ATTACHMENT 4

Carpinteria SD, Brief

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BEFORE THE CENTRAL COAST

REGIONAL WATER QUALITY CONTROL BOARD

IN THE MATTER OF:	Complaint No. R3-2015-0011
Carpinteria Sanitary District,	For Administrative Civil Liability
WDID: 3 420101001	NPDES Permit No. CA 0047364 and Order No. R3-2011-0003
	Carpinteria Sanitary District's Initial Statement and Legal Argument; and Evidentiary Submission
	Hearing Date: May 29, 2015 Time: 9:00 a.m.

The Carpinteria Sanitary District (hereinafter the "District") submits its Initial Statement, Legal Argument and Evidentiary Submission, including a list of proposed witnesses, in advance of the hearing to be held before the Regional Water Quality Control Board (hereinafter referred to as the "Board") on May 29, 2015, to consider Administrative Civil Liability Complaint, No. R3-2015-0011 ("ACLC"), filed by the Central Coast Water Board Prosecution Team (hereinafter referred to as the "Prosecution Team") on March 2, 2015, which recommends the imposition of a total penalty amount of $96,775, as well as other related staff and investigative costs, for alleged violations of the District's National Pollutant Discharge Elimination System ("NPDES") permit issued in 2010 and Waste Discharge Requirements ("WDRs") issued in 2011. The recommended $96,775 penalty includes the following: a discretionary administrative civil liability ("ACL") of

$81,775 for a one-time, aberrational loss of chlorination incident occurring at the District's wastewater collection, treatment and disposal facility located in Carpinteria, California (the "Facility") on October 3, 2012 (hereinafter referred to as the "October 2012 Incident" or "Incident"); plus a mandatory minimum penalty ("MMP") of $15,000, based on five alleged unrelated settleable solids and chlorine residual violations that occurred in December 2011 and January 2013, respectively, (the "MMP Violations"), with each subject to a MMP of $3,000.

The District has no objection to and has stipulated and agreed to pay the proposed $15,000 in MMPs for the MMP Violations alleged in the ACLC, which is an enforcement approach and penalty amount consistent with both applicable statutory authority and the State Water Resources Control Board's Water Quality Enforcement Policy ("Enforcement Policy") that became effective in 2010. (See Enforcement Policy, attached hereto as District Exhibit A and incorporated herein by reference). However, for the reasons set forth in more detail below, the District strenuously objects to the Prosecution Team's unprecedented and overly-aggressive pursuit of an ACL for the October 2012 Incident, which is entirely inconsistent with the spirit, principles and goals of the Enforcement Policy and thereby, does not warrant the imposition of the recommended discretionary $81,775 ACL penalty.

Rather, the District believes and contends that, consistent with both the Enforcement Policy and historic and well-documented enforcement practices and actions of this Board, the single, short-duration October 2012 Incident, which caused, or posed, absolutely no harm whatsoever to any beneficial uses, should similarly be subject to a MMP of $3,000 and not the discretionary ACL penalty recommended by the Prosecution Team. The District is therefore willing and prepared to pay a total MMP of $18,000, which would include the five MMP Violations alleged in the ACLC (and stipulated to by the District), plus a $3,000 MMP for the October 2012 Incident. The District believes that this proposal is fair, appropriate and consistent not only with the Enforcement Policy, but also with this Board's known and published enforcement actions involving similarly-situated violators.

In imposing the District's proposed $18,000 MMP for all of the violations at issue, including the October 2012 Incident, this Board would be acting appropriately, fairly and

consistently with the Enforcement Policy, as well as its own historic enforcement practices, and would not be venturing into the unprecedented and unchartered enforcement actions as recommended by the Prosecution Team, including the imposition of the extraordinarily punitive discretionary sanctions proposed for the relatively minor violation at issue in the October 2012 Incident. As such, the District respectfully submits that the Prosecution Team's recommendations for a discretionary ACL penalty relating to the October 2012 Incident should be rejected by this Board.

The District's position regarding the appropriate penalty to be imposed for the violations at issue, including its opposition to the Prosecution Team's recommendations regarding the October 2012 Incident, is set forth in and supported by this Initial Statement and Legal Argument, along with the attached Evidentiary Submission, as well as by witness testimony and any additional rebuttal evidence, exhibits, testimony and arguments to be presented at the time of the hearing on May 29, 2015 or thereafter.

I. INTRODUCTION

A. The Imposition of a Discretionary ACL Penalty for the October 2012 Incident at Issue Would Be Precedent-Setting.

The Prosecution Team is correct in asserting that, "This is an important, precedent setting decision." (See Prosecution Team Opening Brief, p. 2). Unfortunately, the Prosecution Team fails to recognize and appreciate the fact that this Board would be setting a precedent by imposing the discretionary ACL penalty for the October 2012 Incident that is recommended in the ACLC. More specifically, in the event this Board were to impose the recommended discretionary ACL penalty, it would be a first in this Region for a violation of the nature and type at issue in this particular matter (i.e., a short-duration unforeseeable mechanical failure or other minor permit excursion having no water quality impacts, and in particular, at a facility with an outstanding compliance history and documented operational excellence).[1]

Therefore, the primary issue before this Board is whether the Prosecution Team can meet

[1] The Prosecution Team concedes that the District is a "well-run facility," having "received the 'Collection System of the Year' award from the Tri-Counties Section of the California Water Environment Association." (See Prosecution Team Opening Brief, p. 1).

its burden of supporting its inexplicable decision to pursue a ACL enforcement action, rather than a MMP, against the District, which has an excellent compliance history, for a discharge violation, which has been conclusively shown to have caused no harm to water quality or public health, and that in every other similar circumstance in the Central Coast Regional Water Quality Control Board (hereinafter referred to as "Central Coast Region," "Regional Board" or "Region"), where enforcement action has been undertaken, has been handled and resolved by this Board as a MMP. In other words, this Board must closely scrutinize the Prosecution Team's rationale for requesting that this Board break with the long-standing precedent of imposing MMPs for such alleged, where enforced, violations and instead, impose the recommended discretionary ACL penalty against the District. In conducting such an inquiry, the District is confident that this Board will find and hold that the Prosecution Team has not, and cannot, meet its burden in proving that the recommended discretionary ACL penalty is either justified or warranted in this particular matter or is consistent with the stated principles and goals of the Enforcement Policy.

Specifically, after a full review and consideration of the facts at issue in this matter (the majority of which are undisputed and have been stipulated and agreed to by the parties), the District believes that this Board will find that the October 2012 Incident is in fact not a "significant" violation as alleged by the prosecution Team, and will conclude that the District should pay an appropriate MMP for that Incident consistent with the Enforcement Policy and other similarly-situated enforcement actions previously undertaken in the Region. The District further believes that this Board will similarly find that the Prosecution Team's assertion that the imposition of a MMP for the October 2012 Incident will "not serve as a sufficient deterrent," is misplaced based on the actual facts and circumstances of the Incident at issue.

For example, as noted in more detail below, the October 2012 Incident involved the discharge of 297,896 gallons of treated wastewater that had not been fully chlorinated as a result of the unforeseeable and one-time only malfunction of a reliable chemical feed pump, which was immediately reported to Regional Board permitting staff and others, and caused no actual or potential harm to the receiving waters or beneficial uses. More importantly, within days after reporting the Incident, the District unilaterally and voluntarily undertook corrective measures to

effectively prevent any reoccurrence of the circumstances that caused this loss of chlorination Incident. To date, more than two and half years later, the District has experienced no other loss of chlorination at the Facility. The District also recently completed a major Facility upgrade, which included the construction of an entirely new chemical disinfection system.

Moreover, contrary to the claims of the Prosecution Team, the District has never expected nor is requesting a "pass" for the October 2012 Incident. (See Prosecution Team's Opening Brief, p. 1). Rather, the District has not only accepted responsibility for the Incident and been willing to pay an appropriate MMP, but has clearly and repeatedly demonstrated its good faith and cooperative spirit by voluntarily expending the necessary time and resources to prevent any reoccurrence of the anomalous malfunction – and doing so, more than a year before it was aware that the Prosecution Team had initiated an investigation of this Incident.

Accordingly, there is no compelling reason to impose an unprecedented discretionary ACL penalty for such a violation in order to "serve as a sufficient deterrent" either upon the District or other similarly-situated dischargers since, among other factors, the October 2012 Incident was obviously aberrational in nature and was immediately reported, abated and corrected. In addition, in recommending that this Board assess and impose such an unprecedented ACL penalty, the Prosecution Team is acting contrary to the tenets and principles of the Enforcement Policy, especially those relating to fairness and consistency, which will undermine the credibility and effectiveness of the State's long-term enforcement and water quality protection goals.

B. The Prosecution Team's Recommended ACL Penalty is Inconsistent With and Not Supported By the Enforcement Policy.

As this Board is aware, in order to assist regional boards in determining whether to pursue an enforcement action or not for certain alleged violations, and to what degree and in what manner, the State Water Resources Control Board ("State Water Board") adopted and implemented the Enforcement Policy, which provides in pertinent part:

> The goal of this Water Quality Enforcement Policy is to protect and enhance the quality of the waters of the State by defining an enforcement process that addresses water quality problems in the most efficient, effective and consistent manner. In adopting this Policy, the State Water Board intends to provide guidance that will enable Water Board staff to expend its limited resources in ways that openly address the greatest needs, deter harmful conduct, protect the public, and achieve maximum water quality benefits. Toward that

> end, it is the intent of the State Water Board that the Regional Water Boards' decisions be consistent with this Policy.

(See Enforcement Policy, District Exhibit A, p.1).

The Enforcement Policy cites a number of principles to be followed in furthering its "water quality regulatory goals." The first principle cited is the establishment of "a process for ranking enforcement priorities based on *actual or potential impact* to the beneficial uses or the regulatory program and for using *progressive levels of enforcement*, as necessary, to achieve compliance." (Id., emphasis added). The second principle cited is the establishment of "an administrative civil assessment methodology to create a *fair and consistent* statewide approach to liability assessment." (Id., emphasis added).

The Enforcement Policy further provides that, "It is the policy of the State Water Board that the Water Boards shall strive to be *fair, firm and consistent* in taking enforcement actions throughout the State, while recognizing the unique facts of each case." (Id. at p. 2, emphasis added). Under the heading, "Suitable Enforcement," the Enforcement Policy clarifies that, "The Water Boards' enforcement actions shall be suitable for each type of violation, providing *consistent treatment for violations that are similar in nature and have similar water quality impacts*. Where necessary, enforcement actions shall also ensure a timely return to compliance." (Id., emphasis added).

