entered most of this data into TEMPO. About 170 stack test reviews are complete and awaiting entry into TEMPO, while about 120 have been reviewed by staff, but require manager approval. Another 100 test reports have not yet been assigned for review. KDEP estimates that they will be "caught up' with the backlog of reviews by December 2011, and their goal is to address the data entry backlog by the end of FY 2012. KDEP advises that high staff turnover, staff shortages, and a heavy field workload are factors that contributed to the backlog. KDEP has cut back on field activities and developed a draft SOP which streamlines the review process. In addition, they plan to secure assistance on data entry from the local university. Based on File Review Metric 2c, only 3 of the 35 files reviewed (9%) documented all MDRs being reported accurately into AFS. The remaining 32 files had one or more discrepancies identified. The most common problem was 23 files with missing results in AFS for the Title V Annual Compliance Certification (ACC) reviews (i.e. "in compliance" or "in violation"), which the State advised was a coding issue. Minor differences such as Standard Industrial Classification

	(SIC) code, facility name, address, operating status, or pollutants were identified in 12 files. More significantly, 15 files showed a discrepancy in the air program (MACT, NSR, NSPS) applicability of the source, 10 files revealed incorrect compliance status or HPV information in AFS, and 7 files revealed missing or incorrect enforcement, compliance, or penalty data in AFS. The number and type of data inaccuracies under Data Metric 2b1 and File Review Metric 2c suggest a pattern of incorrect implementation in updating or maintaining compliance data in AFS. In addition, the Round 1 SRF review noted a concern with the backlog of stack test results, indicating that this is a persistent problem. Therefore, this element is designated as an area for State improvement, and recommendations are outlined below.
Metric(s) and Quantitative Value(s)	Data Metric — National Goal — State 2a - # of HPVs / # of Noncompliance sources — ≤ 50% — 53.8% 2b1 - % Stack Tests without Pass/Fail result — 0% — 0% 2b2 - Number of Stack Test Failures — - — 0 File Review Metric — State 2c - % files with all MDR data accurate in AFS — - — 9%
State Response	The issue of maintaining the current compliance status will be addressed under Element 7. KDEP acknowledges that the compliance status for both HPVs and non-HPVs was not kept current during FY09, for various reasons. With respect to HPVs the main reason was the absence of a trained staff person. This problem has been fully resolved and compliance status for HPVs in AFS is now accurate. KDEP will submit a description of, and implement, procedures to ensure accurate reporting of enforcement and compliance MDRs into AFS. With respect to Data Metric 2a, # of HPVs / # of noncompliance sources, KDEP, using 2010 data, found that the percentage of HPV violations to all violations of major and synthetic minor sources (approximately the same metric as 2a) was 12.6%, well within EPA's national goal. As discussed above, KDEP estimates that it will be "caught up' with the backlog of reviews by December 2011, and its goal is to address the data entry backlog by the end of FY 2012. KDEP will submit a plan for addressing the backlog of stack test reviews and data entry. Outside of the compliance status issue to be addressed under Element 7, the most significant MDR reporting problem was entering ACC review data. It had been discovered that these data were not being picked up by the Universal Interface (UI). A simple code change to the UI corrected this oversight and ACC data are now routinely reported to AFS. The minor discrepancy issues discussed above are corrected as they are identified.
Recommendation(s)	By April 30, 2012, KDEP should submit and implement revised procedures to EPA to ensure accurate reporting of enforcement and

	compliance MDRs into AFS. The procedures should be designed to address the causes of the inaccurate reporting. EPA's Air and EPCRA Enforcement Branch (AEEB) will monitor the improvement of the accuracy of KDEP's MDR data entry through the existing oversight calls and other periodic data reviews conducted by EPA. If by December 31, 2012 these periodic reviews indicate progress toward meeting the national goal, the recommendation will be considered completed. In addition, by March 1, 2012, KDEP should submit and implement a comprehensive plan for addressing the backlog of stack test reviews and data entry aimed at eliminating the backlog and getting current on the reviews by the end of FY2012. The plan should identify the backlog universe, prioritize them for review, and provide for written quarterly progress reports to EPA AEEB. These quarterly reports should include a list of the stack tests reviewed, the results (pass or fail), and any follow up action taken by the KDEP to address failed tests. These progress reports should continue to be submitted to EPA until KDEP has eliminated the backlog and demonstrates the ability to effectively manage their annual stack test workload. If by December 31, 2012, the backlog has been addressed, no new backlog has been created, and stack test data is current in AFS, this recommendation will be considered completed.

CAA Element 3 - Timeliness of Data Entry: Degree to which the Minimum Data Requirements are timely.	
This finding is a(n)	❒ Meets SRF Program Requirements ☑ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	The timeliness of data entry for enforcement, compliance monitoring, and HPV related MDRs fell short of the national goal, but KDEP has made staffing and procedural changes which have resulted in significant improvements to data timeliness.
Explanation	Kentucky's performance in FY2009 for timely entry of enforcement, compliance monitoring, and HPV related MDRs fell short of the national goal of 100%. However, KDEP has self corrected these deficiencies to the extent that the routine oversight calls already conducted by EPA should be sufficient for KDEP to maintain a high level of performance. Therefore, this is designated as an area for State Attention, and further discussion is provided below. With respect to HPV data entry (Data Metric 3a), only 2 of 15 of the HPVs were entered within 60 days. The remaining 13 HPVs were entered more than 170 days after discovery. Data Metric 3b1 indicates

<table>
<tr><td></td><td>that only about one-fourth of the compliance monitoring MDRs (25.2%, or 181 of 718) was entered within 60 days. Further analysis reveals that 79% of these late actions were Title V ACC reviews, and another 20% were Full Compliance Evaluations (FCEs). Data Metric 3b2 indicates that 64.6% of the enforcement related MDRs (73 of 113) were entered within 60 days. Of the 40 late entries, 85% were NOVs, and the rest were formal enforcement actions.

In their response to the official data set, the State indicated that during FY2009, the staff person entering data into AFS resigned. KDEP advised that resources have been allocated and procedures have been changed to facilitate monthly data entry. A review of FY2010 data confirms a dramatic improvement in the timely entry of both compliance monitoring and enforcement MDRs (95.9% and 94.9%, respectively). The improvement in timely data entry may seem inconsistent with the backlog of stack test reviews identified under Element 2. However, since stack test reviews are occurring at such a slow pace, very little stack test data is being entered into AFS, so Data Metric 3b1 does not “detect” a timeliness problem. In any case, the timely entry of stack test dates and results should be addressed by the recommendation under Element 2. Data Metric 3a, which measures HPV timeliness, improved to 40% in FY2010 and 88.9% in FY2011 to date. These improvements suggest that the self corrections KDEP put in place are working. Therefore, EPA will continue to monitor progress through the monthly HPV oversight calls, but no specific recommendations will be tracked for this element.</td></tr>
<tr><td>Metric(s) and Quantitative Value(s)</td><td><table>
<tr><th>Data Metric</th><th>National Goal</th><th>National Average</th><th>State</th></tr>
<tr><td>3a - % HPVs entered in ≤ 60 days</td><td>100%</td><td>31.6%</td><td>13.3%</td></tr>
<tr><td>3b1 - % Compliance Monitoring MDRs entered in ≤ 60 days</td><td>100%</td><td>51.4%</td><td>25.2%</td></tr>
<tr><td>3b2 - % Enforcement MDRs entered in ≤ 60 days</td><td>100%</td><td>66.1%</td><td>64.6%</td></tr>
</table></td></tr>
<tr><td>State Response</td><td>As identified above, KDEP has, with the exception of stack test data, corrected the data entry timeliness problems, particularly regarding ACC reviews. Under its new procedures, KDEP has a more streamlined, but more focused, process for reviewing HPVs. One of the issues identified was that, regarding stack tests as the initiating action, the date of discovery was incorrectly used as the discovery date rather than the date that the stack test report was received and reviewed. This would add considerable time to the number of days between discovery and HPV entry into AFS. KDEP continues to analyze the process of discovering and entering HPVs to minimize delays.</td></tr>
<tr><td>Recommendation(s)</td><td>No formal recommendations are being tracked for this element.</td></tr>
</table>

CAA Element 4 - Completion of Commitments: Degree to which all enforcement/compliance commitments in relevant agreements are met and any products or projects are completed.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	Kentucky met its enforcement and compliance commitments outlined in the CMS and Air Planning Agreement.
Explanation	KDEP follows a traditional Compliance Monitoring Strategy (CMS) plan and completed 95% of all planned evaluations (403 of 422 FCEs) under their FY2008/2009 CMS plan. In addition KDEP met all of its enforcement and compliance commitments (100%) under the FY2009 Air Planning Agreement with EPA Region 4. Therefore, this element meets SRF program requirements.
Metric(s) and Quantitative Value(s)	File Review — State 4a - Planned evaluations completed for year of review pursuant to CMS plan — 95% 4b – Planned commitments completed — 100%
State Response	No response necessary, KDEP has worked diligently to achieve this success rate.
Recommendation(s)	No action is needed.

CAA Element 5 – Inspection Coverage: Degree to which state completed the universe of planned inspections/compliance evaluations	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	Kentucky met its annual inspection and compliance evaluation commitments.
Explanation	Based on the Data Metrics 5a1 and 5b1, KDEP completed FCEs at 95.9% of its Major and 94.9% of its SM80 sources during the relevant CMS timeframe. With respect to the State's obligation to review the Title V annual compliance certifications, KDEP provided a corrected value for Data Metric 5g of 88.6%, indicating that 225 of 254 of these reviews had been completed. KDEP indicated that a problem with the Universal Interface (UI) programming and other coding problems resulted in the data not transferring into AFS. EPA confirmed during the file review that these reviews were being performed, but the results were not always reflected in AFS. Since this issue is a data accuracy issue, it is addressed under Element 2. Therefore, KDEP met all SRF

	program requirements for this element.
Metric(s) and Quantitative Value(s)	<table><tr><th>Data Metrics</th><th>National Goal</th><th>National Average</th><th>State</th></tr><tr><td>5a1 - FCE coverage Majors (CMS cycle)</td><td>100%</td><td>87.8%</td><td>95.9%</td></tr><tr><td>5a2 - FCE coverage All Majors (last 2 FY)</td><td>100%</td><td>83.0%</td><td>93.7%</td></tr><tr><td>5b1 - FCE coverage SM80 (CMS cycle)</td><td>20-100%</td><td>83.7%</td><td>94.9%</td></tr><tr><td>5b2 - FCE coverage CMS SM80 (last 5 FY)</td><td>100%</td><td>90.1%</td><td>92.1%</td></tr><tr><td>5c - FCE/PCE coverage All SMs (last 5 FY)</td><td>NA</td><td>80.5%</td><td>91.4%</td></tr><tr><td>5d - FCE/PCE coverage other minors (5 FY)</td><td>NA</td><td>29.4%</td><td>14.3%</td></tr><tr><td>5e - Sources with unknown compliance status</td><td>NA</td><td>-</td><td>16</td></tr><tr><td>5g - Review of Self Certifications completed</td><td>100%</td><td>94.0%</td><td>88.6%</td></tr></table>
State Response	No response necessary, KDEP has worked diligently to achieve this success rate. KDEP notes that it does not generally enter compliance and enforcement data into AFS for minor sources.
Recommendation(s)	No action is needed.

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CAA Element 6 – Quality of Inspection or Compliance Evaluation Reports: Degree to which inspection or compliance evaluation reports properly document observations, are completed in a timely manner, and include an accurate description of observations.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	In general, compliance monitoring reports (CMRs) properly documented observations, were completed in a timely manner, and include an accurate description of observations.
Explanation	File Metric 6b evaluates whether all applicable elements of an FCE have been addressed. Based on the file review, 96% of the files reviewed (26 of 27) had documentation in the files to show that they contained all of the elements of the FCE, per the CMS. The remaining file was a Title V source, and the inspection report, AFS, and files did not indicate that an annual compliance certification was submitted and reviewed during FY2009. For File Metric 6c, 100% of the files reviewed contained all of the CMR

	requirements listed in the CMS, providing sufficient documentation to determine compliance at the facility. Therefore, this element meets SRF program requirements.
Metric(s) and Quantitative Value(s)	File Review Metric — State 6a – Number of FCEs reviewed — 27 6b – % FCEs that meet definition — 96% 6c – % CMRs sufficient for compliance determination — 100%
State Response	No response necessary, KDEP has worked diligently to achieve this success rate.
Recommendation(s)	No action is needed.

CAA Element 7 – Identification of Alleged Violations: Degree to which compliance determinations are accurately made and promptly reported in the national database based upon compliance monitoring report observations and other compliance monitoring information.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	Although the file review indicated that KDEP is making accurate compliance determinations based on inspection reports and other compliance monitoring information, the appropriate Compliance Status code is often not reported into AFS.
Explanation	File Metric 7a indicates that all of the CMRs reviewed (100%) led to an accurate compliance determination. With respect to File Metric 7b, only 2 of 8 files reviewed with non-HPV violations (25%) had the Compliance Status reported accurately and timely into AFS. Of the remaining six sources with a non-HPV violation, three of them were resolved with no formal enforcement action. KDEP advises that in these instances, when the violations are resolved quickly with no enforcement, they do not change the Compliance Status in AFS. However, the other three sources were addressed through a formal enforcement action, and the duration from identification to resolution of these violations ranged from 4 months to 23 months. Since the Compliance Status of these sources should have been coded as "in violation" from the date the violation was identified to the date the enforcement action was resolved (i.e. payment of penalty and completion of injunctive relief), this is designated as an area for state improvement. KDEP indicated three primary reasons for inaccurate or incomplete reporting of compliance status: staffing issues prior to FY2010; the fact that compliance status is manually reported by KDEP into AFS for each source (the universal interface does not transfer compliance status information from TEMPO into AFS); and

	KDEP had not expended the resources required to manually enter compliance status for non-HPV sources. Data Metrics 7c1 and 7c2 are designed to measure the compliance status reporting of the state program. Metric 7c1 exceeded the national goal, but Metric 7c2 (0%) indicates there were no failed stack tests in noncompliance status. However, KDEP reports a significant backlog in reviewing and reporting stack test results. Due to this backlog, the stack test data in AFS is inaccurate, making it difficult to assess whether the Compliance Status for sources with a failed stack test is being accurately reported. This is considered a data accuracy issue and is addressed via the recommendation in Element 2.
Metric(s) and Quantitative Value(s)	File Review Metrics — State 7a - % CMRs leading to accurate compliance determination — 100% 7b - % non-HPVs with timely compliance determination in AFS — 25% Data Metrics — National Goal — National Average — State 7c1 - % facilities in noncompliance with FCE, stack test, or enforcement (1 FY) — >11.0% — 22.1% — 12.3% 7c2 - % facilities with failed stack test and have noncompliance status (1 FY) — >22.0% — 43.9% — 0%
State Response	KDEP has revised procedures ensuring that the compliance status of HPVs is accurately reported in AFS. KDEP will develop, submit, and implement a plan to address reporting accurate compliance status for non-HPV violations. If a way to do this cannot be developed by code changes in the UI, then this will need to be done manually.
Recommendation(s)	By April 30, 2012, KDEP should submit and implement revised procedures to EPA which ensure timely and accurate reporting of the compliance status of both HPV and non-HPV violating sources into AFS. EPA AEEB will monitor the improvement of KDEP's timeliness of Compliance Status reporting of HPVs through the existing oversight calls and other periodic data reviews conducted by EPA. If by December 31, 2012, these periodic reviews indicate progress toward meeting the national goal, the recommendation will be considered completed.

CAA Element 8 - Identification of SNC and HPV: Degree to which the state accurately identifies significant noncompliance/high priority violations and enters information into the national system in a timely manner.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required

	❒ Good Practice
Finding	High Priority Violations (HPVs) are accurately identified.
Explanation	KDEP exceeded the national goal for all but one of the data metrics in this element. With respect to metric 8e, which measures the percent of sources with a failed stack test that receive HPV listing, KDEP has advised that there is a significant backlog of stack test reviews, so the stack test data in AFS is incomplete. This issue is addressed under Element 2. Files were also reviewed to further verify the accuracy of HPV identification. File Metric 8f indicated that in all 9 files reviewed, KDEP accurately identified HPVs and entered the information into AFS.
Metric(s) and Quantitative Value(s)	Data Metrics — National Goal — State 8a - HPV discovery rate - Majors sources — >3.9% — 4.0% 8b - HPV discovery rate - SM sources — >0.3% — 1.5% 8c - % formal actions with prior HPV - Majors (1 yr) — >37.4% — 50.0% 8e - % sources with failed stack test actions that received HPV listing - Majors and Synthetic Minors — >21.5% — 0% File Review Metrics — State 8f - % accurate HPV determinations — 100%
State Response	No response necessary, KDEP has worked diligently to achieve this success rate for HPV identification.
Recommendation(s)	No further action is needed.

CAA Element 9 - Enforcement Actions Promote Return to Compliance: Degree to which state enforcement actions include required corrective action (i.e., injunctive relief or other complying actions) that will return facilities to compliance in a specific time frame.
☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Enforcement actions include corrective actions that return facilities to compliance in a specific time frame, or facilities are brought back into compliance prior to issuance of a final enforcement order.
All enforcement action files reviewed (13 of 13) returned the source to compliance. For enforcement actions that were penalty only actions, the order itself or the files documented the actions taken by the facility to return to compliance prior to issuance of the order.

Metric(s) and Quantitative Value(s)	File Review — State 9a – number of enforcement actions reviewed — 13 9b - % enforcement actions returning source to compliance — 100%
State Response	No response necessary, KDEP has worked diligently to achieve this success rate.
Recommendation(s)	No further action is needed.

CAA Element 10 - Timely and Appropriate Action: Degree to which a state takes timely and appropriate enforcement actions in accordance with policy relating to specific media.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP takes appropriate enforcement action in accordance with EPA policy to address HPVs through the issuance of formal enforcement actions. However, about two-thirds of these actions took longer than 270 days to address.
Explanation	Based on the file review, the state took appropriate enforcement action to resolve 100% of its HPVs through a formal enforcement action (Metric 10c). However, both the PDA and the file review indicate that KDEP is not addressing HPVs in a timely manner. Data Metric 10a shows that in the last two years, 64.3% of Kentucky's HPV actions (18 of 28) have taken longer than 270 days to address, which is significantly higher than the national average of 35.9%. About 28% of the late actions (5 of 18) have taken a year or more to address, with timeframes ranging from 366 days to 890 days. In addition, File Metric 10b indicates that only half of the HPVs reviewed (3 of 6) were addressed within the 270 days specified in EPA's HPV policy. Therefore, this is designated as an area for State improvement.
Metric(s) and Quantitative Value(s)	Data Metrics — National Average — State 10a - % HPVs not timely (2 FY) — 35.9% — 64.3% File Review Metrics — State 10b - % timely HPV enforcement actions — 50% 10c - % HPVs appropriately addressed — 100%
State Response	There are many reasons for delay in addressing HPVs. In many of these instances, the federal regulations are not clear, and thus determining compliance or violations becomes difficult. Negotiations between KDEP and the companies when requirements are not clear often becoming protracted. Notwithstanding these issues, KDEP will continue to review its procedures and make changes as deemed appropriate to minimize the timeframe for addressing HPVs.

Recommendation(s)	By April 30, 2012, KDEP should submit and implement revised procedures to improve the timeliness of HPV addressing actions. These procedures should identify and address the causes of the untimely actions, include notification to EPA when the complexity of a case may warrant additional time, and identify other enforcement mechanisms available when negotiations become protracted. The timeliness of HPV addressing actions will be monitored by AEEB through the existing monthly oversight calls between KDEP and EPA and through a formal consultation on or around day 150. If by December 31, 2012, these periodic reviews indicate progress toward meeting the national goal, the recommendation will be considered completed.

CAA Element 11 - Penalty Calculation Method: Degree to which State documents in its files that initial penalty calculation includes both gravity and economic benefit calculations, appropriately using the BEN model or other method that produces results consistent with national policy.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	Kentucky's penalty documentation does not include gravity and economic benefit calculations, and the BEN model or another method that produces results consistent with national policy is not used to determine economic benefit.
Explanation	Element 11 examines the state documentation of its penalty calculations. Specifically, the metric determines if the state penalty includes a gravity component and, where appropriate, economic benefit. Based on an analysis of enforcement actions with penalties, none of the 12 files reviewed by EPA (File Review Metric 11a) provided sufficient documentation of the calculation of gravity and economic benefit components of the penalty. This was also identified as a concern in Round 1. Therefore, this element is designated as an area for State improvement. KDEP uses factors referred to as the Maggard Factors when determining penalty. *NREPC v. Wendell Maggard* was a state administrative case which set out factors to be used to determine penalties under KRS224.99. The factors include both a gravity and economic benefit component and are consistent with EPA's policies. KDEP asserts that statutory provisions in KRS 13A.130 and KRS 224.99 preclude them from documenting penalty calculation information. KDEP's General Counsel states that detailed civil penalty calculations would constitute guidance in clear violation of KRS 13A.130. EPA does not agree that the documentation of penalty calculations is prohibited by KRS 13A.130 because such documentation

	does not expand or limit the underlying statute (KRS 224.99) but rather implements the statue by reflecting how the Maggard factors were applied.
Metric(s) and Quantitative Value(s)	File Review — State 11a - % penalty calculations that consider & include gravity and economic benefit — 0%
State Response	The KDEP is subject to KRS 13A-130, which prohibits modifying or expanding a statute or regulation by internal policy, memorandum, or other form of action. The Cabinet's Office of General Counsel has, in very strong terms, recommended that penalties be established for the entire case and not on a violation-by-violation basis. In accordance with this recommendation, KDEP determines the civil penalty in accordance with KRS 224.99 using the factors determined listed in "NREPC vs. Wendell Maggard". This method of establishing penalty has been upheld by the Kentucky Court of Appeals. U.S. EPA's criteria for documenting penalty calculations are contrary to Kentucky law.
Recommendation(s)	By September 30, 2012 Kentucky should submit and implement procedures for the documentation of penalty calculations, including both gravity and economic benefit calculations, appropriately using the BEN model or other method that produces results consistent with national policy. This documentation should be made available for review by EPA. If, by December 31, 2012, appropriate penalty calculation documentation is being observed, this issue will be considered completed.

CAA Element 12 - Final Penalty Assessment and Collection: Degree to which differences between initial and final penalty are documented in the file along with a demonstration in the file that the final penalty was collected.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	Kentucky assessed penalties for all HPVs actions and maintained documentation that the final penalty was collected. However, the State does not document the rationale for any difference between the initial and final penalty in most instances.
Explanation	Data Metric 12b measures the percentage of HPV enforcement actions that included a penalty as part of the settlement. Although the PDA initially indicated that only 5 of 7 HPVs had a penalty (71.4% for Data Metric 12b), the file review confirmed that the remaining two HPVs did have a penalty assessed, so the revised value for 12b is 100%, which exceeds the national goal of 80%. In addition, File Metric 12d indicates that 100% of the files reviewed (12 of 12) documented collection of the assessed penalty. However, based on the file review, File Metric 12c

	indicates that only one file (8% or 1 of 12) provided documentation of the difference between the initial penalty assessed and the final penalty paid. KDEP usually identifies a target penalty range in their case resolution proposal, and most penalties fall within that range. In one case, the final penalty was reduced by the Deputy Commissioner, and the memo outlining his rationale was in the file. However, in the remaining cases reviewed, no rationale was provided to explain any differences between the initial and final penalty. This is a continuing problem from Round 1 of the SRF and is an area for state improvement.
Metric(s) and Quantitative Value(s)	Data Metrics — National Goal — State 12a - Actions with penalties — NA — 12 12b - % HPV actions with penalty — ≥ 80% — 100% File Review Metrics — State 12c - % actions documenting difference between initial & final penalties — 8% 12d - % files that document collection of penalty — 100%
State Response	The KDEP disagrees that initial and final penalty calculations are not maintained. Before entering into a negotiation, KDEP establishes an initial penalty offer, a penalty goal, and a minimum penalty. KDEP staff is allowed to negotiate within this range without further approval from management. If negotiations move outside of this range, management approval and additional documentation is required. When negotiations move the civil penalty out of the approved range, KDEP prefers to refer the case to the Office of General Counsel (OGC) and have a complaint filed with the Office of Administrative Hearings. However, KDEP must be cognizant of OGC staffing limitations and the staffing resources required to move a case through the administrative hearing process and the lengthy amount of time it takes to move a case through hearings. On a case-by-case basis, KDEP will determine whether it is better to refer a case to the administrative process or to settle for a smaller civil penalty and more immediate injunctive relief.
Recommendation(s)	As part of the recommendation in Element 11, the procedures to calculate penalties should also include how the state will document differences between the initial and final penalty. If, by December 31, 2012, documentation of differences between initial and final penalties are being observed, this issue will be considered completed.

CWA Program

CWA Element 1 – Data Completeness: Degree to which the Minimum Data Requirements (MDRs) are complete.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	The MDRs in PCS for Kentucky were not complete.
Explanation	CWA Element 1 evaluates the completeness of 40 data metrics. Three of the 40 metrics have national performance goals: Data Metric 1b1: % of NPDES major facilities with individual permits that have permit limits in PCS. The performance goal for this metric is >=95%. Data Metric 1b2: % of outfalls for which Discharge Monitoring Report (DMR) data is entered in the national database. The national performance goal for this metric is >=95%. Data Metric 1b3: % of NPDES major facilities with individual permits that have DMR data in PCS. The national performance goal for this metric is >=95%. KDEP met the national goal for Data Metric 1b2. For Data Metrics 1b1 and 1b3, the ODS values both showed 86.2% (94 of 112). Upon further evaluation of additional State information, the 18 facilities with data issues were operating under expired NPDES permits for a period of time. These expired permits caused the generation of inaccurate permit limits and inaccurate DMR data in the national data system. Subsequent to the analysis of KDEP's FY09 data, KDEP reissued these NPDES permits and the data is now being populated in ICIS-NPDES. Though this is no longer a problem, KDEP should maintain vigilance on expiring permits so this problem does not resurface. For the remaining 37 data metrics examined for completeness, KDEP noted 10 discrepancies between the data that Kentucky reports into PCS and the data reported in the State system, TEMPO. One discrepancy was considered minor as the difference in the reported numbers between the State and EPA data was less than 10%. No follow up is needed. The other 9 data discrepancies were significant and include: discrepancies with respect to informal and formal actions at non-major facilities (found with 4 data metrics), discrepancies with respect to penalty data (found with 3 data metrics), discrepancies with unresolved compliance schedule violations, and discrepancies in inspection data. The Water Enforcement National Data Base (WENDB) guidance document

	specifically requires the State to enter inspection and enforcement data into the national data system. For the category of non-major facilities with formal and informal enforcement actions, further examination of the data revealed that the most significant difference between the data sets is due to state actions at unpermitted sources not being reflected in PCS. At the time of the data analysis, KDEP had a number of unpermitted facilities, including those covered by an expired industrial stormwater general permit. Unpermitted facilities do not have a NPDES permit number and without a permit number, PCS cannot accept enforcement data (or any other data) from TEMPO. With the recent conversion by the State to ICIS-NPDES, the enforcement actions for the unpermitted major facilities are now linked to facilities and not permits. No further actions are needed to correct the data, however, the State should ensure general permits are re-issued in a timely manner. For the penalty action category, the discrepancies appeared to be data errors (3 cases) and duplication errors (3 cases). For unresolved compliance schedule violations, KDEP acknowledges data maintenance issues and commenced measures to correct the process. Improving data related to both of these discrepancies is an area for state improvement. The Department for Natural Resources, Division of Mine Reclamation and Enforcement (DMRE) largely conducts NPDES compliance and enforcement activities for mining facilities for KDEP. With respect to this data for mining facilities and, specifically, the non-major general inspection coverage category, the State entered no activities, including approximately 1,700 inspections at coal mining facilities, into PCS during the review year FY09. This is an area for state improvement. Kentucky should ensure complete information is entered into ICIS-NPDES. This pattern of not entering complete compliance and enforcement data in the national data system is significant. Data completeness is designated as an area for state improvement.
Metric(s) and Quantitative Value(s)	<table><tr><th>Data Metrics</th><th>National Goal</th><th>State</th></tr><tr><td>1b1 – Facilities with permit limits</td><td>95%</td><td>86.2%</td></tr><tr><td>1b2 - DMR Entry Rate</td><td>95%</td><td>100.0%</td></tr><tr><td>1b3 - DMR with permit limits</td><td>95%</td><td>86.2%</td></tr></table>
State Response	The State will work to re-issue its general permits in timely manner. The improvement of data from the DMRE compliance activities will be more difficult. In order for this to occur, data will have to be automated between Doctree and TEMPO and ICIS-NPDES because the agency does not have enough resources to enter all the information manually.

