UNITED STATES ENVIRONMENTAL PROTECTION AGENCY
WASHINGTON, D.C. 20460

OFFICE OF
INSPECTOR GENERAL

June 9, 2014

The Honorable Rafael Moure-Eraso
Chairperson and Chief Executive Officer
U.S. Chemical Safety and Hazard Investigation Board
2175 K Street, NW, Suite 400
Washington, D.C. 20037-1809

Dear Dr. Moure-Eraso:

The Office of Inspector General is beginning work to update the fiscal year 2014 list of areas we consider to be the key management challenges confronting the U.S. Chemical Safety and Hazard Investigation Board (CSB). We also plan to provide you information on internal control weaknesses for your consideration as a part of your Federal Managers' Financial Integrity Act review. In fiscal year 2013, we identified three management challenges and one internal control weaknesses (see attachment).

The Government Performance and Results Act Modernization Act of 2010 provides a new governmentwide definition of major management challenges. According to the act, major management challenges are programs or management functions, within or across agencies, that have greater vulnerability to waste, fraud, abuse and mismanagement, wherein a failure to perform well could seriously affect the ability of an agency or the federal government to achieve its mission or goals. Internal control weaknesses are deficiencies in internal control activities designed to address and meet internal control standards.

To start our fiscal year 2014 review, we would like to schedule a meeting for June 25, to discuss the update to last year's challenges, along with any new areas that you consider to be management challenges or internal control weaknesses. Your input, along with audit and evaluation reports issued to date, will be used to develop the fiscal year 2014 management challenges and internal control weaknesses.

If you or your staff have any questions, please contact Michael Davis, Director, at (513) 487-2363 or davis.michaeld@epa.gov; or Gloria Taylor-Upshaw, Project Manager, at (404) 562-9842 or taylor-upshaw.gloria@epa.gov.

Sincerely,

Michael D. Davis for

Kevin Christensen
Acting Assistant Inspector General for Audit

Attachment

cc: Mark Griffon, Board Member, CSB
Beth J. Rosenberg, Board Member, CSB
Daniel M. Horowitz, Managing Director, CSB
John Lau, Deputy Managing Director, CSB
Hillary Cohen, Communications Manager, CSB
Anna Brown, Director of Administration and Audit Liaison, CSB
Bea Robinson, Finance Director, CSB
Johnnie Banks, Washington DC Team Lead, Office of Investigations, CSB
Donald Holmstrom, Director, Western Regional Office of Investigations, CSB
Vidisha Parasram, Director, Office of Incident Screening and Selection, CSB
Mark Kaszniak, Director, Office of Recommendations, CSB
Richard C. Loeb, General Counsel, CSB
Arthur A. Elkins Jr., Inspector General
Charles Sheehan, Deputy Inspector General
Aracely Nunez-Mattocks, Chief of Staff, OIG
Alan Larsen, Counsel to the Inspector General
Carolyn Copper, Assistant Inspector General for Program Evaluation
Patricia Hill, Assistant Inspector General for Mission Systems
Patrick Sullivan, Assistant Inspector General for Investigations
Richard Eyermann, Deputy Assistant Inspector General for Audit
Jennifer Kaplan, Deputy Assistant Inspector General for Congressional and Public Affairs
Jeffery Lagda, Congressional and Media Liaison, OIG

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THE INSPECTOR GENERAL

The Honorable Rafael Moure-Eraso, Ph.D.
Chairperson and Chief Executive Officer
U.S. Chemical Safety and Hazard Investigation Board
2175 K Street, NW, Suite 400
Washington, D.C. 20037-1809

Dear Dr. Moure-Eraso:

The U.S. Environmental Protection Agency's Office of Inspector General is providing its recommended fiscal year 2013 management challenges and internal control weaknesses for consideration as part of the Chemical Safety and Hazard Investigation Board's Federal Managers' Financial Integrity Act review. The OIG identified three management challenges and one internal control weakness for FY 2013 (see enclosure). We previously provided you a draft of this documentation, and we considered your comments in finalizing these management challenges and internal control weakness.