As noted in the Enforcement Policy, once a potential violation is ranked by priority (i.e., Class I, II or III) based on the actual or potential threat to water quality, with Class I violations posing the greatest risk, the Regional Board should examine the enforcement records of the particular entity subject to potential enforcement action. (Id. at pp. 4-6). The Enforcement Policy further identifies enforcement priorities and provides that, "To the greatest extent possible, [the] Regional Water Board shall target entities with class I priority violations for formal enforcement action." (Id. at p. 6).

The Enforcement Policy thereafter identifies specific criteria that the Regional Board should use in "determining the importance of addressing the violations of a given entity," which include the following:

1. Class of entity's violations
2. History of the entity
   a. Whether the violations have continued over an unreasonably long period after being brought to the entity's attention and are reoccurring;
   b. Whether the entity has a history of chronic non-compliance;
   c. Compliance history of the entity and good faith efforts to eliminate non-compliance;
3. Evidence of, or threat of, pollution or nuisance caused by violations;
4. The magnitude of impacts of the violations;
5. Case-by-case factors that may mitigate a violation;
6. Impact of threat to high priority watersheds or water bodies (e.g., due to the vulnerability of an existing beneficial use or an existing state of impairment);
7. Potential to abate effects of the violations;
8. Strength of evidence in the record to support the enforcement action; and
9. Availability of resources for enforcement.

(Id. at p. 7).

Here, in light of the clear directives of the Enforcement Policy, the facts and circumstances of the October 2012 Incident, as described and set forth in more detail below, clearly do not warrant the imposition of the discretionary ACL penalty recommended by the Prosecution Team. Specifically, the October 2012 Incident is undisputedly *not* a "Class I" violation, and at most, could be characterized as a "Class III" violation, which is defined in pertinent part as posing "only a minor threat to water quality and [having] little or no known potential for causing a detrimental impact on human health and the environment." (Id. at p. 6).

In addition, applying the specific criteria noted above in the Enforcement Policy, there is absolutely no justifiable reason for the Prosecution Team to have targeted the District for such an aggressive enforcement action, given the limited nature of the October 2012 Incident and the outstanding compliance history of the District. For example, the October 2012 Incident was a one-time, short duration event that posed no harm or potential harm to beneficial uses and was not "reoccurring." In addition, the District does not have a history of "chronic noncompliance," but rather, as was demonstrated in this Incident and others, has always engaged in "good faith efforts to eliminate noncompliance."

Based on the above, it is difficult to discern the criteria used and bases relied upon by the Prosecution Team in deciding to pursue and recommend a discretionary ACL rather than a MMP for the October 2012 Incident. The Prosecution Team's recommendation relating to the October

2012 Incident also disregards the Enforcement Policy's principle of "progressive levels of enforcement to achieve compliance" (Id. at p. 1), because that one-time Incident, which was immediately abated and addressed with effective corrective measures, obviously does not warrant an escalated and aggressive formal enforcement action, including an ACL penalty, in order to achieve compliance – an accomplishment attained voluntarily by the District several years ago. In sum, there is no rational basis either in the factual record or in the Enforcement Policy to support the Prosecution Team's recommended discretionary ACL penalty for the October 2102 Incident.

As such, the District submits that the Prosecution Team will not be able to meet its burden in supporting the requested imposition of the ACL penalty. The District therefore respectfully requests that the Board reject the Prosecution Team's recommendation and in the alternative, impose the District's proposed $3,000 MMP for the October 2012 Incident.

II. STATEMENT OF FACTS

A. Stipulations

The parties have agreed and stipulated to the vast majority of the relevant and material facts and issues in this matter, including, among other things, the estimated volume of the discharge involved in the October 2012 Incident, the District's agreement to pay the proposed $15,000 penalty for the five alleged MMP Violations and the scoring of various factors that could be used in assessing and calculating any potential discretionary ACL penalty should this Board be inclined to impose such a penalty.[2] There remain, however, significant disagreements between the parties regarding the nature and any attendant impacts of the Incident and discharge at issue, as well as relating to the appropriate scoring and application of several of the factors to be used in assessing any ACL penalty. Therefore, notwithstanding these stipulations, the District believes it is important for this Board to fully and thoroughly review the actual nature and underlying circumstances of the October 2012 Incident in considering and rendering its ultimate decision

[2] In light of the fact that the majority of the facts relating to the nature and circumstances of the October 2012 Incident are undisputed and were immediately known and reported to the Regional Board on the date of the Incident, the District readily stipulated to such facts. However, while it remains opposed to the assessment and imposition of any discretionary ACL penalty for that particular Incident, in the interest of administrative economy and being sensitive to the time and resource constraints of this Board, the District has stipulated to some, but not all, of the various factors used in assessing and calculating any such penalty.

regarding the appropriate penalty for the Incident.

B. Summary of Relevant Facts

The District's consultant, Carollo Engineers, Inc., prepared and submitted a Technical Report to the Board on January 27, 2014 pursuant to California Water Code section 13267 (the "Technical Report") in response to the Notice of Violation for Unauthorized Discharge Events to Waters of the United States dated December 10, 2013 (the "NOV"). The Technical Report, which appears as "Exhibit 8" on the Prosecution Team's Evidence List submitted on April 15, 2015, is incorporated in its entirety herein by reference. As this Board will note, the Technical Report provides a very detailed objective and independent discussion and analysis, along with various related and supporting documents and reports, of the October 2012 Incident.

1. The District's Facility.

The District, which is a public agency, owns and operates the wastewater collection, treatment, and disposal Facility, and provides service to the City of Carpinteria and portions of Santa Barbara County. Treated wastewater is discharged from Discharge Point No. 001, which is an outfall diffuser (approximately 93 feet long, with diffuser ports located every six feet) located approximately 1000 feet offshore and approximately 30 feet below the surface of the water (hereafter referred to as the "Outfall"), to the Pacific Ocean in accordance with WDRs Order No. R3-2011-0003 and NPDES Order No. CA0047364 (hereinafter collectively referred to as "WDRs/NPDES," "Permit" or "Order").

The WDRs/NPDES include effluent limitations for total coliform organisms to ensure adequate disinfection of discharged treated wastewater (i.e., an average weekly of 23 MPN/100mL and maximum daily of 2,300 MPN/100mL). There are, however, no specific limitations associated with the "loss of disinfection," such as duration of loss or total volume of non-disinfected discharged flow. In addition, included in the WDRs as Provision VII.A.2 of the Monitoring and Reporting Program ("MRP") is a provision "to monitor for total coliform, fecal coliform and enterococcus at receiving water-sampling stations RSW-F and RSW-G, in addition to three shore sampling stations approved by the Executive Officer, for seven days after a loss of

disinfection."[3] There is, however, no specific definition for "loss of disinfection," including any duration or threshold volume, provided in the Order that "triggers" this particular monitoring and sampling requirement.

2. The District Has an Excellent Compliance History.

The District has no previous violations similar to the aberrational October 2012 Incident, including no previous loss of chlorination events. Previous reported violations involved a very limited number of suspended solids exceedances in 2006 and one minor total coliform exceedance in 2008. In addition, the District has never been prosecuted for or been assessed an ACL penalty. As a consequence, Board staff stated in the District's NPDES that it "considers the facility to be well run and in compliance with the NPDES permit." (See Prosecution Team Exhibit 1, Attachment F, p. F-9, Section II.D.1).

In fact, the Prosecution Team also concedes that the District's Facility is a "well-run facility," which has earned it many awards and commendations. (See Prosecution Team Opening Brief, p. 1). These awards and commendations include, among others, the following:

- 2008 California Water Environment Association ("CWEA") State Plant of the Year;
- 2008 CWEA Tri-Counties Section Plant of the Year;
- 2013 CSDA Santa Barbara County Chapter General Manager of the Year (for District General Manager Craig Murray);
- 2014 CWEA State Collection System of the Year;
- 2014 CWEA Tri-Counties Section Plant of the Year; and
- 2014 CWEA Tri-Counties Section Operator of the Year (for District Operator Kenneth Balch).

(See District Exhibit B attached hereto and incorporated herein by reference).

The District also received several awards and commendations for its recent successful completion of the "Rincon Point Septic-to-Sewer Conversion Project," including the 2014 American Society of Civil Engineers' Capital Project of the Year and the 2014 Project of the Year from the Central Coast Chapter of the American Public Works Association. It is also important to note that the District's Operations Manager, Mark Bennett, was one of the original beta testers for

[3] A review of similar permits for ocean dischargers in the Region reveals an inconsistency in the presence of this particular requirement. For example, the permits for the San Simeon Wastewater Treatment Plant and the El Estero Wastewater Treatment Facility (City of Santa Barbara) do not contain similar offshore water quality sampling upon a loss of disinfection.

the California Integrated Water Quality System Project ("CIWQS") online reporting system, and for many years, has assisted numerous other public agencies with their online reporting and system setup.

3. The October 2012 Incident.

At approximately 9:30 a.m. on October 3, 2012, during the course of a daily, routine Facility inspection, it was noted that sodium hypochlorite was not being delivered to the injection point in the chlorine contact chamber. More specifically, during this routine inspection, the continuous chlorine analyzer downstream of the sodium hypochlorite injection point was found to be reading 0.0 mg/L. Within ten minutes, it was determined by District supervisors and operations staff on duty that the primary sodium hypochlorite feed pump had experienced a malfunction.

Upon discovering the loss of chlorination, District staff immediately inspected the continuous chlorine analyzer and sample feed pump and confirmed that this equipment was operating normally. A visual inspection of the sodium hypochlorite feed pump also indicated normal pump operation other than the fact that no chemical was being delivered to the chlorine contact chamber. An inspection of the bulk sodium hypochlorite storage tank also verified that the tank level transducer was operating correctly, with a tank level reading of 1,200 gallons, which was confirmed by visual observation of the chemical level in the tank through an inspection hatch. An inspection of chemical feed piping, valves and fittings, including the associated pressure relief valve and pressure regulator between the sodium hypochlorite feed pump and the injection location at the chlorine contact chamber, also indicated normal operation.

On that date, the Facility had a pre-scheduled bulk sodium hypochlorite delivery, which occurred shortly after the initial discovery at 9:30 a.m. of the loss of chlorination. At approximately 9:40 a.m., during the transfer of bulk sodium hypochlorite from the delivery truck to the chemical storage tank, the sodium hypochlorite feed pump returned to normal operation. Soon thereafter, District staff confirmed normal operation of the sodium hypochlorite feed pump and the disinfection system by sampling and analyzing for chlorine residual at the chlorine contact basin (via online meter and grab samples).