Recommendation(s)	Kentucky should immediately take steps to ensure that all data required by WENDB and the State's 106 Work Plan are thoroughly and completely entered into ICIS-NPDES. Specific attention should be paid to (1) ensuring mining data is being populated in ICIS-NPDES and (2) re-issuing the expired industrial stormwater general permit. Region 4's Clean Water Enforcement Branch (CWEB), in consultation with the Region 4 Pollution Control and Implementation Branch, will monitor the State's reissuance of the industrial stormwater general permit. The CWEB will also, in partnership with OEA, monitor the State's data entry of the aforementioned areas with data discrepancies and verify progress during the end of year FY 2012 data quality review. If, by January 31, 2013, a pattern of accurate data entry is observed, this issue will be considered completed.

CWA Element 2 – Data Accuracy: Degree to which data reported into the national system is accurately entered and maintained.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	Data reported into PCS is not accurately entered and maintained.
Explanation	Data Metric 2a reports the percent of enforcement actions linked to violations for major facilities. EPA has set a national goal of >=80% and Kentucky's data metric indicates 0% of enforcement actions were linked to violations for major facilities. Files were reviewed to further examine the accuracy of data between the information in the file and PCS. Data accuracy is vital because the data is used by EPA and the public to judge state-wide and facility-specific performance. A facility record is considered accurate when data points in national data system are the same as the information found in one or more inspection and/or enforcement files. Of the 29 facilities randomly selected for this review, 16 (55%) documented that the selected data points were reported accurately into PCS. The review noted 13 facilities (four major facilities and nine non-major facilities, including six mining facilities) with missing or inaccurate data between the files and PCS. For the six mining facilities reviewed, the State had not entered any compliance and enforcement data in the national data system. The 7 remaining major and non-major facilities had inaccurate or missing inspection and enforcement data in the files as compared to the data in PCS. Kentucky has a pattern of not accurately entering and maintaining compliance and enforcement data in the data systems. The State should

	ensure all WENDB requirements are accurately entered and maintained in ICIS-NPDES. This is an area for state improvement.
Metric(s) and Quantitative Value(s)	Data Metric / National Goal / State 2a - % of actions linked to violations for major facilities / 80 % / 0% File Metric / State 2b - % files reviewed where data is accurately reflected in the data system (16 of 29) / 55%
State Response	Kentucky has always linked violations to enforcement actions by appropriately checking the "VIOLATIONS THAT CAUSED THE ENFORCEMENT ACTION TO BE ISSUED" boxes at the bottom of the PCS ENAC screen. Kentucky did have a problem with ENACs entered PCS not dropping permit off of the QNCR. This problem was related to the Enforcement Action Code (ENAC) that was selected and with the entry of compliance schedules into PCS. During the Round 1 SRF, Kentucky identified training on the Federal database as a need. U.S. EPA never provided that training. Even without the training, Kentucky put a considerable effort into resolving the data issues. This was accomplished in mid-2010.
Recommendation(s)	KDEP should ensure all WENDB requirements are accurately entered into ICIS-NPDES per EPA's December 28, 2007 memo entitled "*ICIS Addendum to the Appendix of the 1985 PCS Policy Statement"*. Specific focus should be placed on the need to link enforcement actions at major facilities with enforcement violation codes in ICIS-NPDES. EPA Region 4's CWEB in partnership with OEA will monitor this during the EOY FY 2012 data quality review. If, by January 31, 2013, a pattern of accurate data entry is observed, including the need for enforcement actions to be linked to violations, this issue will be considered completed.

CWA Element 3 - Timeliness of Data Entry: Degree to which the Minimum Data Requirements are timely.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	The minimum data requirements are timely.
Explanation	Timely entry of data into the national data systems is important to EPA's mission. The Agency must ensure that the most up-to-date and reliable information is available to regulators and to the public. Timeliness of data is determined by comparing "frozen" data (i.e., data

	which is frozen in ICIS-NPDES after the end of each fiscal year) with current "production" data that is pulled at the beginning of the SRF evaluation. Kentucky's data for FY 2009 was "frozen" in February 2010 and the production data was pulled in July 2010. Differences in data indicate potential issues with timeliness in entering data.
Metric(s) and Quantitative Value(s)	Differences between the frozen data and the production data were insignificant.
State Response	
Recommendation(s)	No further action needed.

CWA Element 4 - Completion of Commitments: Degree to which all enforcement/compliance commitments in relevant agreements are met and any products or projects are completed.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP met most of the compliance and enforcement commitments/tasks in their FY2009 CWA Section §106 Work Plan. However, five program tasks were not met.
Explanation	KDEP's FY 2009 CWA §106 Grant Workplan describes planned inspection requirements; data management requirements; reporting/enforcement requirements; pretreatment facilities requirements; and policy, strategy and management requirements for the fiscal year. KDEP's FY 2009 Grant Work Plan contained 27 compliance and enforcement tasks with numerous sub tasks. Twenty-two of the Grant Workplan tasks were met. KDEP did not maintain the required level of data entry in PCS as required by the five tasks below. It is expected that data be entered manually in ICIS-NPDES if other mechanisms are not available: Task 15 – Enter inspection data for all NPDES program areas within 15 days of completion of the inspection report or no later than 45 days from the date of the inspection. This includes inspection data related to coal mining inspections. Task 16 – Enter and maintain data in ICIS-NPDES for all formal and informal actions, including penalties assessed and collected, within 30 days of issuance of the enforcement action and penalties collected within 30 days of data of collection. This includes enforcement actions and penalties related to coal mining activity. Task 17 – Enter and maintain data in ICIS-NPDES for all single event violations (SEV) within 90 days of inspection. Task 18 – Enter and maintain NPDES compliance and enforcement schedule data in ICIS-NPDES within 30 days of issuance. This includes schedule data related to coal mining actions.

	Task 19 –Enter completion of schedule milestones within 30 days of notification of completion. This includes milestones related to coal mining actions. Since five grant work plan tasks were not met, this is an area for state improvement.
Metric(s) and Quantitative Value(s)	<u>Metric</u> 4a – Planned inspections completed: 100% 4b – Planned commitments complete: 82% (22 of 27)
State Response	Kentucky will work to improve the communication of its TEMPO database to with ICIS NPDES to capture required program information. However, Tasks 16 and 17 will require automation to implement effectively, because the agency does not have enough resources to enter all the information manually.
Recommendation(s)	KDEP should promptly take actions to fulfill the commitments in the CWA §106 Grant Workplan and the requirements of the EPA/Kentucky NPDES MOA. This includes the entry of the required level of data into ICIS-NPDES. The State is expected to enter data into ICIS-NPDES whether such is automated or occurs manually. EPA's Region 4 CWEB will continue to monitor progress of this recommendation through the existing Work Plan review process. If, by March 31, 2012, it is shown that all FY11 Work Plan/MOA commitments have been met, this action will be considered completed.

CWA Element 5 – Inspection Coverage: Degree to which state completed the universe of planned inspections/compliance evaluations.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP met the core inspection requirements in their FY2009 CWA §106 Grant Workplan.
Explanation	Element 5 measures the degree that core inspection coverage is completed. In the OECA FY2009 National Program Managers (NPM) Guidance, there is a national goal of 100% annual inspection coverage of all major NPDES facilities, or equivalent coverage of a combination of major and priority minor facilities. The State submits annually a detail inspection plan based on the Compliance Monitoring Strategy (CMS) to the region. In the FY2009 Work Plan, KDEP committed to inspect 50% of their NPDES majors (102 major facility inspections) and 20% of their NPDES minor facilities (402) non-major individual permit inspections) based on the CMS. Per the data metrics and the end-of-year review of the Work Plan,

	KDEP exceeded their FY2009 core inspection commitments. As a result, there are no issues identified under this element and this meets SRF program requirements,
Metric(s) and Quantitative Value(s)	<table><tr><th>Data Metrics</th><th>Grant Workplan Goal</th><th>Data Metric</th></tr><tr><td>5a - Inspection Coverage - Majors</td><td>50% (65 majors)</td><td>77.7% (101 majors)</td></tr><tr><td>5b1- Inspection Coverage - Non-major individual permits</td><td>20% (402 non-majors)</td><td>31.8% (561 non-majors)</td></tr><tr><td>5b2- Inspection Coverage - non-major general permits</td><td>215</td><td>247</td></tr></table>
State Response	
Recommendation(s)	No further action needed.

CWA Element 6 – Quality of Inspection or Compliance Evaluation Reports: Degree to which inspection or compliance evaluation reports properly document observations, are completed in a timely manner, and include accurate description of observations.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP's mining inspection reports were not complete and did not contain the necessary documentation so proper compliance determinations could be drawn. Generally, inspection reports were completed in a timely manner for both mining and non-mining inspections.
Explanation	Element 6 file metrics evaluate inspection report completeness, determine if compliance determinations could be drawn from documentation found in the inspection files, and evaluate timeliness of the inspection reports. Thirty-one inspection reports were reviewed for this element: 18 non-mining facilities and 13 mining facilities. Of the 18 non-mining facility inspection reports, all were determined complete, (i.e., the inspection report contained the critical information found on the SRF inspection checklist) and all had proper documentation of inspection observations so proper compliance determinations could be drawn. Of the 13 mining facility inspection reports, 12 of 13 were determined to be incomplete based on the SRF inspection checklist. Examples of incomplete information found were insufficient descriptions of field activities, insufficient information on areas evaluated during the inspection such as site specific file records reviewed, and incomplete information on physical areas evaluated (i.e., outfalls, effluent/receiving

	streams, sludge handling, laboratory operations, and self-monitoring techniques). Also, 12 of 13 mining inspection reports did not have sufficient documentation such that proper compliance determinations could be drawn for all areas. EPA could not easily confirm whether the facility inspected complied with BMPs, permits, self-monitoring inspections, laboratory analyses, etc. In addition, no mining facilities DMR forms included the required information so that compliance could be easily drawn by a third party. This is an area for state improvement As to the timelines of completing mining and non-mining inspection reports, the SRF CWA File Review Plain Language Guide (PLG) states that the timeline for completing inspection reports should be the timeline in the state-specific Enforcement Management System (EMS). Since the State does not have a timeframe in the EMS, then the PLG default rate of 30 days is used. The review showed timeliness in completing inspection reports as being acceptable. With respect to KDEP's response that data needs to be automated between the state system and ICIS-NPDES, Task Element 11 of the grant work plan requires that all WENDB or RIDE data elements be entered into ICIS-NPDES within 15 days after the fact. This is irrespective of the availability of automatic data flow.
Metric(s) and Quantitative Value(s)	File Metric — State 6a - Inspection reports reviewed — 31 6b - % of inspection reports that were complete (19 of 31) — 61.3 % 6c - % reports reviewed with sufficient documentation for an accurate compliance determination (19 of 31) — 61.3 % 6d - % inspection reports reviewed that were timely (31 of 31) — 100%
State Response	In order for this to occur, data will have to be automated between Doctree and TEMPO and ICIS-NPDES because the agency does not have enough resources to enter all the information manually.
Recommendation(s)	KDEP needs to develop and implement a mining compliance plan to ensure mining inspection reports (which may be prepared by DMRE staff) are complete and include sufficient documentation to determine compliance for all areas reviewed. The plan should include KDEP's process to (1) lead inspections with DMRE/conduct oversight of DMRE's inspections, (2) provide training to DMRE and (3) ensure all DMRE inspections are sufficient and equivalent to KDEP's NPDES inspections. KDEP's plan should be developed and submitted to Region 4's Clean Water Enforcement Branch (CWEB) by June 30, 2012. In addition KDEP's FY 2013 CMS should clearly reflect the State's mining inspection commitments. The FY 2013 CMS draft is due to Region 4 by May 31, 2012, and should be finalized by July 15, 2012. If, by September 30, 2013, mining inspection reports are shown to be complete and contain sufficient documentation to determine compliance, this issue will be considered completed. The state is

	expected to enter data into ICIS-NPDES whether such is automated or occurs manually.

CWA Element 7 – Identification of Alleged Violations: Degree to which compliance determinations are accurately made and promptly reported in the national database based upon compliance monitoring report observations and other compliance monitoring information.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP does not report single event violations (SEVs) in the national database, but accurately makes compliance determinations.
Explanation	Data Metrics 7a1 and 7a2 tracks SEVs for active majors and non-majors, respectively, which are reported in PCS. SEVs are one-time or long-term violations discovered by the State, typically during inspections and not through automated reviews of Discharge Monitoring Reports. In FY2009, KDEP entered 1 SEV for majors and 0 SEVs for non-majors. Per Agency guidance, KDEP should ensure major facility SEVs are entered into the national data system. This pattern of not entering complete SEV data into the national data system is significant and is a carryover issue from Round 1. This is designated as an area for state improvement. Data Metrics 7b and 7c report, respectively, the percent of facilities with unresolved compliance schedule violations at the end FY2009, and the percent of facilities with unresolved permit schedule violations at the end of the FY2009. Data Metric 7c shows no facilities with unresolved permit schedule violations. For Data Metric 7b, KDEP's data shows 6 facilities (15.4%) with unresolved compliance schedule violations. Subsequent analyses indicate that 1 facility remains unresolved, but is on a schedule for completion that was not accurately reflected in PCS. For the remaining 5 facilities, PCS was updated by the State to reflect the actual date of compliance. Data Metric 7d reports the percent of major facilities with DMR violations in PCS. For KDEP, 64 of 130 major facilities (49.2%) have DMR violations reported to the national database. Data Metric 7d is slightly below the national average of 52.6%. To further analyze this data metric, five major facility files were examined to see if violations

	that appear on DMRs are correctly recorded in PCS. For all five facilities, all violations were coded correctly, so there are no additional actions necessary to address Data Metric 7d. File Review Metric 7e measures the percent of inspection reports reviewed that led to an accurate compliance determination. Since accurate compliance determinations were made for each cited violation, there are no additional actions required to address File Metric 7e.
Metric(s) and Quantitative Value(s)	Data Metrics — State 7a1 - # SEVs at active majors — 1 7a2 - # SEVs at non-majors — 0 7b - % facilities with unresolved compliance schedule violations — 15.4% 7c - % facilities with unresolved permit schedule violations — 0% 7d - Major facilities with DMR violations — 49.2% File metric — State 7e - % inspection reports reviewed that led to an accurate compliance determination (31 of 31) — 100%
State Response	As with other elements that involve increasing the volume of data supplied to ICIS NPDES, this must be automated (dataflows) between TEMPO and ICIS to be practical. The agency does not have the resources to enter this information manually.
Recommendation(s)	KDEP should immediately take steps to begin reporting SEVS for NPDES major facilities into ICIS-NPDES. As required by the Work Plan, all single event violations should be entered within 90 days of the inspection, but no later than December 31 for the prior fiscal year cycle. Region 4's CWEB will immediately begin monitoring the progress of this recommendation through quarterly Pacesetter calls and/or other routine calls. The state is expected to enter data into ICIS-NPDES whether such is automated or occurs manually. If, by December 31, 2012, SEVs are being appropriately entered in the national data system, this issue will be considered completed.

CWA Element 8 – Identification of SNC and HPV: Degree to which the state accurately identifies significant noncompliance/high priority violations and enters information into the national system in a timely manner.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP identifies and reports SNCs into PCS.
Explanation	Element 8 addresses the accurate identification of SNCs and the timely entry of SEVs that are SNCs into the national system.

	(1) Accurate identification of SNCs: Data Metric 8a1, the active major facilities in SNC during the reporting year, lists 16 facilities as SNC during FY2009. To verify the accuracy of SNC data in PCS, six facilities were evaluated during the SRF file review process to see if the SNC designations were supported by the files. Of the facilities reviewed, five had information in the files that matched the information in the data system. Thus Kentucky accurately identifies SNCs. For Data Metric 8a2, percent of active major facilities in SNC during the reporting year, the metric shows 12.1% (16/132). The national average is 22.6%. Kentucky's level of SNC identification is below the national average and, thus, in line with the national program. No further action is needed. ((2) Accurate identification of SEVs as SNC & timely entry of SEVs that are SNCs into PCS: As discussed in Element 7, KDEP does not report SEVs into PCS and the file reviews did not identify any SNC SEVs. As a result, SEVs were not evaluated for timely data entry.
Metric(s) and Quantitative Value(s)	Data Metric — National Average — State 8a1 - Number of major facilities in SNC — 16 8a2 - % active major facilities in SNC — 22.6%. — 12.1% File Metric — State 8b - % SEVs that are accurately reported as SNCs or non-SNCs — n/a 8c - % SEVs that are SNCs timely reported in PCS — n/a
State Response	
Recommendation(s)	No further action needed.

CWA Element 9 - Enforcement Actions Promote Return to Compliance: Degree to which state enforcement actions include required corrective action (i.e., injunctive relief or other complying actions) that will return facilities to compliance in a specific time frame.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP's enforcement actions generally do not include complying or corrective action that will return facilities to compliance in a specified time frame for SNC facilities, but includes a complying or corrective action for non-SNC facilities.
Explanation	As referenced in the 1989 National EMS, formal enforcement "requires actions to achieve compliance, specifies a timetable, contains consequences for noncompliance that are independently enforceable without having to prove the original violation, and subjects the person to adverse legal consequences for noncompliance."

	KDEP's Enforcement Management System revised in 2008 discusses the jurisdictions, statutes, organization, compliance processes and enforcement processes for both mining and non-mining programs. Examples of formal enforcement actions include: Abate and Alleviate Orders issued by the Cabinet, Secretary's Orders, and Agreed Orders signed by the Cabinet Secretary. On the other hand, examples of informal actions include Demand Letters signed by Division of Enforcement management, notices of violations, letters of warnings, etc. For File Metric 9a, EPA reviewed a total of five SNC and 20 non-SNC facility enforcement files totaling 65 enforcement actions, 50 informal actions and 15 formal actions. This number of enforcement actions exceeds the number of facility enforcement files reviewed as it is common for multiple enforcement actions to occur at a facility in the same year due to exceedences from monthly DMRs File Metric 9b is the percentage of enforcement responses reviewed that has returned or will return a source in SNC to compliance. Of the five SNC actions reviewed, three contained enforcement responses that returned or will return the source to compliance. The remaining two SNC facility files reviewed did not contain enforcement responses that either returned or will return a source to compliance. KDEP must ensure that formal actions specify a timetable to achieve compliance and contain requirements that will return the facility to compliance. This is a significant issue and is a continuing concern identified in Round 1. This is an area for State improvement. File Metric 9c is the percentage of enforcement responses reviewed that has returned or will return a non-SNC violation to compliance. Of the 53 actions at non-SNC facilities, 49 (93%) had compliance schedules that have or will return the non-SNC violations to compliance or were penalty-only actions where the facility had a previous action that returned or will return the violation to compliance. The other four enforcement actions taken at non-SNC facilities did not have compliance schedules. These four instances do not constitute a pattern of deficiencies or a significant problem. The State should self correct these infrequent occurrences without additional EPA oversight and thus, this file metric meets SRF requirements.
Metric(s) and Quantitative Value(s)	File Metric — Results Metric 9a – # of Enforcement Responses Reviewed — 65 Metric 9b - % of Enforcement Responses that have returned or will return a source in SNC to compliance (3/5) — 60% Metric 9c - % of Enforcement Responses that have or will return a source non-SNC violations to compliance (49 /53) — 93%

State Response	
Recommendation(s)	KDEP should take immediate steps to ensure formal enforcement actions not only have complying actions but include a specific time table to address SNC violations. Region 4's CWEB will evaluate formal responses developed and/or executed by Kentucky to ensure the actions appropriately address SNC violations through the quarterly Pacesetter calls and/or other routine calls. If, by December 31, 2012, it is seen that formal enforcement actions include specific time tables for addressing SNC violations, this issue will be considered completed.

CWA Element 10 - Timely and Appropriate Action: Degree to which a state takes timely and appropriate enforcement actions in accordance with policy relating to specific media.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP generally does not take timely or appropriate enforcement action for SNCs in accordance with the NPDES EMS Guidance on Timely and Appropriate Response to SNC.
Explanation	The 1989 National EMS and the May 29, 2008, memo *Clarification of NPDES EMS Guidance on Timely and Appropriate Response to Significant Noncompliance* defines timely and appropriate enforcement response for SNC violations at major facilities. These documents state that timely action is where a formal enforcement action is taken before the violations appears on the second quarterly non-compliance report (QNCR), generally within 60 days of the first QNCR. KDEP noted in their response that they disagree with this conclusion as it did not completely align with the timelines as written in their NPDES MOA. Although written slightly differently, the MOA still provides for a timely enforcement action within 60 days. Data Metric 10a shows 9.1 % (12 of 132) major facilities without timely action. The national goal for this data metric is less than 2%. KDEP provided additional information on the 12 facilities. For five facilities, EPA agreed that an enforcement action was never required or that the violations were addressed under a previously executed order. Thus only 5.3% (7 of 132) of KDEP's SNCs were not addressed in a timely manner. The revised data still supports a need for KDEP to improve the timeliness of their enforcement actions for SNC violations at major facilities and is an area for state improvement. File Metric 10b is used to assess the accuracy of data metric 10a. Five

<table>
<tr><td></td><td>files with SNCs at major sources were reviewed. Only 40% (2 of 5) showed timely action using the timeframes established in EPA's timely and appropriate guidance. This supports Data Metric 10a and the need for the state to improve the time it takes to commence a formal action for a major source SNC.

File Metric 10c assesses whether the enforcement action taken for a SNC is appropriate, meaning was a formal enforcement action taken or, if informal action, was there a written record to justify informal enforcement action. Of the five SNC files reviewed, three contained a formal enforcement action (meaning the action contained a compliance date and an action that requires the source to return to compliance). For the other two SNC files reviewed, the enforcement tool used had no complying action or complying date. KDEP should adhere to EPA's guidance that requires formal action for all major facility SNCs. This is an area for state improvement.

File Metric 10d assesses whether the enforcement action taken for a non-SNC is appropriate. Ninety–six percent (51 of 53) of enforcement responses reviewed appropriately addressed non-SNCs.

File Metric 10e examines the timeliness of enforcement for non-SNCs. Since there is no EPA guidance for timeliness of enforcement for non-SNCs and KDEP did not include timeframes for non-SNCs in the State EMS, File Metric 10e was not evaluated.</td></tr>
<tr><td>Metric(s) and Quantitative Value(s)</td><td>
<table>
<tr><th>Data Metric</th><th>National Goal</th><th>State (Revised)</th></tr>
<tr><td>10a - Major facilities without timely action</td><td><2%</td><td>5.2 %</td></tr>
<tr><th>File Metric</th><th></th><th>State</th></tr>
<tr><td>10b - % timely SNC enforcement responses (2 of 5)</td><td></td><td>40 %</td></tr>
<tr><td>10c - % of enforcement responses that appropriately address SNC violations (3 of 5)</td><td></td><td>60 %</td></tr>
<tr><td>10d - % of enforcement responses that appropriately address non-SNC violations (51 of 53)</td><td></td><td>96 %</td></tr>
<tr><td>10e - % timely non-SNC enforcement responses</td><td></td><td>n/a</td></tr>
</table>
</td></tr>
</table>

State Response	KDEP disagrees with the explanation and conclusion. "Timely and appropriate" is defined on pp. 21-23 of the "National Pollutant Discharge Elimination System Memorandum of Agreement Between the Commonwealth of Kentucky and the United States Environmental Protection Agency Region 4" (MOA). This document was signed by the Cabinet Secretary of February 14, 2008 and the US EPA Region 4 Administrator on March 10, 2008. The MOA lays out the following schedule for timely enforcement: • 30 days to determine the appropriate initial response to a violation • 30 days from determination to commence the appropriate enforcement action • 60 days from identification of the violation to document the appropriate response in the file • Follow-up with other, more significant enforcement action once the initial response proves not to be effective
Recommendation(s)	KDEP should immediately take steps to ensure that timely and appropriate enforcement is used to address SNCs as established by the NPDES EMS Guidance on Timely and Appropriate Response to Significant Noncompliance. Specifically, KDEP needs to take formal actions against all SNC violations at major facilities (or a written record to justify an informal action) and ensure that a formal action or return to compliance has occurred before the violations appear on the second quarterly non-compliance report (QNCR), generally within 60 days of the first QNCR. Region 4's CWEB will oversee KDEP's adherence to the Agency's CWA timely and appropriate guidance through the quarterly Pacesetter calls and/or other routine calls. If by January 31, 2013 timely and appropriate enforcement responses are being observed, this issue will be considered completed.

CWA Element 11 - Penalty Calculation Method: Degree to which state documents in its files that initial penalty calculation includes both gravity and economic benefit calculations, appropriately using the BEN model or other method that produces results consistent with national policy.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	Kentucky's files did not contain complete documentation of the penalties assessed, so EPA could not evaluate how economic benefit or gravity components of a penalty are addressed.
Explanation	Element 11 examines the state documentation of its penalty

	calculations. Specifically, the metric determines if the state penalty includes a gravity component and, where appropriate, economic benefit. For non-mining facilities, the procedures to assess penalties are based on eight factors defined in *NRECP vs. Wendell Maggard,* a state administrative case which set out factors to be used to determine penalties under KRS 224.99. The factors include both gravity and an economic benefit component and are consistent with EPA policy. The procedures for the assessment of civil penalties for mining facilities are described in 405 KAR 7:095. DMRE penalty procedures use the point system as a basis for assessing penalty. Economic benefit is not considered unless multiple violations points are assessed. There are points which relate to dollar amounts assessed for the gravity component of the penalty, as applicable. The 14 files reviewed (including 4 mining facilities), did not contain penalty calculations to show gravity and economic benefit. EPA could not determine how the economic benefit and gravity portion of the penalties were assessed or recovered or whether the BEN model or equivalent was used appropriately. KDEP asserts that statutory provisions in KRS 13A.130 and KRS 224.99 preclude them from documenting penalty calculation information. KDEP's General Counsel states that detailed civil penalty calculations would constitute guidance in clear violation of KRS 13A.130. EPA does not agree that the documentation of penalty calculations is prohibited by KRS 13A.130 because such documentation does not expand or limit the underlying statute (KRS 224.99) but rather implements the statue by reflecting how the Maggard factors were applied. Failure to appropriately document penalty calculations is a continuing issue from Round 1 of the SRF and is an area for state improvement.
Metric(s) and Quantitative Value(s)	File Metric — State 11a - % of penalty calculations reviewed that consider and include where appropriate gravity and economic benefit, consistent with national policy (0 of 14) — 0%

State Response	The KDEP is subject to KRS 13A-130, which prohibits modifying or expanding a statute or regulation by internal policy, memorandum, or other form of action. The Cabinet's Office of General Counsel has, in very strong terms, recommended that penalties be established for the entire case and not on a violation-by-violation basis. In accordance with this recommendation, KDEP determines the civil penalty in accordance with KRS 224.99 using the factors determined listed in "NREPC vs. Wendell Maggard". This method of establishing penalty has been upheld by the Kentucky Court of Appeals. U.S. EPA's criteria for documenting penalty calculations are contrary to Kentucky law.
Recommendation(s)	By September 30, 2012, KDEP should submit and implement procedures for the documentation of penalty calculations, including both gravity and economic benefit calculations, appropriately using the BEN model or other method that produces results consistent with national policy. This documentation should be made available for review by EPA. If, by December 31, 2012, EPA observes a pattern of appropriate penalty calculation documentation, this issue will be considered completed.

