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WEST TEXAS A&M UNIVERSITY

Review of Financial Management Services

Catherine A. Smock, C.P.A.
Chief Auditor
PROJECT SUMMARY

Overview

The controls established over the financial management services’ operations at West Texas A&M University provide reasonable assurance that assets are safeguarded and resources are used in compliance with applicable laws, policies, regulations and rules except in the area of account reconciliations. Significant weaknesses were identified in the periodic reconciliation processes. In addition, significant opportunities exist to improve operational efficiencies in the University’s business operations by automating existing manual processes. Opportunities for improvements were also noted in the areas of cash handling, procurement cards, and receivables.

Summary of Significant Results

Reconciliations

Processes and procedures are not in place to ensure that reconciliations are completed and outstanding items are identified and cleared in a timely manner. Unexplained differences ranging between $200,000 and $300,000 each month for four months in 2011 were noted on the student receivable reconciliations. Periodic reconciliations ensure that all related transactions between two sets of records are appropriate. Without adequate review and monitoring of the reconciliation process, the risk of errors, discrepancies or misappropriations occurring and not being detected is significantly increased.

Processing Efficiencies

Modifications to current business processes should be made to gain significant increases in efficiency. Purchasing and travel advance processes are manual and redundant, creating inefficiencies. The University maintains large working fund balances to facilitate cash based transactions that could be more efficiently processed using electronic accounting transactions. Review of business and accounting processes to use more
electronic and modern banking options would provide for more efficient use of University resources.

Summary of Management’s Response

The University will implement processes and procedures to ensure that reconciliations are completed timely including identifying and clearing outstanding items. Additionally, the University will review potential solutions to improve business process efficiencies and the impact on working fund balances.

Scope

The review of financial management services’ processes focused on reconciliations, accounts payable, accounts receivable, purchasing, revenue management, records retention, working funds, and property management. The audit covered the period January 1, 2010 through May 31, 2011. Fieldwork was conducted from June to August 2011.
OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. Reconciliations

Observation

| Improvements are needed to ensure that reconciliations and clearing of outstanding items are completed timely. |
| Processes and procedures are not in place to ensure that reconciliations are completed and outstanding items are identified and cleared in a timely manner. Unexplained differences ranging between $200,000 and $300,000 each month were found on the monthly February through May 2011 student receivable reconciliations. The differences were later determined to be the result of accounting system processing errors. Outstanding checks from 1995 were still carried on the April 2011 bank reconciliation as well as additional outstanding items dating from July 2010. Periodic reconciliations are necessary to identify differences between two or more sets of records or systems so that appropriate actions can be taken to resolve any discrepancies or outstanding items. Monitoring needs to include procedures to ensure reconciliations are completed, all differences are explained and reconciling items are cleared in an appropriate timeframe. Without adequate review and monitoring procedures, the risks are increased that errors or discrepancies would remain undetected. |
| The University has not completed and submitted an unclaimed property report to the State Comptroller since 2007. The unclaimed property report is required to be completed annually to send information on unclaimed items, such as old outstanding checks on bank reconciliations, to the State Comptroller for resolution. |

Recommendation

| Establish monitoring procedures to ensure that reconciliations are prepared timely and completely, adequately explaining all identified differences, and ensuring that all outstanding items are cleared in a timely manner. |
| Complete unclaimed property reports annually, remitting old outstanding checks to the state as permitted. |
Management’s Response

1. Reconciliations (cont.)

Reconciliation monitoring procedures will be updated by January 1, 2012 to include timely reconciliations and the monitoring of outstanding items. Unclaimed property procedures will be reviewed and updated by April 2012 to include an annual report to be submitted to the State Comptroller.

2. Processing Efficiencies

Observation

Opportunities to gain efficiency exist in the University's business processes.

Modifications to current business processes should be made to gain significant increases in efficiency. Purchasing and travel advance processes are manual and redundant which creates inefficiencies. In addition, the University maintains large working funds to facilitate cash based transactions that could be more efficiently processed using electronic accounting transactions.

All University expenditure requests, including travel, that are not paid for with a procurement card must be manually submitted to Purchasing Services to be processed and approved by the Director of Purchasing regardless of amount. Purchasing Services enters an encumbrance into the accounting system, DataTel, for each purchase. The current process to purchase an item under $5,000 without using the procurement card is as follows:

- The department inputs information into the financial accounting system, Datatel, and prints a paper requisition which is approved by the department head.

- The department sends the paper requisition to Purchasing Services specifying the items(s) and cost.

- One of the buyers reviews the requisition and prints the purchase order (PO).

- The Director of Purchasing reviews the PO, reviews the account for sufficient funds, and manually signs it. If funds are insufficient, he will contact the department head and request a new account number or a fund transfer.

- The Director of Purchasing forwards the signed paper PO to the department.
2. Processing Efficiencies  
(cont.)

- The department orders the item and returns a copy of the paper PO to Purchasing Services once the item is received.

All of the above steps are manual, but could be automated to expedite the purchasing process and eliminate redundancies. Purchase requisitions and vouchers are prepared in Datatel, printed, and manually routed, although the accounting system has the capability for electronic routing. The University also has an imaging system, but it is not currently used in the purchasing/vouchering process.

The travel advance and travel expense reimbursement processes also have opportunities to eliminate manual and redundant procedures to increase efficiencies. Current procedures include the following:

- The travel advance process uses several separate forms with redundant information. These forms are completed, approved and routed at separate times.

- Travel advances are provided to employees as cash transactions rather than issuing checks to employees. Employees must come to the Business Office to receive their cash advance. The Business Office maintains approximately $40,000 in the cash working fund for cash travel advance payments.

- A negative cash receipt is issued to the traveler when they receive the cash travel advance from the Business Office rather than recording the transaction as a disbursement transaction. The employee travel advance receivable is recorded in the accounting system, DataTel, when the negative cash receipt is issued.

- Although travel advance receivables are recorded in Datatel, manual spreadsheets are also maintained and reconciled to the accounting system.

- Travel expense reimbursement vouchers are not adjusted for travel advances. Travel expense reimbursement checks are issued to the traveler for the full amount of travel expenses. If there is an advance, the check is held in the Business Office. The traveler comes to the Business Office to receive their reimbursement check. The traveler endorses the check back to the University. If the expense is greater than the advance, the cashier gives the difference to the traveler in cash. If the advance is greater than the expense, the traveler must pay the cashier the difference.
2. Processing Efficiencies

- The endorsed travel expense reimbursement checks are “cashed” at the bank to put the cash funds back in the Business Office working fund.

Consolidating advance forms, using direct deposit options rather than all cash based transactions, and consolidating financial transactions would increase the overall efficiency and effectiveness of the travel advance and reimbursement process for employees, employee department administrators and the Business Office.

The University also maintains large working funds at both the Business Office ($70,000) and the Bookstore ($40,000). These working funds are significantly more than other working funds maintained at other A&M System universities. Accounting procedures have manual, paper-based components such as writing checks and then depositing them into the University bank account rather than using journal entries or account transfer transactions. In addition, there are procedures to provide cash services which may no longer be necessary in today’s electronic banking environment.

Potential efficiencies may also be gained by the University by moving to a student debit card program administered by a third-party banking institution, as some System members have done, rather than maintaining an in-house debit card included with the Buffalo Gold Card system administered by the University. All student financial aid refunds and student payroll could potentially be processed on the third-party student debit cards. By moving to a third-party debit card, the University would no longer need to process weekly payments to local vendors (approximately 50) that accept the University’s Buffalo Gold Card as payment.

Reviewing business and accounting processes to use more electronic and modern banking options would provide the Business Office personnel more time for review and analysis of transactions as well as providing efficiencies and enhanced customer service for University students, faculty and staff.

**Recommendation**

The University should modify its current business processes to use more electronic and modern business and banking options. Specifically, to improve processing efficiencies, the University should:

- Fully implement electronic routing of purchasing and voucher processes to provide responsible departmental account holders the ability to more efficiently approve purchase and
2. Processing Efficiencies
(cont.)

- Review travel and travel advance processes to eliminate duplicate and manual processing steps. Consolidate forms used for travel and travel advance approvals. Eliminate the use of cash for every travel advance transaction and reduce the Business Office working fund accordingly. Disburse travel advances to travelers via checks, direct deposit transactions or debit/credit cards. Offset travel expenses against outstanding advances and issue travel expense reimbursements to travelers via checks or direct deposit transactions.

- Review cash handling processes to increase efficiency and reduce redundancy. Explore the use of electronic interdepartmental transfers and other methods to eliminate writing checks for redeposit.

- Explore options for student debit cards administered by third-party banking institutions to increase efficiencies and provide additional customer service opportunities for students.

Management’s Response

The University will review current business processes and available technology to identify potential efficiencies in our current work flow processes and improved customer service. The University updated its delegated purchasing authority effective October 2010.

We will review and implement potential electronic approval processes supported by Datatel, Image Now, and other technology available to the University, including studying options and developing work flow processes. Testing and implementation is expected to begin June 2012.

The University is currently implementing new travel processes. With implementation of the State of Texas Citibank Travel Program this fall we elected to make three changes: (1) For individuals who frequently travel during the year, we are requiring application for the use of "individually billed" cards - implemented fall 2011. (2) For employees that do not have access to the individual billed cards, we are providing a travel advance card. (3) We have expanded the use of CBA (centrally billed accounts) for selected travel, commencing fall 2011. These changes should reduce our working fund needs and adjustments will be made, as appropriate, as we implement these changes. Implementation is expected by April 1, 2012.
Management has reviewed card services and believes the current “one card” for multiple purposes provides the best level of customer service for our students. Higher-One is being implemented by some System universities who currently do not have a comprehensive system. Once Higher-One is implemented by other institutions, the University will have an opportunity to compare the cost/benefits of the two systems.