The Reports Consolidation Act of 2000 requires our office to report what we consider to be the most serious management and performance challenges facing CSB. We used audit and evaluation work, as well as additional analysis of CSB operations, to arrive at the three management challenges and one internal control weakness. Additional challenges and weaknesses may exist in areas we have not yet reviewed, and other significant findings could result from additional work.

The Government Performance and Results Modernization Act of 2010 (known as GPRA 2010) requires agencies to include the management challenges prepared by their inspectors general in their annual performance plans. The act also requires agencies to identify planned actions to address challenges; performance goals, performance indicators and milestones to measure progress toward resolving the challenges; and the agency official responsible for resolving the challenges. In addition, Office of Management and Budget Circular A-136, *Financial Reporting Requirements,* dated October 27, 2011, requires agencies' performance and accountability reports to include a statement prepared by the inspector general summarizing what the inspector general considers to be the most serious management and performance challenges facing the agency and to briefly assess the agency's progress in addressing those challenges. Comments by the agency head should follow the inspector general's statement and address each inspector general challenge, but the agency head may not modify the inspector general's statement.

GPRA 2010 provides a new governmentwide definition for major management challenges. According to GPRA 2010, major management challenges are programs or management functions, within or across agencies, that have greater vulnerability to waste, fraud, abuse and mismanagement, wherein a failure to perform well could seriously affect the ability of an agency or the federal government to achieve its mission or goals. Internal control weaknesses are deficiencies in internal control activities designed to address and meet internal control standards. In FY 2012, we identified two management challenges and

two internal control weaknesses. Based on your responses to our prior audit recommendations, we have revised and carried over two challenges and one weakness to FY 2013.

Further details concerning CSB's management challenges and internal control weakness are provided in the enclosure. We are available at your convenience to discuss these matters with you or your staff and answer any questions.

Sincerely,

Arthur A. Elkins Jr.

Enclosure

**Enclosure**

***Proposed Management Challenges and Internal Control Weakness***

## Clarifying CSB's Statutory Mandate

The U.S. Chemical Safety and Hazard Investigation Board is not investigating all accidents that fall within its legal jurisdiction. CSB has an investigative "gap" between the number of accidents that it investigates and the number of accidents that fall under its statutory responsibility to investigate. CSB believes it is operating according to its statutory mandate and cites a lack of resources to investigate the additional accidents cited. As stated below, the U.S. Department of Homeland Security Office of Inspector General, the U.S. Government Accountability Office, and the Environmental Protection Agency Office of Inspector General have all identified a gap between the number of accidents that CSB investigates and the number of accidents that fall under its statutory responsibility to investigate. CSB has sought to clarify its mandate to no avail in November 2009 with a letter to Congress and in March 2013 by meeting with congressional staffers. CSB should seek to close its investigative gap between the number of accidents that it investigates and the number of accidents that fall under its statutory responsibility by reprioritizing its resources.

Created under the Clean Air Act Amendments of 1990,[1] CSB began operating in 1998 as an independent federal government organization. The board that governs CSB consists of five members appointed by the President and confirmed by the U.S. Senate. One of the board members serves as the chairperson and chief executive officer. As of April 2013, there were three appointed board members, including the chairperson, and a professional staff of 39.

CSB's mission is to enhance the health and safety of the public, workers, and the environment by determining the root causes of accidental chemical releases and using these findings to promote preventive actions by the private and public sectors. CSB's investigations examine all aspects of chemical accidents, including physical causes such as equipment failures, as well as inadequacies in safety management systems that define safety culture and adherence to government regulations. The board makes safety recommendations to plants, industry organizations, labor groups, and regulatory agencies. Safety recommendations are suggestions for actions to prevent accidents based on lessons learned from each investigation or study.