Based on available information and data, District staff determined that the feed pump malfunction and resulting loss of chlorination event occurred between approximately 4:08 a.m. and 9:45 a.m. (5 hours and 37 minutes) on October 3, 2012. The District was thereafter able to estimate the total volume of non-chlorinated wastewater discharged to be approximately 281,250 gallons.[4]

a. Notification to Regulatory Agencies.

At approximately 11:00 a.m. on October 3, the District began notifying regulatory and other agencies, including the Regional Board, of the loss of chlorination Incident. Specifically, the District notified via telephone a representative of the Preharvest Shellfish Unit of the Environmental Management Branch of the California Department of Public Health ("CDPH"), who stated that based on the estimated volume of the discharge and ocean currents at the time of discharge, no impact to shellfish growing areas would occur or be expected. More specifically, the representative of CDPH stated that the maximum radius of the estimated discharge, on a volumetric basis, would be no greater than 1.57 miles and would therefore, have no impact to shellfish growing areas.[5]

The District thereafter notified via telephone and left voice messages for both Peter Von Langen and Harvey Packard of the Regional Board with details of the loss of chlorination Incident. The District also notified via telephone and left a voice message with Willie Brummett of the Santa Barbara County Environmental Health Services ("EHS") Department regarding the Incident.

The following day, on October 4, 2012, the District received a return telephone call from Mr. Brummett, who stated that, based on the details provided regarding the Incident, there was no need to post the beach or take any additional response measures.

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[4] The parties have stipulated that the estimated volume of the discharge is 297,896 gallons.

[5] The nearest shellfish harvesting area is located 13 miles north of the District's outfall off the coast of Santa Barbara near Arroyo Burro Beach.

On the morning of October 4, 2012, the District again contacted Peter Von Langen of the Regional Board and described the loss of chlorination Incident. In response, Mr. Von Langen stated that the District should submit a letter to the Regional Board explaining the Incident, as well as documenting the District's response thereto. Mr. Von Langen, who is the Regional Board permitting staff member who drafted the WDRs/NPDES permit and negotiated with the District on its terms, conditions and requirements, provided no other direction, advice or guidance to the District regarding the loss of chlorination Incident, including whether any additional actions or future mitigation measures the District was required to, or should, undertake in response to the Incident. Within a few hours of that conversation, as requested, the District provided via email a written notification of the loss of chlorination Incident to both Ken Harris, then-Interim Executive Officer, and Mr. Von Langen. (See District's Exhibit C attached hereto and incorporated herein by reference).[6] On October 4, 2012, in addition to the written notice provided to the Regional Board, the District also reported the Incident in the CIWQS electronic reporting database.

b. Causes and Circumstances of the Loss of Chlorination.

The cause of the malfunction of the sodium hypochlorite feed pump was not definitively determined on the date of the Incident. However, as noted in more detail in the Technical Report, based on the evaluation and review of many possible causes, including pump failure, power loss, absence of chemical to deliver or clogging within the system due to debris, it was determined that the most probable cause was a malfunction due to air-locking of that particular pump.

The District's chemical feed pumps, including the sodium hypochlorite feed pump at issue, were Encore 700 series diaphragm pumps manufactured by Wallace and Tiernan, and have been exceptionally reliable over their service lives. In fact, the chemical feed pump at issue, which had been in service since 1998, had not previously experienced any failure of this nature. In addition, on October 3, 2012, the District immediately inspected the feed pump following the discovery of

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[6] Other than this written communication on October 4, 2012, and the District's Discharge Monitoring Report for October 2012 dated November 28, 2012 (see District Exhibit J attached hereto and incorporated by reference), the District had no further contact or communication with the Regional Board regarding the October 2012 Incident until State Water Board investigators and Regional Board staff visited and inspected the Facility in October 2013, as described in more detail below.

the loss of chlorination and found no mechanical issues. More importantly, in that the feed pump immediately regained its normal operation without mechanical interference during the bulk chemical delivery on October 3, and as noted below in more detail, remained in continuous operation until April 2015 without experiencing any additional problems, it is clear that pump failure was not the likely cause of the Incident.

c. The District's Corrective Actions in Response to the Loss of Chlorination Incident.

As mentioned, the District received advice from the Santa Barbara County EHS Department that beach closure was unnecessary given the limited nature of the loss of chlorination Incident. Therefore, no beach or other water of the United States was closed or posted in response to the reported loss of chlorination. In addition, Regional Board staff did not direct or advise the District to undertake any specific responses to the reported Incident.

Repairs to the sodium hypochlorite feed pump at issue were also not required for two reasons: 1) no mechanical issues could be identified; and 2) the pump regained normal operation within approximately 10 minutes after the Incident was discovered by District staff.

However, in direct response to, and within a week of, this anomalous Incident, the District engaged AIA Automation, its regular SCADA and instrumentation contractor, to create a control system alarm that would notify operations staff in the event of a low chlorine condition at the head of the chlorine contact basin. Within two weeks of the Incident (by October 22, 2012), several modifications had been made, including the addition of a real-time chlorine dosage display at SCADA, including trending, and the addition of low-chlorine dosage alarm. The new alarm was specifically designed to notify District operations staff at any time, day or night, in the event of loss of chlorination.

It is important to note that at the time of the October 2012 Incident, the District did in fact have a fully functional industry-standard and comprehensive SCADA-based monitoring and notification (i.e., alarm) system in place, which covered all plant processes, including alarms for the disinfection system and parameters such as "high chlorine residual," "low tank level," and other potential failure conditions. A major SCADA upgrade had been undertaken in 2010 to

convert from Wonderware to Rockwell Factory Talk, including an enhanced version of Win911 with triple redundancy in external communications. Additional improvements to the District's SCADA have continued since that time.

In regard to the October 2012 Incident, the District merely lacked an instantaneous alarm for one small mechanical pump, namely, the sodium hypochlorite feed pump at issue.[7] The District also acquired a backup Strantrol 960 disinfection controller, which provides additional disinfection system redundancy and will allow for immediate response in the event of a controller failure.

d. <u>The District's Planned and Capital Improvement Projects.</u>

In April 2015, the District completed construction of an entirely new chemical disinfection system at a cost of over $1.1 million.[8] This new state-of-the-art system, which commenced construction in the second quarter of 2014, includes enhanced monitoring and alarm systems and incorporates automatic pump switching in order to respond to any pump failures similar to that experienced in the October 2012 Incident. As part of this new disinfection system, the sodium hypochlorite feed pump at issue was retired from service, having only experienced one short-duration (approximately five hours) malfunction during its entire tenure (on October 3, 2012). This new disinfection system, however, was not undertaken in response to the October 2012 Incident. Rather, it was part of a larger Facility upgrade project planned and intended to proactively replace critical infrastructure (hereinafter referred to as the "Capital Improvement Project").

Although the capital improvement project was initially planned and undertaken for the primary purpose of replacing the Facility's two aerobic digesters as part of a major Facility upgrade, it also includes ancillary plant improvements such as replacing the chemical system. The

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[7] As discussed in more detail below, it was not required and was not practical to have alarms for every single piece of equipment at the Facility. Moreover, hard alarms for chemical feed pump failures are not common and are not industry standard. Newer installations, however, may have such alarms, which is now the case for the District's recently-constructed new disinfection facility discussed below.

[8] <u>See</u> the "Chemical Disinfection System Replacement – Schedule of Values" attached hereto as District Exhibit E and incorporated herein by reference.

estimated total construction cost of this project is $5.14 million. Specifically, this capital improvement project resulted in the installation of new chemical storage tanks, new chemical feed pumps and piping systems, new disinfection instrumentation and control systems and a new chemical feed building. The new chemical system includes the installation of new Encore 700 series diaphragm pumps, similar to those that were previously in use at the Facility, based on their excellent performance history. (See Photos of upgraded Facility and equipment attached hereto as Exhibit D and incorporated herein by reference).

In addition to the planned capital improvement project, the District has initiated operational modifications at the Facility that will allow for more consistent tracking of information and, ultimately, minimize the risk of any non-compliance. For example, the procedure for logging of daily operations has been modified to more closely follow the recommendations for operations logging by the Regional Board. As a result, all District operators have been trained with the improved logging expectations. Moreover, the District has implemented electronic field inspection sheets, which will allow the District's operational staff to view SCADA trending and alarm conditions while in the field.

e. State and Regional Board Enforcement Inspections of the District's Facility in October 2013.

On October 28 and 29, 2013, representatives of the State Water Board's Office of Enforcement, Special Investigations Unit, and Regional Board staff, including Mr. Von Langen, appeared unannounced at the Facility to conduct an inspection and obtain relevant records and documents from the District. Prior to conducting the inspections of the Facility on both of those dates, the State investigators requested permission from the District to enter the premises. The District immediately and readily granted the State's requests to enter and inspect the Facility.

During the course of these inspections, the State investigators interviewed District management and operations staff regarding the October 2012 Incident and other related matters, inspected Facility operations and requested originals and copies of various records and data. The District answered all of the investigators' questions and provided any available requested materials and data.

It was during these inspections that the District first learned that that the State and Regional Boards were actively investigating the District for the October 2012 Incident. At that time, District management advised the State investigators that the District believed that the one-time, short-duration and immediately reported October 2012 Incident was a "run-of-the-mill" WDRs/NPDES permit excursion resulting from the unforeseeable chemical feed pump malfunction, which at worst, would be subject to a $3,000 MMP. In response, the State investigators stated that they had not yet determined whether a violation had occurred, adding that these inspections were part of the investigation necessary to make that determination. Interestingly, during the course of these inspections, one of the State inspectors also inquired if the District had considered whether the chemical feed pump had been "sabotaged."[9]

Shortly after these inspections, the District's Operations Manager, Mark Bennett, sent an email to one of State Board's investigators confirming that in response to the October 2012 Incident, the District had installed a low chlorine dose alarm that had "been active and functional since 10/22/12." (See District Exhibit F attached hereto and incorporated herein by reference). In that email, the District further advised the State Board that it remained "standing by to provide you any documentation or additional information you may need." (Id.).

f. Notice of Violation Dated December 10, 2013.