CWA Element 12 - Final Penalty Assessment and Collection: Degree to which differences between initial and final penalty are documented in the file along with a demonstration in the file that the final penalty was collected.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP does not generally document the rationale between initial and assessed penalty. Files reviewed had documentation that the penalty was collected.
Explanation	File Metric 12a evaluates the percentage of files with penalties where the state documented the difference between the initial and final penalty. For nine (non-mining) penalty cases, KDEP provided a Case Resolution Sheet that discusses the eight Maggard Factors used to assess the initial penalty. The State did not provide adequate documentation and rationale for the final penalty assessed for nine cases. Thus, no assessment could be made on any differences between an initial and final penalty for any non-mining case.

	Five mining penalty cases were reviewed. For two mining penalty actions, DMRE did provide documentation and rationale for the final penalty assessed although both assessed and final penalty amounts were the same so no additional documentation was required. For the other three penalty actions, the State did not provide adequate rationale for the difference between the initial and final penalty assessed. This is a continuing problem from Round 1 of the SRF and is an area for state improvement. For File Metric 12b, 100% (13 of 13) of the enforcement actions with penalties documented collection of penalty. Copies of the checks or check stubs were found in the enforcement files. This meets the SRF program requirements for this metric.
Metric(s) and Quantitative Value(s)	File Metric — State 12a - % of formal enforcement actions that document the difference and rational between initial and final assessed penalty (2 of 14) — 14% 12b - % of final enforcement actions that document collection of final penalty (13 of 13) — 100%
State Response	KDEP disagrees that initial and final penalty calculations are not maintained. Before entering into a negotiation, KDEP establishes an initial penalty offer, a penalty goal, and a minimum penalty. KDEP staff is allowed to negotiate within this range without further approval from management. If negotiations move outside of this range, management approval and additional documentation is required. When negotiations move the civil penalty out of the approved range, KDEP prefers to refer the case to the Office of General Counsel (OGC) and have a complaint filed with the Office of Administrative Hearings. However, KDEP must be cognizant of OGC staffing limitations and the staffing resources required to move a case through the administrative hearing process and the lengthy amount of time it takes to move a case through hearings. On a case-by-case basis, KDEP will determine whether it is better to refer a case to the administrative process or to settle for a smaller civil penalty and more immediate injunctive relief.
Recommendation(s)	As part of the recommendation in Element 11, the procedures to calculate penalties should also include how the state will document differences between the initial and final penalty. If, by December 31, 2012 documentation of differences between initial and final penalties are being observed, this issue will be considered completed.

Resource Conservation and Recovery Act Program:

RCRA Element 1 – Data Completeness: Degree to which the Minimum Data Requirements are complete.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP has entered the MDRs into RCRAInfo for regulated universes, compliance monitoring and enforcement information.
Explanation	Element 1 is supported by SRF Data Metrics 1a through 1g, and measures the completeness of the data in RCRAInfo. EPA provided the SRF data metrics to KDEP for comment on April 16, 2010. In their response, KDEP only highlighted data differences in the five year inspection coverage for active SQGs. Thirty-two (32) of the 82 SQGs not inspected in the last five years either registered as generators or modified their generator status from CESQG to SQG in the last half of FY2009 or in FY2010. According to KDEP, these facilities have not been inspected in the last five years because they have only been SQGs 18 months or less. Based on this information, KDEP inspected 88% of the SQG universe during the five year timeframe. Since there is no national goal for SQGs, the 88% inspection coverage is acceptable. The RCRAInfo data is considered complete since there were no other data inaccuracies noted.
Metric(s) and Quantitative Value(s)	Data Metrics — Frozen State Data 1a1 - # of operating TSDFs in RCRAInfo: 14 1a2 - # of active LQGs in RCRAInfo: 276 1a3 - # of active SQGs in RCRAInfo: 446 1a5 - # of LQGs per latest official biennial report: 269 1b1 - # of inspections: 947 1c1 - # of sites with violations: 213 1d2 - Informal Actions: number of actions: 211 1e1 - SNC: number of sites with new SNC: 16 1e2 - SNC: number of sites in SNC: 25 1f2 - Formal action: number taken: 12 1g - Total amount of assessed penalties: $61,000
State Response	
Recommendation(s)	No further action is needed.

RCRA Element 2 – Data Accuracy: Degree to which data reported into the national system is accurately entered and maintained	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	In general, KDEP accurately reports data into RCRAInfo. There were only a few instances of missing and/or incorrect data elements in RCRAInfo and/or the files.
Explanation	RCRA Element 2 is supported by data metrics 2a, 2b, and file review metric 2c and measures the accuracy of data in RCRAInfo. Data metrics 2a1 and 2a2 compare the date of the SNC determination with the date of the first formal action that comes after the SNC. This is a potential indicator of the state delaying the SNC identification in RCRAInfo until the enforcement action is taken. This practice negates the ability to see if the enforcement action was timely (i.e. taken within 270 days of SNC determination). KDEP had 12 formal actions in FY2009 and all actions were taken at least one week after the SNC determination. Therefore, delayed SNC entry into RCRAInfo is not a concern. Data metric 2b measures the longstanding RCRA secondary violators (non-SNCs) that are not "returned to compliance" or redesignated as SNC. Data problems in this area can result in the display of inaccurate compliance status. According to the RCRA Enforcement Response Policy (ERP), all secondary violators should be returned to compliance within 240 days, or elevated to SNC status and addressed through formal enforcement. In FY09, KDEP had three facilities in SV status greater than 240 days. Since the time of the SRF review, the three facilities have been evaluated and resolved by either designating the facility as a SNC, taking appropriate enforcement, and/or by returning the facility to compliance. Although KDEP should be more diligent in ensuring all SVs are appropriately addressed by day 240, the three facilities that were identified as longstanding and subsequently resolved by KDEP do not constitute a concern. File review metric 2c measures the percentage of files where corresponding data was reported accurately in RCRAInfo. If any relevant information in the inspection reports, enforcement actions, or civil and administrative enforcement responses is missing or reported inaccurately in RCRAInfo, the data for that file is considered inaccurate. A total of 27 files were reviewed. Of the 27 files reviewed, 23 (85%) had complete and accurate data reported in RCRAInfo. Among the many data elements examined for each file, there were only

	four instances of inaccurate data either in the file or RCRAInfo. • In one file, the date of the final order was not entered into RCRAInfo. • In second file, the date of the enforcement referral review did not match the SNY date. • In the third file, the follow up inspection date was not entered into RCRAInfo. • In the fourth file, the date of the initial civil judicial action for compliance was entered into RCRAInfo; however, reference to this action was not found in TEMPO. Since the number of data inaccuracies found does not constitute a serious problem, data accuracy is not an area of concern.
Metric(s) and Quantitative Value(s)	Data Metrics — State 2a1 - # of sites SNC determinations made on day of formal action — 0 2a2 - # of sites SNC determinations made within one week of formal action — 0 2b – # of sites in violation greater than 240 days — 3 File Review Metric — State 2c – % files with accurate data elements in RCRAInfo — 85%
State Response	
Recommendation(s)	No formal recommendation is being tracked for this element.

RCRA Element 3 - Timeliness of Data Entry: Degree to which the Minimum Data Requirements are timely.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	All SNCs were entered timely into RCRAInfo.
Explanation	RCRA Element 3 is supported by SRF Data Metric 3a, which measures the percentage of SNCs that are entered into RCRAInfo more than 60 days after the SNC determination date. It is used as an indicator of late data entry. According to the RCRA ERP, SNCs should be entered into RCRAInfo upon SNC determination, and not withheld to enter at a later time. For FY2009, data metric 3a indicates that 11 of 15 SNCs were entered into RCRAInfo within 60 days. Upon further investigation, it was determined that the four facilities shown as being untimely were

	initially designated as SVs. Day zero is calculated differently for SNCs that were initially designated as SVs. Data metric 3a does not account for this situation. When data metric 3a is adjusted for this, the four SNCs appear to have been timely identified. Therefore, all of KDEP SNCs were entered timely in RCRAInfo. When these facilities are removed from the metric calculation, the SNC universe becomes 11 instead of 15, and thus KY does not have an issue with timeliness of data entry.
Metric(s) and Quantitative Value(s)	Data Metrics — State (initial) — Revised 3a –% of SNCs that were entered within 60 days — 73% (11 of 15 — 100% (11 of 11)
State Response	
Recommendation(s)	No further action is needed.

RCRA Element 4 - Completion of Commitments: Degree to which all enforcement/compliance commitments in relevant agreements are met and any products or projects are completed.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	For FY2009, KDEP met all of the compliance monitoring commitments from their RCRA grant workplan.
Explanation	In the KDEP RCRA grant workplan for FY2009, the State included specific *commitments* and *projections* for inspection and enforcement activity. There are grant workplan *commitments* for compliance monitoring activities, which include core program inspections for TSDs, LQGs, and SQGs. Workplan *projections* are included for record reviews, compliance assistance visits, workshops, enforcement actions, etc. These projected activities are not always within the control of the State and are therefore not actual workplan commitments. All of the planned compliance monitoring commitments was completed, and the majority of the workplan projections were met in FY2009.
Metric(s) and Quantitative Value(s)	File Metric — State 4a – Planned inspections complete — 100% 4b – Planned commitments complete — 100%
State Response	
Recommendation(s)	No further action is needed.

RCRA Element 5 – Inspection Coverage: Degree to which state completed the universe of planned inspections/compliance evaluations.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP completed core inspection coverage for RCRA TSDs (two-year coverage) and LQGs (one-year and five-year coverage).
Explanation	Element 5 is supported by data metrics 5a, 5b, and 5c. The OECA NPM Guidance provides the core program inspection coverage for TSDs and LQGs. KDEP met the two-year TSD inspection requirement (Metric 5a) and exceeded the annual requirement for LQG inspections (Metric 5b). The OECA NPM Guidance also provides that 100% of the RCRA LQGs must receive a Compliance Evaluation Inspection (CEI) every five years. SRF Data Metric 5c shows that 98.9% (266 of 269) of the LQGs received a CEI between FY2004-FY2009. This metric uses the LQG universe from the RCRA Biennial Reporting System (BRS), and includes LQGs that reported in the 2005 and/or 2007 BRS reporting cycles. There were only three facilities that were not LQGs for the entire five-year period (as recorded in the BRS). This is not a cause for concern.
Metric(s) and Quantitative Value(s)	Data Metrics / National Goal / State 5a - TSD inspection coverage (2 years) / 100% / 100% 5b - LQG inspection coverage (1 year) / 20% / 61.7% 5c - LQG inspection coverage (5 years) / 100% / 98.9% (266 of 269)
State Response	
Recommendation(s)	No further action is needed.

RCRA Element 6 – Quality of Inspection or Compliance Evaluation Reports: Degree to which inspection or compliance evaluation reports properly document observations, are completed in a timely manner, and include accurate description of observations.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP's RCRA inspection reports were of very good quality, found complete, and provided documentation to appropriately determine compliance. KDEP is timely in the completion of the majority of their inspection reports.
Explanation	Element 6 is supported by SRF file review metrics 6a, 6b, and 6c.

	Metric 6a identifies the number of inspection reports reviewed. During the file review, 23 inspection reports were reviewed. File Metric 6b assesses the completeness of inspection reports and whether they provide sufficient documentation to determine compliance at the facility. Of the inspection reports reviewed, 100% (23 of 23) had sufficient documentation to determine compliance at the facility. In addition, 96% (22 of 23) of the inspection reports were considered complete. For the inspection report found incomplete, details on the type of hazardous waste generated/regulated at the facility were not included, and the description of the facility was very limited. File review metric 6c measures the timely completion of inspection reports. Absent a state-defined deadline for the completion of inspection reports, the EPA Region 4 guideline of 45 days was used in the file review metric, and 91% (21 of 23) of the inspection reports were completed in this timeframe. Based on these findings, no action is required by the state.
Metric(s) and Quantitative Value(s)	File Review Metrics — State 6a - # of inspection reports reviewed — 23 6b - % of inspection reports that are complete — 96% (22 of 23) 6c - % of inspection reports that are timely — 91% (45 days)
State Response	
Recommendation(s)	No further action is needed.

RCRA Element 7 - Identification of Alleged Violations: Degree to which compliance determinations are accurately made and promptly reported in the national database based upon compliance monitoring report observations and other compliance monitoring information.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	For KDEP, all of the inspection reports reviewed included correct compliance determinations, and the inspection findings were promptly entered into RCRAInfo.
Explanation	File metric 7a assesses whether accurate compliance determinations were made based on inspection reports. Of the 23 inspection reports reviewed, 100% had accurate compliance determinations (i.e., proper identification of SNCs or SVs). File Metric 7b assesses whether determination of violations is reported

	to RCRAInfo in a timely manner. The RCRA Enforcement Response Policy (ERP) states that compliance determinations for either SNC or SVs should be reported at the time the determination is made but no later than Day 150. Twenty-three files were examined to see if the documentation of a violation (e.g. a formal or informal action was taken) was entered into RCRA Info within 150 days of the inspection. For all 23 files, the violation was reported into RCRA Info by day 150.
Metric(s) and Quantitative Value(s)	File Review Metrics — State 7a - % of inspection reports reviewed that led to accurate compliance determinations — 100% 7b - % of violation determinations in the files that are reported within 150 days — 100%
State Response	
Recommendation(s)	No further action is needed.

RCRA Element 8 - Identification of SNC and HPV: Degree to which the state accurately identifies significant noncompliance/high priority violations and enters information into the national system in a timely manner.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	In the files reviewed, KDEP correctly identified SNC and SV violations.
Explanation	Data metric 8a identifies the percentage of the facilities evaluated by the State during FY2009 that received a state SNC designation. KDEP's SNC identification rate is 2.1%, which means that 16 of the 755 inspections conducted were identified as SNCs. The 2.1% SNC identification rate is slightly above the national goal of 1.6%. Data metric 8b measures the number of SNCs determinations that were made within 150 days of the first day of inspection, which is the requirement in the RCRA ERP. In FY2009, Kentucky entered 100% (15 of 15) of their SNCs into RCRAInfo in a timely manner. The national goal is 100%. File Metric 8d measures the percentage of violations in the files that were accurately determined to be in SNC. It serves as a verification measure for data metric 8a. In the 23 inspection reports reviewed, 14 were identified as SNCs. All 14 (100%) contained violations that were accurately determined to be SNCs. In the other nine inspections reports, the violations were accurately determined to be non-SNCs. Thus, KDEP accurately identifies SNCs.

Metric(s) and Quantitative Value(s)	Data Metrics — State 8a - SNC identification rate — 2.1% 8b - % of SNC determinations made within 150 days — 100% File Review Metric 8d - % of violations in files reviewed that were accurately determined to be SNC — 100% (14 of 14)
State Response	
Recommendation(s)	No further action is needed.

RCRA Element 9 - Enforcement Actions Promote Return to Compliance: Degree to which state enforcement actions include required corrective action (i.e., injunctive relief or other complying actions) that will return facilities to compliance in a specific time frame.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	In the files reviewed, 100% of SNCs and 100% of SVs were issued enforcement responses that included corrective action to return the facilities to compliance.
Explanation	EPA reviewed a total of 25 enforcement responses: 14 SNCs and 11 SV under file review metric 9a. File review metric 9b is the percentage of the SNC enforcement responses reviewed that returned or will return the facility to compliance. From a review of the files, all 14 had documentation in the files showing the source returned to compliance or that the enforcement action required them to return to compliance in a specified timeframe. File review metric 9c is the percentage of SV enforcement responses reviewed that returned or will return the facility to compliance. From a review of the files, all 11 had documentation in the files showing the source returned to compliance or that the enforcement action required them to return to compliance in a specified timeframe.
Metric(s) and Quantitative Value(s)	File Review Metrics — State 9a - # of enforcement responses reviewed — 14 SNCs 11 SVs 9b - % of enforcement responses that returned SNCs to compliance — 100% (14 of 14) 9c - % of enforcement responses that returned SVs to compliance — 100% (11 of11)
State Response	

Recommendation(s)	No further action is needed.

RCRA Element 10 - Timely and Appropriate Action: Degree to which a state takes timely and appropriate enforcement actions in accordance with policy relating to specific media.	
This finding is a(n)	☑ Meets SRF Program Requirements ❒ Area for State Attention ❒ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP takes appropriate and timely enforcement actions.
Explanation	Element 10 is supported by Data Metrics 10a, and File Review Metrics 10c and 10d. Data Metric 10a reflected a 62.5% (10/16) timeliness rate for addressing SNCs. This means that 10 of 16 enforcement actions at SNCs had been taken with the required time of 360 days from the inspection date. The goal is for 80% of SNCs to receive enforcement or be referred to the state attorney general within the time requirement. Upon examination during the on-site review, KDEP noted several discrepancies with their data. In reality, the state did meet the 80% goal as one enforcement action was rescinded and two others were taken within 360 days. When the data is adjusted for these discrepancies, 12 or 15 (80%) SNCs were addressed timely. File review metric 10c also measures the timeliness of enforcement responses for both SVs and SNCs. It partly serves as a verification measure for 10a. Twenty-five enforcement actions were reviewed for timeliness (11 SVs and 14 SNCs) The reviewed showed: • SV timeliness: All 11 SV enforcement actions at SVs were taken in a timely manner (i.e., within 240 days). • SNC timeliness: Eleven of the 14 (79%) enforcement actions at SNCs were taken within the 360-day timeframe. Timeliness of enforcement actions at SVs and SNCs is not considered an area of concern. File Review Metric 10d assesses the appropriateness of enforcement actions for SVs and SNCs. For KDEP, 100% of the SVs and SNC enforcement responses that were reviewed addressed the violations appropriately. This means that for SNCs, all actions were formal enforcement actions that appropriately and expeditiously returned the source to compliance and for SVs all were identified as SNCs. All 14 (100%) contained violations that were accurately determined to be SNCs. For the remaining 9 inspection reports, the violations were

	accurately determined to be non-SNCs. KDEP accurately identifies SNCs.
Metric(s) and Quantitative Value(s)	Data Metric / National Goal / State 10a - % timely SNC actions / 80% / 80%(12/15) File Review Metrics / State 10c - % of enforcement actions taken in a timely manner / SV 100% (11/11); SNC 79% (11/14); Combined 88% (22/25) 10d - % of enforcement actions that are appropriate to the violations / 100% (25/25)
State Response	
Recommendation(s)	No formal recommendation is being tracked for this element.

RCRA Element 11 – Penalty Calculation Method: Degree to which state documents in its files that the initial penalty calculation includes both gravity and economic benefit calculations, appropriately using the BEN model or other method that produces results consistent with national policy.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP does not adequately document penalty calculations in their enforcement files in accordance with Agency policy.
Explanation	Element 11 examines the state documentation of its penalty calculations. Specifically, the metric determines if the state penalty includes a gravity component and, where appropriate, economic benefit. For all 14 penalties reviewed, there was no documentation in the files to show how the penalties were calculated. KDEP uses factors referred to as the Maggard Factors when determining penalty. *NREPC v. Wendell Maggard* was a state administrative case which set out factors to be used to determine penalties under KRS 224.99. The factors include both a gravity and economic benefit component and are consistent with EPA's policies. KDEP asserts that statutory provisions in KRS 13A.130 and KRS 224.99 preclude them from documenting penalty calculation information. KDEP's General Counsel states that detailed civil penalty calculations would constitute guidance in clear violation of KRS 13A.130. EPA does not agree that the documentation of penalty calculations is prohibited by KRS 13A.130 because such documentation does not expand or limit the underlying statute (KRS 224.99) but rather

	implements the statue by reflecting how the Maggard factors were applied. Failure to appropriately document penalty calculations is a continuing issue from Round 1 of the SRF and is an area for state improvement.
Metric(s) and Quantitative Value(s)	File Review Metric — State 11a - % of penalty calculations reviewed that consider and include where appropriate gravity and economic benefit consistent with national policy — 0%
State Response	The KDEP is subject to KRS 13A-130, which prohibits modifying or expanding a statute or regulation by internal policy, memorandum, or other form of action. The Cabinet's Office of General Counsel has, in very strong terms, recommended that penalties be established for the entire case and not on a violation-by-violation basis. In accordance with this recommendation, KDEP determines the civil penalty in accordance with KRS 224.99 using the factors determined listed in "NREPC vs. Wendell Maggard". This method of establishing penalty has been upheld by the Kentucky Court of Appeals. U.S. EPA's criteria for documenting penalty calculations are contrary to Kentucky law.
Recommendation(s)	By September 30, 2012, KDEP should submit and implement procedures for the documentation of penalty calculations, including both gravity and economic benefit calculations, appropriately using the BEN model or other method that produces results consistent with national policy. This documentation should be made available for review by EPA. If, by December 31, 2012 appropriate penalty calculation documentation is being observed, this issue will be considered completed.

RCRA Element 12 - Final Penalty Assessment and Collection: Degree to which differences between initial and final penalty are documented in the file along with a demonstration in the file that the final penalty was collected.	
This finding is a(n)	❒ Meets SRF Program Requirements ❒ Area for State Attention ☑ Area for State Improvement – Recommendations Required ❒ Good Practice
Finding	KDEP does not document the rationale between the initial and final penalties. KDEP does document the collection of penalties assessed.
Explanation	File Metric 12a evaluates the percentage of files with penalties where the state documented the difference between the initial and final penalty. As discussed under Element 11, KDEP does not include penalty calculation documentation of any kind in its files. Thus, the files do not reflect the differences in initial and final penalties or the rationale for those differences. This is a continuing problem from Round 1 of the SRF and is an area for state improvement.

	Files Metric 12b evaluates whether the collection of penalties is documented. Kentucky maintains records of all penalty collections both in the file and through a central financial database. Of the 14 enforcement orders reviewed as part of the SRF, all had documentation that penalties were collected. This meets the SRF program requirements for this metric.
Metric(s) and Quantitative Value(s)	File Review Metrics — State 12a - % of formal enforcement actions that document the difference and rationale between initial and final assessed penalty — 0% 12b - % of final formal actions that document the collection of the final penalty — 100% (14 of 14)
State Response	The KDEP disagrees that initial and final penalty calculations are not maintained. Before entering into a negotiation, KDEP establishes an initial penalty offer, a penalty goal, and a minimum penalty. KDEP staff is allowed to negotiate within this range without further approval from management. If negotiations move outside of this range, management approval and additional documentation is required. When negotiations move the civil penalty out of the approved range, KDEP prefers to refer the case to the Office of General Counsel (OGC) and have a complaint filed with the Office of Administrative Hearings. However, KDEP must be cognizant of OGC staffing limitations and the staffing resources required to move a case through the administrative hearing process and the lengthy amount of time it takes to move a case through hearings. On a case-by-case basis, KDEP will determine whether it is better to refer a case to the administrative process or to settle for a smaller civil penalty and more immediate injunctive relief.
Recommendation(s)	As part of the recommendation in Element 11, the procedures to calculate penalties should also include how the state will document differences between the initial and final penalty. If, by December 31, 2012 differences between initial and final penalties are being observed, this issue will be considered completed.

ELEMENT 13

The Field Operations Branch has collected elemental mercury and mercury containing devices from individuals for recycling when calls are received regarding disposal of these items as household hazardous waste.

APPENDIX A: STATUS OF RECOMMENDATIONS FROM PREVIOUS REVIEWS

During the first SRF review of KDEP's compliance and enforcement programs, Region 4 identified a number of actions to be taken to address issues found during the review. The table below shows the status of progress toward completing those actions.

State	Status	Due Date	Media	Element	Finding	Completion Verification
KY - Round 1	Completed	11/30/2007	CAA E1	Inspection Universe	KDEP should analyze why the data system does not credit all the FCEs at their Title V and propose measures that will ensure the implementation and fulfillment of its CMS Plan.	KDEP researched data quality problems between AFS and KY's database and corrected discrepancies. Data quality in AFS is now believed to be extremely high and very closely agrees with KY's TEMPO database records.
KY - Round 1	Completed	11/30/2007	CAA E4	SNC Accuracy	KDEP's HPV discovery rate was 4.7% (national average 10.3%) based on FCE coverage in FY2005. KDEP needs to implement their plan for HPV training.	KDEP has implemented HPV training.
KY - Round 1	Completed	11/30/2007	CAA E6	Timely & Appropriate Actions	14 of KDEP's 17 HPVs (82 %) remained in unaddressed status for greater than 270 days. EPA's policy is that all HPVs be addressed within 270 days	KDEP has implemented HPV training
KY - Round 1	Not Comp Round 1 Identified in Round 2	9/30/2010	CAA E8	Penalties Collected	None of the case resolution proposals reviewed clearly denoted consideration of gravity or economic benefit penalty components. KDEP should continue use of clearly denoting consideration of the gravity and economic benefit components in their penalty documentation and retain this documentation for a period of time to be determined by KDEP.	

KY - Round 1	Completed	11/30/2007	CAA E11	Data Accurate	Stack test data is not properly coded in AFS.	AFS updated
KY - Round 1	Completed	11/30/2007	CAA E12	Data Complete	There is a data issue of appropriately identifying KY's CMS Plan sources. KDEP should examine the sources coded in AFS with the CMS identifier and develop a plan to ensure accuracy of this MDR.	KDEP has completed a comprehensive review of historic AFS data and updated/corrected MDR and CMS identifier data for a number of facilities. KDEP believes that AFS data integrity/accuracy is now extremely high. KDEP staff will continue to review AFS data and update as necessary.
KY - Round 1	Completed	11/30/2007	CWA E2	Violations ID'ed Appropriately	The quality of inspection reports reviewed in the TEMPO database and hard copy files varied from being very detailed with narratives and supporting photographic evidence, to brief with little to no description. The on-site file review of inspections conducted noted inconsistencies in documented level of review between different inspectors conducting similar types of inspections. KDEP should improve inspection reports and DSMRE processes.	DOW reviewed the documents and discussed the MRE inspection form with that agency and concurs that the elements of the Coal Mining NPDES/KPDES Discharge Permit are comprehensively addressed. (This correlation between surface mining and the wastewater management requirements will be emphasized in the agencies cross training.)
KY - Round 1	Completed	11/30/2007	CWA E4	SNC Accuracy	KDEP should respond to repeat violations by escalating enforcement in accordance with the EMS, and the DENF standard operating procedure (SOP).	KDEP responded by addressing the recommendation to update its Enforcement Management System is to adequately address enforcement follow-up, responding to repeat violations by escalating enforcement, etc..