Pursuant to statutory authority provided in the Clean Air Act Amendments of 1990, CSB "shall … investigate (or cause to be investigated), determine, and report to the public in writing the facts, conditions, and circumstances, and the cause or probable cause, of any accidental chemical release resulting in a fatality, serious injury, or substantial property damages."[2] The CAA also require CSB to issue periodic reports to Congress; federal, state, and local agencies concerned with the safety of chemical production, processing, handling and storage; and other interested persons. These reports should recommend measures to reduce the likelihood or the consequences of accidental releases, and propose corrective steps to make chemical production, processing, handling, and storage as safe and free from risk of injury as possible. CSB must also establish, by regulation, requirements that persons report accidental releases into the ambient air subject to the board's investigatory jurisdiction. The CAA further provides in pertinent part, "In no event shall the Board forego an investigation where an accidental release causes a fatality or serious injury

[1] 42 U.S. Code Section 7412(r) (6).
[2] 42 U.S. Code Section 7412(r) (6) (C) (i).

among the general public, or had the potential to cause substantial property damage or a number of deaths or injuries among the general public."[3]

In 2004, the U.S. Department of Homeland Security Office of Inspector General identified an investigative gap, defined as the difference between the number of accidents the CSB investigates and the number of accidents that fall under CSB's statutory responsibility to investigate. The DHS OIG recommended that CSB develop a plan to describe and address the investigative gap and include the information in future budget submissions to Congress and the Office of Management and Budget.[4]

In fiscal year 2008, the U.S. Government Accountability Office found that CSB had not fully responded to the DHS OIG recommendations to address the investigative gap. GAO recommended that CSB develop a plan to address the investigative gap and request the necessary resources from Congress to meet its statutory mandate or seek an amendment to its statutory mandate.[5]

To implement GAO's recommendation, CSB examined its existing approach to investigating serious chemical accidents and defined a new investigatory methodology to close the gap. The board's traditional model focused exclusively on deployments to major chemical process accident sites, resulting in full investigations lasting more than 1 year. In 2010, CSB investigators began assessing smaller accidents with significant consequences and generating internal reports outlining the details of the accident. Also in 2010, the board initiated three short, focused safety bulletins and case studies on critical issues facing the chemical and petrochemical industries. Using this model, CSB is able to target high-risk industries using data collected from assessments as well as data in the incident-screening database.[6]

CSB believes it is operating according to its statutory mandate, but cites a lack of resources to investigate more than a portion of the accidents that fall within its legal jurisdiction. In FYs 2009 through 2012, we noted that CSB recorded a number of accidents that involved fatalities—to either people employed where the accidents took place or members of the public—for which CSB did not deploy investigators. Table 1 notes the number of instances in which investigations were initiated for accidents involving fatalities compared with the number of accidents for which investigations were not initiated, as well as the percent of instances in which accidents involving fatalities were not investigated.

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[3] 42 U.S. Code Section 7412(r) (6) (E).
[4] DHS OIG, *A Report on the Continuing Development of the U.S. Chemical Safety and Hazard Investigation Board*, OIG-04-04, January 7, 2004, pp. 30–31.
[5] GAO, *Chemical Safety Board—Improvements in Management and Oversight Are Needed*, GAO-08-864R, August 22, 2008, p. 11.
[6] *Final Budget Justification, Fiscal Year 2012*, February 2011, pp. 3–4.

**Table 1: Percent of accidents with fatalities not investigated by fiscal year**

| Fiscal year | Accidents and investigations with fatalities | | | |
|---|---|---|---|---|
| | Initiated | Not initiated * | Total | Percent Not investigated |
| 2012 | 1 | 64 | 65 | 98% |
| 2011 | 5 | 46 | 51 | 90% |
| 2010 | 6 | 32 | 38 | 84% |
| 2009 | 2 | 25 | 27 | 93% |

Sources: CSB budget justifications for FYs 2011, 2012 and 2013; CSB performance and accountability reports for FYs 2009 and 2010; and other supporting data.

* The 64 accidents in FY 2012 involved 80 fatalities; the 46 accidents in FY 2011 involved 52 fatalities; the 32 accidents in FY 2010 involved 38 fatalities; and the 25 accidents in FY 2009 involved 33 fatalities.

In June 2010, CSB stated it was seriously overcommitted in terms of open investigations—with an unsustainable, record-high level of 22 open cases—which necessitated a temporary reduction in new deployments. In addition, CSB agreed to initiate an investigation of the 2010 Deepwater Horizon accident in the Gulf of Mexico as requested by Congress, and this investigation has been unprecedented in terms of scale and cost. CSB communicated to Congress that taking on a large-scale investigation would necessitate "certain extraordinary measures," including possible termination of cases, reassignment of personnel from existing cases, and requesting significant supplemental funds from Congress. Although no supplemental funds were provided, CSB remains committed to this massive case.