3. Cash Handling

Observation

Weaknesses in cash handling procedures increase the University’s risk of noncompliance and loss of financial resources.

The University’s cash handling processes at the Business Office and the Bookstore need improvements to strengthen controls over cash resources and comply with A&M System requirements.

The University’s current check cashing practices are not in compliance with A&M System regulations which prohibit the cashing of personal checks. Business Office cashiers cash employee personal checks up to $50. The Bookstore customer service desk cashes student personal checks up to $25, student payroll checks up to $200, and student third-party checks up to $300. Check cashing practices were established years ago as a customer service to employees and students. However, there is now an ATM machine in the student center and the University’s depository bank is within several blocks of the campus.

The Business Office did not have documentation of the transfer of fund custodian responsibility for the vault working fund ($70,000) from the Controller to the Bursar who has daily custody and responsibility of the working fund. A&M System regulation requires that records be maintained indicating who has been assigned custody of working funds and changes in custody of working funds.

Temporary working fund increases by the University Bookstore for textbook buyback periods are not returned timely. At the time of our auditor cash count on June 15, 2011, the Bookstore safe included a University check for $13,135, dated May 26, 2011, written to the Bookstore to reimburse the temporary working fund for spring buyback purchases. However, additional cash funds were not needed and the check was not cashed. Rather than reduce the temporary working fund at that time, the check was retained at the Bookstore.

The Bookstore’s textbook buyback process does not include acknowledgement by the seller of the funds they receive for their textbooks. The buybacks are recorded through a cash register;
3. Cash Handling (cont.)

however, there is no record of the person selling the books back to the Bookstore and receiving the funds. Maintaining a record or log of individual textbook buyback purchases and sellers allows for reconciliation and verification of buybacks and reduces the risk of undetected discrepancies and misappropriations.

Recommendation

To improve cash handling processes and ensure compliance with applicable A&M System regulations, the University should:

- Discontinue the cashing of personal, payroll, and third-party checks.
- Maintain documentation for authorization of custody and assignment of responsibility when the primary custodian does not maintain physical custody of the fund.
- Ensure that temporary working fund increases are reduced as soon as possible.
- Obtain customer name, identification, and signature for all textbook buybacks.

Management’s Response

The University will discontinue cashing personal, payroll, and third-party checks effective January 2012.

Management believes that appropriate documentation for authorization of custody and assignment of responsibility based on physical custody of the funds are in place and updated as required. Management also believes that the physical custody of the vault working funds is that of the Controller based on the close location of the Controller to the vault and that the Controller is also responsible for these funds on a daily basis. Additional monitoring procedures will be implemented by December 2011 to provide documentation and assignment of responsibility.

Working fund increases will be monitored. Changes were implemented July 2011 with the Bookstore returning working funds when they are not needed based on the business cycle.

The University Bookstore will obtain customer name, identification and signature for all University Bookstore textbook buybacks beginning January 1, 2012.
4. Procurement Card Management

Observation

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<th>Monitoring of overall procurement card usage and procurement card procedures need improvement.</th>
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The University does not have monitoring processes for overall procurement card usage analysis to determine if limits are appropriate. Analysis of monthly card limits and usage indicates that limits are significantly higher than actual usage for some cards. Nine of 30 monthly billing statements reviewed were not used during either of the two months reviewed. Nine of 15 cards reviewed used less than 50% of the cards’ monthly spending limit during the 17-month period reviewed. One card had a $20,000 monthly spending limit, but had $1,015 as the highest monthly statement amount during the 17-month period reviewed.

Although post payment reviews are performed on all cards each month, procurement card transaction data, available through the credit card reallocation system, is not analyzed for trends or identification of high risk cardholder activity. Proactive and routine monitoring processes are efficient and effective ways to manage the risks associated with the procurement card program, as well as providing timely and useful information for management decisions to achieve overall purchasing program goals and objectives.

The University’s procurement card procedures could be strengthened in the area of gift card purchases. The University procurement card manual does not require documentation and signature of individuals receiving gift cards that were purchased with the procurement card which is a high risk area for fraud. Enhancing procurement card procedures to address gift cards reduces the risk of misappropriation or loss of University assets without timely detection.

The University entered into a contract and implemented an American Express Corporate Charge Card program without obtaining approval from the State Comptroller. Texas Administrative Code requires that an institution of higher education may not enter into a contract for a corporate charge card without approval by the State Comptroller. The University was unaware of the contract restrictions on corporate charge card contracts for institutions of higher education.

Recommendation

| Establish procedures for periodic analysis of procurement card usage to identify high risk areas and determine if limits are |
Management’s Response

With implementation of the State of Texas Citibank Pro Card Program in September 2011, the Purchasing department now has the ability to provide management reports accessed through Citibank reporting tools. Management will review and monitor card activity. Reports to analyze card activity by cardholder and vendor activity will be prepared for management’s review beginning February 2012.

Procedures will be implemented for the purchase and distribution of all gift cards to be effective February 2012.

The use of the American Express Corporate Charge card payment process was discontinued July 2011.

5. Accounts Receivable Collection Procedures

Observation

Accounts receivable collection processes do not ensure outstanding accounts receivable are collected in compliance with A&M System Regulation 21.01.04, Extension of Credit. The University does not have procedures to provide guidance on a tolerance threshold to determine when delinquent accounts should be referred for collections and when to use the state warrant hold process. Collection efforts for past due student receivables were not timely. Spring 2009 past due receivables were not sent to collections until April 2011. A&M System regulations and the Texas Administrative Code require that the State Comptroller’s warrant hold process be used when debts are determined to be delinquent. The loss of University funds due to ineffective collection efforts over accounts receivable is increased without timely collection processes.

Recommendation

Establish accounts receivable monitoring and collection procedures in compliance with A&M System Regulation 21.01.04.
Management’s Response

5. Accounts Receivable Collection Procedures (cont.)

The University will establish accounts receivable monitoring and collection procedures in compliance with A&M System regulation 21.01.04 by March 2012.
BASIS OF REVIEW

Objective

The objective of this audit was to review the financial and management controls over the University’s financial management services' operations to determine if resources are used efficiently and effectively; assets are safeguarded; and compliance is achieved with applicable laws, policies, regulations and rules.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

West Texas A&M University celebrated its centennial year in 2010 with record enrollment. The University offers 61 undergraduate programs, 45 masters’ degree programs and one doctoral program through its five colleges. In academic year 2010, the University had annual expenditures of approximately $113 million.
AUDIT TEAM INFORMATION

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First Quarter Report for Fiscal Year 2012

WEST TEXAS A&M UNIVERSITY

Review of Human Resources

Catherine A. Smock, C.P.A.
Chief Auditor

Project #20111803
PROJECT SUMMARY

Overview

Overall, West Texas A&M University has processes and controls in place to provide reasonable assurance that human resources operations are performed effectively and efficiently and in compliance with applicable laws, policies, regulations, and rules except for its hiring and termination processes. Significant improvements need to be made in the documentation of hiring decisions and consistency of hiring processes, and in the timely cancellation of access to information systems for terminating employees.

Opportunities for improvement were also identified in human resources information systems, completion of Form I-9s, and faculty and staff grievance processes.

The University had approximately 900 faculty and staff employees with combined salaries, wages and benefits of approximately $60 million in fiscal year 2010.

Summary of Significant Results

Hiring Process

Employee hiring files did not contain the appropriate information to support the selection of the employee hired. For the faculty and staff hiring files reviewed, 39 of 40 (98%) had incomplete documentation. Hiring file documentation that was lacking included verification of educational degrees and required credentials, reference checks, interview responses, and applicant ratings or scores. In addition, five new hires (13%) did not have criminal background checks completed prior to the employee’s first day of work. Weaknesses in the University’s hiring process increases the risk that the University cannot demonstrate that the
best qualified candidate is hired and that its hiring decision is supported and well documented.

**Termination Process**

The University’s termination processes are not consistently followed to ensure that all requirements are completed in a timely manner when faculty or staff leave employment. Current controls do not ensure timely removal of access to information systems. Limited guidance and lack of monitoring of employee terminations increases the risk of unauthorized access to information systems which could result in the loss or misuse University resources.

**Summary of Management’s Response**

The University will comply by developing documentation requirements for hiring and will train hiring committee participants to ensure hiring decisions can be justified. In addition, the University will implement a process to ensure access to information systems is removed as soon as possible following employee separations.

**Scope**

The review of human resources at West Texas A&M University focused on both faculty and staff human resources processes for the period May 1, 2010 through April 30, 2011. Areas reviewed included hiring, state-mandated training, performance evaluations, annual reviews, terminations, and grievance processes. Fieldwork was conducted from May to July, 2011.
OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. Hiring Process

Observation

Comprehensive rules, procedures and monitoring processes are needed for faculty and staff hiring.

Hiring files did not contain sufficient information to support the selection of the employee hired and demonstrate that the best qualified candidate was selected in an objective and unbiased evaluation of the candidate’s knowledge, skills, education, abilities, and experience. Current procedures do not address all faculty and staff positions for consistency in hiring processes and do not assign responsibility for all hiring steps. For the faculty and staff hiring files reviewed, 39 of 40 (98%) had incomplete documentation (some had multiple exceptions):

- Twenty-nine (19 faculty, 10 staff) files did not have documentation of reference checks.
- Twenty-eight (8 faculty, 20 staff) files did not have documentation of interview responses.
- Eighteen (staff) files did not have documentation of degree verifications or other minimum job requirement verifications.
- Six (faculty) files did not have documentation of the applicants’ ranking or scores.
- Six (1 faculty, 5 staff) files did not have documentation to verify selective service registration.