KY - Round 1	Completed	11/30/2007	CWA E5	Return to Compliance	KDEP chooses to issue additional NOVs for the same violation(s) instead of escalating enforcement appropriately by pursuing formal administrative actions such as a CO or a UO or pursuing a civil judicial action. The State should be more systematic in enforcement follow-up; responding to repeat violations, escalating enforcement in accordance with the EMS, and case referral.	KDEP responded by addressing the recommendation to update its Enforcement Management System is to adequately address enforcement follow-up, responding to repeat violations by escalating enforcement, etc..
KY - Round 1	Completed	11/30/2007	CWA E6	Timely & Appropriate Actions	The state is above the 2% threshold for SNC facilities that are beyond required enforcement timeliness milestones reported at 6.4%, but below the national average of 7.7%. One penalty order (PO) for a major facility identified in PCS was not found in the TEMPO database or the facility hard copy file, therefore could not be reviewed. On two occasions the state's enforcement response was not issued timely to address violations at a major facility. Formal enforcement action should be pursued when an informal enforcement action has not been successful in returning a facility back to compliance and/or when a formal enforcement action is more appropriate.	KDEP responded by addressing recommendation to update its Enforcement Management System to adequately address enforcement issues.

KY - Round 1	Not Comp Round 1 Identified in Round 2	9/30/2010	CWA E7	Penalty Calculations	KDEP has no written penalty policies. KDEP generally attempts to follow EPA's penalty guidelines, however, penalty worksheets are not included in the compliance and enforcement files nor are they formally maintained elsewhere, due to the statutory prohibition. Kentucky should adopt a singular form/format for documenting penalty rationale. Additionally, Kentucky should utilize EPA's BEN model or other similar methodology as a useful tool in calculating economic benefit.	
KY - Round 1	Not Comp Round 1 Identified in Round 2	9/30/2010	CWA E8	Penalties Collected	Of the formal enforcement actions reviewed that had associated penalties, payment acknowledgement documentation (i.e. closure letter, copy of check/payment) was not consistently found in the files reviewed, nor was documentation provided by KDEP that supported that such information was maintained elsewhere. Additionally, KDEP has/does not enter penalty collected information into PCS (see Elements 9, 10 and 12). The KDEP should pursue collection of assessed penalties and provide better documentation.	

KY - Round 1	Completed	11/30/2007	CWA E9	Grant Commitments	KDEP should comply with negotiated grant workplan commitments. KDEP has not consistently entered penalty collected data and enforcement actions into PCS. The Field Operations Branch has not been entering enforcement actions into PCS stating limited resources available for data entry.	KDEP, OECA and the PCS Manager have initiated a process to timely enter penalty collected information into PCS and are having on-going discussions since mid-January 2008 to reconcile enforcement action counts in both PCS and TEMPO. At least quarterly, EPA Pacesetters meet with KDEP to discuss work plans, watchlist and other priorities. EPA is open to more frequent discussions, whenever requested or deemed appropriate.
KY – Round 1	Completed	11/30/2007	CWA E10	Data Timely	Minimum data requiring PCS data entry per the CWA §106 workplan include all formal and informal enforcement actions, assessed and collected penalty amount, compliance schedules, and inspections. The file review discovered that penalty information, informal enforcement actions and inspection documentation were found to be in the facility file but not entered into PCS consistently.	KDEP, OECA and the PCS Manager have initiated a process to timely enter penalty collected information into PCS and are having on-going discussions since mid-January 2008 to reconcile enforcement action counts in both PCS and TEMPO.
KY – Round 1	Completed	11/30/2007	CWA E11	Data Accurate	Data quality with respect to DMR and parameter measurement coding into PCS should be at least 95%.Major facilities having correctly coded limits is below the national goal of at or above 95%, but close to the national average of 88.8%, reported at 87.1%.	KDEP responded by addressing recommendation to update its Enforcement Management System to include penalty and cost recovery information to be entered into PCS in addition to TEMPO within a certain defined timeframe.

						KDEP, OECA and the PCS Manager have initiated a process to timely enter penalty collected information into PCS and are having on-going discussions since mid-January 2008 to reconcile enforcement action counts in both PCS and TEMPO.
KY – Round 1	Complete	11/30/2007	CWA E12	Data Complete	During the file review, 6 inspections and 21 NOVs were documented in the file but not entered into PCS. Although KDEP was able to maintain a DMR and parameter entry rate for majors at an impressive 100%, data completeness is a concern.	KDEP's Enforcement Management System, 106 workplan and MOU, etc. will be updated to comply with the minimum data requirement
KY – Round 1	Complete	11/30/2007	RCRA E1	Inspection Universe	Kentucky did not meet two of the statutory and/or OECA FY2005-2007 MOA Guidance requirements for RCRA inspections. KDEP should meet all statutory requirements, and ensure data in RCRAInfo is timely and accurate.	KDEP is reviewing status codes in RCRAInfo of facilities brought to our attention during the state framework review. Going forward KDEP will review the status annually of all facilities inspected during the fiscal year. SRF Data Metric for LQG inspection coverage has increased from 78.6% during the FY2005 SRF evaluation to 97.4% in the FY2007 pull of RCRA data metrics. GME/OAM coverage can be negotiated in the annual RCRA grant workplan (inspection frequency in accordance with OECA NPM guidance).

KY – Round 1	Complete	11/30/2007	RCRA E2	Violation IDd appropriately	Approximately one third of the inspection reports reviewed at part of the SRF did not contain sufficient documentation of inspection findings and/or descriptions of facility operations. KDEP should outline steps to ensure that (a) RCRA inspectors are trained in conducting and documenting RCRA inspections, including process descriptions and hazardous waste management activities; and (b) future inspection reports include sufficient documentation, including that for process descriptions and hazardous waste management activities. A timeline for implementation of this training should also be developed.	EPA verified with RCRA enforcement program, that inspection report quality has improved since SRF evaluation. Reports will be reviewed again in the next SRF evaluation. KDEP has identified additional training needs to EPA R4, and training will be secured as available.
KY – Round 1	Complete	11/30/2007	RCRA E4	SNC Accuracy	KDEP's low RCRA SNC rate may be attributed to inadequate training in conducting RCRA inspections. The state should take steps to ensure that RCRA inspectors are trained.	EPA verified with RCRA enforcement program that inspection report quality has improved since SRF evaluation.

KY – Round 1	Complete	11/30/2007	RCRA E5	Return to compliance	KDEP enforcement actions do require complying actions that will return facilities to compliance in a specific timeframe. However, this information is not reflected in RCRAInfo. The enforcement actions are not being "linked" in RCRAInfo to a return to compliance that has been documented by a compliance inspection, facility submittal, etc. It is recommended that KDEP staff receive training on RCRAInfo V3 compliance and enforcement module. EPA Region 4 will work with Kentucky to secure this training.	KDEP has agreed to attend when the conference is held. Meanwhile, an overview of enf/compliance data elements will be reviewed in the RCRA Enforcement Response Policy training that will be provided to KDEP in December 2007.
KY – Round 1	Complete	11/30/2007	RCRA E6	Timely and Appropriate action	The review of the FY2005 KDEP files disclosed a prolonged enforcement response time to SNC violators. KDEP should continue to make resolution of SNCs a high priority and reexamine ways this could be improved so the goal of all SNCs being resolved in 360 days is met. Specifically, it is recommended that KDEP analyze their SNY resolution rate and submit a findings report, including recommendations, to EPA. This can be fulfilled as part of the established bi-monthly conference calls between KDEP and the EPA Region 4 RCRA & OPA Compliance and Enforcement Branch.	KY DENF has started placing documents (case resolution proposals and Agreed Orders) containing SNC information in red folders so that personnel reviewing these documents know that immediate attention is required. KDEP believes that a SNC analysis has already been completed during the 2007 EPA audit. The DENF is taking steps to improve timely resolution of SNC violations.

KY – Round 1	Not Comp Round 1 Identified in Round 2	9/30/2010	RCRA E7	Penalty Calculations	No penalty documentation or penalty calculations are permanently maintained in the case files after the cases are fully resolved. In order to maintain consistency in enforcement proceedings and penalty calculations, KDEP should consider options to permanently document the penalty calculations in the enforcement files.	
KY – Round 1	Not Comp Round 1 Identified in Round 2	9/30/2010	RCRA E8	Penalty Collected	KDEP does not maintain penalty calculations in the enforcement files.	
KY – Round 1	Complete	11/30/2007	RCRA E9	Grant Commitments	KDEP did not meet several of the enforcement related grant commitments,	KDEP will continue to work with Region 4 in developing a work plan to ensure that statutory inspections and OECA guidance requirements are included in the grant commitments.
KY – Round 1	Complete	11/30/2007	RCRA E10	Data Timely	The RCRA SRF data metrics and file review both point to a timeliness concern for the entry of SNCs into RCRAInfo.	KDEP will review their procedures for data entry into RCRAInfo V3 for timely and accurate data entry.

KY – Round 1	Complete	11/30/2007	RCRA E11	Data Accurate	Secondary Violators (SVs) that have not returned to compliance within 240 days should be redesignated as SNC facilities, and undergo formal enforcement actions.	As of March 2008, there were 15 Kentucky SVs in RCRAInfo that were in violation for greater than 240 days. KDEP has been working closely with the R4 RCRA enforcement program to resolve the SVs - most of which have turned out to be RCRAInfo data accuracy issues.
KY – Round 1	Complete	11/30/2007	RCRA E12	Data Complete	There are two TSDFs in Kentucky with incorrect operating status. Potentially, there may be other discrepancies in the LQG universe. It is recommended that KDEP review that accuracy of the regulated universes in RCRAInfo. A beneficial time to review the universe accuracy would be during the development of the annual fiscal year grant workplans.	RCRAInfo indicates that KDEP has updated both the TSD and LQG universes to current operating status.

APPENDIX B: OFFICIAL DATA PULL

The Official Data Set (ODS) was pulled from the Online Tracking Information System (OTIS) Web site using FY2009 data that was "frozen" on March 13, 2010. EPA also will send an electronic version in Excel format by email. States can access these reports online with additional links and information on the OTIS site. The ODS also provides the "production data" which reflects the data in the national data systems current as of the last OTIS refresh date. The FY2009 production data in the attached ODS was refreshed on June 12, 2010.

Please confirm that the data shown in the enclosed ODS spreadsheet accurately depicts state activity. Please pay particular attention to numbers shown under Elements 1 and 2. For example, do you agree with the number of inspections performed, violations found, actions taken, etc.? Significant discrepancies could have a bearing on the results of the SRF Round 2 review. If significant discrepancies exist (i.e., the state count of an activity is +/- 10 percent of the number shown, or the facility lists accessed in OTIS for a particular metric do not closely match state records), please note this on the spreadsheet in the columns provided to the right of the data. Please note that you do not need to provide exact counts when your numbers do not differ much from those provided – minor differences in the numbers are often the result of inherent lags between the time a state enters data in its system and when the data is uploaded to the program system and OTIS.

EPA encourages you to document significant differences between EPA and state numbers using the reporting format included with the spreadsheet. There are two major reasons for this: (1) it is important for EPA to understand these differences in the course of its work, and (2) in the event of a Freedom of Information Act (FOIA) request, the official record would include the disputed number along with the correct number according to the state and an explanation of the discrepancy.

If you would like to get a sense of the facilities behind the numbers shown, you can use OTIS http://www.epa-otis.gov/cgi-bin/stateframework.cgi. SRF data metrics results are shown on the OTIS SRF Web site on the first screen that is returned after a search is run. Lists of facilities that make up the ODS results are provided in most cases by clicking an underlined number. (Please note that OTIS data are updated monthly, so differences may exist between the hard copy and the site.) If core inspection, violation, or enforcement actions totals shown on the spreadsheet are not close to what you believe the true counts to be, please consider providing accurate facility lists to assist us with file selection.

Please respond by September 3, 2010, with an indication that you agree with the ODS or with a spreadsheet indicating any discrepancies. This can be submitted electronically to Shannon Maher, the Region 4 SRF Coordinator, at maher.shannon@epa.gov. Shannon can also be reached at (404) 562-9623 with any questions. If you do not respond by this date, EPA will proceed with our preliminary data analysis under the assumption that the ODS is correct.

Clean Air Act ODS

Metric Description	Metric Type	Agency	Natl Goal	Natl Average	KY Metric Prod	Count Prod	Universe Prod	Not Counted Prod	KentuckyMetric Froz	Count Froz	Universe Froz	Not Counted Froz
Title V Universe: AFS Operating Majors (Current)	Data Quality	State			250	NA	NA	NA	250	NA	NA	NA
Title V Universe: AFS Operating Majors with Air Program Code = V (Current)	Data Quality	State			235	NA	NA	NA	230	NA	NA	NA
Source Count: Synthetic Minors (Current)	Data Quality	State			194	NA	NA	NA	197	NA	NA	NA
Source Count: NESHAP Minors (Current)	Data Quality	State			0	NA	NA	NA	0	NA	NA	NA
Source Count: Active Minor facilities or otherwise FedRep, not including NESHAP Part 61 (Current)	Informational Only	State			4	NA	NA	NA	1	NA	NA	NA
CAA Subprogram Designations: NSPS (Current)	Data Quality	State			192	NA	NA	NA	210	NA	NA	NA

CAA Subprogram Designations: NESHAP (Current)	Data Quality	State			16	NA	NA	NA	16	NA	NA	NA
CAA Subprogram Designations: MACT (Current)	Data Quality	State			120	NA	NA	NA	115	NA	NA	NA
CAA Subpart Designations: Percent NSPS facilities with FCEs conducted after 10/1/2005	Data Quality	State	100%	84.5%	78.7%	155	197	42	77.1%	148	192	44
CAA Subpart Designations: Percent NESHAP facilities with FCEs conducted after 10/1/2005	Data Quality	State	100%	46.6%	28.3%	13	46	33	28.3%	13	46	33
CAA Subpart Designations: Percent MACT facilities with FCEs conducted after 10/1/2005	Data Quality	State	100%	92.5%	96.1%	99	103	4	96.1%	98	102	4
Compliance Monitoring: Sources with FCEs (1 FY)	Data Quality	State			277	NA	NA	NA	278	NA	NA	NA

Compliance Monitoring: Number of FCEs (1 FY)	Data Quality	State			287	NA	NA	NA	289	NA	NA	NA
Compliance Monitoring: Number of PCEs (1 FY)	Informational Only	State			0	NA	NA	NA	0	NA	NA	NA
Historical Non-Compliance Counts (1 FY)	Data Quality	State			39	NA	NA	NA	39	NA	NA	NA
Informal Enforcement Actions: Number Issued (1 FY)	Data Quality	State			97	NA	NA	NA	97	NA	NA	NA
Informal Enforcement Actions: Number of Sources (1 FY)	Data Quality	State			63	NA	NA	NA	63	NA	NA	NA
HPV: Number of New Pathways (1 FY)	Data Quality	State			15	NA	NA	NA	15	NA	NA	NA
HPV: Number of New Sources (1 FY)	Data Quality	State			13	NA	NA	NA	13	NA	NA	NA
HPV Day Zero Pathway Discovery date: Percent DZs with discovery	Data Quality	State	100%	50.3%	6.7%	1	15	14	6.7%	1	15	14

HPV Day Zero Pathway Violating Pollutants: Percent DZs	Data Quality	State	100%	75.4%	100.0%	15	15	0	100.0%	15	15	0
HPV Day Zero Pathway Violation Type Code(s): Percent DZs with HPV Violation Type Code(s)	Data Quality	State	100%	79.3%	73.3%	11	15	4	73.3%	11	15	4
Formal Action: Number Issued (1 FY)	Data Quality	State			16	NA	NA	NA	16	NA	NA	NA
Formal Action: Number of Sources (1 FY)	Data Quality	State			15	NA	NA	NA	15	NA	NA	NA
Assessed Penalties: Total Dollar Amount (1 FY)	Data Quality	State			$192,500	NA	NA	NA	$192,500	NA	NA	NA
Major Sources Missing CMS Policy Applicability (Current)	Review Indicator	State	0		0	NA	NA	NA	1	NA	NA	NA
Number of HPVs/Number of NC Sources (1 FY)	Data Quality	State	<= 50%	59.8%	53.8%	14	26	12	53.8%	14	26	12

Stack Test Results at Federally-Reportable Sources - % Without Pass/Fail Results (1 FY)	Goal	State	0%	1.8%	0.0%	0	45	45	0.0%	0	5	5
Stack Test Results at Federally-Reportable Sources - Number of Failures (1 FY)	Data Quality	State			0	NA	NA	NA	0	NA	NA	NA
Percent HPVs Entered <= 60 Days After Designation, Timely Entry (1 FY)	Goal	State	100%	31.6%	13.3%	2	15	13	13.3%	2	15	13
Percent Compliance Monitoring related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY)	Goal	State	100%	51.4%	23.9%	182	761	579	25.2%	181	718	537

Percent Enforcement related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY)	Goal	State	100%	66.1%	64.6%	73	113	40	64.6%	73	113	40
CMS Major Full Compliance Evaluation (FCE) Coverage (2 FY CMS Cycle)	Goal	State	100%	87.8%	95.9%	235	245	10	95.9%	235	245	10
CAA Major Full Compliance Evaluation (FCE) Coverage(most recent 2 FY)	Review Indicator	State	100%	83.0%	94.0%	236	251	15	93.7%	236	252	16
CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (5 FY CMS Cycle)	Review Indicator	State	20% - 100%	83.7%	95.0%	170	179	9	94.9%	168	177	9
CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (last full 5 FY)	Informational Only	State	100%	90.1%	91.3%	178	195	17	92.1%	176	191	15

CAA Synthetic Minor FCE and reported PCE Coverage (last 5 FY)	Informational Only	State		80.5%	91.3%	178	195	17	91.4%	181	198	17
CAA Minor FCE and Reported PCE Coverage (last 5 FY)	Informational Only	State		29.4%	100.0%	3	3	0	14.3%	2	14	12
Number of Sources with Unknown Compliance Status (Current)	Review Indicator	State			16	NA	NA	NA	16	NA	NA	NA
CAA Stationary Source Investigations (last 5 FY)	Informational Only	State			0	NA	NA	NA	0	NA	NA	NA
Review of Self-Certifications Completed (1 FY)	Goal	State	100%	94.0%	0 / 0	0	0	0	0 / 0	0	0	0
Percent facilities in noncompliance that have had an FCE, stack test, or enforcement (1 FY)	Review Indicator	State	> 1/2 National Avg	22.1%	12.1%	38	313	275	12.3%	38	309	271

Percent facilities that have had a failed stack test and have noncompliance status (1 FY)	Review Indicator	State	> 1/2 National Avg	43.9%	0 / 0	0	0	0	0 / 0	0	0	0
High Priority Violation Discovery Rate - Per Major Source (1 FY)	Review Indicator	State	> 1/2 National Avg	7.8%	4.0%	10	250	240	4.0%	10	250	240
High Priority Violation Discovery Rate - Per Synthetic Minor Source (1 FY)	Review Indicator	State	> 1/2 National Avg	0.6%	1.5%	3	194	191	1.5%	3	197	194
Percent Formal Actions With Prior HPV - Majors (1 FY)	Review Indicator	State	> 1/2 National Avg	74.7%	50.0%	5	10	5	50.0%	5	10	5
Percent Informal Enforcement Actions Without Prior HPV - Majors (1 FY)	Review Indicator	State	< 1/2 National Avg	45.6%	70.3%	26	37	11	70.3%	26	37	11

Percentage of Sources with Failed Stack Test Actions that received HPV listing - Majors and Synthetic Minors (2 FY)	Review Indicator	State	> 1/2 National Avg	43.0%	0 / 0	0	0	0	0 / 0	0	0	0
Percent HPVs not meeting timeliness goals (2 FY)	Review Indicator	State		35.9%	66.7%	20	30	10	64.3%	18	28	10
No Activity Indicator - Actions with Penalties (1 FY)	Review Indicator	State			15	NA	NA	NA	15	NA	NA	NA
Percent Actions at HPVs With Penalty (1 FY)	Review Indicator	State	>= 80%	87.4%	71.4%	5	7	2	71.4%	5	7	2

Clean Water Act ODS

Metric Description	Metric Type	Agency	Natl Goal	Natl Average	KentuckyMetric Prod		Universe Prod	Not Counted Prod	KentuckyMetric Froz	Count Froz	Universe Froz	Not Counted Froz
Active facility universe: NPDES major individual permits (Current)	Data Quality	Combined			130	NA	NA	NA	130	NA	NA	NA
Active facility universe: NPDES major general permits	Data Quality	Combined			0	NA	NA	NA	0	NA	NA	NA

(Current)												
Active facility universe: NPDES non-major individual permits (Current)	Data Quality	Combined			1,756	NA	NA	NA	1,764	NA	NA	NA
Active facility universe: NPDES non-major general permits (Current)	Data Quality	Combined			4,187	NA	NA	NA	4,198	NA	NA	NA
Major individual permits: correctly coded limits (Current)	Goal	Combined	>=; 95%	88.0%	84.6%	110	130	20	86.2%	112	130	18
Major individual permits: DMR entry rate based on MRs expected (Forms/Forms) (1 Qtr)	Goal	Combined	>=; 95%	94.6%	100.0%	1,159	1,159	0	100.0%	1,159	1,159	0
Major individual permits: DMR entry rate based on DMRs expected (Permits/Permits) (1 Qtr)	Goal	Combined	>=; 95%	93.3%	86.2%	112	130	18	86.2%	112	130	18
Major individual permits: manual RNC/SNC override rate (1 FY)	Data Quality	Combined			6.2%	1	16	15	0.0%	0	16	16

Non-major individual permits: correctly coded limits (Current)	Informational Only	Combined			74.7%	1,311	1,756	445	74.5%	1,315	1,764	449
Non-major individual permits: DMR entry rate based on DMRs expected (Forms/Forms) (1 Qtr)	Informational Only	Combined			0.8%	36	4,662	4,626	0.8%	36	4,662	4,626
Non-major individual permits: DMR entry rate based on DMRs expected (Permits/Permits) (1 Qtr)	Informational Only	Combined			0.3%	5	1,757	1,752	0.3%	5	1,757	1,752
Violations at non-majors: noncompliance rate (1 FY)	Informational Only	Combined			6.8%	119	1,756	1,637	6.7%	119	1,764	1,645
Violations at non-majors: noncompliance rate in the annual noncompliance report (ANCR)(1 CY)	Informational Only	Combined			0 / 0	0	0	0	0 / 0	0	0	0
Violations at non-majors: DMR non-receipt (3 FY)	Informational Only	Combined			1,075	NA	NA	NA	1,085	NA	NA	NA

Informal actions: number of major facilities (1 FY)	Data Quality	State			83	NA	NA	NA	83	NA	NA	NA
Informal actions: number of actions at major facilities (1 FY)	Data Quality	State			180	NA	NA	NA	180	NA	NA	NA
Informal actions: number of non-major facilities (1 FY)	Data Quality	State			455	NA	NA	NA	455	NA	NA	NA
Informal actions: number of actions at non-major facilities (1 FY)	Data Quality	State			530	NA	NA	NA	530	NA	NA	NA
Formal actions: number of major facilities (1 FY)	Data Quality	State			11	NA	NA	NA	11	NA	NA	NA
Formal actions: number of actions at major facilities (1 FY)	Data Quality	State			13	NA	NA	NA	12	NA	NA	NA
Formal actions: number of non-major facilities (1 FY)	Data Quality	State			53	NA	NA	NA	53	NA	NA	NA
Formal actions: number of actions at non-major facilities (1 FY)	Data Quality	State			58	NA	NA	NA	58	NA	NA	NA
Penalties: total number of penalties (1 FY)	Data Quality	State			63	NA	NA	NA	62	NA	NA	NA
Penalties: total penalties (1 FY)	Data Quality	State			$556,000	NA	NA	NA	$543,000	NA	NA	NA

Penalties: total collected pursuant to civil judicial actions (3 FY)	Data Quality	State			$0	NA	NA	NA	$0	NA	NA	NA
Penalties: total collected pursuant to administrative actions (3 FY)	Informational Only	State			$1,233,300	NA	NA	NA	$1,220,300	NA	NA	NA
No activity indicator - total number of penalties (1 FY)	Data Quality	State			$556,000	NA	NA	NA	$543,000	NA	NA	NA
Actions linked to violations: major facilities (1 FY)	Data Quality	State	>=; 80%		15.4%	2	13	11	0.0%	0	12	12
Inspection coverage: NPDES majors (1 FY)	Goal	State	100%	64.9%	80.8%	105	130	25	77.7%	101	130	29
Inspection coverage: NPDES non-major individual permits (1 FY)	Goal	State			34.0%	597	1,756	1,159	31.8%	561	1,764	1,203
Inspection coverage: NPDES non-major general permits (1 FY)	Goal	State			6.8%	283	4,187	3,904	5.9%	247	4,198	3,951
Inspection coverage: NPDES other (not 5a or 5b) (1 FY)	Informational Only	State			0.1%	6	4,456	4,450	0.1%	4	4,901	4,897
Single-event violations at majors (1 FY)	Review Indicator	Combined			1	NA	NA	NA	1	NA	NA	NA

Single-event violations at non-majors (1 FY)	Informational Only	Combined			0	NA	NA	NA	0	NA	NA	NA
Facilities with unresolved compliance schedule violations (at end of FY)	Data Quality	Combined		26.1%	15.4%	6	39	33	15.4%	6	39	33
Facilities with unresolved permit schedule violations (at end of FY)	Data Quality	Combined		26.7%	0 / 0	0	0	0	0 / 0	0	0	0
Percentage major facilities with DMR violations (1 FY)	Data Quality	Combined		52.6%	50.0%	65	130	65	49.2%	64	130	66
Major facilities in SNC (1 FY)	Review Indicator	Combined			16	NA	NA	NA	16	NA	NA	NA
SNC rate: percent majors in SNC (1 FY)	Review Indicator	Combined		22.6%	12.1%	16	132	116	12.1%	16	132	116
Major facilities without timely action (1 FY)	Goal	Combined	< 2%	18.6%	9.1%	12	132	120	9.1%	12	132	120

Resource Conservation and Recovery Act ODS

Metric Description	Metric Type	Agency	Natl Goal	Natl Average	KY Metric Prod	Count Prod	Universe Prod	Not Counted Prod	KY Metric Froz	Count Froz	Universe Froz	Not Counted Froz
Number of operating TSDFs in RCRAInfo	Data Quality	State			14	NA	NA	NA	14	NA	NA	NA
Number of active LQGs in RCRAInfo	Data Quality	State			282	NA	NA	NA	276	NA	NA	NA
Number of active SQGs in RCRAInfo	Data Quality	State			444	NA	NA	NA	446	NA	NA	NA
Number of all other active sites in RCRAInfo	Data Quality	State			2,101	NA	NA	NA	2,102	NA	NA	NA
Number of LQGs per latest official biennial report	Data Quality	State			270	NA	NA	NA	269	NA	NA	NA
Compliance monitoring: number of inspections (1 FY)	Data Quality	State			950	NA	NA	NA	947	NA	NA	NA
Compliance monitoring: sites inspected (1 FY)	Data Quality	State			758	NA	NA	NA	755	NA	NA	NA
Number of sites with violations determined at any time (1 FY)	Data Quality	State			214	NA	NA	NA	213	NA	NA	NA
Number of sites with violations determined during the FY	Data Quality	State			188	NA	NA	NA	188	NA	NA	NA

Informal action: number of sites (1 FY)	Data Quality	State			187	NA	NA	NA	187	NA	NA	NA
Informal action: number of actions (1 FY)	Data Quality	State			211	NA	NA	NA	211	NA	NA	NA
SNC: number of sites with new SNC (1 FY)	Data Quality	State			16	NA	NA	NA	16	NA	NA	NA
SNC: number of sites in SNC (1 FY)	Data Quality	State			26	NA	NA	NA	25	NA	NA	NA
Formal action: number of sites (1 FY)	Data Quality	State			11	NA	NA	NA	11	NA	NA	NA
Formal action: number taken (1 FY)	Data Quality	State			12	NA	NA	NA	12	NA	NA	NA
Total amount of final penalties (1 FY)	Data Quality	State			$61,000	NA	NA	NA	$61,000	NA	NA	NA
Number of sites SNC-determined on day of formal action (1 FY)	Data Quality	State			0	NA	NA	NA	0	NA	NA	NA
Number of sites SNC-determined within one week of formal action (1 FY)	Data Quality	State			0	NA	NA	NA	0	NA	NA	NA
Number of sites in violation for greater than 240 days	Data Quality	State			2	NA	NA	NA	3	NA	NA	NA

Percent SNCs entered ≥ 60 days after designation (1 FY)	Review Indicator	State			26.7%	4	15	11	26.7%	4	15	11
Inspection coverage for operating TSDFs (2 FYs)	Goal	State	100 %	86.6%	100.0%	14	14	0	100.0%	14	14	0
Inspection coverage for LQGs (1 FY)	Goal	State	20%	25.2%	61.5%	166	270	104	61.7%	166	269	103
Inspection coverage for LQGs (5 FYs)	Goal	State	100 %	68.7%	98.9%	267	270	3	98.9%	266	269	3
Inspection coverage for active SQGs (5 FYs)	Informational Only	State			80.9%	359	444	85	81.6%	364	446	82
Inspections at active CESQGs (5 FYs)	Informational Only	State			1,306	NA	NA	NA	1,321	NA	NA	NA
Inspections at active transporters (5 FYs)	Informational Only	State			228	NA	NA	NA	354	NA	NA	NA
Inspections at non-notifiers (5 FYs)	Informational Only	State			3	NA	NA	NA	3	NA	NA	NA
Inspections at active sites other than those listed in 5a-d and 5e1-5e3 (5 FYs)	Informational Only	State			294	NA	NA	NA	291	NA	NA	NA
Violation identification rate at sites with inspections (1 FY)	Review Indicator	State			24.8%	188	758	570	24.9%	188	755	567

SNC identification rate at sites with inspections (1 FY)	Review Indicator	State	1/2 National Avg	3.2%	2.1%	16	758	742	2.1%	16	755	739
Percent of SNC determinations made within 150 days (1 FY)	Goal	State	100 %	75.6%	100.0%	15	15	0	100.0%	15	15	0
Percent of formal actions taken that received a prior SNC listing (1 FY)	Review Indicator	State	1/2 National Avg	61.2%	100.0%	13	13	0	100.0%	13	13	0
Percent of SNCs with formal action/referral taken within 360 days (1 FY)	Review Indicator	State	80%	45.2%	75.0%	12	16	4	62.5%	10	16	6
No activity indicator - number of formal actions (1 FY)	Review Indicator	State			12	NA	NA	NA	12	NA	NA	NA
No activity indicator - penalties (1 FY)	Review Indicator	State			$61,000	NA	NA	NA	$61,000	NA	NA	NA
Percent of final formal actions with penalty (1 FY)	Review Indicator	State	1/2 National Avg	81.3%	50.0%	2	4	2	50.0%	2	4	2

APPENDIX C: PDA TRANSMITTAL LETTER

Appendices C, D, and E provide the results of the Preliminary Data Analysis (PDA). The Preliminary Data Analysis forms the initial structure for the SRF report, and helps ensure that the data metrics are adequately analyzed prior to the on-site review.