CSB stated that it needed to seek additional guidance from OMB and Congress before it commits to a long-term plan of action, and agreed to work with Congress to clarify its statutory mandate. In a letter dated November 5, 2009, CSB requested that Congress clarify CSB's statutory mandate as it relates to investigating chemical accidents.[7] To date, there has been no response from Congress. Since the issuance of its letter to Congress, CSB noted it does not believe the mandate requires it to investigate every incident, but it can select incidents at its discretion based on funding and resources. In our March 2013 meeting, CSB stated it met with congressional staffers to clarify its mandate to no avail. CSB reported that the congressional staffers advised CSB should perform its mission within the approved appropriation. CSB reiterated that the OIG should remove this challenge and, in the event Congress opts to consider reauthorization of the CSB, it will remind Congress of this management challenge. In our draft challenges, we recommended that CSB follow up with relevant congressional committees concerning the status and resolution of this issue or seek to close its investigative gap.

CSB provided the following comments on the draft management challenge:

> The CSB disagrees with this recommendation, and does not believe that its enabling statute, the Clean Air Act Amendments of 1990, 42 U.S.C. § 7412(r) (6),

[7] Letter from the CSB Chairperson to the Chairperson and Ranking Member of the Subcommittee on Superfund, Toxics, and Environmental Health, Committee on Environment and Public Works, United States Senate; and the Chairperson and Ranking Member of the Subcommittee on Energy and Environment, Committee on Energy and Commerce, U.S. House of Representatives; November 5, 2009.

requires the investigation of all accidents that may fall under the agency's statutory jurisdiction.

Moreover, although we have for some time asserted this position to your office, we believe that the Supreme Court recently settled the issue in City of Arlington, *Texas et al. v. Federal Communications Commission et al.,* 569 U.S. ____ (2013). In that decision, the Court relying on *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837 (1984), applied an agency's interpretation of its own statutory jurisdiction. The Court held, applying the *Chevron* doctrine to an ambiguous statute, that it would not upset an agency's permissible construction of its own authorizing legislation and the broad grant of authority entrusted to the agency administering the law.

Accordingly, we believe that this recommendation should now be considered closed.[8]

*Arlington* addresses deference to agency interpretation when a statute is silent or ambiguous as to intended construction. However 42 U.S.C. Sec. 7412(r)(6) is not ambiguous with regard to the issue of scope of cases to be investigated, stating that CSB "shall" investigate. CSB's investigative "gap" between the number of accidents that it chooses to investigate and the number of accidents that fall under its statutory responsibility to investigate increased during the FY 2010 through FY 2012 time period. Although CSB believes it is operating according to its interpretation of its statutory mandate based on the cited case, CSB should seek to close the investigative gap by reprioritizing its resources to investigate accidents with fatalities within its statutory mandate. We will continue to report this issue as a management challenge, until CSB seeks to close its investigative gap.

## Meeting Goal Related to Timely Investigations [9]

Our audit report of CSB's investigative process identified that it is a challenge for CSB to timely complete investigations. CSB does not have an effective management system to meet its established performance goal to "[c]onduct incident investigations and safety studies concerning releases of hazardous chemical substances."[10] Specifically, CSB has not fully accomplished its related strategic objective to "[c]omplete timely, high quality investigations that examine the technical, management systems, organizational, and regulatory causes of chemical incidents."[11] Our review identified five reasons why CSB did not meet its objective to timely complete investigations:

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[8] U.S. Chemical Safety and Hazard Investigation Board, Response to OIG Report on Management Challenges, July 15, 2013, p. 1.
[9] EPA OIG Report, *U.S. Chemical Safety and Hazard Investigation Board Needs to Complete Investigations More Timely,* 13-P-0337, July 30, 2013.
[10] U.S. Chemical Safety and Hazard Investigation Board, 2012-2016 Strategic Plan, June 2012, p. 11.
[11] *Ibid.*, p. 10.