Current procedures do not include all necessary documentation requirements. A&M System Regulation 33.99.01 requires that employment decisions be based on job-related factors such as education, experience, knowledge, skills, abilities, license/certification preferences requirements, results of reference checks, and success in previous employment. It also requires that relevant information be retained. Supervisors were not aware of hiring documentation requirements such as completing reference checks and degree verifications which provide corroborative evidence of the applicant’s expertise, accomplishments, and character.
Properly completing the hiring process, including documentation requirements, reduces the risk that supervisors will make poor decisions and not hire the most qualified applicant. Monitoring processes are not in place for timely review of hiring files for all positions to ensure completeness and compliance with hiring procedures and requirements.

Five of 40 (13%) new hires did not have background checks completed prior to the employee’s first day of work. Three (2 faculty, 1 staff) new hires did not have criminal background checks performed, and two (part-time faculty) background checks were performed after the employee began working (7 days). The responsibility for contacting the University Police Department and obtaining criminal background checks was not fully centralized which contributed to the inconsistencies. In addition to Personnel Services and the Student Employment Office, various hiring departments contacted the University Police Department for background checks. Criminal background checks must be performed for each potential new hire with the information obtained remaining confidential and following stringent distribution and retention requirements. Without a centralized process for conducting background checks, Personnel Services cannot ensure background checks are completed prior to employment as required by A&M System Regulation 33.99.14 and the applicant’s personal information remains confidential and retained in accordance with the State of Texas Records Retention Schedule.

When the hiring of part-time staff positions is processed by the individual hiring department, Personnel Services does not participate in the hiring process and the hiring file is not maintained or monitored by Personnel Services to ensure compliance with applicable hiring laws and requirements. One part-time staff position, processed through the hiring department rather than Personnel Services, was lacking completion of hiring requirements. The position was not posted with the Texas Workforce Commission, there was no application on file, interview questions and answers were not documented, a criminal background check was not performed, the Form I-9 was not completed by the third day of employment, and the employee information sheet was not signed.

In addition, signed offer letters were not obtained for staff employees to document the employment offer and acceptance. Management was not aware of the benefits of obtaining signed offer letters for staff employees. Offer letters, signed by both parties, provide an effective communication tool documenting understanding and agreement to the terms and conditions of the employment offer.
Recommendation

1. Hiring Process (cont.)

To improve the hiring process for faculty and staff, the University should:

- Establish comprehensive rules and procedures to address the documentation requirements for the faculty and staff hiring processes and the timely monitoring of hiring files.

- Require hiring supervisors to periodically attend training on the hiring process which includes training on the documentation that should be completed and properly retained.

- Require that all staff hires (full- and part-time) be processed through Personnel Services, and establish procedures to monitor and detect staff hires that have not been approved and processed through Personnel Services.

- Establish centralized procedures for obtaining criminal background checks and monitor to ensure that background checks are obtained prior to the employee’s first day of employment.

- Obtain signed offer letters for new staff employees.

Management’s Response

By March 1, 2012, comprehensive rules and procedures will be implemented to address the documentation requirements for faculty and staff hiring processes and timely monitoring of hiring files. All hiring supervisors who currently have posted positions and have not completed the A&M System online training, “Effective Hiring Practices”, within the past six months will be required to do so. This training will be required every two years, thereafter. A process will also be implemented for the collection and review of documentation supporting the hiring process (i.e., interview questions, degree verification, reference checks, applicant rating) by Human Resources. Procedures will be established to monitor and detect staff hires that have not been approved and processed through Human Resources. By March 1, 2012, a centralized procedure will be established for obtaining criminal history background checks prior to employees’ first day of employment. By March 1, 2012, the University will develop and implement procedures to obtain offer letters.
2. Termination Process

Observation

The University’s termination processes are not consistently followed to ensure that all requirements are completed in a timely manner when faculty and staff leave employment. The following exceptions were noted during a review of 30 terminated faculty and staff employee files:

- Eleven (36%) terminated employees did not have access to information technology or other systems removed timely (some had multiple exceptions). Eleven employees did not have computer access to the active directory deactivated within one business day of termination, taking between 2 and 22 days to remove access. Three employees did not have access to the financial accounting system removed timely, and one employee’s ID card that included building access and a debit account was not deactivated timely, taking 16 days to deactivate.

- Departments do not always provide timely notification to Personnel Services that employees are terminating. In addition, the current procedures do not include verification that access has been terminated. Although the University’s Information Technology Office has implemented a monthly process to ensure that all terminated employees have their access to information systems terminated within 30 days, more timely access termination is necessary to reduce the risk of unauthorized access to confidential information and noncompliance with state and A&M System requirements.

- Three (10%) terminated employees had active WTAMU Works accounts, the web-based human resources system (People Admin). Account deactivation for WTAMU Works was not included as part of the termination process nor was there a periodic review of active users to ensure the continued need for access. Monitoring of active user accounts in information systems ensures that access to personal and confidential information is appropriate, and the information remains secure, therefore reducing the likelihood of unauthorized access.

- Seven (23%) terminated employee files did not contain a completed termination checklist. Four of these files were also missing the property clearance form. There was no process in place to ensure that all necessary checklists were completed before the exit process was final. Without standardized

Improvements are needed to ensure all steps in the termination processes are consistently completed in a timely manner.
processes in place to ensure all employees complete the termination process, the risk that required steps have been overlooked is increased.

The University’s termination procedures also included retention of the employee’s final paycheck and lump sum vacation pay until all paperwork is completed. Management has instituted this procedure to ensure terminating employees complete all out-processing steps before they leave; however, this increases the risk of penalties or fines resulting from noncompliance with labor laws that prohibit holding employee paychecks.

Recommendation

To improve the termination process the University should:

- Ensure access to information and financial systems are cancelled immediately when employees terminate, and monitor to ensure timely cancellation.
- Ensure that termination checklists are consistently completed before finalizing the termination process.
- Revise termination procedures to ensure that final paychecks and lump sum vacation payments are issued to terminating employees in compliance with laws, policies and regulations.

Management’s Response

West Texas A&M University has formal termination procedures. The termination procedures include final checkout from the department, as well as procedures limiting access to computer information. Since the University is prohibited by law from holding the employees final paycheck until the termination procedures have been properly completed, we are limited in our ability to insure the terminating employee is in compliance with the termination process.

The University has developed a process where monthly payrolls are compared to employee access to computer information as an additional check in the termination process. The University will continue to seek best practices, but have noted this is a problem across the Texas A&M University System. The University will reinforce termination processes to all departments by February 1, 2012.
3. Human Resources Procedures

Observation

There is a lack of documented procedures for the University’s web-based human resource system, WTAMU Works (People Admin), which is administered by Personnel Services. Personnel Services has not developed documented procedures for granting and removing access, and monitoring accounts for the appropriate level of access. The password parameters for WTAMU Works allowed six character passwords and enforced a password change annually, which is not compliant with WTAMU SAP 24.99.99.W1.16 Information Resources – Identification/Authentication, which outlines password procedures and guidelines.

In addition, University procedures for faculty and staff grievances are not in compliance with A&M System Regulation 32.01.02. The A&M System regulation requires that a non-faculty grievance be filed within seven business days of the date of action that caused the complaint. However, the University’s rule allows for a consulting process with the Vice President for Business and Finance, and then requires the grievance to be filed within seven days of meeting with the Vice President for Business and Finance. A&M System Regulation 32.01.01 requires that the grievance committee who reviews faculty grievances be selected by the president; however, the WTAMU faculty handbook states that the president of the faculty senate selects the grievance committee members. Without periodic review and updating of documented procedures, the risk is increased that important procedures and guidelines will be bypassed, incompletely performed, or inappropriately handled.

Recommendation

Establish documented procedures for administration of WTAMU Works in compliance with information technology requirements established by the University and Texas Administrative Code.

Review and update faculty and staff grievance procedures for compliance with A&M System regulations.

Management’s Response

By February 1, 2012, department heads will be required to review and verify the “User Types” assigned to their employees in PeopleAdmin (WTAMU Works) to ensure the assigned “User Types”
are still valid, based on the employees’ current job responsibilities. This process will be completed annually, thereafter. The faculty and staff grievance procedures have been revised, as of September 13, 2011 to comply with A&M System Regulation 31.01.01 and have been submitted to Office of General Counsel for review and approval.

4. Records Retention

Observation

Records are not maintained and destroyed in accordance with the System Records Retention Schedule. Personnel Services currently maintains complete personnel records of former employees dating back to the 1950’s. Maintaining complete personnel documents beyond the records retention requirements increases the risk that confidential personal information is mishandled or compromised, noncompliance with System Regulation 61.99, and is an inefficient use of space and resources.

The System Records Retention Schedule, which complies with the State of Texas Records Retention Schedule, identifies the minimum information needed to verify employment including name, social security number, exact dates of employment, last known address, and most recent public access options form. No additional information is required to be maintained. These five pieces of information can be kept on an Excel spreadsheet.

Recommendation

Properly dispose of personnel files and records in accordance with the A&M System’s Records Retention Schedule and other external requirements. Consider having the University records officer consult with the A&M System records management officer as necessary for guidance on the retention and disposition of personnel files and other state records.

Management’s Response

By November 1, 2012, the University will review personnel files and records for retention purposes in compliance with the System regulation. The A&M System records management officer will be consulted, as necessary.
5. Payroll Processing Efficiency

Observation

Opportunities exist to improve the efficiency of certain payroll processes.

The University is using a manual rather than electronic payroll change process. Paper forms from the Budget/Personnel/Payroll system (B/P/P) are printed and routed for manual signatures and approvals. The electronic Employee Payroll Action (EPA) process is available and could replace the manual forms. The EPA system is an efficient method of routing payroll actions for approvals as well as providing electronic document storage and easier access to the information as it is needed.