On December 10, 2013, the Regional Board issued the NOV to the District. (See Prosecution Team "Exhibit 7"). The NOV alleged a violation for the October 2012 Incident, as well as for the two chlorine residual exceedances in January 2013 (which are included in the five MMP Violations stipulated to by the parties). Specifically, the NOV alleged that the loss of chlorination event during the October 2012 Incident constituted a violation of the "Discharge Prohibitions" set forth in Section III.B. of the WDRs/NPDES, which prohibit the "[d]ischarge of waste in any manner other than described by [the Order]."

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[9] Then, as now, the District has no information indicating that the sodium hypochlorite feed pump at issue was "sabotaged." However, should the State and Regional Boards have any evidence or information to the contrary, the District requests that such information be provided to it immediately, so it can fully defend itself in this pending matter.

g. **The District's Response to the NOV – Technical Report.**

The District's Technical Report prepared in response to the NOV was submitted to the Regional Board on January 27, 2014. In addition to the facts and analysis noted above in the Technical Report, Carollo Engineers found and concluded in pertinent part the following regarding the October 2012 Incident:

> The District's response was immediate and effective at mitigating the discharge of non-chlorinated wastewater to the Pacific Ocean. In addition, follow up activities were proactive and thorough, with the exception of the requirement to conduct offshore water quality monitoring (of which the District was unaware). In our review, it appears that the District has continued to work cooperatively with the RWQCB, not only at the time of the event, but in follow up activities since that time.
>
> In conclusion, the actions and conduct of the District appeared reasonable and prudent based on our independent review, and as such, we support the District's pursuit of lenience from the RWQCB regarding this matter.

(See Prosecution Team Exhibit 8, p. 12).

In response to the NOV, the District also retained the services of Aquatic Bioassay Consulting Laboratories, Inc. and its consultants, Anchor QEA, LLC, (hereinafter collectively referred to as "ABCL") to conduct an assessment of the potential short and long-term impacts of the October 2012 Incident on public health, beneficial uses and ecosystems in the ocean in the proximity of the District's outfall, including water contact recreation, marine habitat and shellfish harvesting. In conducting this assessment and preparing a report (the "ABCL Report"), ABCL considered and applied water quality objectives specified in the District's WDRs/NPDES permit. The ABCL Report was attached as "Appendix L" and incorporated into the Technical Report, and is attached hereto as District Exhibit G and incorporated herein by reference.

The ABCL Report included a detailed discussion of its assessment and findings, concluding in pertinent part that:

> Under reasonable maximum exposure scenarios, none of the events [including the October 2012 Incident] resulted in an exceedance of applicable water quality limits and no adverse impacts to human direct contact recreation or shellfish harvesting or aquatic life would be expected.

(Id. at p. 13). This conclusion was based on, among other things, on the collection and analysis of certain effluent samples from the Facility in January 2014, as well as evaluating the "high energy

environment of the beach where the [District] outfall is located [and] the distribution of the effluent beyond the initial dilution zone. . ." (Id. at p. 5).[10]

Specifically, on January 6, 2014, in support of its assessment of the October 2012 Incident, samples of both treated, but non-chlorinated, secondary effluent from the Facility and ocean water were collected.[11] The District's certified laboratory then conducted multi-tube fermentation bacteriological analyses for total and fecal coliform most probable number ("MPN") on the following samples: 1) on treated effluent before chlorination; 2) on treated effluent after chlorination; 3) on ocean water; and 4) on treated effluent before chlorination that was diluted 93:1 with ocean water.[12]

The test results for the sample of treated effluent before chlorination found total coliform of 160,000 MPN/mL and fecal coliform of 92,000 MPN/100mL, with the test results for the sample of treated effluent before chlorination diluted 93:1 with ocean water finding a total coliform concentration of 490 MPN/100 mL and a fecal coliform concentration of 330 MPN/100mL. Based on these sample test results, the ABCL Report found and concluded that neither the NPDES permit limit for total coliform (2,300 MPN/100 mL as a daily maximum) nor the Ocean Plan (2012) receiving water standards (for a single maximum total coliform of 10,000 MPN/mL or fecal coliform of 400 MPN/100 mL) would have been exceeded during the October 2012 Incident. (Id. at p. 13).[13]

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[10] The ABCL report notes that "the dilution zone is defined as the region in which the rapid, initial mixing occurs and provides the basis for determining the minimum initial dilution ratio of seawater to effluent achieved during the initial mixing phase in the dilution zone." (Id. at p. 8).

[11] In that no bacterial samples were available for the October 2012 Incident, the District collected such samples in January 2014, in order to conduct analyses using treated, but non-chlorinated, effluent in a 93:1 ocean water-to-effluent dilution test to estimate conditions present on October 3, 2012 in the initial dilution zone.

[12] As noted in the ABCL Report, the WDRs/NPDES permit establishes a limit of 2,300 MPN/100mL as a daily maximum and a 23 MPN/100 mL as a weekly median, as well as applies a ratio of 93:1 to such a discharge to determine effluent limitations derived from the Ocean Plan water quality objectives. (See Prosecution Team Exhibit 1, Section VI.C.7, p. 23 and District Exhibit G, p. 11). The ABCL Report also noted that the receiving water standards of the Ocean Plan (2012) include a single maximum total coliform limit of 10,000 MPN/100mL and a fecal coliform limit of 1,000 MPN/100mL, with a 30-day geometric mean standard for total coliform of 1,000 MPN/100 mL and fecal coliform of 200 MPN/100mL. (Id.).

[13] The ABCL Report also recognized that: "During the loss of chlorination event, the effluent flowed through the 80,000-gallon serpentine chlorine contact tank prior to entering the ocean outfall pipe. Therefore, some level of

The ABCL Report found that within "approximately 20 seconds and at a distance of approximately 2 feet from the point of discharge," the effluent would have a concentration of 400 MPN/100mL, which is the single maximum total for fecal coliform, cooncluding that "no adverse impacts to human direct contact recreation or shellfish harvesting would be expected from the loss of disinfection event." (Id.). The ABCL Report therefore concluded that "it is unlikely that the loss of disinfection event posed any threat to people involved in water contact recreation or shellfish harvesting." (Id. at p. 6).

III. ARGUMENT

A. A $3,000 MMP for the October 2012 Incident is Appropriate, Fair and Consistent with the Enforcement Policy.

The District is willing and prepared to pay a total MMP of $18,000, which would include the $15,000 MMP for the five minor effluent violations (MMP Violations) alleged in the ACLC and stipulated to by the District, as well as a $3,000 MMP for the October 2012 Incident. Given the nature and circumstances of that Incident, in addition to being appropriate and fair, the imposition of a $3,000 MMP for that alleged violation would be consistent with applicable statutory law, the Enforcement Policy and this Board's known and published historic enforcement actions involving similarly-situated violators.

Specifically, a MMP for the October 2012 Incident would be appropriate under California Water Code Section 13385. The Enforcement Policy also clearly supports the use of MMPs, as well as encourages the use of "progressive levels of enforcement, as necessary, to achieve compliance." (See Enforcement Policy, District Exhibit A, p. 1). In other words, in addition to other aggravating factors to be considered, should compliance not be achieved, progressively more aggressive and punitive enforcement actions, such as a discretionary ACL penalty, could be pursued against a violator.

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disinfection likely continued due to mixing within the reactor for a period of time after failure of the chemical feed pump. As such, the laboratory test using untreated effluent diluted with ocean water at the permit-established dilution factor of 93:1 is the most appropriate measure of bacterial concentrations released from the outfall diffuser to the initial dilution zone during the [October 2012 Incident]." (Id. at p. 11).

Here, however, where the October 2012 Incident involved a one-time, short-duration equipment malfunction having little, if any, water quality impacts, and where the Facility has an acknowledged reputation as being "well-run" and having and outstanding compliance history, there is no reason to escalate the enforcement action beyond a MMP and pursue a discretionary ACL penalty. The imposition of a MMP, rather than the more aggressive ACL penalty, would therefore be fair, appropriate and consistent with the Enforcement Policy in addressing this particular Incident.

1. A MMP for the October 2012 Incident Would Be Consistent with this Board's Historic Enforcement Actions Taken Against Similar-Situated Public Agencies and Violations.

Contrary to the Prosecution Team's claim, the District is not attempting to obtain a "pass" for the October 2012 Incident. As noted above, the District has readily admitted the short-duration Incident and is willing to pay an appropriate MMP.

In the instant matter before this Board, the District is merely requesting that it be treated no differently than other similarly-situated public entities alleged to have engaged in similar violations for which enforcement, if even pursued, has uniformly been in the form of a MMP assessed by this Board. Unfortunately, inconsistent with those historic practices, the Prosecution Team is asking this Board to impose a discretionary ACL for a violation that would otherwise be sanctioned with a MMP.

Notwithstanding the District's willingness to resolve the matter, the Prosecution Team insists on pursuing an aggressive and unprecedented course of enforcement, which leaves the District with no option other than to object and counter with the relevant facts, past Board practices and applicable policies. The District therefore hopes that this Board will act more responsibly and thereby, impose a sanction more consistent with the tenets and principles of the Enforcement Policy and its well-documented enforcement practices.

Since first becoming aware in October 2013 of the Prosecution Team's investigation of the October 2012 Incident, the District has repeatedly voiced its concerns that the Team's response to the Incident has been unnecessarily aggressive and disproportionate to the nature, extent and circumstances of that Incident. In addition, given the District's immediate and voluntary

implementation of remedial measures to correct this obviously aberrational Incident, which was not the result of any negligent conduct, the District has consistently opined that there was no rational reason for this matter to be viewed as an enforcement priority for the Prosecution Team.

A diligent review and analysis of the violations and enforcement actions listed on the State Board's internet web page, the CIWQS online reporting web page, other public sources and direct examination of Regional Board files for all publicly owned treatment works ("POTWs") within the Central Coast Region, confirms that violations similar to the October 2012 Incident have not been considered enforcement priorities by this Board, and when pursued, are typically and more appropriately handled as MMPs. In fact, based on an even broader search, the District found only one other enforcement action, in any region, where a violation similar to the October 2012 Incident was pursued by an enforcement action other than a MMP. Specifically, a discretionary penalty was assessed against the City of Chico, Chico Water Pollution Control Plant (R5-2010-0505) for a loss of disinfection event, but only after having previously been assessed multiple and repeated MMPs for the recurring type of violation without any responsive efforts on the City's part to remedy the non-compliance. (See District Exhibit H attached hereto and incorporated herein by reference). Obviously, the facts and circumstances of the City of Chico matter are distinctly different and far more egregious than those present in the October 2012 Incident.