This is a critical component of the SRF process because it allows the reviewers to be prepared and knowledgeable about potential problem areas before the on-site review. In addition, it gives the region focus during the file reviews and/or basis for requesting supplemental files based on potential concerns raised by the data metric results.

This section, Appendix C, contains the letter transmitting the results of the Preliminary Data Analysis to the state. This letter identifies areas that the data review suggests the need for further examination and discussion during the review process.

Mr. Bruce Scott
Commissioner
Kentucky Department for Environmental Protection
300 Fair Oaks Lane
Frankfort, Kentucky 40601

Dear Mr. Scott:

On July 16, 2010, the Environmental Protection Agency (EPA) Region 4 notified the Kentucky Department for Environmental Protection (KDEP) of its intention to begin the State Review Framework (SRF) evaluation via an opening letter. As the next step in the process, the region has analyzed the SRF data sent with the opening letter against established goals and commitments, incorporating any data corrections or discrepancies provided by KDEP.

This follow-up letter includes (1) EPA's preliminary analysis of the state SRF data metrics results, (2) the official preliminary data analysis (PDA) worksheets, and (3) the files that have been selected for the SRF file reviews. The file reviews have been coordinated between KDEP and EPA to take place during December 6-10, 2010, for the CWA and RCRA programs, and December 13-17, 2010, for the CAA program. All reviews will take place at KDEP's offices in Frankfort, Kentucky.

We are providing this information to you in advance so that your staff will have adequate time to compile the files that we will review and can begin pulling together any supplemental information that you think may be of assistance during the review. After reviewing the enclosed information, if there are additional circumstances that the region should consider during the review, please have your staff provide that information to us prior to the on-site file review. Shannon Maher, the Region 4 SRF coordinator, can be reached at (404) 562-9623.

Please note that the enclosed preliminary analyses are largely based only on the FY2009 data metrics results that were "frozen" in March 2010. Any corrections or updates to the data in the national data systems since that time may not be reflected in the preliminary analyses. Final SRF findings may be significantly different based upon the revised and/or updated FY2009 data, the results of the file review, and ongoing discussions with your staff.

Please also note that all information and material used in this review may be subject to federal and/or state disclosure laws. While EPA intends to use this information only for discussions with KDEP, it may be necessary to release information in response to a properly submitted information request.

At this time I would also like to bring to your attention the opportunity for KDEP to highlight any priorities and accomplishments that you would like to have included in the SRF Report. EPA is also requesting specific information on your resources, staffing, and the current data systems used by your state for the SRF Report. An outline of this information is included in Enclosure 10 of this letter. EPA is requesting this information be sent electronically to Shannon Maher at maher.shannon@epa.gov by January 31, 2011.

We look forward to working with you and your staff in this effort. Should you require additional information, or wish to discuss this matter in greater detail, please feel free to contact Scott Gordon, the Associate Director of the Office of Environmental Accountability, at
(404) 562-9741.

Sincerely,

Mary J. Wilkes
Regional Counsel and Director
Office of Environmental Accountability

Enclosure 1 – CAA Preliminary Data Analysis
Enclosure 2 – CAA Preliminary Data Analysis Worksheet
Enclosure 3 – CAA Table of Selected Files and selection logic
Enclosure 4 – CWA Preliminary Data Analysis
Enclosure 5 – CWA Preliminary Data Analysis Worksheet
Enclosure 6 – CWA Table of Selected Files and selection logic
Enclosure 7 – RCRA Preliminary Data Analysis
Enclosure 8 – RCRA Preliminary Data Analysis Worksheet
Enclosure 9 – RCRA Table of Selected Files and selection logic

Enclosure 10 – Background Information for SRF Report

APPENDIX D: PRELIMINARY DATA ANALYSIS CHART

This section provides the results of the Preliminary Data Analysis (PDA). The Preliminary Data Analysis forms the initial structure for the SRF report and helps ensure that the data metrics are adequately analyzed prior to the on-site review. This is a critical component of the SRF process because it allows the reviewers to be prepared and knowledgeable about potential problem areas before initiating the on-site portion of the review. In addition, it gives the region focus during the file reviews and/or basis for requesting supplemental files based on potential concerns raised by the data metrics results.

The PDA reviews each data metric and evaluates state performance against the national goal or average, if appropriate. The PDA chart in this section of the SRF report only includes metrics where potential concerns or areas of exemplary performance are identified. (The full PDA worksheet in Appendix E contains every metric: positive, neutral, or negative.) Initial Findings indicate the observed results. Initial Findings are preliminary observations. They are used as a basis for further investigation that takes place during the file review and through dialogue with the state. Final Findings are developed only after evaluating them against the file review results where appropriate, and dialogue with the state have occurred. Through this process, Initial Findings may be confirmed, modified, or determined not to be supported. Findings are presented in Section IV of this report.

Clean Air Act

Original Data Pulled from Online Tracking Information System (OTIS)							EPA Preliminary Analysis
Metric	**Metric Description**	**Metric Type**	**Agency**	**National Goal**	**National Average**	**State Metric**	**Initial Findings**
A01C4S	CAA Subpart Designations: Percent NSPS facilities with FCEs conducted after 10/1/2005	Data Quality		100%	84.5%	77.1%	State correction tentatively accepted. Obtain additional documentation from state database to confirm state corrected values. Discuss data transfer issues with State during onsite visit. Recording of applicable NSPS subparts for the natural gas facilities in particular could be key to accurate targeting by EPA for the new energy extraction National Enforcement Initiative. Supplemental files selected.

A01C5S	CAA Subpart Designations: Percent NESHAP facilities with FCEs conducted after 10/1/2005	Data Quality		100%	46.6%	28.3%	State correction tentatively accepted. Obtain additional documentation from state database to confirm state corrected values.
A01C6S	CAA Subpart Designations: Percent MACT facilities with FCEs conducted after 10/1/2005	Data Quality		100%	92.5%	96.1%	State correction tentatively accepted. Obtain additional documentation from state database to confirm state corrected values. The state values differ from AFS by 20%, but no explanation is given for the discrepancy.

Metric	Metric Description	Metric Type	Agency	National Goal	National Average	State Metric	Initial Findings
A01D1S	Compliance Monitoring: Sources with FCEs (1 FY)	Data Quality				278	State correction tentatively accepted. Obtain additional documentation from state database to confirm state corrected values. Discuss data transfer issues with State during onsite visit. Determine if training provided is addressing the problem.
A01D2S	Compliance Monitoring: Number of FCEs (1 FY)	Data Quality				289	State correction tentatively accepted. Obtain additional documentation from state database to confirm state corrected values. Discuss data transfer issues with State during onsite visit.
A01H1S	HPV Day Zero Pathway Discovery date: Percent DZs with discovery	Data Quality		100%	50.3%	6.7%	Supplemental files selected to evaluate HPV management.
A01H3S	HPV Day Zero Pathway Violation Type Code(s): Percent DZs with HPV Violation Type Code(s)	Data Quality		100%	79.3%	73.3%	Supplemental files selected to evaluate HPV management.

A02A0S	Number of HPVs/Number of NC Sources (1 FY)	Data Quality		<= 50%	59.8%	53.8%	Supplemental files selected to evaluate HPV management.
A02B1S	Stack Test Results at Federally-Reportable Sources - % Without Pass/Fail Results (1 FY)	Goal		0%	1.8%	0.0%	Only 5 stack tests for a universe of 450 sources is a potential concern. Discuss with state. Production data show 45 entries, suggesting that additional tests have been done, but entry into AFS was delayed. Supplemental files selected.
A02B2S	Percent HPVs Entered <= 60 Days After Designation, Timely Entry (1 FY)	Data Quality				0	Discuss data management issues with State during onsite visit. Supplemental files selected.
A03A0S	Percent HPVs Entered <= 60 Days After Designation, Timely Entry (1 FY)	Goal		100%	31.6%	13.3%	Discuss data management issues with State during onsite visit. Supplemental files selected.
A03B1S	Percent Compliance Monitoring related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY)	Goal		100%	51.4%	25.2%	Discuss data management issues with State during onsite visit. Supplemental files selected.
A03B2S	Percent Enforcement related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY)	Goal		100%	66.1%	64.6%	Discuss data management issues with State during onsite visit. Supplemental files selected.

A05G0S	Review of Self-Certifications Completed (1 FY)	Goal		100%	94.0%	0/0	State correction tentatively accepted. Obtain additional documentation from state database to confirm state corrected values. Discuss data transfer issues with State during onsite visit.
A07C2S	Percent facilities that have had a failed stack test and have noncompliance status (1 FY)	Review Indicator		>1/2 Natl. Avg	43.9%	0/0	Supplemental files selected to evaluate stack testing procedures, documentation, and data recording in AFS.
A08E0S	Percentage of Sources with Failed Stack Test Actions that received HPV listing - Majors and Synthetic Minors (2 FY)	Review Indicator		>1/2 Natl. Avg	43.0%	0/0	Supplemental files selected to evaluate stack testing procedures, documentation, and data recording in AFS.
A10A0S	Percent HPVs not meeting timeliness goals (2 FY)	Review Indicator			35.9%	64.3%	State metric is twice the national average. Discuss HPV & enforcement procedures with State during file review. Supplemental files selected.
A12B0S	Percent Actions at HPVs With Penalty (1 FY)	Review Indicator		>= 80%	87.4%	71.4%	Discuss HPV & enforcement procedures with State during file review. Supplemental files selected.

Clean Water Act

Original Data Pulled from Online Tracking Information System (OTIS)							EPA Preliminary Analysis
Metric	**Metric Description**	**Metric Type**	**Agency**	**National Goal**	**National Average**	**State Metric**	**Initial Findings**
W01B1C	Major individual permits: correctly coded limits (Current)	Goal	Combined	>=; 95%	88.0%	88.0%	Since data entry percentage is below the national goal, further discussions and analyses are warranted.
C01B3C	Major individual permits: DMR entry rate based on DMRs expected (Permits/Permits) (1 Qtr)	Goal	Combined	>=; 95%	93.3%	86.20%	Since data entry percentage is below the national goal, further discussions and analyses are warranted.
W01E3S	Informal actions: number of non-major facilities (1 FY)	Data Quality	State			455	Since 246 non-permitted facilities had enforcement actions that are not in the state database (TEMPO), this is a potential area of concern.
W01E4S	Informal actions: number of actions at non-major facilities (1 FY)	Data Quality	State			530	Since 269 enforcement actions from non-permitted sources are not in the state database (TEMPO), this is a potential area of concern.

W01F2S	Formal actions: number of actions at major facilities (1 FY)	Data Quality	State			12	Difference is deemed significant. Additional research is necessary since this is required data.
W01F3S	Formal actions: number of non-major facilities (1 FY)	Data Quality	State			53	Difference is deemed significant. Additional research is necessary since this is required data.
W01F4S	Formal actions: number of actions at non-major facilities (1 FY)	Data Quality	State			58	Difference is deemed significant. Additional research is necessary since this is required data.
W01G1S	Penalties: total number of penalties (1 FY)	Data Quality	State			62	The KY CWA § 106 workplan requires penalty assessed and collected to be entered into ICIS - NPDES for all enforcement actions. Further discussion is needed.
Metric	**Metric Description**	**Metric Type**	**Agency**	**National Goal**	**National Average**	**State Metric**	**Initial Findings**
W01G2S	Penalties: total penalties (1 FY)	Data Quality	State			$543,000	Although 57 cases matched exactly and 3 cases are duplicate errors, this discrepancy requires further analyses.
W01G4S	Penalties: total collected pursuant to administrative actions (3 FY)	Informatio nal Only	State			$1,220,300	Significant discrepancy in penalty information. The KY CWA § 106 workplan requires penalty assessed and collected to be entered into ICIS -NPDES for all enforcement actions. Further discussion is needed.
W02A0S	Actions linked to violations: major facilities (1 FY)	Data Quality	State	>=; 80%		0.0%	No major facility has actions linked to violations. Further analysis and discussion are warranted

W05B2S	Inspection coverage: NPDES non-major general permits (1 FY)	Goal	State			5.9%	KY CWA §106 Workplan requires entry of all inspections into the national database,
W07A1C	Single-event violations at majors (1 FY)	Review Indicator	Combined			1	This is an area for further EPA/State discussion.
W07B0C	Facilities with unresolved compliance schedule violations (at end of FY)	Data Quality	Combined		26.1%	15.4%	Difference is deemed significant. Data is required for major facilities, but is not required for non-major facilities. Additional research is necessary.
W10A0C	Major facilities without timely action (1 FY)	Goal	Combined	< 2%	18.6%	9.1%	This is an area for further EPA/State discussion.

Resource Conservation and Recovery Act

Original Data Pulled from Online Tracking Information System (OTIS)							EPA Preliminary Analysis
Metric	**Metric Description**	**Metric Type**	**Agency**	**National Goal**	**National Average**	**State Metric**	**Initial Findings**
R10A0S	Percent of SNCs with formal action/referral taken within 360 days (1 FY)	Review Indicator		80%	45.2%	62.5%	The RCRA ERP allows for 360 days from the first day of inspection for a SNC facility to be resolved by final enforcement, referral to the state attorney general, or EPA. The metric shows that six of the 16 facilities exceeded the ERP timeline.

APPENDIX E: PDA WORKSHEET (with State and EPA Comments)

Clean Air Act PDAClean Air Act

Metric	Metric Description	Metric Type	National Goal	National Average	Kentucky Metric Frozen	Count Frozen	Universe Frozen	Not Counted Frozen	Significant Discrepancy (Yes/No)	State Correction	State Data Source	Discrepancy Explanation	Initial
A01A1S	Title V Universe: AFS Operating Majors (Current)	Data Quality			250	NA	NA	NA	No	250	TEMPO		
A01A2S	Title V Universe: AFS Operating Majors with Air Program Code = V (Current)	Data Quality			230	NA	NA	NA	Yes	250	TEMPO	Historically, DAQ has not used Program Code "V" for Title V sources, resulting in 20 operating majors not being counted in the frozen data. When the 2009 Emissions Inventory data have been reviewed and approved, DAQ will reprogram TEMPO to always have a	State corre accepted. sources re than 10% universe, & plan for co issue.
A01B1S	Source Count: Synthetic Minors (Current)	Data Quality			197	NA	NA	NA	No	209	TEMPO	Designation as Synthetic Minor (SM) source was not current in AFS. The discrepancies were updated in March, but since then additional SM permits were issued but AFS not changed before June Production Data pull. AFS Report 670, CMS Illogical Assignments	The missin represent l of the univ AFS Repo evaluate w problem re
A01B2S	Source Count: NESHAP Minors (Current)	Data Quality			0	NA	NA	NA	No	1	TEMPO	AFS updated to include Part 61 NESHAPs Subpart for this minor source.	State corre accepted.
A01B3S	Source Count: Active Minor facilities or otherwise FedRep, not including NESHAP Part 61 (Current)	Informational Only			1	NA	NA	NA	No	0-2?	TEMPO	Two of the four were not designated in AFS as SM, but appropriately designated for CMS, thus federal reportable (fixed). Other two- unknown as to why AFS includes as federally reportable.	Informatio
A01C1S	CAA Subprogram Designations: NSPS (Current)	Data Quality			210	NA	NA	NA	No	182	TEMPO	Neither TEMPO nor AFS is correct. Nine removed from AFS because not NSPS. TEMPO report needs filter to remove NSPS "Under Construction" (Done).	State corre tentatively Obtain add documenta state datab confirm sta values. Dis state modi TEMPO ha the proble
A01C2S	CAA Subprogram Designations: NESHAP (Current)	Data Quality			16	NA	NA	NA	No	15	TEMPO	Corrected AFS, now AFS and TEMPO match.	State corre accepted.

A01C3S	CAA Subprogram Designations: MACT (Current)	Data Quality			115	NA	NA	NA	No	115	TEMPO	TEMPO report needs filter to remove MACT "Under Construction" (Done). Several sources no longer subject to MACT but not changed in AFS. Area source "G" GACT should not be reported to AFS.	State corre tentatively Obtain add documenta state datab confirm sta values. Dis state modif TEMPO ha the problen
A01C4S	CAA Subpart Designations: Percent NSPS facilities with FCEs conducted after 10/1/2005	Data Quality	100%	84.5%	77.1%	148	192	44	Yes	**98.9%** 182 184	TEMPO	This metric determines the percent of NSPS sources (that have been inspected since 10-5-05) for which an NSPS subpart is specified. 27 (of the 42 not counted) of the sources identified in AFS as being NSPS (but did not have a subpart specified) were prev	State corre tentatively Obtain add documenta state datab confirm sta values. Dis transfer iss State durin Recording NSPS subp natural gas
A01C5S	CAA Subpart Designations: Percent NESHAP facilities with FCEs conducted after 10/1/2005	Data Quality	100%	46.6%	28.3%	13	46	33	Yes	100% 14 14	TEMPO	This metric determines the percent of NESHAP sources (that have been inspected since 10-5-05) for which a NESHAP subpart is specified. A large percentage of the sources identified in AFS as being NESHAPS (but did not have a subpart specified) were previo	State corre tentatively Obtain add documenta state datab confirm sta values.
A01C6S	CAA Subpart Designations: Percent MACT facilities with FCEs conducted after 10/1/2005	Data Quality	100%	92.5%	96.1%	98	102	4	No	98.4% 122 124	TEMPO	This metric determines the percent of NESHAP sources (that have been inspected since 10-5-05) for which a NESHAP subpart is specified. The 2 sources not counted in TEMPO are closed.	State corre tentatively Obtain add documenta state datab confirm sta values. The differ from but no expl given for th discrepanc
A01D1S	Compliance Monitoring: Sources with FCEs (1 FY)	Data Quality			278	NA	NA	NA	Yes	314	TEMPO	Some staff were putting the flat file line (with task completed date) in the work activity log when the inspection was done. The UI makes this an action reported to AFS, but if the inspection report was not completed before the UI is run, then the report	State corre tentatively Obtain add documenta state datab confirm sta values. Dis transfer iss State durin Determine provided is the problen

A01D2S	Compliance Monitoring: Number of FCEs (1 FY)	Data Quality			289	NA	NA	NA	Yes	325	TEMPO		State corre tentatively Obtain add documenta state datab confirm sta values. Dis transfer iss State durin
A01D3S	Compliance Monitoring: Number of PCEs (1 FY)	Informational Only			0	NA	NA	NA	Yes	155	TEMPO	The DAQ does not report partial compliance evaluations (PCEs) to AFS. This is not a required reporting element.	Informatior
A01E0S	Historical Non-Compliance Counts (1 FY)	Data Quality			39	NA	NA	NA					
A01F1S	Informal Enforcement Actions: Number Issued (1 FY)	Data Quality			97	NA	NA	NA					
A01F2S	Informal Enforcement Actions: Number of Sources (1 FY)	Data Quality			63	NA	NA	NA					
A01G1S	HPV: Number of New Pathways (1 FY)	Data Quality			15	NA	NA	NA					
A01G2S	HPV: Number of New Sources (1 FY)	Data Quality			13	NA	NA	NA					
A01H1S	HPV Day Zero Pathway Discovery date: Percent DZs with discovery	Data Quality	100%	50.3%	6.7%	1	15	14				Data quality issue - discovery action must be manually linked to HPV Day Zero and had not been done consistently. New procedures to address this issue.	Supplemer selected to HPV mana
A01H2S	HPV Day Zero Pathway Violating Pollutants: Percent DZs	Data Quality	100%	75.4%	100.0%	15	15	0					
A01H3S	HPV Day Zero Pathway Violation Type Code(s): Percent DZs with HPV Violation Type Code(s)	Data Quality	100%	79.3%	73.3%	11	15	4				Data quality issue - violation type code must be manually entered to HPV Day Zero and had not been done consistently. New procedures to address this issue.	Supplemer selected to HPV mana
A01I1S	Formal Action: Number Issued (1 FY)	Data Quality			16	NA	NA	NA					
A01I2S	Formal Action: Number of Sources (1 FY)	Data Quality			15	NA	NA	NA					
A01J0S	Assessed Penalties: Total Dollar Amount (1 FY)	Data Quality			$192,500	NA	NA	NA					
A01K0S	Major Sources Missing CMS Policy Applicability (Current)	Review Indicator	0		1	NA	NA	NA					
A02A0S	Number of HPVs/Number of NC Sources (1 FY)	Data Quality	<= 50%	59.8%	53.8%	14	26	12				Violations, whether HPV or non-HPV, are what they are. The ratio of HPVs to violations is increased by having more HPVs (not good) or less non-HPV violations (good).	Supplemer selected to HPV mana
A02B1S	Stack Test Results at Federally-Reportable Sources - % Without Pass/Fail Results (1 FY)	Goal	0%	1.8%	0.0%	0	5	5					Only 5 stac universe of is a potenti Discuss wi Production entries, sug additional t been done AFS was d Supplemer selected.