Recommendation

Consider options for using the electronic processes to route and retain forms for increased efficiency.

Management’s Response

West Texas A&M University will explore all the options for using electronic processes to route and retain forms to achieve the maximum efficiency possible. We will analyze and consider all options for implementation by June 1, 2012.
BASIS OF REVIEW

Objective

The objective of the audit was to analyze the University’s management processes over human resources to determine if strategic and operational results and outcomes are achieved in an efficient and effective manner, and to determine compliance with laws, policies, regulations, and rules.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The University’s Personnel Services reports to the Vice President for Business and Finance. Human resources functions are generally centrally performed and monitored to ensure compliance with laws, policies, regulations, rules, and procedures by Personnel Services for staff and the Office of Academic Affairs for faculty.

The University had approximately 900 faculty and staff employees with combined salaries, wages and benefits of approximately $60 million in fiscal year 2010.
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First Quarter Report for Fiscal Year 2012

TEXAS A&M UNIVERSITY - KINGSVILLE

Review of University Facilities

Catherine A. Smock, C.P.A.
Chief Auditor
PROJECT SUMMARY

Overview

Texas A&M University – Kingsville has controls and processes in place over University Facilities’ operations to provide reasonable assurance that resources are used efficiently and effectively and in compliance with laws, policies, regulations, and rules except in the areas of warehouse inventory management and employee safety training. Weak controls over warehouse inventory operations increase the risk of inappropriate and inefficient use of inventory resources. The absence of safety training could result in employees not being prepared to handle hazardous materials, creating an increased risk of injuries and property damage. Other improvements needed include further development of the Engineering and Planning billing rate and associated procedures, timely close out of work orders, and documentation of construction project management.

University Facilities has approximately 100 full-time staff and had operating expenses of approximately $9.4 million according to the fiscal year 2010 annual financial report. The department performs a wide range of services to the University including building maintenance, custodial, utilities, grounds maintenance, and general services and minor construction projects.

Summary of Significant Results

Warehouse Inventory

Controls over warehouse inventory processes are weak and require improvement to ensure that resources are properly accounted for and used efficiently and effectively to achieve the department’s objectives. Improvements needed include completion of comprehensive written inventory control procedures, maintaining updated and accurate perpetual inventory records, periodically counting and reconciling physical inventory to the inventory records, and proper management of surplus and obsolete inventory items. Weaknesses in controls over the
Physical Plant’s warehouse inventory operations increase the risk for inappropriate and inefficient use of inventory resources.

Employee Safety Training

Adequate controls are not in place over employee safety training processes to ensure that all necessary safety training is completed and documented in a timely manner. New employees potentially exposed to hazardous chemicals and bloodborne pathogens did not receive training timely after hire and annual recurring training was not taken by current employees. Safety training is an important preventative control to ensure the safety of all affected employees.

Summary of Management’s Response

Management acknowledges the need for improvement in the areas of inventory management and safety training and has begun implementing action plans to address all audit recommendations.

Policy and control procedures will be finalized for shop inventory and additional training will be arranged for shop staff on the tracking of inventory. The policy will identify the need for annual counts and random spot checks and procedures will include a separation of duties requirement during all counts. Additionally, the University is considering the potential for outsourcing inventory management.

Shortly after the audit, a full annual count was completed as well as a complete purge of obsolete materials from shop stock to surplus. Project and consigned materials were separated from shop stock for easier identification and counting. On-hand adjustments for the annual count were conducted and entered into TMA Systems. Documentation has been filed for perpetual inventory records.

Employee safety training has been reviewed and steps have been taken to ensure the gaps between hiring and training are closed. Upon hire, employees required to work with hazardous chemicals and/or may be exposed to bloodborne pathogens will automatically have their TrainTraq profiles updated to include these mandatory trainings. Follow-up trainings will also be assigned and tracked through TrainTraq.

Scope

The review of financial and management controls within the University Facilities’ operations focused on the areas of warehouse inventory management, billing rates and cost.
allocations, construction administration, procurement card processes, employee certifications, safety training, and work order system and deferred maintenance processes. Transactions and activities related to these areas were reviewed for the period of June 1, 2010 through May 31, 2011. Fieldwork was conducted in July 2011.
OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. Warehouse Inventory

Observation

<table>
<thead>
<tr>
<th>Controls over warehouse inventory processes are weak and require improvement.</th>
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</table>

Controls over warehouse inventory processes are weak and require improvement to ensure that resources, valued at approximately $101,000 as of the audit, are properly accounted for and used efficiently and effectively to achieve the department’s objectives. Inventory listings in use were not accurate. The quantity on hand for seventeen of thirty-six (47%) items tested did not agree to the inventory listing with variances being greater than 10% of physical count and $100 in value. A process for periodically reconciling between the inventory listing and physical inventory counts has not been formalized. In addition, construction surplus items were identified which were not included in the inventory listing and obsolete items were noted throughout the Physical Plant shops. Two Physical Plant shops, Grounds and Carpentry, reported no inventory according to the listing although inventory items were held in the shops. The lack of controls and inaccurate information also limits the ability to establish accurate inventory reorder points for items which are regularly kept in stock.

Comprehensive written procedures regarding inventory processes are currently being drafted. In addition, the University implemented a newer version of The Maintenance Authority (TMA) work order system in November 2010 and at that time began using the inventory module of the software. Physical Plant employees do not yet have a full understanding of the inventory process and the necessary related controls.

Lack of adequate controls over the Physical Plant’s warehouse inventory operations increases the risk for inappropriate and inefficient use of inventory resources. The Committee of Sponsoring Organizations (COSO) Report, Internal Control – Integrated Framework, states that as a physical control – “Equipment, inventories, securities, cash and other assets are secured physically, and periodically counted and compared with amounts shown on control records.”
Recommendation

1. Warehouse Inventory (cont.)

Complete written procedures regarding inventory management including performance of periodic inventory spot checks and an annual full inventory count. Ensure the procedures are disseminated to all Physical Plant employees.

Ensure current inventory items in the Physical Plant shops are correctly accounted for in the warehouse inventory listing.

Perform both spot and annual inventory counts in accordance with procedures. Promptly investigate and correct all differences noted.

Add excess supplies that have continuing value to the University such as those remaining from construction projects, other departments or Physical Plant activities to the inventory records to ensure those items are properly safeguarded and accounted for.

Identify all obsolete items and send to surplus in order to reduce the amount of inventory that must be tracked and controlled.

Ensure warehouse staff has the necessary knowledge, skills and abilities to perform their duties, and provide training as needed on the work order system and inventory management processes.

Management’s Response

Written procedures on inventory management will be reviewed to ensure necessary information regarding spot checks and annual counts are included. These procedures will be finalized and disseminated to all staff.

A full count was recently completed and all inventory items were entered into the TMA System. Within TMA, separate warehouses were created for easier tracking of non-physical plant stock. All project stock and consigned items were also physically separated from shop stock for better identification, counting and reconciliation. Obsolete items were removed from shop inventories and will be auctioned according to University policy.

Additional training for shop personnel will be provided and documented.

Physical Plant is also investigating the feasibility and benefits of an integrated supply system. Potential benefits include expert management of warehouse operations, reduced just-in-time runs for needed supplies, reduction of inventory costs, agreed-upon pricing
1. Warehouse Inventory (cont.)

from a wholesale distributor, and onsite personnel to assist with product needs.

The basic recommendations have been addressed. The decision on outsourcing inventory management will be made before September 1, 2012.

2. Employee Safety Training

Observation

<table>
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<tr>
<th>Monitoring processes are not in place to ensure that all necessary safety training is completed in a timely manner. Three of three (100%) newly hired Physical Plant employees did not complete initial bloodborne pathogen (BBP) training in a timely manner. The time between the initial hire date and training date was 123 and 138 business days for two of the employees while the third employee had no evidence training was completed during his six months of employment. Eight of eight (100%) newly hired Physical Plant employees did not receive initial hazard communication (HazCom) training. These employees were hired between June 2010 and February 2011.</th>
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<tbody>
<tr>
<td>Three of ten (30%) Physical Plant employees and twenty of twenty (100%) Physical Plant employees did not receive annual BBP and HazCom refresher training, respectively. HazCom refresher training is typically provided during the Annual Safety Stand Down Day coordinated by the Environmental Health and Safety Office. Although the Safety Stand Down Day was held in late 2010, HazCom training was not included as a topic. Neither HazCom nor BBP training was provided as stand-alone training during the past year.</td>
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<tr>
<td>The Physical Plant does not have a process in place to ensure employees receive initial and refresher trainings in a timely manner. Texas Administrative Code, Title 25 Health Services, Rule 295.7 requires that employers develop a hazard communication program to provide training for new or newly assigned employees which must be completed prior to assigning any duties that may result in exposure to hazardous chemicals. Without periodic training, employees may not be fully prepared to handle situations involving hazardous materials resulting in increased risk of injuries and property damage. University procedures require employees assigned to specific departments to complete both initial and annual refresher courses for BBP and HazCom training.</td>
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**Initial and annual safety training courses were either incomplete or untimely.**
Recommendation

2. Employee Safety Training (cont.)

| Develop standardized guidelines for newly hired University Facilities’ employees including a timeframe in which necessary trainings must be completed. Continue current efforts to utilize the automated features in TrainTraq to monitor and track employee safety training, both initial and recurring, for timely completion. |

Management’s Response

| The basic recommendations have been addressed. Physical Plant has worked with the Departments of Risk Management and Human Resources to ensure all new personnel that require HazCom and bloodborne pathogen training receive it in a timely manner, via TrainTraq. TrainTraq will also be utilized for the tracking of all annual refresher training. |

3. Billing Rates

Observation

| Certain rate procedures are not in place and the Engineering and Planning billing rate is not inclusive of all overhead costs. |

| Comprehensive written procedures have not been developed for allocation of utility costs or establishment of the Engineering and Planning project management rate. In addition, the Engineering and Planning project management rate, first developed in 2010 as a result of separating Engineering and Planning activities from Physical Plant, was based solely on salary and benefit expenses incurred in 2010 as compared to total vouchers paid on construction projects for the past three fiscal years. This rate should be inclusive of all overhead costs incurred in overseeing construction projects including administrative salaries, depreciation, office supplies, and other indirect service expenses. Service rates in place for Physical Plant operations appeared to be inclusive of necessary costs and had been reviewed within the last year. |

| Adequate cost allocation processes are important to ensure that customers are properly billed and that University Facilities receives appropriate cost recovery for services performed. This also helps ensure that education and general funds are not indirectly used to subsidize auxiliary enterprises, which is prohibited by the state’s General Appropriations Act. A&M System Regulation 21.01.05, Service Departments, states that each System member is responsible for establishing user rates, maintaining proper documentation of rate calculations, verifying that rates are not discriminatory towards different groups of users, and periodically reviewing operations for compliance. |
Recommendation

3. Billing Rates (cont.)

Develop comprehensive procedures for the allocation of utility costs and development of the Engineering and Planning project management rate. This documentation should include references to supporting schedules and accounting records used to establish rates and allocate costs including indirect costs such as overhead and depreciation.