- A lack of defined performance indicators in CSB's annual performance plan, which are necessary to assess the efficiency of its investigations process.
- A backlog of open investigations without documented plans for resolution.
- An average investigative staff turnover rate of 15 percent.
- Non-collocation of files and incorrectly classified or coded investigation files.
- A need for updated policies over current investigative procedures and a policy that defines final investigative products.

We reviewed and compared CSB's accomplishments reported in its FYs 2007 through 2012 performance accountability reports and the status of current and completed investigations. Over a 6-year fiscal period, there has been a steady decrease in the number and percentage of investigations completed in a fiscal year. In 2007, CSB planned 10 investigations and completed them all; in 2012, CSB planned eight investigations but only completed two of them (25 percent) by the end of the fiscal year. CSB has steadily fallen behind in accomplishing its objective related to timeliness. Although CSB states in its strategic plan that it endeavors to complete an investigation as soon as possible, CSB has not clearly defined a "timely completed investigation."

Various federal laws and policies, including the Government Performance and Results Modernization Act of 2010 and GAO's *Standards for Internal Control in the Federal Government*, address how federal agencies should manage and monitor their performance. CSB does not have specific performance indicators to measure the efficiency of its investigative process. As a result, CSB does not have information to identify areas for improvement, plan for future investigations, and allocate resources. In addition, CSB has a backlog of six investigations that have been open for over 3 years. Closing its backlog would provide more time for investigative management to focus on recent and new incidents. Additionally, CSB's electronic investigation files are not in one location and the electronic records were incorrectly classified or coded by staff. CSB investigators use several in-house documents that support its investigation file, such as work plans, scoping documents and recommendation briefs. These documents provide an ongoing investigation status summary of what happened, how it happened, what has been done, and what remains to be done with the timelines and preliminary recommendations to correct the problems found. CSB does not maintain these documents in its electronic investigation file. Lastly, we noted that CSB should address employee concerns and update its policies concerning the investigative process to help with timely completion of investigations.

In our draft challenges, we stated that by completing investigations more timely, CSB can better fulfill its mission and improve its ability to ensure that it provides the community and other stakeholders with findings and recommendations to help reduce the occurrence of similar incidents, which would protect human health and the environment.

CSB provided the following comments on the draft management challenge:

> On June 21, 2013, the CSB commented on the OIG draft Report OA-FY12-0513. In our response, we agreed with the majority of the recommendations and noted that much of what was recommended reflected work that is already in progress at the agency. Please update this management challenge to reflect our recent

> comments. Although the CSB agreed with most of the recommendations, we do not believe that the issues identified by the OIG (such as minor findings about the organization of records) materially contribute to how long it takes to complete CSB investigations. Rather, the overwhelming factor is the overall investigative workload of the agency in comparison with the small number of investigators. We believe it is inappropriate for the OIG to categorize "Meeting Goal Related to Timely Investigations" as a management challenge when the primary causes relate to workload and budgetary issues that are largely outside the CSB's control.[12]

Our report identified several reasons that contributed to CSB not having an effective management system to meet its established performance goal and objective related to completing timely investigations. In the CSB's response to our draft report, CSB stated it currently estimates completing a major investigation in 1.5 to 3 years. According to CSB, "...the overwhelming factor in how quickly investigations can be completed is the agency's staffing level and the constraints on the agency's budget, which following sequestration is less than $10.6 million and has remained largely stagnant, after adjusting for inflation, for more than a decade."

CSB also stated: "Staffing and budget limitations mean that in response to new and unforeseen chemical disasters, our very tiny staff of about 20 investigators is constantly being pulled off existing projects and redeployed to new cases." Workload, staffing, and budgetary constraints are all areas that contribute to the CSB experiencing challenges when trying to meet its performance objective of completing timely investigations. As a result, we selected the lack of completing timely investigations as a management challenge for the CSB.

### Promulgating a Chemical Incident Reporting Regulation

CSB has not published a chemical incident reporting regulation as required in the CAA. In 2008, GAO recommended that CSB publish a regulation requiring facilities to report all chemical accidents. In 2009, CSB notified the public of a proposed reporting regulation. CSB has not yet published the regulation.