Within the Central Coast Region, the District found no reported enforcement case or instances where a discretionary ACL penalty was assessed for any type of WDRs/NPDES violation, regardless of whether such incidents were associated with equipment failures, effluent limit exceedances, improper reporting or any other category of violation. The only examples of discretionary ACL penalties assessed in this Region were for significant and avoidable raw sewage spills to waters of the State with observed, documented and/or confirmed water quality impacts. (See District Exhibit I attached hereto and incorporated herein by reference). In other words, based on the reported cases, when sanctioned for any violation other than a sanitary sewage overflow ("SSO"), no other public wastewater agency has suffered a penalty other than a MMP.

More specifically, during the period 2010 through 2014, the District noted that several public facilities, including publicly-owned treatment works ("POTWs"), located in the Central

Coast Region experienced similar loss of disinfection incidents for various reasons, resulting in the discharge of hundreds of thousands (if not more) gallons of effluent with partial or no disinfection, some of which involved fecal coliform violations. (Id.). The District also noted that in most instances, no enforcement action was taken, but when pursued, the responsible dischargers were subjected to MMPs, and none were subjected to discretionary penalties based on the amount of discharge or assessed using the ACL penalty calculator. In addition, many of these recent permit violations, which included, among others, those reported by the Avila Wastewater Treatment Plant ("WWTP"), the Cuyama Community Services District WWTP, the City of Santa Barbara El Estero WWTP, the South San Luis Obispo Sanitation District WWTP, the Soledad WWTP and the California Men's Colony WWTP, represent violations that were far more serious (because they involved fecal coliform exceedances) than that alleged against the District regarding the October 2012 Incident, which involved treated (albeit non-chlorinated) effluent, and not coliform violations. (Id.). In sum, this Board is regularly notified of violations where partially-treated effluent, or worse, namely, sewage, is discharged and thereafter only imposes a MMP, or in many instances, pursues no enforcement action.

While the District recognizes and concedes that the State has limited enforcement staff and resources, and must judiciously exercise its discretion in effectively assigning and applying those resources toward certain enforcement priorities and efforts, including whether to initiate and pursue enforcement actions or not, the exercise of such discretion should not create disparate results, especially within the same region. Specifically, once enforcement actions have in fact been initiated and pursued, similarly-situated violations and violators should not be treated or punished differently for essentially the same conduct. The District submits that should this Board follow the Prosecution Team's recommendation and impose a discretionary ACL penalty for the October 2012 Incident, instead of a MMP, it would be unfairly and inconsistently sanctioning the District in comparison with other similarly-situated public agencies, especially other POTWs.

2. The Enforcement Cases Cited by the Prosecution Team Relating to Other Public Agencies are Distinguishable from the October 2012 Incident.

The public record clearly shows that in recent years, numerous public wastewater

dischargers within the Region have committed, and continue to commit, dozens and in some cases, hundreds, of serious and chronic violations as reported to CIWQS, but have only been subjected to MMPs by this Board. (Id.). In contrast to those chronic violators, the District has an excellent record of WDRs/NPDES permit compliance. The fact that the Prosecution Team is pursuing an ACL based on the penalty calculator methodology for the single October 2012 Incident, when it has not done so for any of the other chronic dischargers having far more egregious compliance histories, seems unfair and entirely inconsistent with both the Enforcement Policy and this Board's practices. It therefore remains difficult for the District to understand the reason(s) why the Incident at issue has warranted such an aggressive posture by the Prosecution Team. The question remains, "Why is the District being subjected to such disparate treatment?"

In response, the Prosecution Teams cites a number of recent enforcement cases, both within and outside the Region, purportedly showing that the State and this Board have pursued ACL actions and discretionary penalties for violations similar to the October 2012 Incident. Specifically, according to the Prosecution Team, other similarly-situated dischargers have been penalized to a much greater extent than to that recommended for the District, and that "enforcement is not reserved for raw sewage discharges." (See Prosecution Team Opening Brief, p. 6).

The enforcement cases cited by the Prosecution Team, however, do not support its position in that the facts and circumstances of those cases involved untreated sewage overflows and/or dischargers that had lengthy and extensive histories of serious violations and recurring non-compliance – which is clearly not the case with the District. For example, the cited cases relating to the Cambria Community Services District and the Santa Cruz County Sanitation District both involved untreated SSO violations, which are far more serious than the October 2012 Incident. The other cases cited by the Prosecution Team are similarly distinguishable from the Incident.

In the cited matter involving the Napa Berryessa Resort Improvement District Wastewater Treatment System ("Napa WWTS"), unlike the District, the NAPA WWTS had a lengthy history of discharge violations and enforcement actions, including those involving SSOs and the discharge of overflowing treatment ponds into creeks and Lake Berryessa. In addition, unlike the District,

the Napa WWTS had previously been assessed with an ACL for these very serious and recurring violations.

Similarly distinguishable from the District, in the matter involving the City of Redding, Department of Public Works ("City") cited by the Prosecution Team, the ACLC filed against the City charged, among other things, 76 SSO violations. Moreover, unlike the District, the City had a lengthy history of noncompliance, including suffering numerous MMPs and several prior ACL penalties for multiple, recurring violations.

A plain reading of the facts and records of the enforcement cases cited by the Prosecution Team shows that those cases are starkly different from and exceedingly more serious than the circumstances relating to the October 2012 Incident. Furthermore, in light of the spotty compliance records of those other cited public entities, it appears reasonable to have pursued more aggressive or "progressive" enforcement actions them, including the imposition of an ACL penalty, in order to eventually achieve compliance from those entities.

The Prosecution Team, however, has cited no case or enforcement matter, whether before this Board or statewide, involving facts or circumstances similar (or even close) to those surrounding the October 2012 Incident to support or justify its request for a discretionary ACL penalty. As noted above, after a diligent search, the District has also not yet found any such ACL enforcement case against a similarly-situated public agency.

Based on the foregoing, it is manifestly clear that the Prosecution Team cannot meet its burden in supporting its recommended discretionary ACL penalty for the October 2012 Incident, either through the Enforcement Policy or historic enforcement actions pursued by this Board or statewide. The imposition of such an ACL penalty would therefore be precedent-setting and purely punitive in nature, especially since no actual or potential was harm involved, the District voluntarily implemented corrective measures and more importantly, achieved immediate compliance. This Board should therefore reject the Prosecution Team's request to impose the ACL penalty and instead, impose a MMP of $3,000 for the October 2012 Incident, as recommended by the District.

B. In the Event This Board Decides to Assess and Impose a Discretionary ACL Penalty, It Should Impose a Minimal or Low-End Penalty Given the Facts and Circumstances of the October 2012 Incident

Assuming arguendo that this Board were to take the unprecedented step of assessing and imposing a discretionary ACL penalty pursuant to Water Code sections 13327 and 13385(e) against the District for the October 2012 Incident, the District respectfully requests that any such penalty be minimal in amount, based on the District's recommended scoring of the applicable factors and adjustments set forth herein-below. Specifically, in using those scores stipulated to and recommended by the District, an appropriate discretionary ACL penalty would be based on a Total Base Liability of $1,698, which would be entirely consistent with both the facts of this matter and the provisions of applicable statutory law and the Enforcement Policy.

The ACL penalty proposed by the Prosecution Team is excessive and not factually supportable, because, among other things, in calculating that penalty, it significantly overstates both the potential harm to beneficial uses and the anticipated economic benefit gained by the District. As such, the Prosecution Team has overreached and is violating the Enforcement Policy because the proposed ACL penalty does not "bear a reasonable relationship to the gravity of the violation and the harm to beneficial uses or regulatory program resulting from non-compliance," (See Enforcement Policy, District Exhibit A, p. 10).

1. Applicable Statutory and Enforcement Policy Provisions

In assessing the appropriate amount of any ACL, Section 13327 provides in pertinent part that this Board shall consider the following factors:

> [T]he nature, circumstance, extent, and gravity of the violation or violations, whether the discharge is susceptible to cleanup or abatement, the degree of toxicity of the discharge, and, with respect to the violator, the ability to pay, the effect on ability to continue in business, any voluntary cleanup efforts undertaken, any prior history of violations, the degree of culpability, economic benefit or savings, if any, resulting from the violation, and other matters as justice may require.

Section 13385(e) similarly provides:

> In determining the amount of any liability imposed under this section, the regional board, the state board, or the superior court, as the case may be, shall take into account the nature, circumstances, extent, and gravity of the violation or violations, whether the discharge is susceptible to cleanup or abatement, the degree of toxicity of the discharge, and, with respect to the

> violator, the ability to pay, the effect on its ability to continue its business, any voluntary cleanup efforts undertaken, any prior history of violations, the degree of culpability, economic benefit or savings, if any, resulting from the violation, and other matters that justice may require. At a minimum, liability shall be assessed at a level that recovers the economic benefits, if any, derived from the acts that constitute the violation.

Under the heading, "Penalty Calculation Methodology," the Enforcement Policy also provides in pertinent part that any ACL assessed by this Board should:

> Be assessed in a fair and consistent manner;
>
> Fully eliminate any economic advantage obtained from non-compliance;
>
> Fully eliminate any unfair competitive advantage obtained from noncompliance;
>
> Bear a reasonable relationship to the gravity of the violation and the harm to beneficial uses or regulatory program resulting from the violation;
>
> Deter specific person(s) identified in the ACL from committing further violations; and
>
> Deter similarly-situated person(s) in the regulated community from committing the same or similar violations.

(See Enforcement Policy, District Exhibit A, p. 10). The Enforcement Policy further provides that "the liability process set forth in the chapter provides the decision-maker with a methodology for arriving at a liability amount consistent with these objectives, " including following certain steps and the scoring and consideration of various factors. (Id.).

2. Stipulated ACL Penalty Calculation Factors

The parties have stipulated to the following facts and scoring of relevant factors relating to the October 2012 Incident that should be considered in assessing any ACL using the penalty calculation methodology:

> Estimated discharge volume: 297,896 gallons.
>
> Step 1: Potential for Harm for Discharge Violations
>
> > Factor 3: Susceptibility to Cleanup or Abatement - Score of 1.0.
>
> Step 2: Assessments for Discharge Violations
>
> > The volume of the discharge at issue, which does not involve sewage of stormwater, allows the prosecution Team, in its discretion, to recommend a reduction in the maximum penalty of $10.00 per gallon to $2.00 per gallon.

Step 4: Adjustment Factors - Table 4 Violator Conduct Factors

History of Violations - Score of 1.0.