Ensure the Engineering and Planning project management rate is inclusive of both direct and indirect costs such as salaries and wages, depreciation, and office supplies. Retain documentation used in the development of the rate, including supporting schedules and accounting records used to establish the rate. Review and adjust the rate, as necessary, on an annual basis.

Ensure the requirements in A&M System Regulation 21.01.05, Service Departments, are incorporated into the rate setting and documentation process.

Management's Response

The University has developed a robust model for charging of utilities and will document this methodology and the procedures used to bill the various entities. Management will also develop a project charge rate based on the same model currently used by Physical Plant operations for their services which will include overhead expenses. These procedures and rates will be created, documented, reviewed and approved for implementation by August 31, 2012.

4. Work Order System

Observation

Works orders are not closed out in a timely manner.

Physical Plant work orders are not being closed out in a timely manner. An aging of open work orders as of July 5, 2011 revealed that 20% (387 of 1906) were greater than 60 days old. The Heating, Ventilation, and Air Conditioning and Plumbing shops comprised 61% of the open work orders. It is management's goal to complete 90% of work orders within thirty days of submission of the order.

Management indicated the length of outstanding work orders could be due to delays in finalization of documentation. While the work may be performed timely, shop supervisors and/or superintendents must complete documentation within the University’s work order system to fully close out the work order. Only upon full close out of
4. Work Order System (cont.)

a work order does the billing cycle begin for Physical Plant to receive payment for services. The work order system allows entry of both work completion dates and work order close out dates; however, the work completion dates are not regularly entered.

According to the National Association of College and University Business Officers, a work order system is a comprehensive tool for managing operations and maintenance through the process of budgeting, initiating, planning, scheduling, executing, and reporting of work. Poor turnaround in the completion of physical work or documentation close out could result in customer dissatisfaction and unnecessary delays in the billing cycle.

Recommendation

Research existing open work orders and take necessary actions to close out aged work orders. Implement a procedure to regularly monitor and address open work orders in a timely manner. Ensure dates the work was actually completed are entered in the University's work order system to allow better tracking of work order turnaround, both for physical completion of the work as well as final close out of the order.

Management’s Response

Physical Plant has been implementing new processes and procedures within a new Work Center that will help ensure all work orders are closed in a timely manner after completion. An aging work orders report will be printed and reviewed monthly to determine if any action is necessary on open work orders. The Work Center will also modify current operating procedures regarding the recording of both work order completion dates and work order closed dates.

The programmatic aspects of this action have been completed. The actual management review has been delayed due to two recent key vacancies. Once these vacancies are filled, the complete solution will be implemented. We anticipate that the vacant positions will be filled by June 1, 2012.

5. Construction Project Management

Observation

Documentation of construction project management was not administered in accordance with certain provisions of the A&M System “Uniform General and Supplementary Conditions” for
5. Construction Project Management (cont.)

construction projects. Testing was performed on six of the forty-one (15%) construction projects completed during the audit period which had a total value of approximately $5.1 million. Six of six (100%) projects had no documented evidence that inspections took place prior to substantial completion of the work or were inspected after completion of the final punch list. Three of six (50%) projects had no documented evidence that the contractor issued a contractor’s general warranty and guarantee to make repairs within one year from the date of substantial completion of work.

Management has implemented the use of a checklist to provide general guidance for management of construction projects; however, monitoring processes are not in place to ensure all required items are included in the construction project files. Without supporting documentation, the University could encounter difficulty in proving proper, thorough inspections were performed and requiring contractors to perform repairs as required by the general warranty and guarantee.

**Recommendation**

Ensure documentation of project inspections is retained for inspections performed both during construction as well as after completion of the final punch list. Maintain evidence of each contractor's general warranty and guarantee to make repairs within one year from the date of substantial completion of work.

**Management’s Response**

*The basic recommendations have been addressed. As an immediate response, management has developed a more sophisticated file management system which includes checklists and documented milestones. Training on project documentation requirements has been and continues to be required of all project managers. The best solution will involve a construction project management system. The Ebuilder program has been introduced and is being used on a trial basis. The A&M System Facilities Planning & Construction division is also pursuing a programmatic solution to construction documentation. The University believes that its file management system will meet the basic requirements, but will continue to consider other programmatic solutions.*
6. Construction Contract Language

Observation

<table>
<thead>
<tr>
<th>Construction contract requirements should be strengthened.</th>
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<tr>
<td>The contract for construction projects used between the University and its general contractors does not include clauses that provide for the right-to-audit and business ethics expectations. Management was not aware of the need to include such contract clauses. Absence of these direct provisions could result in the University being held liable for intentional or unintentional unethical behaviors including billing errors, fraudulent activities, and noncompliance with State of Texas laws, A&amp;M System policies and regulations, and contract provisions. Inclusion of right-to-audit and business ethics expectations clauses is considered standard business practice in construction contract provisions.</td>
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Recommendation

| To reduce risks associated with construction projects, consult with the System Office of General Counsel regarding the incorporation of the right-to-audit and business ethics expectation clauses within construction contracts or other contract documents, such as the System Uniform General and Supplementary Conditions. |

Management’s Response

| The University has submitted one contract for review and has received approval by the System Office of General Counsel (OGC) which did not include the referenced clauses. Management will resubmit the latest approved template for consideration of additional clauses. There are several other contract templates that need to be revised; especially when considering some recent legislative changes. The University will work with OGC to implement clauses that will protect the University and the A&M System. The University will recommend that clauses concerning audit and ethics be included in contracts greater than $100,000. |

| The review and approval of contract templates should be completed by September 1, 2012. |

BASIS OF REVIEW

Objective

The objective of the audit was to review and assess the University’s financial and management controls over University Facilities’ operations to determine if resources are used efficiently and effectively and in compliance with laws, policies, regulations, and rules.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System; Texas Administrative Code; Texas A&M University – Kingsville’s Rules and procedures; the Texas A&M University System’s “Uniform General and Supplementary Conditions” for construction projects; the Treadway Commission’s Committee of Sponsoring Organization’s Internal Control – Integrated Framework (COSO); the National Association of College and University Business Officers practices; and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

University Facilities is comprised of approximately 100 full-time positions that report to the Executive Director of Support Services who in turn reports to the Vice President of Finance and Administration. The mission of University Facilities is to assess, plan, and improve the appearance, safety, security, and operational condition of all University facilities enhancing the environment for quality living and academic programs. To achieve this mission, University Facilities has two primary functional divisions which provide most of the facilities’ operations for the University. The two divisions are Engineering and Planning and Physical Plant. The
Physical Plant is further divided into eleven shops including Electrical; Plumbing; Heating, Ventilation, and Air Conditioning; General Repair; Painting; Carpentry; Locksmith; Auto Tech; Service Work; Grounds; and Custodial. Fiscal year 2010 operation and maintenance of plant expenses totaled approximately $9.4 million according to the annual financial report.
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Mr. Robert Ramirez, Associate Director of Physical Plant
Texas A&M University – Corpus Christi

Review of Physical Plant Operations

Catherine A. Smock, C.P.A.
Chief Auditor
PROJECT SUMMARY

Overview

Texas A&M University – Corpus Christi was in the process of transitioning their Physical Plant operations during this review to ensure financial and management controls over resources are used efficiently, effectively, and in compliance with laws, policies, regulations, and rules. Recent changes include a new leadership team and the drafting of new operating procedures which should help improve future operations. During this audit period, it was noted that significant improvements need to be made in the construction project management process. Opportunities for improvement also exist in the areas of staff safety training, facilities assessment and maintenance, and construction contract language.

The University’s Physical Plant has approximately 100 full-time staff and operating expenditures of approximately $9 million. The department performs a wide range of services and activities including facilities support, planning and construction services, custodial services, grounds maintenance, and facilities maintenance.

Summary of Significant Results

Construction Project Management

University construction projects were not administered in accordance with certain provisions of the A&M System “Uniform General and Supplementary Conditions” (UGSC) for construction projects. Overall, the construction project files were not well organized, and did not contain documentation to support that required procedures were performed. Our testing of 28 construction project files resulted in significant exception rates for several construction related requirements, such as final inspections. Without a formal standardized process for the management of all construction projects, the University’s risk is increased for noncompliance with construction requirements, unforeseen liabilities, and undetected errors in the quality of construction projects.
Summary of Management’s Response

The University agrees with the recommendations and will make improvements in the construction management process, and in the other areas identified in this report.