A02B2S	Stack Test Results at Federally-Reportable Sources - Number of Failures (1 FY)	Data Quality			0	NA	NA	NA					Supplemen selected to stack testin procedures documentat recording in
A03A0S	Percent HPVs Entered <= 60 Days After Designation, Timely Entry (1 FY)	Goal	100%	31.6%	13.3%	2	15	13				Data quality, procedure, and resource issue - During FY09, the staff person entering data to AFS resigned. Current resources procedures have changed and HPVs and related data are entered monthly.	Discuss dat manageme State during Supplemen selected.
A03B1S	Percent Compliance Monitoring related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY)	Goal	100%	51.4%	25.2%	181	718	537				Data quality, procedure, and resource issue - During FY09, the staff person entering data to AFS resigned. Current resources procedures have changed and HPVs and related data are entered monthly.	Discuss dat manageme State during Supplemen selected.
A03B2S	Percent Enforcement related MDR actions reported <= 60 Days After Designation, Timely Entry (1 FY)	Goal	100%	66.1%	64.6%	73	113	40				Data quality, procedure, and resource issue - During FY09, the staff person entering data to AFS resigned. Current resources procedures have changed and HPVs and related data are entered monthly.	Discuss dat manageme State during Supplemen selected.
A05A1S	CMS Major Full Compliance Evaluation (FCE) Coverage (2 FY CMS Cycle)	Goal	100%	87.8%	95.9%	235	245	10				Field staff are doing an excellent job in meeting their inspection requirements, with statistics improving with increased staffing and experience.	
A05A2S	CAA Major Full Compliance Evaluation (FCE) Coverage (most recent 2 FY)	Review Indicator	100%	83.0%	93.7%	236	252	16				Field staff are doing an excellent job in meeting their inspection requirements, with statistics improving with increased staffing and experience.	
A05B1S	CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (5 FY CMS Cycle)	Review Indicator	20% - 100%	83.7%	94.9%	168	177	9					
A05B2S	CAA Synthetic Minor 80% Sources (SM-80) FCE Coverage (last full 5 FY)	Informational Only	100%	90.1%	92.1%	176	191	15				Field staff are doing an excellent job in meeting their inspection requirements, with statistics improving with increased staffing and experience.	
A05C0S	CAA Synthetic Minor FCE and reported PCE Coverage (last 5 FY)	Informational Only		80.5%	91.4%	181	198	17					
A05D0S	CAA Minor FCE and Reported PCE Coverage (last 5 FY)	Informational Only		29.4%	14.3%	2	14	12				Minor sources are not generally reported to AFS; PCEs are not reported to AFS.	Information
A05E0S	Number of Sources with Unknown Compliance Status (Current)	Review Indicator			16	NA	NA	NA					Less than 1 universe. D state during

A05F0S	CAA Stationary Source Investigations (last 5 FY)	Informational Only			0	NA	NA	NA					
A05G0S	Review of Self-Certifications Completed (1 FY)	Goal	100%	94.0%	0 / 0	0	0	0	Yes	88.6% 225 254	TEMPO	Originally, the Universal Interface (UI) was not programmed to report completed Annual Compliance Certification (ACC) reviews completed by staff. Although the UI programming was changed, expected ACC submittals and completed ACC reviews still show up as	State corre tentatively Obtain add documenta state datab confirm sta values. Dis transfer iss State durin
A07C1S	Percent facilities in noncompliance that have had an FCE, stack test, or enforcement (1 FY)	Review Indicator	> 1/2 National Avg	22.1%	12.3%	38	309	271					
A07C2S	Percent facilities that have had a failed stack test and have noncompliance status (1 FY)	Review Indicator	> 1/2 National Avg	43.9%	0 / 0	0	0	0					Supplemer selected to stack testir procedures documenta recording i
A08A0S	High Priority Violation Discovery Rate - Per Major Source (1 FY)	Review Indicator	> 1/2 National Avg	7.8%	4.0%	10	250	240					
A08B0S	High Priority Violation Discovery Rate - Per Synthetic Minor Source (1 FY)	Review Indicator	> 1/2 National Avg	0.6%	1.5%	3	197	194					
A08C0S	Percent Formal Actions With Prior HPV - Majors (1 FY)	Review Indicator	> 1/2 National Avg	74.7%	50.0%	5	10	5					
A08D0S	Percent Informal Enforcement Actions Without Prior HPV - Majors (1 FY)	Review Indicator	< 1/2 National Avg	45.6%	70.3%	26	37	11					
A08E0S	Percentage of Sources with Failed Stack Test Actions that received HPV listing - Majors and Synthetic Minors (2 FY)	Review Indicator	> 1/2 National Avg	43.0%	0 / 0	0	0	0					Supplemer selected to stack testir procedures documenta recording i
A10A0S	Percent HPVs not meeting timeliness goals (2 FY)	Review Indicator		35.9%	64.3%	18	28	10					State metri national av Discuss HP enforceme with State review. Su files selecte
A12A0S	No Activity Indicator - Actions with Penalties (1 FY)	Review Indicator			15	NA	NA	NA					
A12B0S	Percent Actions at HPVs With Penalty (1 FY)	Review Indicator	>= 80%	87.4%	71.4%	5	7	2				There may be some data quality issues with this metric, but some HPVs are appropriately resolved without assessing a penalty.	Discuss HP enforceme with State review. Su files selecte

Clean Water Act
PDA

Metric	Metric Description	Metric Type	Agency	National Goal	National Average	Kentucky Metric	Count	Universe	Not Counted	State Discrepancy (Yes/No)	State Correction	State Data Source	Discrepancy Explanation	Initial Findir
W01A1C	Active facility universe: NPDES major individual permits (Current)	Data Quality	Combined			130	NA	NA	NA	No		OTIS/PCS/ TEMPO		
W01A2C	Active facility universe: NPDES major general permits (Current)	Data Quality	Combined			0	NA	NA	NA	No		OTIS/PCS/ TEMPO		
W01A3C	Active facility universe: NPDES non-major individual permits (Current)	Data Quality	Combined			1,764	NA	NA	NA	No		OTIS/PCS/ TEMPO		
W01A4C	Active facility universe: NPDES non-major general permits (Current)	Data Quality	Combined			4,198	NA	NA	NA	No		OTIS/PCS/ TEMPO		
W01B1C	Major individual permits: correctly coded limits (Current)	Goal	Combined	>=; 95%	88.0%	86.2%	112	130	18	No		OTIS/PCS/ TEMPO		Since data entry percen the national goal, furthe and analyses are warra
C01B2C	Major individual permits: DMR entry rate based on MRs expected (Forms/Forms) (1 Qtr)	Goal	Combined	>=; 95%	94.6%	100.0%	1,159	1,159	0	No		OTIS/PCS/ TEMPO		This is a minor issue sir discharge monitoring re (DMR) is slightly below goal.
C01B3C	Major individual permits: DMR entry rate based on DMRs expected (Permits/Permits) (1 Qtr)	Goal	Combined	>=; 95%	93.3%	86.20%	112	130	18	No		OTIS/PCS/ TEMPO		Since data entry percen the national goal, furthe and analyses are warra
W01B4C	Major individual permits: manual RNC/SNC override rate (1 FY)	Data Quality	Combined			0.0%	0	16	16	No		OTIS/PCS/ TEMPO		
W01C1C	Non-major individual permits: correctly coded limits (Current)	Informational Only	Combined			74.5%	1,315	1,764	449	No		OTIS/PCS/ TEMPO		This metric is informatio data are not required to
C01C2C	Non-major individual permits: DMR entry rate based on DMRs expected (Forms/Forms) (1 Qtr)	Informational Only	Combined			0.8%	36	4,662	4,626	No		OTIS/PCS/ TEMPO		This metric is informatio data are not required to
C01C3C	Non-major individual permits: DMR entry rate based on DMRs expected (Permits/Permits) (1 Qtr)	Informational Only	Combined			0.3%	5	1,757	1,752	No		OTIS/PCS/ TEMPO		This metric is informatio data are not required to
W01D1C	Violations at non-majors: noncompliance rate (1 FY)	Informational Only	Combined			6.7%	119	1,764	1,645	No		OTIS/PCS/ TEMPO		This metric is informatio data are not required to

C01D2C	Violations at non-majors: noncompliance rate in the annual noncompliance report (ANCR)(1 CY)	Informational Only	Combined			0 / 0	0	0	0	No		OTIS/PCS/ TEMPO		This metric is informatio data are not required to
W01D3C	Violations at non-majors: DMR non-receipt (3 FY)	Informational Only	Combined			1,085	NA	NA	NA	No		OTIS/PCS/ TEMPO		This metric is informatio data are not required to
W01E1S	Informal actions: number of major facilities (1 FY)	Data Quality	State			83	NA	NA	NA	No	81	OTIS/PCS/ TEMPO	No discrepancy - within 5%	Difference deemed insig
W01E2S	Informal actions: number of actions at major facilities (1 FY)	Data Quality	State			180	NA	NA	NA	No	186	OTIS/PCS/ TEMPO	No discrepancy - within 5%	Difference deemed insig
W01E3S	Informal actions: number of non-major facilities (1 FY)	Data Quality	State			455	NA	NA	NA	Yes	724	OTIS/PCS/ TEMPO	Due to wastewater violations cited at unpermitted facilities.	Since 246 non-permitted enforcement actions tha the state database (TEM potential area of concer
W01E4S	Informal actions: number of actions at non-major facilities (1 FY)	Data Quality	State			530	NA	NA	NA	Yes	846	OTIS/PCS/ TEMPO	Due to wastewater violations cited at unpermitted facilities.	Since 269 enforcement a non-permitted sources a state database (TEMPO potential area of concer
W01F1S	Formal actions: number of major facilities (1 FY)	Data Quality	State			11	NA	NA	NA	Yes	12	OTIS/PCS/ TEMPO	Process problem in transferring data for entry into PCS. Corrected.	Difference deemed insig
W01F2S	Formal actions: number of actions at major facilities (1 FY)	Data Quality	State			12	NA	NA	NA	Yes	14	OTIS/PCS/ TEMPO	Process problem in transferring data for entry into PCS. Corrected.	Difference is deemed si Additional research is ne since this is required dat
W01F3S	Formal actions: number of non-major facilities (1 FY)	Data Quality	State			53	NA	NA	NA	Yes	71	OTIS/PCS/ TEMPO	Process problem in transferring data for entry into PCS. Corrected.	Difference is deemed si Additional research is ne since this is required dat
W01F4S	Formal actions: number of actions at non-major facilities (1 FY)	Data Quality	State			58	NA	NA	NA	Yes	74	OTIS/PCS/ TEMPO	Process problem in transferring data for entry into PCS. Corrected.	Difference is deemed si Additional research is ne since this is required dat
W01G1S	Penalties: total number of penalties (1 FY)	Data Quality	State			62	NA	NA	NA	Yes	76	OTIS/Docu ments	Process problem in transferring data for entry into PCS. Corrected.	The KY CWA § 106 worl requires penalty assesse collected to be entered i NPDES for all enforcem Further discussion is nee

W01G2S	Penalties: total penalties (1 FY)	Data Quality	State			$543,000	NA	NA	NA	Yes	$557,039.33	OTIS/Documents	Process problem in transferring data for entry into PCS. Corrected.	Although 57 cases matcl and 3 cases are duplicat discrepancy requires furt analyses.
W01G3S	Penalties: total collected pursuant to civil judicial actions (3 FY)	Data Quality	State			$0	NA	NA	NA	No		OTIS/PCS/ TEMPO		
W01G4S	Penalties: total collected pursuant to administrative actions (3 FY)	Informational Only	State			$1,220,300	NA	NA	NA	Yes	$4,634,484.27	OTIS/PCS/ TEMPO	Process problem in transferring data for entry into PCS. Corrected.	Significant discrepancy i information. The KY CW workplan requires penalt and collected to be enter NPDES for all enforceme Further discussion is nee
W01G5S	No activity indicator - total number of penalties (1 FY)	Data Quality	State			$543,000	NA	NA	NA	No		OTIS/PCS/ TEMPO		
W02A0S	Actions linked to violations: major facilities (1 FY)	Data Quality	State	>=; 80%		0.0%	0	12	12	No		OTIS/PCS/ TEMPO		No major facility has acti violations. Further analys discussion are warranted
W05A0S	Inspection coverage: NPDES majors (1 FY)	Goal	State	100%	64.9%	77.7%	101	130	29	No		OTIS/PCS/ TEMPO		Although national goal is CWA §106 workplan req (as allowed in the EPA C strategy).
W05B1S	Inspection coverage: NPDES non-major individual permits (1 FY)	Goal	State			31.8%	561	1,764	1,203	No		OTIS/PCS/ TEMPO		
W05B2S	Inspection coverage: NPDES non-major general permits (1 FY)	Goal	State			5.9%	247	4,198	3,951	Yes		OTIS/PCS/ TEMPO	Excludes inspections at approximately 1700 coal general permits (KYG04)	KY CWA §106 Workplan entry of all inspections in national database,
W05C0S	Inspection coverage: NPDES other (not 5a or 5b) (1 FY)	Informational Only	State			0.1%	4	4,901	4,897	No		OTIS/PCS/ TEMPO		This metric is information data are not required to b
W07A1C	Single-event violations at majors (1 FY)	Review Indicator	Combined			1	NA	NA	NA	No		OTIS/PCS/ TEMPO		This is an area for furthe discussion.
W07A2C	Single-event violations at non-majors (1 FY)	Informational Only	Combined			0	NA	NA	NA	No		OTIS/PCS/ TEMPO		This metric is information data are not required to b
W07B0C	Facilities with unresolved compliance schedule violations (at end of FY)	Data Quality	Combined		26.1%	15.4%	6	39	33	Yes	0	OTIS/PCS/ TEMPO	Process problem in transferring data for entry into PCS. Corrected.	Difference is deemed sig Data is required for majo but is not required for no facilities. Additional rese necessary.

W07C0C	Facilities with unresolved permit schedule violations (at end of FY)	Data Quality	Combined		26.7%	0 / 0	0	0	0	No		OTIS/PCS/ TEMPO		
W07D0C	Percentage major facilities with DMR violations (1 FY)	Data Quality	Combined		52.6%	49.2%	64	130	66	No		OTIS/PCS/ TEMPO		
W08A1C	Major facilities in SNC (1 FY)	Review Indicator	Combined			16	NA	NA	NA	No		OTIS/PCS/ TEMPO		
W08A2C	SNC rate: percent majors in SNC (1 FY)	Review Indicator	Combined		22.6%	12.1%	16	132	116	No		OTIS/PCS/ TEMPO		
W10A0C	Major facilities without timely action (1 FY)	Goal	Combined	< 2%	18.6%	9.1%	12	132	120	No		OTIS/PCS/ TEMPO		This is an area for furthe discussion.

Resource Conservation and Recovery Act PDA

Metric	Metric Description	Metric Type	National Goal	National Average	Kentucky Metric	Count	Universe	Not Counted	State Discrepancy (Yes/No)	State Correction	State Data Source	Discrepancy Explanation	Initial Findi
R01A1S	Number of operating TSDFs in RCRAInfo	Data Quality			14	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01A2S	Number of active LQGs in RCRAInfo	Data Quality			276	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01A3S	Number of active SQGs in RCRAInfo	Data Quality			446	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01A4S	Number of all other active sites in RCRAInfo	Data Quality			2,102	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01A5S	Number of LQGs per latest official biennial report	Data Quality			269	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01B1S	Compliance monitoring: number of inspections (1 FY)	Data Quality			947	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01B2S	Compliance monitoring: sites inspected (1 FY)	Data Quality			755	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01C1S	Number of sites with violations determined at any time (1 FY)	Data Quality			213	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01C2S	Number of sites with violations determined during the FY	Data Quality			188	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01D1S	Informal action: number of sites (1 FY)	Data Quality			187	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01D2S	Informal action: number of actions (1 FY)	Data Quality			211	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01E1S	SNC: number of sites with new SNC (1 FY)	Data Quality			16	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01E2S	SNC: number of sites in SNC (1FY)	Data Quality			25	NA	NA	NA	No		RCRAInfo/ TEMPO		

R01F1S	Formal action: number of sites (1 FY)	Data Quality			11	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01F2S	Formal action: number taken (1 FY)	Data Quality			12	NA	NA	NA	No		RCRAInfo/ TEMPO		
R01G0S	Total amount of final penalties(1 FY)	Data Quality			$61,000	NA	NA	NA	No		RCRAInfo/ TEMPO		
R02A1S	Number of sites SNC-determined on day of formal action (1 FY)	Data Quality			0	NA	NA	NA	No		RCRAInfo/ TEMPO		
R02A2S	Number of sites SNC-determined within one week of formal action (1 FY)	Data Quality			0	NA	NA	NA	No		RCRAInfo/ TEMPO		
R02B0S	Number of sites in violation for greater than 240 days	Data Quality			3	NA	NA	NA	No		RCRAInfo/ TEMPO		**KYD000622993** - Tl listed does not have RTC date in RC **KYD049059579** - T violations listed. Tw show the state as agency, and 11 show lead agency. RCRAI show a RTC da
R03A0S	Percent SNCs entered ≥ 60 days after designation (1 FY)	Review Indicator			26.7%	4	15	11	No		RCRAInfo/ TEMPO		All four facilities are o same company. All fo evaluation date of 10- 290 SNC designation
R05A0S	Inspection coverage for operating TSDFs (2 FYs)	Goal	100%	86.6%	100.0%	14	14	0	No		RCRAInfo/ TEMPO		
R05B0S	Inspection coverage for LQGs (1 FY)	Goal	20%	25.2%	61.7%	166	269	103	No		RCRAInfo/ TEMPO		
R05C0S	Inspection coverage for LQGs (5 FYs)	Goal	100%	68.7%	98.9%	266	269	3	No		RCRAInfo/ TEMPO		

R05D0S	Inspection coverage for active SQGs (5FYs)	Informational Only			81.6%	364	446	82	Yes		RCRAInfo/ TEMPO	Thirty-two (32) of the 82 SQGs not inspected in the last five years either registered as generators or modified their generator status from CESQG to SQG in the last half of FY2009 or in FY2010. These facilities have not been inspected in the last 5 years	
R05E1S	Inspections at active CESQGs (5 FYs)	Informational Only			1,321	NA	NA	NA	No		RCRAInfo/ TEMPO		
R05E2S	Inspections at active transporters (5FYs)	Informational Only			354	NA	NA	NA	No		RCRAInfo/ TEMPO		
R05E3S	Inspections at non-notifiers (5 FYs)	Informational Only			3	NA	NA	NA	No		RCRAInfo/ TEMPO		
R05E4S	Inspections at active sites other than those listed in 5a-d and 5e1-5e3 (5 FYs)	Informational Only			291	NA	NA	NA	No		RCRAInfo/ TEMPO		
R07C0S	Violation identification rate at sites with inspections (1 FY)	Review Indicator			24.9%	188	755	567	No		RCRAInfo/ TEMPO		
R08A0S	SNC identification rate at sites with nspections (1 FY)	Review Indicator	1/2 National Avg	3.2%	2.1%	16	755	739	No		RCRAInfo/ TEMPO		
R08B0S	Percent of SNC determinations made within 150 days (1 FY)	Goal	100%	75.6%	100.0%	15	15	0	No		RCRAInfo/ TEMPO		
R08C0S	Percent of formal actions taken that received a prior SNC listing (FY)	Review Indicator	1/2 National Avg	61.2%	100.0%	13	13	0	No		RCRAInfo/ TEMPO		
R10A0S	Percent of SNCs with formal action/referral taken within 360 days (1 FY)	Review Indicator	80%	45.2%	62.5%	10	16	6	No		RCRAInfo/ TEMPO		The RCRA ERP allow days from the first day inspection for a SNC f resolved by final enfor referral to the state at general, or EPA. The shows that six of the 1 exceeded the ERP tim
R10B0S	No activity indicator - number of formal actions (1 FY)	Review Indicator			12	NA	NA	NA	No		RCRAInfo/ TEMPO		
R12A0S	No activity indicator - penalties (1FY)	Review Indicator			$61,000	NA	NA	NA	No		RCRAInfo/ TEMPO		
R12B0S	Percent of final formal actions with penalty (FY)	Review Indicator	1/2 National Avg	81.3%	50.0%	2	4	2	No		RCRAInfo/ TEMPO		

APPENDIX F: FILE SELECTION

Files to be reviewed are selected according to a standard protocol (available here: http://www.epa-otis.gov/srf/docs/fileselectionprotocol_10.pdf) and using a web-based file selection tool (available here: http://www.epa-otis.gov/cgi-bin/test/srf/srf_fileselection.cgi). The protocol and tool are designed to provide consistency and transparency in the process. Based on the description of the file selection process in section A below, states should be able to recreate the results in the table in section B.

A. File Selection Process

Clean Air Act

Using the OTIS File Selection Tool, 30 files were selected for review during the December 2010 file review visit. As specified in the SRF File Selection Protocol, since the Kentucky universe includes between 300 and 700 facilities, 20 to 35 files must be reviewed.

Representative Files

Although the entire Kentucky universe in OTIS was over 450 facilities, the file review will focus on Major and Synthetic Minor 80% (SM80) sources, which reduces the universe to about 317 facilities with compliance and enforcement activities occurring during the review period (FY09). Therefore, the targeted number of files to review was determined to be about 30 files. The initial breakdown will be about 10 representative files for both enforcement and compliance monitoring, leaving about 10 files available for supplemental review.

Enforcement files: In order to identify files with enforcement related activity, the facility list was sorted to identify those facilities which had a formal enforcement action during the review period (FY09). There were 15 sources with a formal enforcement action. To randomly select the target number of files, the first two of every three facilities was selected, which yielded 10 "representative" files.

Compliance files: Nearly 320 sources had full compliance evaluations (FCEs) during FY09, so in order to identify approximately 10 files, every 32nd file was selected. This process led to the selection of an additional 10 "representative" files.

Supplemental Files

Metrics 1h1, 1h3, 2a, & 3a: The PDA indicated that HPV discovery dates (Metric 1h1) and HPV type codes (Metric 1h3) were not being entered into AFS. In addition, the PDA identified a concern with a high proportion of violating sources being designated as HPVs (Metric 2a). Finally, the timeliness of data entry for HPV-related minimum data requirements (MDRs) was also identified as a concern (Metric 3a). To evaluate these issues, three supplemental files were selected from among the FY09 universe of HPV sources (Dow Corning, Westlake Vinyls, & Greif Industrial Packaging).

Metric 3b1 & 3b2: The PDA indicated a potential concern with the timeliness of reporting of minimum data requirements (MDRs) for compliance monitoring and enforcement activities. The majority of the late compliance monitoring activities was Title 5 annual certification reviews, and the majority of the late enforcement actions were notices of violation (NOVs). Two supplemental files (Montebello Packaging & FP International) will be reviewed to evaluate this concern.

Metric 2b1, 2b2, 7c2, & 8e: These data metrics indicate that the state may not be entering stack tests into AFS. Only 5 stack tests were reported for FY09 in the frozen data metrics (Metric 2b1), but the production data indicates a universe of 45 stack tests. Therefore, three supplemental files (North American Stainless, East KY Power Coop – Spurlock, & Big Rivers Electric Corp. - Wilson) were selected for this review to serve as a catalyst for further dialogue with the state concerning stack test procedures.

Metric 10a & 12b: These data metrics suggest a potential concern with the state taking timely and appropriate action to address HPVs. To evaluate the timeliness concern, one file was selected which did not meet the target of 270 days for addressing an HPV (Eastern KY Correctional Complex). Another file (Trim Masters) was selected from among those HPV resolving actions that did not include a penalty.

After these initial representative and supplemental file selections were made, two additional concerns surfaced which resulted in the selection of five more supplemental files. First, the sources were plotted on a map to ensure a relatively uniform distribution of selected files from among the state's eight regional offices. This map revealed that only one source was being evaluated in the two southeastern regions (London and Hazard). As a result, three additional files were selected in these regions (Kellogg USA, Martin Co. Coal, & Vanderbilt Yachts).

In addition, a careful review of the selected files revealed that no gas transmission facilities had been identified for review. This was a concern in light of with the comments made by the state under Metric 1c4 concerning the failure to code the NSPS subparts for these facilities. Therefore, two additional supplemental files were selected to ensure this issue is considered during the file review (EQT Gathering – Maces Creek & TN Gas Pipeline – Station 871). These additional file selections resulted in a total of 35 files being identified for the file review portion of the SRF evaluation.

Clean Water Act

Original Kentucky File Selections:

Files were selected randomly based on major and minor universe index while ensuring a mix of sub-regions and considering other enforcement information such as violation, significant noncompliance, informal action, formal action, and penalty action. The number of facilities with compliance and/or enforcement activities during the review year of FY 2009 retrieved from the Online Tracking and Information System (OTIS) was 2240. Based on the OTIS SRF files selection criteria for any universe with more than 700 records, the number of facilities to select for file reviews is between 25 to 40 files. The initial representative facilities selected for the Commonwealth of Kentucky are 28. (See list below.)

28 of 2240 records being displayed.

28 accepted representative	0 rejected
0 accepted supplemental	0 unknown

Select	Program ID	Universe	Sub Region	Permit Type	Inspection	Violation	Single Event Violation	SNC	Informal Action	Formal Action	Penalty
Accepted Representative:	Update		13		20	18	0	13	16	14	12
Accepted Supplemental:					0	0	0	0	0	0	0

KY0034444,KY0048496,KY0048348,KY0001341,KY0072761,KY0021172,KY0076333,KY0104299,KY0105856,KY0022861,
KY0100404,KY0022934,KY0092118,KY0073377,KYG401199,KYG400498,KYG640103,KYG640119,KYG840063,KYG8401
18,KYG840297,KYG840304,KYR001396,KYR001841,KYS000001,KYU003876,KYU080356

Add/Replace up to 7 Facilities:

Region 4 will work with Kentucky to add or replace up to seven of the randomly selected facilities with mining or wet weather inspections and/or enforcement information. Although EPA's file selection protocol cannot easily differentiate wet weather facilities, Kentucky did provide the FY 2009 inspection plan for non-major facilities to EPA as required by the 106 Workplan. For each wet weather facility selected, the region must verify that the inspections were indeed done and not replace by similar facilities. Mining inspection information is not populated in the national database, so Region 4 will follow the SRF selection protocol and obtain the FY 2009 mining inspection and enforcement information from Kentucky.

Refined Kentucky File Selections after further consultation with program

Final Files Selected Based on Further Discussion with All Parties

28 (After Consultation with all Parties)
+ 7 Mining/Wet Weather Facilities (Names TBD)
35 Total Facilities

Region 4 is requesting files for 27 facilities for the CWA portion of the SRF review using the SRF Selection Protocol and seven wet weather or mining inspection and/or enforcement files. Of the 27 representative facilities files selected using the SRF selection tool, the following will be examined:

a) up to 20 inspection reports because the facility had an inspection during the base review year
b) up to 12 files because penalty actions was taken during the review year
c) up to 14 files because formal enforcement action was taken during the review year, and
d) up to 16 files because informal enforcement actions were taken during the review year.

The inspection files include a mix of facilities with various permit components and various compliance history information in the national system. If an inspection file had an enforcement action associated with it, both activities may be reviewed (and vice-versa when a selected action has an inspection file). A facility could have multiple areas reviewed such as informal action, inspection reports, formal actions, penalty calculations and collections, etc.

Resource Conservation and Recovery Act

Using the OTIS File Selection Tool, 32 files were selected for the RCRA portion of the KY SRF Review based on the period ending FY09. The SRF File Selection Protocol (version 2.0 – September 2008) was used to identify a range of facilities based on the number of facilities in the universe. The Kentucky universe contained over 762 facilities in FY09. According to the protocol, a range of 25 to 40 facilities can be selected for review. Considering this range, 32 representative files were selected. Using the facility identification number, files were randomly selected and sorted by evaluation, violation, SNC, informal and formal action, and penalty. (See Screen Shot Below).

761 of 762 records being displayed.		Advanced Sorting Map Selected Hide Rejected Facilities Reset Facility Selections
32 accepted representative	1 rejected	
0 accepted supplemental	0 unknown	

Select	Program ID	Universe	State District	Evaluation	Violation	SNC	Informal Action	Formal Action	Penalty

Accepted Representative:		Update		30	25	12	16	9	9
Accepted Supplemental:				0	0	0	0	0	0

Of the 32 facilities selected, 30 files will be examined because the facility had at least one inspection. Twenty-five (25) files will be examined with violations resulting from an inspection. At least 12 SNCs will be examined, as well as 16 informal enforcement actions, 9 formal actions, and 9 penalty assessments.

The following files were randomly selected:

KYD055831838	KYD092570407	KYD094202736	KYR000011361
KYD006370159	KYD981021041	KY0000055756	KYD024140196
KYR000050559	KYR000045864	KYD985080704	KYD053348108
KYD024058877	KYD981852924	KYD985082395	KYR000043752
KYD095204814	KYD985086883	KYD045580552	KYR000043448
KYR000050088	KYD072677636	KYR000021212	KYD000828582
KYR000034207	KYD006383392	KYR000046383	KYR000021246
KYD048878805	KYR000033837	KYR000023580	KYD006945802

Note: It was not necessary to select supplemental files for review. The representative sample of facilities identified above should address any potential areas of concern.