Step 6: Ability to Pay

The District has the ability to pay an appropriate penalty.

Step 7: Costs of Investigation

Prosecution Team to be billed at $125 per hour.[14]

3. Disputed ACL Penalty Calculation Factors

The parties have not stipulated to and have significant differences relating to the appropriate scoring of several important factors. The following is a listing of the disputed factors and the respective positions of the parties:

Step 1: Potential for Harm for Discharge Violations

Factor 1 – Harm or Potential Harm to Beneficial Uses:

Prosecution Team recommends a score of 2: Below Moderate Threat.

District recommends a score of 0: Negligible Threat; or at most, a score of 1: Minor Threat.

Factor 2: The Physical, Chemical, Biological or Thermal Characteristics of the Discharge

Prosecution Team recommends a score of 2: Below Moderate Threat.

District recommends a score of 0: Negligible Threat; or at most, a score of 1: Minor Threat.

Step 2: Assessments for Discharge Violations

Deviation from Requirement

Prosecution Team recommends a finding of moderate deviation.

District recommends a finding of minor deviation.

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[14] However, as noted below, the District reserves the right to, and does, object to the imposition of certain staff and investigation costs incurred by the Prosecution Team in the investigation and prosecution of the October 2012 Incident.

Step 4: Adjustment Factors - Table 4 Violator Conduct Factors

Culpability

Prosecution Team recommends a score of 1.1.

District recommends a score of 0.75.

Cleanup and Cooperation

Prosecution Team recommends a score of 1.0.
District recommends a score of 0.75.

Step 8: Economic Benefit

Prosecution Team recommends a value of $25,534.

District recommends a value of $300.

The discussion below provides more detail regarding the respective positions of the parties relating to these disputed factors.

a. Step 1/Factor 1: Harm or Potential for Harm to Beneficial Uses

The appropriate score for Step 1/Factor 1 is 0 (Negligible Threat), which reflects the fact that there was no actual harm caused, or potential harm posed, to beneficial uses as a result of the October 2012 Incident. At worst, given the facts and circumstances at issue, the highest score that could arguably be assigned for this factor would be 1 (Minor Threat), which reflects a low threat to beneficial uses, where no impacts have been observed.

As provided in the Enforcement Policy, the pertinent harms are defined and recommended scoring ranked as follows:

> 0 = Negligible – no actual or potential harm to beneficial uses.
>
> 1 = Minor – low threat to beneficial uses (i.e., no observed impacts but potential impacts to beneficial uses with no appreciable harm).
>
> 2 = Below Moderate – less than moderate threat to beneficial uses (i.e., impacts are observed or reasonably expected, harm to beneficial uses is minor).

(See Enforcement Policy, District Exhibit A, p. 12).

Contrary to the assertion by the Prosecution Team that the Incident should be scored at 2 as a "Below Moderate" threat to water recreation and shellfish harvesting, there is absolutely no evidence whatsoever that any "impacts [were] observed or reasonably expected" from the

discharge. As noted above and substantiated by the ABCL Report, which was prepared by an independent qualified biologist, no receiving water impacts were observed, nor was there any evidence of harm to beneficial uses, resulting from the Incident's short-duration discharge of non-disinfected secondary effluent. (See ABCL Report, District Exhibit G, p. 13). According to the ABCL Report, based on laboratory analyses, even the worst-case scenario plume modeling indicated that all Ocean Plan (2012) water quality objectives would have been met at a distance of two feet from the point of discharge and thereby, would pose a negligible risk to beneficial uses, including recreation contact and shellfish harvesting. (Id.). The ABCL Report therefore concluded:

> Under reasonable maximum exposure scenarios, none of the events resulted in an exceedance of applicable water quality limits and no adverse impacts to human direct contact recreation or shellfish harvesting or aquatic life would be expected."

(Id.).

The ABCL Report's conclusions are further supported by the fact that, after receiving notification of the nature and estimated amount of the discharge involved in the Incident, the Santa Barbara County EHS Department advised the District that there was no need to post the beach or take any additional response measures. In addition, upon being notified of the Incident, a representative of the Preharvest Shellfish Unit of the Environmental Management Branch of CDPH stated that based on the estimated volume of the discharge and ocean currents at the time of discharge, no impact to shellfish growing areas would occur or be expected.

In the face of overwhelming evidence that there was no actual harm or threat of harm caused by the Incident, the Prosecution Team counters with essentially two arguments: 1) that the District should not be "rewarded" for failing to conduct sampling and monitoring after the Incident, as required under Provision VII.A.2 of the MRPs, which according to the Prosecution Team, most likely would have shown actual harm or potential impacts;[15] and 2) that because it is purportedly based on "hypothetical data," the findings and conclusions of the ABCL Report

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[15] As previously noted, this particular MRP requirement for ocean sampling and monitoring is not consistently applied to other POTWs in the Region.

should not be used by this Board to find that there were no impacts or potential harm resulting from the Incident. (See Prosecution Team Opening Brief, pp. 4-5). The Prosecution Team's arguments, however, are misplaced and should be rejected by this Board.

The findings and conclusions of the ABCL Report are clearly not based on "hypothetical data," as claimed by the Prosecution Team. Rather, these findings and conclusions relating to the lack of any harm should be weighed and considered by this Board as circumstantial evidence, which is defined as "evidence that tends to prove a fact by proving other events or circumstances which afford a basis for a reasonable inference of the occurrence of the fact at issue." (Merriam-Webster Dictionary).

As noted above, the collection and analysis of actual samples in January 2014 in response to the NOV was a good faith attempt to recreate and evaluate representative operations and water quality conditions at the time of the Incident. In addition, as noted in the ABCL Report, the sample results obtained during this assessment and evaluation in January 2014 were likely much higher in concentration than what had actually been discharged at the time of the Incident, because:

> [d]uring the loss of chlorination event [October 2012 Incident], the effluent flowed through the 80,000-gallon serpentine chlorine contact tank prior to entering the ocean outfall pipe. Therefore, some level of disinfection likely continued due to mixing within the reactor for a period of time after failure of the chemical feed pump. As such, the laboratory test using untreated effluent diluted with ocean water at the permit-established dilution factor of 93:1 is the most appropriate measure of bacterial concentrations released from the outfall diffuser to the initial dilution zone during the [Incident]."

(See ABCL Report, District Exhibit G, p. 11). Such sampling and analytical data, along with other relevant facts and evidence, can therefore be used to prove circumstantially that there were no impacts and no potential harm to beneficial uses on the date of the Incident.

The real "hypothetical" presented in this matter is the Prosecution Team's statement that "if sampling revealed that exceedances lasted for several days, this factor could have been scored a 4 (above a moderate risk)." (See Prosecution Team Opening Brief, p. 5). While it is not entirely clear what particular point the Prosecution Team intended to make with that statement, it is an undisputed fact that the Incident at issue and any exceedance occurred on one day and only during

a limited period of approximately five hours.[16]

As stated repeatedly, the District is not attempting to avoid responsibility for any failure on its part to adhere to any of the terms and conditions of the WDRs/NPDES permit, including the sampling and monitoring activities required under Provision VII.A.2 of the MRPs. However, this Board should also recognize and consider what the Prosecution Team concedes, namely, that the District detrimentally relied upon the guidance of a Regional Board staff member in not conducting such sampling and monitoring after the Incident. Interestingly, the Prosecution Team argues: "Although a Water Board staff member erroneously told [the District] that it did not have to conduct required sampling, the permit does not allow [the District] or Water Board staff to make that determination. Conversations with Water Board staff do not override permit requirements." (Id. at pp.3-4).[17]

It is also not the intention of the District to cast blame or shift any responsibility to any particular Regional Board staff member. The District recognizes that it is solely and ultimately responsible for complying with its WDRs/NPDES permit. However, the District sincerely and adamantly believes that it is improper, unfair and disingenuous for the Prosecution Team to on one hand argue that the District should not be "rewarded" for detrimentally relying on a Regional Board staff member in failing to conduct sampling and monitoring post-Incident, which the Prosecution Team claims would have purportedly shown potential harm to beneficial uses, while simultaneously arguing that this Board should disregard and not consider as "hypothetical" the ABCL Report, which concluded that there were no actual or potential impacts to water quality resulting from the Incident. In essence, and in the simplest terms, the position taken by the Prosecution Team is akin to a traffic officer, while writing up a speeding ticket, advises the motorist that there is no need to have the speedometer immediately checked for accuracy, then

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[16] Presumptive hypotheses regarding impacts to the ocean environment from bacterial loading are even more difficult to support, considering the fact that the State permits over 20% of the POTW effluent in Region 3, and 65% of all POTW effluent statewide, to be discharged to the Pacific Ocean without any disinfection whatsoever.

[17] The parties have further stipulated that, "In providing notification to the [Regional Board] permitting staff, the [District] was apparently told there was no need to sample after the [Incident]. However, the [District] is responsible for compliance with the terms of the permit despite verbal directives to the contrary."

later, if the motorist later challenges the ticket in court, argues that a recent speedometer check is not representative of the condition of the vehicle at the time of the ticket. This is an untenable and unfair position that has been taken by the Prosecution Team – and is indicative of the overly-aggressive approach and actions taken during the course of the investigation and prosecution of this Incident, including and the severity of the proposed sanctions.

Unfortunately, it is readily apparent that the District, which has a stellar record of compliance and good working relationships with the Regional Board and its staff, is now being penalized for its reliance on the Regional Board regarding this particular post-Incident sampling and monitoring issue. The District therefore respectfully requests that this Board recognize the equitable and mitigating circumstances of this situation and thereby, give full weight to the findings and conclusions of the ABCL Report in considering and determining the appropriate score for this factor. In doing so, the District submits that this Board will find that there was no actual or potential harm to beneficial uses caused by the Incident, and that the appropriate score is 0 (Negligible Threat), and arguably, no greater than 1 (Minor Threat).

b. Step 1/Factor 2: Physical, Chemical, Biological or Thermal Characteristics

Based on the foregoing, as well as additional reasons set forth below, the appropriate score for this factor is 0 (Negligible Risk), which reflects the fact that the chemical and physical characteristics of the discharged material during the Incident were benign and did not impact potential receptors. At most, given the facts and circumstances at issue, the highest score that could arguably be assigned for this factor would be 1 (Minor Risk), which reflects a low threat to potential receptors, where the discharge at issue is relatively benign and not likely to harm such receptors.