Scope

The review of financial and management controls within the University’s Physical Plant focused on the areas of maintenance; construction administration; service contracts; cost accounting; supply inventory; procurement card transactions; employee licenses, certifications, and safety training; and performance measures. Transactions and activities related to these areas were reviewed for the period of September 1, 2009 through December 31, 2010. Fieldwork was conducted from March to May, 2011.
OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. Construction Project Management

Observation

University construction projects were not administered in accordance with certain provisions of the A&M System “Uniform General and Supplementary Conditions” (UGSC) for construction projects. Testing was performed on 28 of 69 construction projects totaling approximately $3.2 million. Overall, the construction project files were not well organized, and did not contain documentation to support that required procedures had been completed. The following exceptions were noted in our review of the construction project files:

- Eighty-two percent (23 of 28) of the project files had no documentation to support that inspections were completed, including final inspections and punch list items at the end of the project.

- Sixty-seven percent (10 of 15) of the Job Order Contractor project files did not contain the “Notice to Proceed” form which documents that Physical Plant management has approved the project to start.

- Forty-seven percent (7 of 15) of the Job Order Contractor project files did not contain the “Facilities Modification Request” form that the requesting department sends to Physical Plant identifying the work they would like to have performed.

- One-hundred percent (13 of 13) of the General Contractor project files did not contain documentation that the Certificate of Insurance was in effect through the warranty period, which is one year after the completion date. In addition, there was no indication that an inspection was conducted near the end of the warranty period to identify any defects for the General Contractor to correct, which could reduce the University’s future liability for such defects.

During the audit period, the Physical Plant’s Planning and Construction area had experienced turnover in several key positions. Additionally, Planning and Construction was in the
1. Construction Project Management (cont.)

process of developing written procedures, which were in the review and approval process, to guide operations and ensure compliance with the A&M System UGSC and provide better supporting documentation of the construction project process. Incomplete construction project files make it difficult to determine if all required project management processes have been carried out. Without a more formal standardized process, the University increases the risk of noncompliance with requirements, unforeseen liabilities, and undetected errors in the quality of the construction project.

Recommendation

Finalize and implement the written procedures and checklists that are currently in draft form to improve the organization and consistency of the construction project management activity.

Monitor construction project activities and files to ensure compliance with the newly implemented procedures and checklists.

Management’s Response

Written procedures and checklists that are in compliance with the A&M System Uniform General and Supplementary Conditions (UGSC) are currently in draft form and will be formally implemented by February 28, 2012.

To facilitate project management processes, all files for fiscal year 2012 and beyond will have a project checklist. These checklists will be reviewed to determine that all documents and processes have been completed. Starting January 2012, the construction project management files will be internally audited for completeness.

2. Safety Training

Observation

Annual refresher training for hazard communication and blood borne pathogen training was not completed.

A review of employee training records indicated nine of thirty (30%) Physical Plant employees did not complete the annual hazard communication refresher training, and eleven of thirty (37%) did not complete the required annual blood borne pathogen refresher training. The lack of completed training was due to staffing shortages which hindered attendance at times and limited monitoring by management due to key position transitions. Without periodic training, employees may not be fully prepared to handle situations involving hazardous materials. University procedures require employees assigned to specific departments
2. Safety Training (cont.)

The University lacks a complete and comprehensive facilities condition assessment. To complete an annual refresher training course for both hazard communication and blood borne pathogen.

**Recommendation**

Ensure that the required annual hazard communication and blood borne pathogen training is properly assigned and completed for all appropriate personnel.

**Management’s Response**

*Both the hazard communication and blood borne pathogen training are now available in TrainTraq. The Training and Development department has now assigned every employee in Facilities Services these training modules as of January 2012, and each year will reassign the training modules for refresher course completion. For new employees, these required trainings will be part of the hiring checklist, and the Training & Development office will ensure they are assigned the courses for completion. There are other required trainings that are delivered in classrooms for specific departments within Facilities Services that will also be tracked in TrainTraq starting January 2012.*

3. Facilities Assessment and Maintenance

**Observation**

The University lacks a complete, comprehensive facilities condition assessment by which to build an appropriate preventive and deferred maintenance program. The absence of a formal facilities condition assessment increases the risk that management may not have sufficient information to plan and implement the repair and renovation of University facilities, including the prioritization of repairs, renovation, and replacement of equipment and other systems and components.

In 2003, the University contracted with a vendor to perform a campus facility condition assessment that included assessing the condition of buildings and benchmarking maintenance levels against comparable peer institutions. This particular engagement had only reviewed nine buildings at the time University management discontinued the contract for performance-related issues. In 2009, management started performing internal facility condition assessments of buildings, and after completing six building assessments this process was discontinued when the staff member performing the assessments was reassigned.
3. Facilities Assessment and Maintenance (cont.)

Currently, only 15 of the University’s 43 buildings, of which five were added in the past year, have been assessed.

**Recommendation**

Develop and implement a process to conduct a comprehensive facilities condition assessment of all buildings on campus, and use this information to develop a preventive and deferred maintenance plan for the future.

**Management’s Response**

As required by Texas Higher Education Coordinating Board, the University is proceeding to follow the guidelines established for campus condition index reporting which will be performed for each building. This reporting requirement began in summer 2011 and the University will be required to complete this process for all facilities by October 15, 2012. The System Physical Plant directors began discussions in October 2011 to have a system-wide facilities condition assessment contract in place to assist those campuses in developing consistently defined planned maintenance and deferred maintenance reporting, as well as, assessment services. As of fall 2011, the campus has identified the building systems that will be part of our campus condition index reporting. As of September 1, 2011, we assessed the condition for three buildings and reported this to the Texas Higher Education Coordinating Board. By June 2012, we will have performed condition assessment for 60% of all facilities. By October 15, 2012, we will perform the condition assessment for the remaining 40% of all facilities. We will be required to continue to update these assessments each year thereafter for the entire campus. The campus currently has an annual budget allocation for planned and deferred maintenance issues. Once the campus has completed the assessments for facilities in October 2012, there will be a review of the financial implications and prioritization of planned expenditures.

4. Construction Contract Language

**Observation**

The contract for construction projects used between the University and its general contractors does not include clauses that provide for the right-to-audit and business ethics expectations. Management was not aware of the need to include such contract clauses. Absence of these direct provisions could result in the University being held liable for the contractor’s intentional or unintentional unethical behaviors including billing errors.
4. Construction Contract Language (cont.)

fraudulent activities, and noncompliance with state law, A&M System policies and regulations, and contract provisions. Inclusion of right-to-audit and business ethics expectation clauses is considered standard business practice in construction contract provisions.

Recommendation

To reduce risks associated with construction projects, incorporate the right-to-audit and business ethics expectation clauses in legal construction documents. Consult with the System Office of General Counsel to determine the appropriate location for the clauses either within construction contracts or other contract documents, such as the System Uniform General and Supplementary Conditions.

Management’s Response

The University has submitted suggested language to the System Office of General Counsel as of December 23, 2011 to include in construction contract forms clauses that provide for the right-to-audit and business ethics expectation. All projects initiated after January 4, 2012 will contain these clauses in the construction contracts, as well as, the written procedures for construction projects.
BASIS OF REVIEW

Objective

The objective of this audit was to review and assess the financial and management controls over the University’s Physical Plant operations to determine if resources are used efficiently, effectively, and in compliance with laws, policies, regulations, and rules.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The Physical Plant at Texas A&M University – Corpus Christi is comprised of approximately 100 full-time positions that report to Executive Vice President for Finance and Administration. Its mission is to provide management of the University’s physical assets to create a campus environment conducive to excellence in instruction, research, other forms of scholarly activity, and public service.
AUDIT TEAM INFORMATION

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First Quarter Report for Fiscal Year 2012

TEXAS A&M UNIVERSITY

Review of Animal Welfare Assurance Program and the Office of Biosafety

Catherine A. Smock, C.P.A.
Chief Auditor

Project #20110219
PROJECT SUMMARY

Overview

Overall, the controls established over research compliance in the areas of animal welfare and biosafety at Texas A&M University are generally effective in providing reasonable assurance that they are operating in compliance with applicable laws, policies, regulations, and rules. However, operational improvements are needed in biosafety training including the clarification of its required frequency, completion of biosafety rules and procedures, and enrollment in the Biosafety Occupational Health Program (BOHP). Improvements are also needed in the process of tracking concerns or complaints reported to the Office of Biosafety and establishing performance targets.

The Animal Welfare Assurance Program has an average of more than 700 active Animal Use Protocols to manage. The Office of Biosafety has over 300 active protocols. The Biosafety Occupational Health Program, within the Office of Biosafety, is currently managing over 7,000 employee enrollment forms. The Office of Biosafety was organized in February 2007 and the BOHP was established within the Office of Biosafety in September 2009.

Summary of Management’s Response

The Office of the Vice President for Research has reviewed the audit findings and concurs with recommendations for improvement to the Animal Welfare Assurance Program and the Office of Biosafety at Texas A&M University.

Detailed responses are described in each of the following sections.