The CAA specifically states:

> Establish by regulation requirements binding on persons for reporting accidental releases into the ambient air subject to the Board's investigatory jurisdiction. Reporting releases to the National Response Center, in lieu of the Board directly, shall satisfy such regulations. The National Response Center shall promptly notify the Board of any releases that are within the Board's jurisdiction.[13]

CSB understood that the purpose of the reporting regulation was to inform CSB of major incidents so that it could deploy investigators. However, in its 2008 report, GAO suggested that the reporting regulation offered additional value. GAO stated that the rule would "better inform

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[12] U.S. Chemical Safety and Hazard Investigation Board, Response to OIG Report on Management Challenges, July 15, 2013, p. 1.

[13] 42 U.S. Code Section 7412(r) (6) (C) (iii).

the agency of important details about accidents that it may not receive from current sources." GAO also suggested that the information obtained through the reporting rule could improve CSB's ability to "target its resources, identify trends and patterns in chemical incidents, and prevent future similar accidents." GAO recommended that CSB "publish a regulation requiring facilities to report all chemical accidents, as required by law, to better inform the agency of important details about accidents that it may not receive from current sources." GAO believed a reporting rule would improve surveillance of chemical accidents.[14]

On June 25, 2009, CSB published an advance notice of proposed rulemaking in the Federal Register, seeking comments and information in advance of drafting a proposed regulation to implement the accidental release reporting requirement.[15] In the advance notice of proposed rulemaking from the Federal Register, CSB identified some general approaches for implementing the statutory requirement:

1. A comprehensive approach would require the reporting of information on all accidental releases subject to the CSB's investigatory jurisdiction. CSB expressed concerns that this approach might be unnecessarily broad in scope, may be duplicative of other federal efforts, and may not be necessary for CSB to learn about most significant incidents that would justify an onsite investigation.

2. A targeted approach would require the reporting of basic information for incidents that met significant consequence thresholds. Such an approach would be consistent with that taken by several other federal agencies.

3. A third approach would require owners and operators to report to CSB more extensive information on chemical incidents in their workplaces when notified by CSB. CSB would continue to rely on existing sources to learn initially about chemical incidents, but would follow up on a subset of the incidents to gather additional information through a questionnaire or online form that the reporting party would be required by regulation to complete and submit to CSB.

4. A fourth approach to a reporting requirement could be based upon the presence or release of specified chemicals and threshold amounts. However, CSB investigations have shown that serious consequences may and do result from the release of relatively small amounts of chemicals that may not meet threshold amounts and chemicals that are not likely to be listed.[16]

CSB should consider other chemical incident reporting requirements, the impact such requirements will have on its resources, and the cost effectiveness associated with using an existing chemical incident reporting system.

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[14] GAO, *Chemical Safety Board—Improvements in Management and Oversight Are Needed,* GAO-08-864R, August 22, 2008, pp. 4, 11, 38 and 59.
[15] Federal Register, Volume 74, No. 121, June 25, 2009, Proposed Rule, pp. 30259 - 62.
[16] *Ibid.*, p. 30262.

CSB has not taken steps to publish a proposed rule or to request changes to the requirement in the CAA. CSB stated that during 2012 it intended to develop a written questionnaire that could be sent to sites that experience accidents, and will augment an already robust incident screening process. Depending on the usefulness of the questionnaire, CSB would consider whether it is appropriate to adopt it as part of a future reporting rule. After further considering this issue, CSB believes that it receives adequate incident notifications through constant media and Internet searches, as well as existing federal sources such as the National Response Center. CSB's ability to consider rulemaking and program development in this area has been further impacted by congressional budget cuts and sequestration, which effectively prevent any hiring for a regulatory reporting program. CSB has developed two written questionnaires that are being sent to companies that have incidents on a discretionary basis.