As with its proposed score regarding harm or potential harm to beneficial uses, the Prosecution Team's recommended score of 2 (Moderate Risk or Threat) is similarly not supported by the facts of the Incident, since no legitimate concerns regarding receptor protection were present or reasonably expected, and is thereby, inconsistent with the Enforcement Policy.

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As provided in the Enforcement Policy, in scoring this particular discharge factor, the pertinent characteristics of the discharge at issue are defined as follows:

> 0 = Discharged material poses a negligible risk or threat to potential receptors (i.e., the chemical and/or physical characteristics of the discharged material are benign and will not impact potential receptors).
>
> 1 = Discharged material poses only a minor risk or threat to potential receptors (i.e., the chemical and/or physical characteristics of the discharged material are relatively benign or are not likely to harm potential receptors).
>
> 2 = Discharged material poses a moderate risk or threat to potential receptors (i.e., the chemical and/or physical characteristics of the discharged material have some level of toxicity or pose a moderate level of concern regarding receptor protection).

As noted above, the ABCL Report conclusively demonstrates that the short-duration discharge of non-disinfected secondary effort during the Incident posed negligible risk of harm to potential receptors, even within two feet of the District's outfall diffusers. More specifically, in the ABCL Report, an independent qualified aquatic biologist stated, "Given the relatively small area this represents, no adverse impacts to human direct contact recreation or shellfish harvesting would be expected from the loss of disinfection event." (See ABCL Report, District Exhibit G, p. 13). The ABCL Report also noted that bacterial loading from secondary effluent is unlikely to have an impact on aquatic biota, including the only identified species of concern, the Southern California distinct population segment of steelhead trout (*Oncorhynchus mykiss irideus*).

Moreover, the inference in the ACLC that the discharge at issue exceeded the applicable effluent limit for coliform by 68 times is inaccurate and misleading. The sample that contained 160,000 MPN/100 mL total coliform was pure secondary effluent collected on January 6, 2014. The actual discharge concentration during the October 2012 Incident would have been reduced, likely by a significant amount, through contact with residual chlorine in the contact tank, and also through degradation by UV light, during the approximately three-hour retention time prior to discharge. However, even the conservative worst-case scenario modeling, which assumed the 160,000 MPN/100mL concentration, determined that no impacts to receptors could be expected.

Accordingly, the District's proposed score of 0, or no more than 1, should be applied to this factor.

c. **Step 2: Assessments for Discharge Violations - Deviation from Requirement**

A rating of "Minor" Deviation from Requirement is appropriate given the cause and circumstances of the Incident. The Prosecution Team's recommendation for a "Moderate" rating is not supported by the facts or the Enforcement Policy.

The Enforcement Policy provides in pertinent part:

> The deviation from requirement reflects the extent to which the violation deviates from the specific requirement (effluent limitation, prohibition, monitoring requirement, construction deadline, etc.) that was violated. The categories for Deviation from Requirement are defined as follows:
>
> Minor – The intended effectiveness of the requirement remains generally intact (e.g., while the requirement was not met, there is general intent by the discharger to follow the requirement).
>
> Moderate – The intended effectiveness of the requirement has been partially compromised (e.g., the requirement was not met, and the effectiveness of the requirement is only partially achieved).
>
> Major – The requirement has been rendered ineffective (e.g., discharger disregards the requirement, and/or the requirement is rendered in effective in its essential functions).

(See Enforcement Policy, District Exhibit A, p. 14).

Contrary to the Prosecution Team's claims, the District did not "fail to have an alarm or backup system" in place at the time of the October 2012 Incident. As noted above, at the time of the Incident, the District did in fact have in place preventative/contingency plans, backup generators, redundant pumps and a fully-functional industry-standard and comprehensive SCADA-based monitoring and notification (i.e., alarm) system, which covered all plant processes, including alarms for the disinfection system and parameters such as "high chlorine residual," "low tank level," and other potential failure conditions. A major SCADA upgrade had also been undertaken in 2010 to convert from Wonderware to Rockwell Factory Talk, including an enhanced version of Win911 with triple redundancy in external communications. In regard to the Incident at issue, the District merely lacked an instantaneous alarm for one small mechanical pump, namely, the highly-reliable sodium hypochlorite feed pump that experienced a one-time, aberrational problem.

More importantly, the District's WDRs/NPDES permit does not specifically require a "low chlorine dose" alarm or any other specific monitoring or alarm that would have mitigated this short- duration equipment failure. The repeated allegation in the ACLC and by the Prosecution Team that the District "failed to maintain" such an alarm is therefore misleading and prejudicial, since the District was not specifically required to have such an alarm for the chemical feed pump at issue.[18] Furthermore, the District is aware of many other wastewater treatment facilities that, by design, lack the very type of alarm that the Prosecution Team maintains in this matter was required.[19]

At the time of the Incident, although the District did not have continuous monitoring/alarms for every piece of mechanical equipment at the Facility, it did have in place a fully-functional SCADA and integrated remote alarm system that monitored many critical elements of the chemical disinfection system. In addition to not being specifically required, given the outstanding and extremely reliable performance history of the particular chemical feed pump at issue (with over 10 years of continuous flawless operation and subjected to daily inspection and routine preventative maintenance), it was not reasonably foreseeable that an alarm would be necessary for that particular pump.

Lastly, the District fully understood and intended to comply with the requirements of its NPDES permit, which is borne out by the District's excellent compliance record and its immediate implementation of effective corrective actions in response to the Incident. As a consequence, the effectiveness of those requirements was not compromised in any manner.

As such, a rating of "Minor" Deviation from Requirement should be assigned.

Based on the foregoing, the District therefore contends that the total score for the sum of the scores applied to Factors 1, 2 and 3 in Step 1 should be 1, or no higher than 3. The Prosecution Team's recommended total final score of 5 (see Prosecution Team Opening Brief, p.

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[18] In an attempt to bolster its argument, the Prosecution Team asserts that "disinfection is a key wastewater treatment process; to reduce the levels of pathogens." (See Prosecution Team Opening Brief, p. 6). However, this Board is no doubt aware that not all POTWs are required to disinfect their affluent with chlorination.

[19] Based on the District's understanding of the operations of other POTWs in the Region, it appears that an equipment-based alarm that would indicate a failed chemical feed pump is not industry standard practice.

7) is grossly overstated and not supported by the facts and circumstances of the Incident.

d. Step 4: Adjustment Factors – Violator Conduct Factors – Culpability

The District recommends a Culpability score of 0.75, and objects to the Prosecution Team's recommended score of 1.1. The Prosecution Team argues that the District's alleged failure to "install redundant detection equipment in order to minimize discharges and potential water quality impacts" supports its recommended score. (See Prosecution Opening Brief, p. 8).

As noted above, the District objects to the allegations that it "failed" to install a low chlorine dosage alarm system prior to this Incident because this specific type of equipment alarm was 1) not required under the NPDES permit; and 2) is not industry standard practice. In addition, this short-duration and one-time loss of chlorination Incident was an unforeseen, non-negligent violation.

Contrary to the ACLC's allegation that "the cause of the discharge was never determined," the District, as supported by the Technical Report, determined that the Incident was caused by the anomalous malfunction of the sodium hypochlorite feed pump. After the evaluation and elimination of several possible causes, the malfunction of the pump was determined to be most likely the result of air-locking. The pump was immediately examined and returned to service without any necessary repairs, and remained in continuous service without any other problems until it was retired from service in April 2015.

Accordingly, the District recommends a Culpability factor above the minimum, namely, 0.75.

e. Step 4: Adjustment Factors – Violator Conduct Factors – Cleanup and Cooperation

The District objects to the Prosecution Team's recommended Cleanup and Cooperation score of 1.0, and recommends a score of 0.75.

As noted, there were absolutely no impacts to receiving waters or public health resulting from the October 2012 Incident, so there were no necessary or required cleanup activities to be undertaken. In addition, the District immediately notified the Regional Board, County of Santa Barbara and the CDPH to report the Incident, along with the estimated volume of the discharge.

None of those agencies advised or directed the District to undertake any cleanup or response actions, including the posting of beaches.

Within several weeks of the Incident, the District voluntarily modified its SCADA alarm system, including installing a low dose chlorine alarm, in order to prevent any future recurrence. In April 2015, the District also completed construction of a new and upgraded chemical disinfection system at the Facility.

The District has also been fully cooperative with both State and Regional Board legal and enforcement staff throughout the entirety of this investigation, including readily providing any and all requested information, materials and data. This cooperation by the District has been acknowledged by the Prosecution Team. (See Prosecution Team Opening Brief, p. 8).

f. Step 5: Determination of Base Liability

Using the District's recommended total score for the sum of the scores applied to Factors 1, 2 and 3 in Step 1, which should be as low as 1, or no higher than 3, the penalty liability is calculated to be either $1,698 or $3,056.70, respectively.

g. Step 8: Economic Benefit

The District recommends that the economic benefit derived from the Incident should be valued at approximately $300, based on the purported "delayed" installation of a low dose chlorine alarm. Although the District believes that a low chlorine dosage alarm system was neither required under the NPDES permit nor is industry standard practice, the District has no objection to the economic benefit assigned by the ACLC and the Prosecution Team to the installation of this specific alarm system.

However, the Prosecution Team's claim that the economic benefit for the District's alleged failure to perform ocean water monitoring following the Incident, with an associated cost in excess of $25,000, is not reasonable. Moreover, this alleged failure to sample should not even be considered an as avoided cost when, as clearly indicated by the Prosecution Team and stipulated to by the parties, the Regional Board staff advised the District that any such sampling was not necessary at the time of the Incident. Had either the Regional Board or the Santa Barbara County Environmental Health Services Department stated that receiving water sampling and analyses

were necessary or appropriate following this short-duration loss of chlorination Incident, the District obviously would have undertaken the sampling protocol indicated in the MRP. As noted, in response to the District's immediate notifications and conversations relating to the Incident, no State, local or private agency suggested or directed that any sampling and testing be conducted.

It is also important to note that the parties have stipulated that, "Although this failure to conduct sampling could be considered a violation of the [District's] permit, it is not included in the proposed [ACL]." Unfortunately, although it is understood that this alleged violation would not be used in calculating the proposed discretionary ACL penalty, the Prosecution Team is proposing to use the estimated economic benefit allegedly derived from such a violation for that very reason. Such a use of the estimated economic benefit for that alleged violation is not appropriate in this matter. In addition to being unfair to the District, the perception of the Regional Board on one day not requiring a discharger to conduct sampling, then later penalizing that same discharger for failing to conduct the sampling, whether through a direct penalty or the factoring in of an economic benefit, is not good regulatory or enforcement practice.