Scope

The review of the Animal Welfare Assurance Program and the Office of Biosafety focused on the approvals of their respective protocols, and completeness of their standard operating procedures when compared to applicable laws, policies, and regulations. Completion and monitoring of required training and
enrollment in the BOHP were reviewed for both areas. Additionally, we reviewed the process for addressing biosafety complaints and concerns and project management controls over the development of a new database system planned, in part, to aid in the tracking of protocols, lab inspections and enrollment in the BOHP. The review focused primarily on activities from September 1, 2010 to April 30, 2011. Fieldwork was conducted from May to August, 2011.
OBSERVATIONS, RECOMMENDATIONS, 
AND RESPONSES

1. Required Training for Biosafety Protocol Participants

Observation

Required biosafety training is not being consistently completed and the frequency of the training has not been clearly defined. The training records for 4 of the 24 (17%) researchers sampled that were associated with biosafety protocols did not include evidence that Biosafety Level 2 (BL2) training was completed when appropriate. Additionally, the training records for 1 of the 8 (13%) principal investigators’ sampled that were associated with biosafety protocols did not include evidence that required National Institutes of Health (NIH) training was completed. The Institutional Biosafety Committee (IBC) requires all participants who will be working in a BL2 lab to complete BL2 training. The NIH requires that all principal investigators working with certain biological agents take biosafety training outlined by the NIH. Failure to complete required training could result in noncompliance with federal, state and University requirements and, in some instances, could cause injury to researchers or others if they were unaware of proper lab and safety procedures.

Members of the Office of Biosafety were not consistently verifying that required training had been taken prior to approving personnel to work on their associated protocols. This is due in part to the current methods used to track training and the way training is delivered. Currently, researchers are tracked by protocol (Animal Use or Biosafety) in different spreadsheets or databases. Names are then cut and pasted into another database to track biosafety training. This process is used since biosafety training is still taught through face-to-face meetings and is not available online. It should also be noted that principal investigators are ultimately responsible for ensuring that all employees working on their studies, including themselves, have completed the training necessary for the work required on their protocol or permit.

In addition to some biosafety participants not completing required biosafety training, conflicting guidance was distributed concerning the frequency of this training. During the February 2009 meeting of the IBC, discussions were held concerning what biosafety training would be required and how often it should be taken. However, when the minutes were released, there was no mention of the frequency
1. Required Training for Biosafety Protocol Participants (cont.)

of the training. Subsequent memos issued by the Office of Biosafety on December 17, 2009 to principal investigators indicated that the committee had approved an annual training requirement. This resulted in the Office of Biosafety attempting to track a training requirement that had not been formally adopted by the IBC or the University.

NIH Guidelines, May 2011 edition, states that it is the responsibility of the institution to ensure that the principal investigators have completed sufficient training. This responsibility may be delegated to the IBC.

**Recommendations**

Ensure that personnel have completed required training prior to being approved to work on a biosafety related protocol. Ensure that biosafety training requirements and the frequency of the training are clearly defined by the University or the Institutional Biosafety Committee. Training requirements should be documented and disseminated to all applicable researchers. Provide additional training for principal investigators to ensure that they are aware of their responsibilities in the area of required participant training. Continue with current efforts to have biosafety training presented and tracked through the A&M System’s TrainTraq system.

**Management’s Response**

Management concurs with the recommendations. Institutional biosafety training requirements and the frequency of the training have now been clearly defined by the University. This includes a requirement to have completed institutional biosafety level 2 training prior to being approved to work in the laboratory in addition to the previously required principal investigator delivered laboratory and agent specific biosafety training. By February 2012, outreach efforts will have been made to ensure principal investigators and research/support staff are aware of their requirements and responsibilities in the area of required participant training. Approval procedures will be modified to ensure that personnel have completed required training prior to being approved to work on a biosafety-related protocol.

In order to ensure individuals will not be unnecessarily held up waiting for the next scheduled training, the frequency of face-to-face training provided by the Office of Biosafety will be increased. In addition, we are in the process of moving some of the content from the face-to-face training to training delivered through the TrainTraq system to facilitate completion of recurring training requirements.
1. Required Training for Biosafety Protocol Participants (cont.)

<table>
<thead>
<tr>
<th>Target implementation dates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval process includes additional training requirement: May 2012</td>
</tr>
<tr>
<td>Institutional Biosafety 2 Training delivered through TrainTraq: May 2012.</td>
</tr>
</tbody>
</table>

2. Standard Operating Procedures

Observation

The Office of Biosafety does not have a final and complete set of standard operating procedures. Twenty of its 22 (91%) standard operating procedures are still in draft form. Nineteen of the 20 (95%) appear to have been started in September 2010. A comparison of the newly revised NIH Guidelines to the draft standard operating procedures indicated that most requirements were incorporated; however, we noted three areas that were not included in the draft standard operating procedures. These three areas are required training; filing of an annual NIH report; and reporting of violations of the NIH Guidelines or research related accidents or illnesses.

While records indicate that the standard operating procedures were started and are fairly comprehensive, the recent focus of the Office of Biosafety has been on day-to-day operations such as protocol review, lab inspections and BOHP enrollment. Given the complexity of biosafety compliance, completed standard operating procedures are important to ensure that processes are carried out consistently and that requirements are adequately addressed. Not having approved, current, and completed procedures increases the risk of noncompliance with applicable requirements such as the NIH Guidelines.

Recommendation

Complete the standard operating procedures for the entire Office of Biosafety. Ensure that the procedures provide complete coverage of all biosafety related requirements. Review procedures periodically and update as necessary.

Management’s Response

Management concurs with the recommendations. Standard operating procedures (SOPs) for the Office of Biosafety have been completed. A review has been conducted to ensure all biosafety related requirements are covered by a SOP. A review will be conducted annually or more often as needed, to ensure procedures
2. Standard Operating Procedures (cont.)

Researchers were approved to work on protocols without evidence of enrolling in the BOHP and completing their Medical Review Form.

3. Enrollment in Biosafety Occupational Health Program

Observation

Members of the Office of Biosafety and Animal Welfare Assurance Program approved personnel to work on protocols without having evidence of enrollment in the Biosafety Occupational Health Program (BOHP) including completion of the Medical Review Form. The University’s Office of Research Compliance promotes the Department of Health and Human Services’ best practice that any person listed on an animal use protocol, an Institutional Biosafety Committee permit for BL2/ABSL2 or BL3/ABSL3, or identified through a BOHP exposure assessment should enroll in the BOHP. Nine of 50 (18%) researchers sampled that participated in animal use protocols did not have evidence of completing the Medical Review Form by the time specified. The University’s BOHP is a service for individuals potentially exposed to biohazards in the course of their duties or possibly their studies. Failure to complete the full BOHP enrollment process can result in covered individuals not receiving the full benefits and protections of the program.

The current process for managing each individual’s BOHP enrollment is a manual tracking spreadsheet that currently contains information for over 7,000 individuals. Although useful tools, spreadsheets do not provide good controls over data and have limited, manual reporting capabilities.

Recommendation

Ensure that personnel are enrolled in the BOHP prior to being approved to work on protocols that require enrollment. Continue with current efforts to obtain a centralized database program that can streamline the enrollment process and reduce the current inefficiencies and inaccuracies. Provide additional training for and communication to principal investigators to highlight their responsibility of ensuring that all personnel working on their protocols are fully enrolled in the BOHP including the completion of the Medical Review Form.

Management’s Response

Management concurs with the recommendations. Procedures have been modified to ensure members of the Office of Biosafety and
Animal Welfare Assurance Program do not approve personnel to work on protocols that require enrollment in BOHP unless evidence is provided by BOHP that the individual has been “cleared”, i.e. enrolled in and meeting all protocol-specific occupational health requirements.

We will continue our efforts to obtain a more efficient database solution. We are currently evaluating commercial research compliance software for possible adoption. Alternatively, an “in-house” database solution will be developed to ensure we have a suitable database if a commercial product does not meet all our requirements.

We are developing information for, and will communicate to, principal investigators regarding their responsibility of ensuring that all personnel working on their protocols are fully enrolled in the BOHP including the completion of the Medical Review Form.

Target implementation dates:

Procedures in place to verify BOHP prior to work approval: completed.


Principal investigator communication: November 30, 2011.

4. Process of Tracking Reported Biosafety Complaints

Observation

The process of tracking reported biosafety complaints needs improvement. Distinction is not made in the current Office of Biosafety standard operating procedures between “incidents” that require immediate attention and “complaints” that need to be thoroughly investigated and addressed. It is unclear what, if any, standard process is used and documentation maintained to track investigations of biosafety complaints from the initial receipt to final disposition. The current procedures for investigating and documenting biosafety incidents and complaints lack consistency with other research compliance areas’ complaint processes. Currently, investigations are documented through email correspondence sent to a shared email account instead of utilizing a standard complaint form similar to the one used in other research compliance areas.
4. Process of Tracking Reported Biosafety Complaints (cont.)

The current standard operating procedures for the Office of Biosafety are still in draft mode and do not provide for adequate documentation of reported concerns. While the NIH or other governing bodies do not specify how the investigation of complaints or incidents should be handled or documented, without complete documentation, the Office of Biosafety is not able to definitively prove that investigations were independent, complete, and performed with due diligence.

**Recommendation**

Complete and approve standard operating procedures for the Office of Biosafety’s incident and complaint investigation process including standard documentation to be used and maintained. Monitor investigations of biosafety complaints to ensure that approved procedures are followed.

**Management’s Response**

*Management concurs with the recommendations.* Standard operating procedures for the Office of Biosafety’s incident and complaint investigation process have been completed that include standard documentation requirements and monitoring procedures. Management will monitor monthly investigations of biosafety complaints to ensure that approved procedures are followed.

*Target implementation date:*

*Completion of initial monitoring period: November 30, 2011.*

5. Performance Measures

**Observation**

Neither the Office of Biosafety nor the Animal Welfare Assurance Program has fully developed performance targets, including the length of time necessary to process animal use and biosafety protocols. Management has considered the time needed to process protocols as noted by a benchmarking and processing analysis recently performed, but has not established official performance targets. Not having performance targets increases the risk that executive management has not established its performance expectations for departments and therefore has greater difficulty in holding departments accountable for their performance.
Performance measures and associated targets provide management with a tool for reviewing operations and identifying areas for improvement. Additionally, a good performance measurement system provides information that is meaningful and useful to decision-makers and is an integral part of daily operations.