B. File Selection Table

Clean Air Act

#	Program ID		City	FCE	PCE	Violation	Stack Test Failure	Title V Deviation	HPV	Informal Action	Formal Action	Penalty	Universe	Selection Criteria
1	2109300054		ELIZABETHTOWN	1	0	0	0	0	1	1	1	7,500	MAJR	Representative
2	2104100002		CARROLLTON	1	0	0	0	0	0	0	0	0	MAJR	Representative
3	2118300069		CENTERTOWN	1	0	0	0	0	0	0	0	0	MAJR	Supplemental
4	2101900113		ASHLAND	1	0	0	0	0	0	1	1	28,000	MAJR	Representative
5	2105900006		OWENSBORO	1	0	0	0	0	0	0	0	0	MAJR	Representative
6	2100900009		GLASGOW	0	0	0	0	0	0	0	1	0	SM80	Representative
7	2104100004		CARROLLTON	1	0	0	0	0	1	1	0	0	MAJR	Supplemental
8	2105900061		OWENSBORO	1	0	0	0	0	0	0	0	0	SM80	Representative
9	2116100009		MAYSVILLE	1	0	0	0	0	0	1	0	0	MAJR	Supplemental
10	2117500019		WEST LIBERTY	1	0	4	0	0	0	0	0	0	SM80	Supplemental
11	2115100007		RICHMOND	0	0	8	0	0	1	0	1	3,000	MAJR	Representative
12	2119300110		VIPER	1	0	0	0	0	0	0	0	0	MAJR	Supplemental
13	2100500002		LAWRENCEBURG	1	0	0	0	0	0	0	0	0	SM80	Representative
14	2104700099		HOPKINSVILLE	1	0	0	0	0	0	0	0	0	MAJR	Supplemental
15	2101500010		FLORENCE	1	0	4	0	0	0	0	1	6,000	MAJR	Supplemental
16	2107500024		HICKMAN	0	0	0	0	0	0	0	1	9,000	MAJR	Representative
17	2111700185		COVINGTON	0	0	0	0	0	0	1	1	6,000	SM80	Representative
18	2115700003		CALVERT CITY	1	0	0	0	0	0	0	0	0	MAJR	Representative
19	2117900014		BOSTON (NELSON)	0	0	0	0	0	0	0	1	0	MAJR	Representative

20	2119500234		KIMPER	1	0	0	0	0	0	0	0	0	SM80	Supplemental
21	2101700034		PARIS	1	0	4	0	0	0	0	1	38,000	SM80	Representative
22	2123900001		VERSAILLES	0	0	0	0	0	1	1	1	20,000	MAJR	Representative
23	2114100038		RUSSELLVILLE	2	0	4	0	0	0	0	0	0	MAJR	Representative
24	2115900002		INEZ	1	0	0	0	0	0	0	0	0	MAJR	Supplemental
25	2100700012		WICKLIFFE	1	0	0	0	0	0	0	0	0	MAJR	Representative
26	2115500028		LEBANON	1	0	0	0	0	0	1	0	0	SM80	Supplemental
27	2104100034		GHENT	0	0	12	0	0	0	2	1	0	MAJR	Supplemental
28	2101900003		ASHLAND	1	0	0	0	0	0	0	0	0	SM80	Representative
29	2102100037		DANVILLE	1	0	0	0	0	0	0	0	0	MAJR	Representative
30	2104700025		HOPKINSVILLE	1	0	0	0	0	0	0	2	75,000	MAJR	Representative
31	2116100032		MAYSVILLE	1	0	0	0	0	0	0	0	0	SM80	Representative
32	2121700034		CAMPBELLSVILLE	1	0	0	0	0	0	0	0	0	MAJR	Supplemental
33	2117900044		BARDSTOWN	0	0	0	0	0	1	1	1	0	SM80	Supplemental
34	2105300019		ALBANY	1	0	0	0	0	0	1	0	0	SM80	Supplemental
35	2115700039		CALVERT CITY	1	0	8	0	0	1	1	0	0	MAJR	Supplemental

Clean Water Act

Program ID	City	Permit Type	Inspection	Violation	Single Event Violation	SNC	Informal Action	Formal Action	Penalty	Universe
KYR001841	CARROLLTON	R	1	0	0	0	0	0	0	Minor
KY0072761	CALLOWAY COUNTY	0	1	21	0	3	8	2	38000	Major
KY0021172	MARSHALL COUNTY	0	3	11	0	2	5	1	8000	Major
KYR001396	CRESCENT SPRINGS	R	0	5	0	0	0	1	4000	Minor
KYG401199	CAMPBELL COUNTY	G	2	8	0	0	1	0	0	Minor
KY0048496	MAYSVILLE	0	0	4	0	4	0	0	0	Major
KY0105856	HARRISON COUNTY	0	1	7	0	1	4	0	0	Major
KYG840118	GARRARD COUNTY	G	0	0	0	0	0	1	2500	Minor
KY0022861	FRANKLIN COUNTY	0	1	4	0	1	2	0	0	Major
KY0048348	GREENUP COUNTY	0	1	4	0	4	1	0	0	Major
KY0001341	HARRODSBURG	0	0	4	0	4	0	0	0	Major
KY0100404	JESSAMINE COUNTY	0	2	4	0	1	2	0	0	Major
KYU080356	SCIENCE HILL	U	0	0	0	0	0	1	3000	Minor
KYG840297	LAWRENCE COUNTY	G	1	0	0	0	1	0	0	Minor
KYS000001	JEFFERSON COUNTY	S	0	0	0	0	1	0	0	Major
KYG640119	CRITTENDEN COUNTY	G	3	0	0	0	1	0	0	Minor
KY0021211	GRAVES COUNTY	0	4	15	0	4	4	1	0	Major
KY0034444	JACKSON COUNTY	0	1	36	0	4	1	1	10000	Minor

KY0104299	ROBERTSON COUNTY	0	1	20	0	1	1	1	2000	Minor
KY0104400	MONTGOMERY COUNTY	0	1	0	0	0	0	2	4000	Major
KYG400498	FLOYD COUNTY	G	0	4	0	0	0	0	0	Minor
KY0076333	PAINTSVILLE	0	1	10	0	2	0	1	6000	Minor
KY0022845	MADISON COUNTY	0	1	1	0	0	1	1	5000	Major
KY0020427	SHELBY COUNTY	0	2	0	0	0	2	1	0	Major
KYG840063	MENIFEE COUNTY	G	1	0	0	0	0	1	9000	Minor
KYG840304	LARUE COUNTY	G	2	0	0	0	0	1	5000	Minor
KYU003876	Unknown	U	0	8	0	4	0	0	0	Minor
KYG640103	GRAYSON COUNTY	G	1	4	0	0	1	0	0	Minor

Resource Conservation and Recovery Act

#	PROGRAM ID	CITY	EVALUATION	VIOLATION	SNC	Informal ACTION	Formal ACTION	PENALTY	UNIVERSE	SELECTION CRITERIA
1	KYD055831838	CALVERT CITY	3	0	0	0	0	0	LQG	Representative
2	KYD006370159	CALVERT CITY	4	8	0	1	0	0	TSD(COM)	Representative
3	KYR000050559	SHELBYVILLE	1	7	1	0	0	0	SQG	Representative
4	KYD024058877	LOUISVILLE	2	4	0	1	0	0	SQG	Representative
5	KYD095204814	COLD SPRING	2	2	0	1	0	0	SQG	Representative
6	KYR000050088	LOUISVILLE	2	13	1	0	0	0	SQG	Representative
7	KYR000034207	BEAVER DAM	5	2	1	0	0	0	TSD(TSF)	Representative
8	KYD048878805	MAYSVILLE	2	2	0	0	0	0	SQG	Representative
9	KYD092570407	CALVERT CITY	2	3	1	0	1	16,000	TSD(LDF)	Representative
10	KYD981021041	HENDERSON	2	3	0	0	1	11,000	SQG	Representative
11	KYR000045864	PADUCAH	0	0	0	0	1	12,000	SQG	Representative
12	KYD981852924	BARDSTOWN	1	4	0	1	0	0	SQG	Representative
13	KYD985086883	LOUISVILLE	2	4	0	1	0	0	SQG	Representative
14	KYD072677636	ASHLAND	3	12	0	1	0	0	SQG	Representative
15	KYD006383392	GUTHRIE	2	0	0	0	0	0	TSD(LDF)	Representative
16	KYR000033837	CALVERT CITY	2	1	0	1	0	0	SQG	Representative
17	KYD094202736	SOUTH SHORE	2	13	1	1	1	10,000	CES	Representative
18	KY0000055756	LOUISVILLE	2	2	0	0	0	0	LQG	Representative

19	KYD985080704	CALVERT CITY	2	3	0	1	0	0	SQG	Representative
20	KYD985082395	PADUCAH	2	0	0	0	0	0	CES	Representative
21	KYD045580552	ALLEN	1	3	1	0	0	0	CES	Representative
22	KYR000021212	WARFIELD	2	0	1	0	1	250	OTH	Representative
23	KYR000046383	HYDEN	2	14	1	1	1	250	OTH	Representative
24	KYR000023580	OWENSBORO	3	0	1	0	1	250	SQG	Representative
25	KYR000011361	IRVINE	3	1	1	1	1	250	SQG	Representative
26	KYD024140196	OWENSBORO	2	2	0	1	0	0	OTH	Representative
27	KYD053348108	SMITHFIELD	26	4	1	1	0	0	TSD(TSF)	Representative
28	KYR000043752	FLORENCE	2	5	1	0	0	0	CES	Representative
29	KYR000043448	LOUISVILLE	0	0	0	0	2	11,000	OTH	Representative
30	KYD000828582	CORYDON	2	2	0	1	0	0	SQG	Representative
31	KYR000021246	MORGANFIELD	2	6	0	1	0	0	LQG	Representative
32	KYD006945802	LOUISVILLE	3	18	0	1	0	0	SQG	Representative

APPENDIX G: FILE REVIEW ANALYSIS

This section presents the initial observations of the region regarding program performance against file metrics. Initial findings are developed by the region at the conclusion of the file review process. The initial finding is a statement of fact about the observed performance, and should indicated whether the performance indicates a practice to be highlighted or a potential issue, along with some explanation about the nature of good practice or the potential issue. The File Review Metrics Analysis Form in the report only includes metrics where potential concerns or areas of exemplary performance are identified.

Initial findings indicate the observed results. They are preliminary observations and are used as a basis for further investigation. These findings are developed only after evaluating them against the PDA results where appropriate, and talking to the state. Through this process, initial findings may be confirmed, modified, or determined not to be supported. Findings are presented in Section IV of this report.

The quantitative metrics developed from the file reviews are initial indicators of performance based on available information and are used by the reviewers to identify areas for further investigation. Because of the limited sample size, statistical comparisons among programs or across states cannot be made.

Clean Air Act Program
Kentucky **Review Period: FY 2009**

CAA Metric #	CAA File Review Metric Description	Metric Value	Initial Findings
Metric 2c	% of files reviewed where MDR data are accurately reflected in AFS.	9%	During the file review, only 3 of the 35 files reviewed (9%) documented all MDRs being reported accurately into AFS. The remaining 32 files had one or more discrepancies identified. The most common problem was 23 files with missing results in AFS for the Title V Annual Compliance Certification (ACC) reviews, which the State advised was a coding issue. Minor differences such as Standard Industrial Classification (SIC) code, facility name, address, operating status, or pollutants were identified in 12 files. More significantly, 15 files showed a discrepancy in the air program (MACT, NSR, NSPS) applicability of the source, 10 files revealed incorrect compliance status or HPV information in AFS, and 7 files revealed missing or incorrect enforcement, compliance, or penalty data in AFS.

Metric 4a	Confirm whether all commitments pursuant to a traditional CMS plan (FCE every 2 yrs at Title V majors; 3 yrs at mega-sites; 5 yrs at SM80s) or an alternative CMS plan were completed. Did the state/local agency complete all planned evaluations negotiated in a CMS plan? Yes or no? If a state/local agency implemented CMS by following a traditional CMS plan, details concerning evaluation coverage are to be discussed pursuant to the metrics under Element 5. If a state/local agency had negotiated and received approval for conducting its compliance monitoring program pursuant to an alternative plan,	95%	KDEP, which follows a traditional Compliance Monitoring Strategy plan, completed 95% of all planned evaluations (403 of 422 FCEs) under their FY2008/2009 CMS plan. In addition, the State met all of its enforcement and compliance commitments (100%) under the FY2009 Air Planning Agreement with EPA Region 4. Therefore, this element meets SRF program requirements.

	details concerning the alternative plan and the S/L agency's implementation (including evaluation coverage) are to be discussed under this Metric.		
Metric 4b	Delineate the air compliance and enforcement commitments for the FY under review. This should include commitments in PPAs, PPGs, grant agreements, MOAs, or other relevant agreements. The compliance and enforcement commitments should be delineated.	100%	See attached table for Metric 4b.
Metric 6a	# of files reviewed with FCEs.	27	
Metric 6b	% of FCEs that meet the definition of an FCE per the CMS policy.	96%	26 of the 27 files reviewed had documentation in the files to show that they contained all of the elements of the FCE, per the CMS.

Metric 6c	% of CMRs or facility files reviewed that provide sufficient documentation to determine compliance at the facility.	100%	All 27 CMRs reviewed contained all of the CMR requirements listed in the CMS and they contained sufficient documentation to determine compliance at the facility.
Metric 7a	% of CMRs or facility files reviewed that led to accurate compliance determinations.	100%	All 27 CMRs reviewed led to an accurate compliance determination.
Metric 7b	% of non-HPVs reviewed where the compliance determination was timely reported to AFS.	25%	2 of the 8 files reviewed with non-HPV violations were reported timely into AFS.
Metric 8f	% of violations in files reviewed that were accurately determined to be HPV.	100%	8 of the 8 files reviewed accurately determined HPVs.
Metric 9a	# of formal enforcement responses reviewed.	13	
Metric 9b	% of formal enforcement responses that include required corrective action (i.e., injunctive relief or	100%	All 13 files reviewed documented injunctive relief or complying actions. Most enforcement actions were penalty only actions, but the files documented that the facility had returned to compliance prior to issuance of the order.

	other complying actions) that will return the facility to compliance in a specified time frame.		
Metric 10b	% of formal enforcement responses for HPVs reviewed that are addressed in a timely manner (i.e., within 270 days).	50%	3 of the 6 HPVs reviewed were addressed in a timely manner.
Metric 10c	% of enforcement responses for HPVs appropriately addressed.	100%	All 6 HPVs were appropriately addressed with a formal enforcement response.
Metric 11a	% of reviewed penalty calculations that consider and include where appropriate gravity and economic benefit.	0%	None of the 12 files with a penalty action provided documentation of appropriate gravity and economic benefit components of the penalty.
Metric 12c	% of penalties reviewed that document the difference and rationale between the initial and final assessed penalty.	8%	Only 1 of the 12 files reviewed which had a penalty action provided documentation of the difference between the initial and final penalty. Although the state identifies a penalty range in its "case resolution proposal memo," the state does not consistently document the rationale for the final assessed penalty. In one case, the final penalty was reduced by the Deputy Commissioner, and the memo outlining his rationale was in the file.

Metric 12d	% of files that document collection of penalty.	100%	All 12 files reviewed documented collection of the penalty.

Clean Water Act Program
Kentucky **Review Period: FY 2009**

CWA Metric #	CWA File Review Metric:	Metric Value	Initial Findings
Metric 2b	% of files reviewed where data is accurately reflected in the national data system. 15 out of 29 = 52% including missing mining files. (15/23 = 66 % excluding mining files)	52%	The total universe number includes 6 mining facility file and does not include the multiple inspections and enforcement actions reviewed per mining facility.
Metric 4a	% of planned inspections completed.	100%	major (75.6% - 102/135 workplan) 50% goal, traditional minors (23.5% 402/1708) - 20% goal, Gen Permits 215/2045 10.5%
Metric 4b	Other Commitments. (These data will not derive from inspection or enforcement file. Reviewers will need to identify specific commitments in grant or PPA file.)	93%	26 of 28 Tasks
Metric 6a	# of inspection reports (Need Mining Cross Walk)	24 facilities (31 inspection reports) including mines	24 facilities (18 non-mining facilities + 6 mining facilities) 18 non-mining inspection reports (includes 6 sampling inspection reports) + 13 mining inspection reports = 31 inspection reports
Metric 6b	% of inspection reports reviewed that are	Still Evaluating	(Need Mining Data)

	complete.		
Metric 6c	% of inspection reports reviewed that provide sufficient documentation to lead to an accurate compliance determination. 18/18 (non-mining) = 100%	Early indications seems ok	NEED Cross walk and DOW/DENF Statement that all KPDES areas are reviewed thoroughly - Round 1 Recommendation
Metric 6d	% of inspection reports reviewed that are timely. 15<30, 2 <45, 1< 60, 0<90, 0 could not be confirmed =15 of 18 non-mining inspection reports Default standard is 30 days (DOES NOT INCLUDE MINING)	Early indications seems ok	EMS gives 20 days after sampling results received to finalize inspection report. 6 Sampling Inspection Reports
Metric 7e	Inspection reports reviewed that led to a compliance determination.	Early indications seems ok	
Metric 8b	% SEVs that are accurately reported as SNCs or non-SNCs in the national data system	0% Potential Concern	7 non mining SEVs found and accurately identified as violations in inspection reports, but no SEVs recorded in data system
Metric 8c	% of single event violation(s) identified as SNC that are reported timely. (DOES NOT INCLUDE MINING)	n/a	no SNC SEVs
Metric 9a	# of enforcement files reviewed	19 non mining facilities	

Metric 9b	% of enforcement responses that have returned or will return a source in SNC to compliance. 10 of 12 Non Mining Enforcement Responses	83% non-mining	Pertains to major facility SNC violations. 5 SNC facilities evaluated Assume no Mining SNCs!
Metric 9c	% of enforcement responses that have returned or will returned a source with non-SNC violations to compliance.	Early indications seems ok	Pertains to minor and major facility non SNC violations, but need to include mining.
Metric 10b	% of enforcement responses reviewed that address SNC that are taken in a taken in a timely manner. 5 SNC Facilities (Assumes No Major Facility in Mining)	40% Potential Issue	2 of 5 Must be return to compliance NLT the time the same violation appears on the 2nd official QNCR, If action not taken, then a written justification why the alternative action (e.g. informal enforcement or permit modification was more appropriate)
Metric 10c	% of enforcement responses reviewed that appropriately address SNC violations.	60% Potential Issue	Three of five major SNC facilities had a formal action that contained requirements that have returned or will return the source to compliance or had a justification for an informal action.
Metric 10d	% of enforcement responses reviewed that appropriately address non-SNC violations.	Early indications seems ok	Need to Include Mining Information
Metric 10e	If State has goal, % enforcement responses for non-SNC violations where a response was taken in a timely manner.	n/a	For minor facilities, 10e will not be evaluated, unless timeliness criteria in State EMS, For NonSnc Violations there is no federally established timeframe for addressing major and minor non SNC.

Metric 11a	% of penalty calculations that consider and include where appropriate gravity and economic benefit.	0% Potential Issue	11 evaluated (0 of 9 + 1 not applicable stipulated penalty + 1 case resolution sheet evaluated although penalty not assessed) Factors considered but no documentation of dollar amounts
Metric 12a	% of penalties reviewed that document the difference and rationale between the initial and final assessed penalty. (0 of 9, 1 stipulated and 1 penalty not assessed	0% Potential Issue	Only Proposed Case Resolution Data Sheets Provided and Evaluated. No Final Case Resolution Sheets Provided! Need to Evaluate Mining Data
Metric 12b	% of enforcement actions with penalties that document collection of penalty	Early indications seems ok	Need to Evaluate Mining Data

Resource Conservation and Recovery Act
Kentucky **Review Period: FY 2009**

RCRA Metric #	RCRA File Review Metric Description:	Metric Value	Initial Findings
Metric 2C	% of files reviewed where mandatory data are accurately reflected in the national data system.	22/27 (82%)	Five (5) of the 27 files reviewed had corresponding data missing or reported inaccurately in RCRAInfo.
Metric 6a	# of inspection reports reviewed.	23	Four (4) Rite Aid Facilities – Failure to notify. SNC & Penalty ($250 each)
Metric 6b	% of inspection reports reviewed that are complete and provide sufficient documentation to determine compliance at the facility.	22/23 (96%)	22 of the 23 (96%) files reviewed provided sufficient documentation to determine compliance at the facility.
Metric 6c	Inspections reports completed within a determined time frame.	21/23 (91%)	Two inspection reports were not completed w/in 45 days.
Metric 7a	% of accurate compliance determinations	23/23 (100%)	All 23/23 (100%) inspection reports reviewed led to accurate compliance determinations. Note: Rite Aid facilities not included.

	based on inspection reports.		
Metric 7b	% of violation determinations in the files reviewed that are reported timely to the national database (within 150 days).	11/11 (100 %)	11 of 11 (100 %) files had violation determinations reported in RCRAInfo w/in 150 days.
Metric 8d	% of violations in files reviewed that were accurately determined to be SNC.	14/14 (100%)	All 14 (100%) SNCs were accurately determined to be SNCs.
Metric 9a	# of enforcement responses reviewed.	25	14 – SNCs; 11 – SVs
Metric 9b	% of enforcement responses that have returned or will return a source in SNC to compliance.	14/14 (100%)	All 14 (100%) SNCs had enforcement responses to demonstrate that the source will return to compliance.
Metric 9c	% of enforcement responses that have returned or will return Secondary Violators (SV's) to compliance.	11/11 (100%)	All 11 (100%) SVs had enforcement responses to demonstrate that the source will return to compliance.

Metric 10c	% of enforcement responses reviewed that are taken in a timely manner.	SNC - 11/14 (79%) SV - 11/11 (100 %) Total - 22/25 (88%)	22 of the 25 (88%) enforcement responses reviewed were taken in a timely manner.
Metric 10d	% of enforcement responses reviewed that are appropriate to the violations.	100%	All 25 (100%) of the enforcement responses reviewed were appropriate to the violations.
Metric 12a	% of penalties reviewed that document the difference and rationale between the initial and final assessed penalty.	0/12 (0%)	Currently, identified as a "long term resolution" in the SRF Tracker from Round 1. (See Attachment)
Metric 12b	% of files that document collection of penalty.	12/12 (100%)	All 12 files (100%) included documentation showing that penalties had been collected or scheduled to be collected.

June 23, 2011

Louisville Metro Air Pollution Control District
State Review Framework Report – Round 2

Table of Contents

I. EXECUTIVE SUMMARY

Major Issues

The State Review Framework (SRF) review of the Louisville Metro Air Pollution Control District (LMAPCD) identified the following major issues:

- More than half of the enforcement minimum data requirements (MDRs) and a quarter of the compliance monitoring MDRs were entered late into the national database.
- There was a continuing problem from Round 1 of the SRF for penalty calculation and documentation. Initial penalty calculations did not consistently document the consideration and calculation of the economic benefit of non-compliance.

Summary of Programs Reviewed

CAA Results

The problems which necessitate local improvement and require recommendations and actions include:

- Area for Local Improvement - There were two CAA Elements where a recommendation for local improvement was identified in the SRF evaluation:
  - Element 3 - Timeliness of Data Entry (continuing problem from Round 1)
  - Element 11 - Penalty Calculation Method (continuing problem from Round 1)

Areas meeting SRF program requirements or with minor issues for correction include:

- Meets SRF Program Requirements – In the CAA SRF evaluation, the following elements met the SRF program requirements:
  - Element 1 - Data Completeness
  - Element 4 - Completion of Commitments
  - Element 5 - Inspection Coverage
  - Element 6 - Quality of Inspection or Compliance Evaluation Reports
  - Element 8 - Identification of SNC and HPV
  - Element 9 - Enforcement Actions Promote Return to Compliance
  - Element 10 - Timely and Appropriate Action
  - Element 12 - Final Penalty Assessment and Collection

- Area for Local Attention – There were two minor areas identified for local attention:
  - Element 2 - Data Accuracy
  - Element 7 - Identification of Alleged Violations

II. BACKGROUND INFORMATION ON LOCAL PROGRAM AND REVIEW PROCESS

In the spring of 2010, the Environmental Protection Agency (EPA) Region 4 initiated the second State Review Framework (SRF) evaluation of the LMAPCD. The SRF is a program designed to ensure EPA conducts oversight of state and local compliance and enforcement programs for the Resource Conservation & Recovery Act (RCRA) Subtitle C program, the Clean Water Act (CWA) National Pollutant Discharge Elimination System (NPDES) program, and the Clean Air Act (CAA) Stationary Source program in a nationally consistent and efficient manner. The LMAPCD is a local air enforcement agency with responsibility for CAA compliance and enforcement within the City of Louisville, Kentucky. The first SRF evaluation at LMAPCD took place in 2006 based on FY2005 data. This second SRF evaluation of the Louisville program is based on FY 2009 compliance and enforcement activities.

SRF evaluations look at twelve program elements covering the following aspects: data (completeness, timeliness, and quality); inspections (coverage and quality); identification of violations; enforcement actions (appropriateness and timeliness); and penalties (calculation, assessment and collection). Reviews are conducted in three phases, including (1) analyzing information from the national data systems, (2) reviewing a limited set of local program files, and (3) developing findings and recommendations. Considerable consultation is built into the process to ensure EPA and the local program understand the causes of issues, and to seek agreement on identifying the actions needed to address problems. The SRF Reports generated by the reviews are designed to capture the information and agreements developed during the review process in order to facilitate program improvements. The reports are designed to provide factual information and do not make determinations of program adequacy. EPA also uses the information in the reports to draw a "national picture" of enforcement and compliance, and to identify any issues that require a national response. SRF Reports are not used to compare or rank state and local programs.

The information in the "General Program Overview" and "Priorities and Accomplishments" sections was submitted to EPA by the Local program, and it is provided below without any substantive editing.

A. General Program Overview

Resources

The Louisville Metro Air Pollution Control District is comprised of 68 FTEs, seven of which positions are currently vacant. The District is also supported by four staff members from the Economic Development Department's business office and three legal professionals from the Jefferson County Attorney's Office.

The Compliance staff is comprised of seven FTEs: a supervisor, an engineering coordinator (sr. engineer), five engineers, and an environmental specialist. The Enforcement staff consists of a manager, an engineering coordinator, and an environmental coordinator

position that is vacant. The legal team consists of two licensed attorneys and a paralegal, who are dedicated exclusively to the District's legal needs.

Because of budget constraints, Metro Government is currently under a hiring freeze. The District has received authorization to fill one of its vacancies, however, and anticipates receiving authorization to fill the environmental coordinator position for the Enforcement section in the very near future.

Staffing /Training

In 2007, the District increased engineering salaries, which has enabled the District to maintain a full engineering staff. Also in 2007, the District split the permitting and compliance unit into separate units, each with its own supervisor. This change has allowed the compliance unit to focus almost exclusively on implementing the Compliance Monitoring Strategy. All but two members of the compliance and enforcement staff have more than five years experience in air quality.

In 2008, the District hired EPA's AFS contractor, TRC, to conduct a multi-day training for four staff members on AFS. The District sent staff to several other AFS training classes as well. All of these staff members remain at the District and have worked to clean up data in AFS and to enter current CMS and HPV data.

In addition to AFS training, the District has established a training program for engineers that takes advantage of all EPA, CARB, or other air quality training offered in the area for new engineers and for engineers who have not previously taken the classes. The District has also implemented an in-house six-month training program for permitting and compliance engineers. The training includes a recently-developed training manual and dedicates one month to each of the following areas: inspections; compliance report evaluations; enforcement and excess emissions reports; permit writing; potential to emit calculations; and emission inventories. The District has also implemented a mentoring program for the engineering section and places an emphasis on professional development.

Data Reporting Systems / Architecture

As described above, the District has trained four employees to enter the minimum data requirements into AFS. Three of the employees regularly enter information: one enters regularly occurring compliance information; one updates the source information (addresses, programs, etc.); and one enters enforcement related data. The fourth person is available as a backup.

Beginning in 2009, the District began to enter into AFS previous years' information that was not entered in a timely fashion in the past. Because the dated information is just now being entered, the appearance is given that much of the information is being entered late. In fact, all MDRs (CMS, annual compliance certification, stack test, and HPV data) are currently being entered on time, but much of the data entered registers as "late," because the District is just now catching up entering data from previous years.

B. Major Local Priorities and Accomplishments

LMAPCD provided the following information concerning the program's current priorities and accomplishments:

Priorities

Following Round 1 of the State Review Framework, in which the EPA found a number of deficiencies in the District's CMS program and data, and the retirement in 2008 of the District's top three officials (director, assistant director, and engineering manager), the District shifted its focus to meeting the basics of a Title V permitting, compliance, and enforcement program.