However, notwithstanding the foregoing, in the event this Board were to determine an economic benefit value that includes avoided monitoring costs, the District contends that the Prosecution Team has significantly over-valued the estimated costs of any necessary and required post-Incident water quality monitoring.

Notwithstanding the Prosecution Team's argument discussed above as to whether the District should be "rewarded" or not for failing to conduct such water quality monitoring post-Incident, the Prosecution Team would have to concede that the WDRs/NPDES permit does not specifically require or dictate how such samples are to be obtained – whether by large, small or medium size boat, skiff, dingy or kayak. The District therefore would (or could) have used a much smaller and less expensive charter vessel or boat than the one used in calculating the Prosecution Team's economic benefit estimate, which the District understands was based on the assumed charter of a large vessel normally used to conduct benthic sampling (as required by the District's WDRs/our NPDES permit once every five years). As such, the Prosecution team's estimate is highly-inflated.

In the event the District had conducted such water quality monitoring, it would have chartered a small vessel (e.g., *Finaddict* – www.sbseacharters.com or *Rock Steady* – www.sbsportfishing.com) at a rate of approximately $750 per half day. Samples would have been collected by District operations staff on-board this vessel. The total cost of this effort, including staff time to perform the required laboratory analyses, would have been approximately $6,500. Applying the USEPA BEN model inflation factor, the avoided cost would have been $6,972, which could be rounded up to a total of $7,000. This estimate would be the absolute high end of the costs necessary to perform the indicated sampling, since the District would likely have conducted the sample collection, analysis and reporting duties for far less than this estimated amount.

Accordingly, the District respectfully requests that this Board reject the Prosecution Team's inflated estimate of $25, 534 and instead, appropriately apply only those avoided costs associated with the installation of a low dose alarm, namely, $300.

h. Step 9: Minimum and Maximum Liability

Based on the District's values recommended above, the minimum liability generated from the ACL penalty calculator ranges from $1,698 to $3,056, with the maximum liability being $2,978,960.

i. Step 10: Final ACL Amount

For purposes of this exercise, and based on the foregoing, the District submits that the final liability amount for the short-duration October 2012 Incident generated from the penalty calculator should be $1,698, and at the most $3,056, based on the selection of factors following the clear language and procedural direction set forth in the Enforcement Policy.

4. Investigative and Staff Costs

As noted above, the District sincerely believes that the appropriate sanction for the October 2012 Incident is a MMP and therefore, no investigative or staff costs should be imposed upon the District. The Prosecution Team, however, pursuant to the ACLC, is requesting staff costs of at least $22,000, claiming that, "This is an enforcement action which has taken considerable effort." (See Prosecution Team Opening Brief, p. 9).

The question for this Board is why has this particular matter taken such "considerable effort?" Most, if not all, of the salient and relevant facts to be considered by this Board were reported immediately by the District to the Regional Board on or near the date of the Incident. Specifically, as noted in both District Exhibit C, which is the written report provided by the District to the Regional Board on October 4, 2012, within 24 hours of the Incident, and District Exhibit J, which is the District's Discharge Monitoring Report for October 2012 dated November 28, 2012, all of the material facts and circumstances upon which the Prosecution Team is now arguing its case were fully disclosed to and known to the State. In short, all of the facts and information necessary for the Prosecution Team and this Board to conduct the above-described penalty calculations were known and available within a matter of weeks of the October 2012 Incident.

Since that date, there have only been two substantive changes or updates from that initial notification and reports made by the District in or about October 2012. The first is the re-calculation of the estimated amount of the discharge, which increased the District's initial estimate of 281,250 gallons to the final and stipulated estimate of 297,896 gallons – a difference of less than 17,000 gallons. The second is the District's retention and use of ABCL in January 2014 to conduct the assessment and evaluation of harm described above, which was a cost solely incurred by the District. As such, the District is at a loss as to what, if anything else, the Prosecution Team possibly needed to do in order to pursue this particular matter.

The District has repeatedly questioned the basis or rationale for what appears to be a disproportionate enforcement response undertaken by the Prosecution Team regarding a relatively minor exceedance of the District's WDRs/NPDES permit. More specifically, the District believes that the Prosecution Team's response to and actions in this case are inconsistent with its treatment of other similarly-situated violations having little or no adverse impacts to water quality. As such, the District continues to believe that it is inappropriate to pay for any unnecessary or unreasonable staff costs associated with this matter.

The District, however, understands that some reasonable costs would likely have been incurred by the Prosecution Team in order to responsibly ascertain (or confirm) the exact nature

and magnitude of the reported Incident, even though the District believes that its initial CIWQS report and other notifications were thorough and accurately described the facts of the Incident. Accordingly, the District is willing to pay some reasonably-related staff costs, which would be additive to the Final Liability Amount proposed above.

III. CONCLUSION

The Prosecution Team's proposed ACL penalty is excessive, unfair and does not "bear a reasonable relationship to the gravity of the violation and the harm to beneficial uses or regulatory program resulting from non-compliance," and is thereby, inconsistent with the stated purpose and intent of the Enforcement Policy.

The District therefore respectfully requests that the October 2012 Incident be sanctioned by this Board as a $3,000 MMP, and not a discretionary ACL penalty. Pursuant to the stipulation between the parties, the District also agrees to pay $15,000 in MMPs for the five MMP Violations (each subject to $3,000) as alleged in the ACLC. The District therefore further requests that this Board order the District to pay $18,000 in MMPs for these six alleged violations.

In the alternative, in the event this Board were to assess and impose a discretionary ACL penalty for the October 2012 Incident, the District respectfully requests that this Board use and consider the factors and adjustments recommended by the District in its ACL penalty calculation. More specifically, the District contends that, given the nature and circumstances of the Incident, the appropriate discretionary ACL penalty would be $1,698, but in no case more than $3,056, plus any reasonable staff costs.

DATED: _____, 2015

MUSICK, PEELER & GARRETT LLP

By: _____
William W. Carter
Anthony H. Trembley
Attorneys for CARPINTERIA SANITARY DISTRICT

Carpinteria Sanitary District
ACLC No. R3-2015-011
District Witness List for May 29, 2015 Hearing

Pursuant to the Final Hearing Procedure, each party has been granted 45 minutes of time for use at hearing.

1. Beverly Hann, P.E. (5 minutes)
Senior Engineer Associate, Carollo Engineers, Inc. – Sacramento, CA

Ms. Hann will testify regarding the content of the District's Technical Report submitted in response to the California Water Code section 13267 order that was prepared by Carollo Engineers based on their independent review.

2. Daniel Hennessy (5 minutes)
Managing Scientist, Anchor QEA, LLC – Bellingham, WA

Mr. Hennessey will testify regarding potential receiving water impacts associated with the October 3, 2012 short-duration loss of disinfection incident, and in particular, the findings and conclusions of Appendix L to District's Technical Report submitted in response to the California Water Code section 13267 order, which contains the independent assessment and evaluation performed by Anchor QEA, LLC and Aquatic Bioassay and Consultant Laboratories, Inc.

3. Peter Von Langen, Ph.D (5 minutes)
Engineering Geologist, Central Coast Regional Water Quality Control Board

The District will seek testimony from Dr. Von Langen regarding the District's compliance history and the operating conditions of its wastewater treatment facility. Mr. Von Langen will also be asked to respond to questions regarding regulation and enforcement efforts for comparable discharges from similar municipal wastewater treatment facilities.

4. Craig Murray, P.E. (20 minutes)
General Manager, Carpinteria Sanitary District.

Mr. Murray will testify regarding the District's operations, compliance history and recent recognition within the municipal wastewater industry. Mr. Murray will also provide testimony relating to the October 2012 Incident at issue and associated response measures and activities, including his review and evaluation of Central Coast Regional Board records relating to recent enforcement actions and violations within that Region for the time period May 2010 to the present.

The District reserves the right to call rebuttal witnesses to respond to any legal argument or testimony by Prosecution Team witnesses. Testimony descriptions reflect the evidentiary stipulations reached in this matter.

Carpinteria Sanitary District
ACLC No. R3-2015-011
District Exhibit List for May 29, 2015 Hearing

Exhibit A: State Water Resources Control Board Water Quality Enforcement Policy (May 20, 2010).

Exhibit B: Various commendations and awards for the District and District Management and Operators, including the following:

2008 California Water Environment Association ("CWEA") State Plant of the Year;
2014 CWEA State Collection System of the Year;
2014 CWEA Tri-Counties Section Plant of the Year;
2014 CWEA Tri-Counties Section Operator of the Year (for District Operator Kenneth Balch); and
2014 Capital Project of the Year for the Rincon Point Septic-to-Sewer Conversion Project.

Exhibit C: Email correspondence dated October 3 and 4, 2012 between the District and the Central Coast Regional Board providing notice of the October 2012 Incident.

Exhibit D: Photos depicting various upgrades to the District's Carpinteria Facility, including the new chemical disinfection system.

Exhibit E: Chemical Disinfection System Replacement – Schedule of Values relating to various upgrades to the District's Carpinteria Facility, including the new chemical disinfection system.

Exhibit F: Email Correspondence dated November 6, 2013 between the District and State Water Board and Central Coast Regional Board in follow-up to the State's inspection of the District's Carpinteria Facility in October 2013.

Exhibit G: Aquatic Bioassays Consulting Laboratories Report, attached as Appendix L to the District's Technical Report submitted in response to California Water Code section 13267 order issued on December 10, 2013.

Exhibit H: Administrative Civil Liability Order R5-2010-0505 in the matter of the City of Chico, Chico Water Pollution Control Plant, Butte County (2010).

Carpinteria Sanitary District
ACLC No. R3-2015-011
District Exhibit List for May 29, 2015 Hearing

Exhibit I: Various State Water and Regional Board, CIWQS and public online reports relating to violations and enforcement actions for the time period 2010 through the present date, including Violation Reports, Enforcement Order Reports and Detailed Administrative Civil Liability Reports.

Exhibit J: Selected pages from District's Discharge Monitoring Report for October 2012 dated November 28, 2012, including notice of the October 2012 Incident.

Exhibit K: Email and letter correspondence dated May 8, 2012 through January 28, 2013 relating to PG Environmental NPDES Compliance Evaluation Inspection Report issued in May 2012 relating to the District's Carpinteria Facility.

The District reserves the right to supplement the above-listed exhibits and/or present rebuttal exhibits and evidence in response to any legal argument or testimony by Prosecution Team witnesses.