In our draft challenges, we stated that CSB has no further action planned for this challenge. CSB's comments to our draft management challenge did not change from its FY 2012 response. We recommend that if enacting an incident reporting rule is not in the spirit of Executive Orders 13563 and 13610, CSB should either submit a preliminary plan to OMB noting its determination that such a requirement for a rule should be repealed to make the agency's regulatory program more effective, streamlined and less burdensome in achieving its objectives, [17] or follow up with relevant congressional committees on the need for the regulation. We will continue to report this issue as a management challenge until CSB addresses the regulation requirement in its statutory mandate.

## Establishing Internal Controls Related to Program Operations

CSB has not established and implemented a management control program to evaluate and report on the effectiveness of program operation controls. OMB Circular A-123, *Management's Responsibility for Internal Control*, states that internal controls "include program, operational, and administrative areas as well as accounting and financial management."[18] CSB should develop and implement a comprehensive internal control program encompassing systems and processes for program, operational, administrative, accounting, and financial management functions.

In FY 2011, OIG determined that CSB should develop and implement a management control plan to address prior audit recommendations and improve the board's system of management controls.[19] CSB did not take timely corrective actions to address 34 audit recommendations from three OIGs and GAO.[20] In four instances, it took CSB 4 years beyond the agreed-upon corrective

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[17] EPA OIG, *Proposed Fiscal Year 2012 Management Challenges and Internal Control Weaknesses for the Chemical Safety and Hazard Investigation Board,* September 19, 2012, p. 9.

[18] OMB memorandum, "Revisions to OMB Circular A-123, Management's Responsibility for Internal Control," December 24, 2004, p. 4.

[19] EPA OIG, *Chemical Safety and Hazard Investigation Board Did Not Take Effective Corrective Actions on Prior Audit Recommendations*, Report No. 11-P-0115, February 15, 2011, p. 3.

[20] In FY 2004, Congress designated the EPA OIG to serve as the inspector general for CSB. As a result, EPA OIG has the responsibility to audit, evaluate, inspect and investigate CSB's programs, and to review proposed laws and regulations to determine their potential impact on CSB's programs and operations. This includes an annual audit of CSB's financial statements. Prior to FY 2004, the inspectors general for the Federal Emergency Management Agency and the U.S. Department of Homeland Security served as the inspector general for CSB.

actions date (or report date) to implement corrective actions. CSB's actions to address 13 recommendations were not completely effective and required additional corrective actions, and seven recommendations were not yet completed.[21]

In FY 2012, the U.S. Environmental Protection Agency OIG concluded that CSB did not consistently achieve its goals and standards, as outlined in its current strategic plan, for timely implementation of its safety recommendations. As of December 2010, CSB had issued 588 safety recommendations, of which 218 were open while actions were in progress to resolve them. Of the 218 recommendations, 54 were open for more than 5 years. The Government Performance and Results Act of 1993 require federal agencies to have strategic plans, and OMB Circular A-123 requires policies and procedures to ensure effective and efficient internal controls to achieve program results. Although CSB does not have enforcement authority, and implementation of some of its recommendations may face lengthy regulatory processes, CSB has not established or maintained sufficient internal controls and processes related to safety recommendations. Without effective controls and efficient processes, there is an increased likelihood that recipients will not timely implement CSB safety recommendations and, as a result, chemical accidents may not be prevented to the greatest extent possible.[22] In our draft challenges, we recommended that this internal control weakness remain until CSB completes a management control plan.

CSB did not provide an updated response to this internal control weakness. In FY 2012, CSB agreed with the usefulness of a management control plan, which CSB had planned to approve in coordination with its June 2012 Strategic Plan.[23] In accordance with OMB Circular A-123, CSB said it is developing a management control plan to address program operations and improve accountability. Therefore, we will continue to report this issue as an internal control weakness.

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[21] EPA OIG, Report No. 11-P-0115, *op. cit.*, p. 4.

[22] EPA OIG, *U.S. Chemical Safety and Hazard Board Should Improve Its Recommendations Process to Further Its Goal of Chemical Accident Prevention,* Report No. 12-P-0724, August 22, 2012, pp. 3–22.

[23] EPA OIG, *Proposed Fiscal Year 2012 Management Challenges and Internal Control Weaknesses for the Chemical Safety and Hazard Investigation Board,* September 19, 2012, p. 11.