The District placed an emphasis on training new engineers, implementing the CMS plan, meeting the HPV timelines, and entering all MDRs in AFS. The District has essentially eliminated the compliance and enforcement backlogs.

Having made great strides in accomplishing these goals, the District intends to continue to meet these goals, and for the coming year, plans to place a greater priority on its compliance assistance program.

Accomplishments

The District completed 100% of the FCEs for Title V facilities in FY08, and 100% of the FCEs for all CMS facilities in FY09. The District has trained staff on AFS, has entered FY08 and FY09 data, and has improved the quality of the historical data entered into AFS, including all stack tests reviewed in the past five years. The compliance unit has implemented an improved electronic filing and reviewing process.

In FY09, the District collected $301,625 in penalties; so far the District has collected $427,775 in penalties for FY10.

C. Process for SRF Review

The Louisville SRF Round 2 was initiated with a May 7, 2010, kick-off letter to the LMAPCD Executive Director from the EPA Region 4 Acting Associate Director of the Office of Environmental Accountability (OEA). On July 15, 2010, the Preliminary Data Analysis and File Selections were sent to LMAPCD, and the onsite file review took place August 2-4, 2010, at the LMAPCD office in Louisville, Kentucky. The EPA team held an opening conference in which the initial findings of the PDA were discussed, and the objectives and focus areas for the file review were outlined. In addition, pursuant to the December 9, 2005, memorandum from Lisa Lund entitled "State Review Framework and CAA Compliance Monitoring Strategy Evaluations," EPA conducted a Compliance Monitoring Strategy (CMS) review with the LMAPCD Executive Director and other staff. At the closing conference on August 4, 2010, EPA relayed tentative findings from the file review and discussed the timeline for the remainder of the evaluation.

On November 5, 2010, EPA provided LMAPCD a list of data discrepancies and other issues identified during the file review. This and other EPA communications throughout the review have been primarily with the Environmental Manager, Terri Phelps, and with Steven Gravatte. Finally, EPA forwarded the draft SRF report to LMAPCD for review on March 16, 2011. The fiscal year of the LMAPCD SRF review was FY2009.

Louisville and EPA Region 4 Contacts:

Louisville	**EPA Region 4**
Lauren Anderson, Executive Director – LMAPCD Terri Phelps, Environmental Manager – LMAPCD Steven Gravatte, Environmental Engineer Coordinator – LMAPCD	Mark Fite – OEA Nicole Radford - Air, Pesticides & Toxics Management Division

III. OUTSTANDING STATUS OF RECOMMENDATIONS FROM PREVIOUS REVIEWS

In Round 1 of the SRF, there were a total of nine elements with recommendations that were being tracked. The SRF Tracker indicates that all of these recommendations were satisfactorily completed. The Round 2 evaluation confirmed that seven of the nine elements had improved sufficiently so as not to require any recommendations. However, two elements were again found to need improvement Round 2. These are discussed in more detail in the specific elements in the Findings section below.

IV. FINDINGS and RECOMMENDATIONS

The findings for the LMAPCD Round 2 SRF evaluation are listed below for Elements 1 through 12. For each Element, a finding is made in one of the four following categories:

- "Meets SRF Program Requirements" – This indicates that no issues were identified for that element.

- "Area for Local Attention" – The SRF data metrics and/or the file reviews indicate that activities, processes, or policies are being implemented with minor deficiencies that the local program needs to pay attention to in order to strengthen its performance, but are not significant enough to require the region to identify and track local program actions to correct. This can describe a situation where a local program is implementing either EPA or local policy in a manner that requires self-correction to resolve concerns identified during the review. These are single or infrequent instances that do not constitute a pattern of deficiencies or a significant problem. These are minor issues that the local program should self-correct without additional EPA oversight. However, the local program is expected to improve and maintain a high level of performance.

- "Area for Local Improvement" – The SRF data metrics and/or the file reviews indicate that activities, processes, or policies that are being implemented by the local program have significant problems that need to be addressed and that require follow-up and EPA oversight. This can describe a situation where a local program is implementing either EPA or local policy in a manner requiring EPA attention. For example, these would be areas where the metrics indicate that the local program is not meeting its commitments, there is a pattern of incorrect implementation in updating compliance data in the data systems, there are incomplete or incorrect inspection reports, and/or there is ineffective enforcement response. These would be significant issues and not merely random occurrences. Recommendations are required for these problems, and should have well defined timelines and milestones for completion. The recommendations will be monitored in the SRF Tracker.

- "Good Practice" – The SRF data metrics and/or the file reviews indicate that activities, processes, or policies are being implemented exceptionally well and which the local program is expected to maintain at a high level of performance. This may include specific innovative and noteworthy activities, processes, or policies that have the potential to be replicated by other state or local programs and that can be highlighted as a practice for other states and locals to emulate. No further action is required by either EPA or the local program.

CAA Element 1 – Data Completeness	
Degree to which the Minimum Data Requirements are complete.	
Finding:	Historically LMAPCD did not enter all Minimum Data Requirements (MDRs) into the Air Facility Subsystem (AFS). The program has made significant progress in recent months, and the MDRs are now in AFS.
Is this finding a(n) (select one):	☑ Meets SRF Program Requirements ❒ Area for Local Attention ❒ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	Element 1 of the SRF is designed to evaluate the degree to which the Local program enters minimum data requirements (MDRs) into the national data system. In their response to the Official Data Set (ODS), LMAPCD acknowledged that AFS was not kept updated prior to 2008. A comparison of the frozen and production data for FY 2009 confirms that several MDRs were missing from AFS at the time the data set was frozen. Data in AFS is "frozen" in OTIS each year shortly after it is required to be entered in the database. Louisville's data for FY 2009 was "frozen" in March 2010. When the ODS was pulled in May 2010, it also included data currently in AFS, known as "production" data. Significant differences in the frozen and production data sets indicate potential timeliness problems. The timeliness of data entry is addressed under Element 3. Much of the missing information has subsequently been added. In particular, LMAPCD has populated the missing air program codes and associated subpart data into AFS, and these corrections are reflected in Data

	Metrics 1c4, 1c5, and 1c6, which meet or closely approach the national goal. The remaining Data Metrics for this element (1h1 through 1h3) meet the national goal of 100%, and Data Metric 1k indicates that the appropriate CMS category has been entered into AFS for all major sources. Therefore, this element meets SRF program requirements.
Metric(s) and Quantitative Value:	Data Metric — Goal — Local 1c4 - % NSPS Facilities with subprogram designation: — 100% — 97.6% 1c5 - % NESHAP facilities with subprogram designation — 100% — 100% 1c6 - % MACT facilities with subprogram designation — 100% — 100% 1h1 - HPV Day Zero Pathway Discovery date: Percent DZs reported after 10/1/05 with discovery — 100% — 100% 1h2 - HPV Day Zero Pathway Violating Pollutants: Percent DZs reported after 10/1/05 — 100% — 100% 1h3 - Percent DZs reported after 10/1/05 with HPV Violation Type Code — 100% — 100% 1k – Major Sources Missing CMS Policy Applicability — 0 — 0
Local Response:	
Action(s):	No action needed.

CAA Element 2 – Data Accuracy	
Degree to which data reported into the national system is accurately entered and maintained (example, correct codes used, dates are correct, etc.).	
Finding	Although the majority of data reported into the national system appears to be accurately entered and maintained, several minor discrepancies between the files and AFS were identified during the file review.
Is this finding a(n) (select one):	❒ Meets SRF Program Requirements ☑ Area for Local Attention ❒ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	Because HPV facilities are only a subset of violating facilities, Data Metric 2a, which measures the percentage of noncompliant sources that are HPVs, provides a strong indication of whether the Local is accurately reporting the compliance status of sources. The national goal for this metric is ≤ 50%, and LMAPCD's value of 11.8% meets the national goal. Data Metric 2b1 measures the percentage of stack tests without a results code reported into AFS. LMAPCD's value of 0% meets the national goal, which means that all stack tests entered into AFS also had a pass or fail result reported.

	During the file review, 9 of the 22 files reviewed (41%) documented all MDRs being reported accurately into AFS. The remaining 13 files had one or more discrepancies identified. Minor differences such as SIC, facility name, address, or pollutants were identified in nine files. More significantly, six files showed a discrepancy in the NSPS, MACT, or other program applicability of the source, and four files revealed a missing action (NOV, stack test) in AFS. The Local program is in the process of addressing these discrepancies in AFS. The Round 1 SRF review also identified a concern with data accuracy. These are single or infrequent instances that do not constitute a pattern of deficiencies or a significant problem. Since these are minor issues that the local program should self-correct without additional EPA oversight, this is designated as an area for Local attention, and no formal recommendations are being tracked for this element.
Metric(s) and Quantitative Value:	Data Metric — National Goal — Local 2a – # of HPVs / # of NC sources — ≤ 50% — 11.8% 2b1 - % Stack Tests without Pass/Fail result — 0% — 0% 2b2 - No. of Stack Test Failures — - — 2 File Review Metric — Local 2c - % files with MDR data accurate in AFS — - — 41%
Local Response:	
Action(s):	No formal recommendations are being tracked for this element.

CAA Element 3 - Timeliness of Data Entry	
Degree to which the Minimum Data Requirements are timely.	
Finding:	The timeliness of data entry for HPV-related MDRs met the national goal, but the timeliness of enforcement and compliance monitoring MDRs fell short of the national goal.
Is this finding a(n) (select one):	❒ Meets SRF Program Requirements ❒ Area for Local Attention ☑ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	Louisville's performance in FY2009 for timely entry of HPV related MDRs (Data Metric 3a) met the national goal of 100%. However, the timeliness of enforcement and compliance monitoring MDRs fell short of the national goal. Data Metric 3b1 indicates that about three-fourths of the compliance monitoring MDRs (74.8% or 92 of 123) were entered within 60 days, which falls below the national goal of 100%. The majority of the late entries were stack tests. LMAPCD advises that stack tests are not entered into AFS until after the results have been received and reviewed, which is probably the cause of the late entries. EPA guidance requires that stack tests be entered into AFS within 60 days, and if no result is available at this

<table>
<tr><td></td><td>time, a “results pending” code (99) can be used. The Local then has a total of 120 days from the date of the stack test to change the pending code to a pass/fail result.

In addition, an in depth review of sources with unknown compliance status (Data Metric 5e) indicated that LMAPCD had actually conducted inspections at these sources in FY2007, but the FCEs had not been entered into AFS. The compliance status of these sources is now up to date. Similarly, Data Metric 5g indicated that a number of Title 5 Annual Compliance Certifications had not been reviewed. However, further analysis during the file review confirmed that the ACC reviews had been done, but they were done late, therefore the data was entered late into AFS.

Data Metric 3b2 indicates that less than half of the enforcement related MDRs (42.9% or 3 of 7) were entered within 60 days. Two of the late actions were NOVs, and the other two were formal enforcement actions. Louisville’s metric falls below both the national average of 65.4% and the national goal of 100%.

Although LMAPCD acknowledges that prior to FY2008 the program was not keeping AFS up-to-date, EPA’s discussions with program managers indicate they are making a concerted effort to improve their management of AFS data. However, based on the metrics in this element and the supplemental file review under Element 5, this is designated as an area for Local improvement, and a recommendation is provided below.</td></tr>
<tr><td>Metric(s) and Quantitative Value:</td><td>
<table>
<tr><th>Data Metric</th><th>National Goal</th><th>National Average</th><th>Local</th></tr>
<tr><td>3a - % HPVs entered in ≤ 60 days</td><td>100%</td><td>31.0%</td><td>100%</td></tr>
<tr><td>3b1 - % CM MDRs entered in ≤ 60 days</td><td>100%</td><td>49.7%</td><td>74.8%</td></tr>
<tr><td>3b2 - % Enf. MDRs entered in ≤ 60 days</td><td>100%</td><td>65.4%</td><td>42.9%</td></tr>
</table>
</td></tr>
<tr><td>Local Response:</td><td>The District acknowledges that some of the MDRs were not entered within 60 days. In the past few years, the District has made a concerted effort to enter all MDRs, but has not always entered them within 60 days. The District has developed an SOP for the timely entry of MDRs and has begun to enter all MDRs within 60 days. For the stack tests, in particular, the District has begun to use a “results pending” code when test results have not yet been received. In addition to the SOP for entry of MDRs, the District is utilizing new data management software and improved data management practices that have increased the efficiency of the compliance & enforcement processes.</td></tr>
<tr><td>Action(s):</td><td>LMAPCD should immediately implement the revised procedures recently developed (as described in the Local Response above) to ensure timely reporting of FCEs, ACC reviews, stack tests, NOVs and enforcement actions into AFS. These timeliness issues will be monitored by AEEB</td></tr>
</table>

	through the existing oversight calls and other periodic data reviews conducted by EPA. When these periodic reviews indicate a consistent pattern of improvement, then the recommendation will be considered to have been addressed.

CAA Element 4 - Completion of Commitments.	
Degree to which all enforcement/compliance commitments in relevant agreements (i.e., PPAs, PPGs, categorical grants, CMS plans, authorization agreements, etc.) are met and any products or projects are completed.	
Finding:	All enforcement and compliance commitments have been met.
Is this finding a(n) (select one):	☑ Meets SRF Program Requirements ❒ Area for Local Attention ❒ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	LMAPCD submitted a Compliance Monitoring Strategy (CMS) plan dated January 31, 2006, for the period of FY2007 to FY2009. In the plan, Louisville committed to completing FCEs at 22 of its Major sources and 32 of its SM80 sources in FY2009. LMAPCD successfully completed all planned evaluations. In addition, EPA tracked various compliance and enforcement commitments for FY2009 through the Air Planning Agreement (APA) with LMAPCD. During the end-of-year review for FY2009, Region 4 reviewers indicated that LMAPCD had satisfactorily met all 8 of its commitments under the APA. Therefore, this element meets SRF criteria.
Metric(s) and Quantitative Value:	File Review — Local 4a - Planned evaluations completed for year of review pursuant to CMS plan — 100% 4b – Planned commitments completed — 100% (See the Metric 4b table in the appendix for a more detailed analysis)
Local Response:	
Action(s):	No action needed.

CAA Element 5 – Inspection Coverage	
Degree to which Local completed the universe of planned inspections/compliance evaluations (addressing core requirements and federal, Local and regional priorities).	
Finding:	Louisville met its annual inspection & compliance evaluation commitments.
Is this finding a(n) (select one):	☑ Meets SRF Program Requirements ❒ Area for Local Attention ❒ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	Data Metric 5a1 indicates that LMAPCD completed FCEs at 100% of its Title 5 Major sources during the 2 year CMS cycle. In addition, Data Metric 5b1 indicates that FCEs were completed at 62.6% of its SM80 sources. Since FY2009 is the third year of the CMS cycle for SM80s, Louisville exceeded the target of 60% for SM80 FCEs.

<table>
<tr><td></td><td>Data Metric 5e indicates that Louisville had 62 sources (over 40%) with unknown compliance status at some point during FY2009. A compliance status flag of “unknown” automatically results in AFS if a source is not inspected within the appropriate CMS timeframe (within 2 years for Major sources, 3 years for Mega sources, and 5 years for SM80s). Since this metric is a review indicator, supplemental files were identified to further explore the cause of the unknown compliance status. These supplemental reviews revealed that LMAPCD had actually conducted inspections at these sources in FY2007, but the FCE had not been entered into AFS, resulting in the unknown compliance status. Since the supplemental review indicated that the sources were actually inspected, there is no recommendation under Element 5. However, since the supplemental review indicates a problem with late data entry, a recommendation has been included under Element 3.

In addition, the Local reviewed 72.7% of the Title 5 self certifications submitted (Data Metric 5g), which is below the national goal of 100%. This was identified as a potential concern in the PDA, and two supplemental files were selected to further evaluate this issue. These reviews confirmed that Louisville had reviewed the certifications, but the reviews and associated AFS data entry appear to have been conducted in a subsequent year. Although this issue was identified as an area of concern during the Round 1 review, since Louisville appears to have “caught up” with a backlog of self certifications reviews, and the FY2010 value for Data Metric 5g shows a significant improvement to 93.8%, no further action is necessary.</td></tr>
<tr><td>Metric(s) and Quantitative Value:</td><td>
<table>
<tr><th>Data Metrics</th><th>National Goal</th><th>National Average</th><th>Local</th></tr>
<tr><td>5a1 - FCE coverage
Majors (CMS cycle)</td><td>100%</td><td>88.4%</td><td>100%</td></tr>
<tr><td>5a2 - FCE coverage
All Majors (last 2 FY)</td><td>100%</td><td>83.7%</td><td>100%</td></tr>
<tr><td>5b1 - FCE coverage
SM80 (CMS cycle)</td><td>20-100%</td><td>84.6%</td><td>62.6%</td></tr>
<tr><td>5b2 - FCE coverage
CMS SM80 (last 5 FY)</td><td>100%</td><td>90.5%</td><td>62.6%</td></tr>
<tr><td>5c - FCE/PCE coverage
All SMs (last 5 FY)</td><td>NA</td><td>79.9%</td><td>60.7%</td></tr>
<tr><td>5d - FCE/PCE coverage
other minors (5 FY)</td><td>NA</td><td>29.2%</td><td>6.6%</td></tr>
<tr><td>5e – Sources with unknown
compliance status</td><td>NA</td><td>-</td><td>62</td></tr>
<tr><td>5g - Review of Self
Certifications completed</td><td>100%</td><td>94.0%</td><td>72.7%</td></tr>
</table>
</td></tr>
<tr><td>Local Response:</td><td></td></tr>
<tr><td>Action(s):</td><td>No action needed.</td></tr>
</table>

CAA Element 6 – Quality of Inspection or Compliance Evaluation Reports	
Degree to which inspection or compliance evaluation reports properly document observations, are completed in a timely manner, and include an accurate description of observations.	
Finding:	In general, compliance monitoring reports (CMRs) properly document observations and include an accurate description of observations.
Is this finding a(n) (select one):	☑ Meets SRF Program Requirements ❒ Area for Local Attention ❒ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	File Metric 6b evaluates whether all applicable elements of an FCE have been addressed. Based on the file review, 95% of the files reviewed (20 of 21) had documentation in the files to show that they contained all of the elements of the FCE, per the Compliance Monitoring Strategy (CMS). The one file with problems was missing two of the seven FCE elements, but this appeared to be an isolated occurrence. For File Metric 6c, 95% of the files reviewed (20 of 21) contained all of the CMR requirements listed in the CMS, providing sufficient documentation to determine compliance at the facility. The one file with problems was missing information on two of the seven required elements, but this did not appear to interfere with the Local making an accurate compliance determination.
Metric(s) and Quantitative Value:	File Review Metric — Local 6a – Number of FCEs reviewed — 21 6b – % FCEs that meet definition — 95% 6c – % CMRs sufficient for compliance determination — 95%
Local Response:	
Action(s):	No action needed.

CAA Element 7 – Identification of Alleged Violations.	
Degree to which compliance determinations are accurately made and promptly reported in the national database based upon compliance monitoring report observations and other compliance monitoring information (e.g., facility-reported information).	
Finding:	In general, compliance determinations are accurately made and promptly reported into AFS based on inspection reports and other compliance monitoring information, with a few exceptions.
Is this finding a(n) (select one):	❒ Meets SRF Program Requirements ☑ Area for Local Attention ❒ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation: further action is necessary	File Metric 7a indicates that all of the CMRs reviewed (100%) led to an accurate compliance determination. In addition, Data Metrics 7c1 and 7c2 are designed to measure the compliance status reporting of the Local program, and both metrics exceed the national goal.

	With respect to File Metric 7b, 79% of files reviewed with non-HPV violations (11 of 14) were reported timely into AFS. For the other three sources, the local program accurately identified a violation, but the compliance status in AFS was either not entered timely into AFS, or it was never changed to indicate the violation. These are infrequent instances that do not constitute a pattern of deficiencies or a significant problem. Since these are minor issues that the local program should self-correct without additional EPA oversight, this is designated as an area for Local attention.
Metric(s) and Quantitative Value:	File Review Metrics — Local 7a - % CMRs leading to accurate compliance determination — 100% 7b - % non-HPVs with timely compliance determination in AFS — 79% Data Metrics — National Goal — National Average — Local 7c1 - % facilities in noncompliance with FCE, stack test, or enforcement (1 FY) — >11.0% — 21.8% — 67.6% 7c2 - % facilities with failed stack test and have noncompliance status (1 FY) — >22.7% — 42.9% — 50.0%
Local Response:	
Action(s):	No formal recommendations are being tracked for this element.

CAA Element 8 – Identification of SNC and HPV	
Degree to which the Local accurately identifies significant noncompliance/high priority violations and enters information into the national system in a timely manner.	
Finding:	In general, High Priority Violations (HPVs) are accurately identified.
Is this finding a(n) (select one):	☑ Meets SRF Program Requirements ❒ Area for Local Attention ❒ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	The data metrics under this element are "review indicators," which means that, if they fall short of the national goal, they may point to a potential problem that must be confirmed by reviewing files. LMAPCD exceeded the national goal for data metrics 8c and 8e. However, since data metrics 8a and 8b fell below the national goal, supplemental files were selected to further evaluate the program's identification of HPVs. The review of these supplemental files, as well as randomly selected representative files, is captured in File review metric 8f, which indicated that all 9 files with violations (100%) properly identified whether the violation was an HPV or not. Therefore, this element meets SRF requirements.
Metric(s) and Quantitative Value:	Data Metrics — National Goal — Local 8a – HPV discovery rate – Major sources — >4.0% — 2.6% 8b – HPV discovery rate – SM sources — >0.4% — 0% 8c – % formal actions with prior HPV – — >37.5% — 100%

	Majors (1 yr) 8e - % sources with failed stack test actions that received HPV listing – Majors and Synthetic Minors >21.1% 50% File Review Metrics Local 8f - % accurate HPV determinations 100%
Local Response:	
Action(s):	No action needed.

CAA Element 9 - Enforcement Actions Promote Return to Compliance	
Degree to which Local enforcement actions include required corrective action (i.e., injunctive relief or other complying actions) that will return facilities to compliance in a specific time frame.	
Finding:	Enforcement actions include corrective actions that return facilities to compliance in a specific time frame, or facilities are brought back into compliance prior to issuance of a final enforcement order.
Is this finding a(n) (select one):	☑ Meets SRF Program Requirements ❒ Area for Local Attention ❒ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	All enforcement action files reviewed (4 of 4) returned the source to compliance. For enforcement actions that were penalty only actions, the order itself or the files documented the actions taken by the facility to return to compliance prior to issuance of the order.
Metric(s) and Quantitative Value:	File Review Local 9a – number of enforcement actions reviewed 4 9b - % enforcement actions returning source to compliance 100%
Local Response:	
Action(s):	No action needed.

CAA Element 10 - Timely and Appropriate Action	
Degree to which a Local takes timely and appropriate enforcement actions in accordance with policy relating to specific media.	
Finding:	LMAPCD takes timely and appropriate enforcement actions in accordance with EPA policy to address High Priority Violations (HPVs).
Is this finding a(n) (select one):	☑ Meets SRF Program Requirements ❒ Area for Local Attention ❒ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	Data Metric 10a (0%) indicates that in the last two years, LMAPCD has resolved its high priority violations in a timely manner. File Metric 10b indicates that 100% of HPVs reviewed (2 of 2) were addressed within the

	270 days specified in EPA's HPV policy. In addition, based on the two files reviewed, the Local took appropriate enforcement action to resolve 100% of its HPVs through formal consent orders (File Metric 10c).
Metric(s) and Quantitative Value:	Data Metrics — National Avg. — Local 10a - % HPVs not timely (2 FY) — 36.6% — 0% File Review Metrics — Local 10b - % timely HPV enforcement actions — 100% 10c - % HPVs appropriately addressed — 100%
Local Response:	
Action(s):	No action needed.

CAA Element 11 - Penalty Calculation Method	
Degree to which Local documents in its files that initial penalty calculation includes both gravity and economic benefit calculations, appropriately using the BEN model or other method that produces results consistent with national policy.	
Finding:	Although Louisville has developed a standardized gravity penalty matrix for most violations, economic benefit is not routinely considered and documented.
Is this finding a(n) (select one):	❒ Meets SRF Program Requirements ❒ Area for Local Attention ☑ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	Based on File Metric 11a, only 1 of 4 of the enforcement actions reviewed provided sufficient documentation of both the gravity and economic benefit components of the penalty. The Local has developed a standardized penalty matrix for the gravity portion of the penalty, and this was sufficiently documented in all four files. However, only one file had documentation (a penalty worksheet) to reflect that economic benefit was considered. With respect to the remaining three enforcement actions, one source was required to conduct substantial injunctive relief in the agreed order, suggesting that significant costs had been delayed or avoided. However, no documentation was found in the file to suggest that the economic benefit had been considered. For the remaining two enforcement actions, the economic benefit may have been little to none, but there was no documentation in the file to indicate that this was evaluated. This issue was also identified as a concern in Round 1. Therefore, this is designated as an area for Local improvement, and recommendations are provided below.
Metric(s) and Quantitative Value:	File Review — Local 11a - % penalty calculations that consider & include gravity and economic benefit — 25%
Local	The District does consider economic benefit in assessing penalties, but

Response:	agrees that documentation of the consideration of economic benefit is not present in all files. The District's penalty worksheet for HPVs includes a space for economic benefit, but the District has had no worksheet for non-HPVs; therefore, the consideration of economic benefit has not been documented in non-HPV cases. The District has now created a penalty worksheet for non-HPVs that has a space for economic benefit and has begun to use it for all federally-reported cases.
Action(s):	LMAPCD should immediately implement the revised procedures recently developed (as indicated in the Local Response above) to ensure that economic benefit is considered (where appropriate) and documented for every penalty action. For verification purposes, all penalty worksheets for federally reportable violations should be submitted to EPA (AEEB) for review for the twelve months following issuance of the final SRF report.

CAA Element 12 - Final Penalty Assessment and Collection	
Degree to which differences between initial and final penalty are documented in the file along with a demonstration in the file that the final penalty was collected.	
Finding:	Louisville documented the difference between initial and final penalty, assessed penalties for all HPVs actions, and maintained documentation that the final penalty was collected.
Is this finding a(n) (select one):	☑ Meets SRF Program Requirements ❒ Area for Local Attention ❒ Area for Local Improvement – Recommendations Required ❒ Good Practice
Explanation:	The Local program exceeded the national goal for Data Metric 12b by assessing penalties for 100% of its HPVs during the review period, which exceeds the national goal of 80%. Based on the file review, File Metric 12c indicates that all penalty actions reviewed (100% or 4 of 4) provided documentation of the difference between the initial penalty assessed and the final penalty paid. In addition, File Metric 12d indicates that 100% of the files reviewed (4 of 4) documented collection of the assessed penalty. Therefore, this element meets SRF program requirements.
Metric(s) and Quantitative Value:	Data Metrics — National Goal — Local 12a – Actions with penalties — NA — 4 12b - % HPV actions with penalty — ≥ 80% — 100% File Review Metrics — Local 12c - % actions documenting difference between initial & final penalties — 100% 12d - % files that document collection of penalty — 100%
Local Response:	
Action(s):	No action needed.

V. ELEMENT 13

LMAPCD did not provide any additional information for inclusion in this element.

VI. APPENDICES

a. Status of Recommendations from Previous Reviews
b. Official Data Pull
c. Preliminary Data Analysis & File Selection
d. File Review Analysis
e. Correspondence