**Recommendation**

Develop performance measures, including quantifiable targets, for the Animal Welfare Assurance Program and the Office of Biosafety to help ensure they perform effectively and in compliance with standard operating procedures.

**Management’s Response**

*Management concurs with the recommendations. Official performance targets have been developed. Performance measures will be compared to associated targets quarterly.*

*Target implementation date:*

*Completion of initial quarterly comparison of performance measures and targets: January 2012.*
BASIS OF REVIEW

Objective

The objective of the audit was to review the activities of the Animal Welfare Assurance Program and the Office of Biosafety to determine if the University is in compliance with laws, policies, regulations, and rules and that resources are used efficiently and effectively.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System; Texas A&M University’s rules and procedures; Animal Welfare Act, Code of Federal Regulations Section 2.31; Public Health Service Policy on Humane Care; National Institutes of Health’s Guidelines for Research Involving Recombinant DNA Molecules; and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The Animal Welfare Assurance Program supports the functions of the Institutional Animal Care and Use Committee (IACUC) at the University. The IACUC ensures that federal regulations and guidelines are followed to protect both animals and researchers when research is conducted with animals. IACUC approval of animal use protocols is required before any research with animals can begin. The Office of Biosafety, working through the Institutional Biosafety Committee, is responsible for the oversight, evaluation and assurance of compliance of the University’s program related to research involving bio-hazardous materials or recombinant DNA, and for research requiring a CDC import license or USDA permit. The Biosafety Occupational Health Program is a part of the Office of...
Biosafety. Its mission is to ensure that all persons exposed or potentially exposed to hazardous biological agents in the course of their activities at Texas A&M institutions, are offered information regarding the biological hazards to which they are exposed, and access to competent occupational health medical providers.
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First Quarter Report for Fiscal Year 2012

TEXAS A&M UNIVERSITY

Review of the University Police Department

Catherine A. Smock, C.P.A.
Chief Auditor

Project #20110221
PROJECT SUMMARY

Overview

The University Police Department (UPD) at Texas A&M University has processes and controls in place to provide reasonable assurance that resources are generally used efficiently and effectively to provide a safe environment for students, faculty, staff and visitors. We noted a lack of monitoring and oversight of administrative processes which has led to a number of instances of noncompliance with established administration requirements. Opportunities for improvement were noted in several administrative areas including periodic updating of the department’s goals, objectives and performance measures; obtaining the Commission on Accreditation for Law Enforcement Agencies (CALEA) accreditation; maintaining compliance with the UPD policy manual; creating a disaster recovery plan; monitoring firearm repairs; disclosing conflicts of interest; establishing a contract for Basic Police Academy assistance; and ensuring appropriate staffing for Clery Act responsibilities.

UPD provides law enforcement and security services to all components of Texas A&M University including the academic campus and a variety of satellite facilities throughout Brazos County with an annual operating budget of $6.7 million.

Summary of Management’s Response

UPD strives to provide a safe and secure environment through education, the cooperative spirit of all University community members, and the enforcement of laws and regulations. The recommendations detailed in the audit report will further enhance administrative processes of the department. Efforts are underway to address the recommendations. Detailed responses are included in each section.

Scope

The review of the University Police Department focused on the areas of goals, objectives and performance measures; policies
and procedures; revenue management; Clery Act compliance; evidence inventory management; external complaints; training; and information technology. The review focused primarily on activities from June 1, 2010 through May 31, 2011. Fieldwork was conducted from July to September, 2011.
OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. Monitoring and Oversight

Observation

Insufficient monitoring and oversight of the administrative processes at UPD place the University at risk of noncompliance with applicable laws, policies, regulations, and rules. In addition, the lack of monitoring and oversight increases the risk of departmental resources being used inefficiently and/or inappropriately. In the last year, UPD has experienced turnover in positions responsible for oversight and monitoring of key administrative functions. This coupled with the university-wide required budget cuts in departmental funding over the past few years, has left UPD short-staffed in the administrative area. UPD management chose to focus salaries on direct law enforcement functions instead of administrative functions. The lack of monitoring and oversight of administrative activities helped cause a number of the control weaknesses identified in this report.

Monitoring and oversight are essential components of a strong system of internal controls. Without adequate monitoring and oversight the department’s risk of inefficient and ineffective use of resources and noncompliance with established requirements is increased.

Recommendation

The control environment of UPD should be strengthened by improving the monitoring and oversight by management so that problems and control weaknesses are identified in a timely manner and corrective actions are taken as necessary.

Management’s Response

Monitoring and oversight processes will be enhanced through implementation of the recommendations noted in the audit report. Collectively, the additional management oversight and improvement of processes as detailed in responses two through nine will strengthen the control environment and the department. Additional improvements will be implemented as needs and opportunities are identified. Target date: September 30, 2012.
2. Goals, Objectives and Performance Measures

Observation

<table>
<thead>
<tr>
<th>Formal goals, objectives and performance measures have not been updated since fiscal year 2007.</th>
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</thead>
</table>

UPD has not updated its formal goals, objectives and performance measures since fiscal year 2007 when its strategic plan was created. Goals and objectives provide the department’s employees with a clear understanding of what the department wants to achieve. Annual performance measures define the department’s expectations for accomplishing its goals and objectives. The UPD policy manual states, “Goals and objectives are always associated with each fiscal year of the University and shall be developed with input from all employees.” The absence of current goals, objectives and performance measures increases the risk that employees do not have a good understanding of what the department wants to achieve and that management does not hold divisions accountable for successful achievement of performance expectations.

Recommendation

| Comply with the department’s policy manual by periodically updating goals, objectives, and performance measures for the department. Collect data and evaluate the department’s annual performance related to its performance measure targets. |

Management’s Response

| The department’s mission, vision, goals and metrics will be updated and coordinated with the Division of Administration’s Planning for Performance Excellence Initiative currently being conducted. Available data will be evaluated at the end of the fiscal year. Additionally, the policy manual will be updated to reflect current practices. Target date for evaluation of fiscal year 2012 metrics: September 30, 2012. |

3. Accreditation

Observation

| UPD has not put a plan in place to complete the accreditation process. |

UPD does not have a formal plan in place to ensure it successfully completes the Commission on Accreditation for Law Enforcement Agencies (CALEA) accreditation process. In our prior audit in 2006, management stated it was committed to obtaining accreditation through the International Association of Campus Law Enforcement Administrators (IACLEA). Since that audit, the department decided instead to pursue the CALEA accreditation.
3. Accreditation (cont.)

UPD began the CALEA accreditation process in September 2009. There are five general phases in the accreditation process: enrollment; self-assessment; on-site assessment; commission review and decision; and maintaining compliance and reaccreditation. UPD has until September 2012 to complete the self-assessment phase.

CALEA accreditation enhances the department’s status in that it demonstrates that the department has met an established set of internationally recognized standards for law enforcement.

Recommendation

Create a formal plan with milestones and deliverables that ensure completion of the accreditation process. The plan should also include the resources necessary to ensure completion.

Management’s Response

A team consisting of patrol supervisory and administrative personnel will be assembled to develop a plan to complete the accreditation process. The plan will include an estimated timeline, milestones, deliverables, and identify needed resources. The plan will be submitted to management for review. Target date for completion and review of plan: March 31, 2012.


Observation

UPD is not consistently following requirements set forth in its policy manual. Specific areas of noncompliance include:

- UPD has not performed a complete, annual inventory of the evidence rooms by an independent party. The policy manual states, “Annually, the Chief or his designee shall order an unannounced audit/inspection of the property and evidence storage areas by a supervisor not routinely or directly connected with the control of property.”

- The external complaint log was not updated with the disposition of the complaints and it was not designed to capture the date the investigation was completed. The policy manual states, “A complaint log shall be kept for all complaints received. The complaint log shall include the following information: tracking number; date received; complainant; allegation; employee; date assigned; investigator; and final
4. Compliance with UPD Policy Manual (cont.)

4. Compliance with UPD Policy Manual (cont.)

disposition." The policy manual also states, “All investigations shall be completed within 30 days of assignment.” However, without logging the date the investigation was completed, UPD cannot document that investigations are being handled timely.

Additionally, for three formal complaints reviewed, the Chief did not notify the complainant in writing of the disposition of the complaint. The policy manual states, “Upon completion of the investigation, the Chief shall by letter notify the complainant of the following: the general findings and conclusion of the investigation; that appropriate corrective or disciplinary action is being taken if the allegation is sustained; and that the investigation is officially closed.”

- Outside employment is not monitored to ensure that employees are consistently completing the External Employment and Consulting Application and Approval Form annually. Through interviews it was determined that 10 employees should have completed approval forms for fiscal year 2011. There was no form on file for 6 of the 10 (60%) employees. Management was unaware that one of the employees had external employment. For the other five employees, there was confusion about whether or not a form should be completed. Two of these employees provide security for apartment units and the other three were adjunct instructors for the Texas Engineering Extension Service (TEEX). The policy manual states, “Employees desiring to engage in off-duty employment must prepare a written External Employment and Consulting Application and Approval Form.”

- Training for security and administrative employees is not monitored. Only training that is related to TCLEOSE (Texas Commission on Law Enforcement Officers Standards & Education) certifications is monitored. The policy manual states, “The authority and responsibility for all training, for both sworn and civilian personnel, shall be vested in the Training Section of the department. The duties of the Training Section include... (11) Maintaining accurate employee records of all training... Attendance at all training schools or sessions shall be documented and records maintained, by the Training Coordinator in the employee’s personnel file, which shall be updated immediately upon successful completion of a training program.”

The majority of the information found in the policy manual is required to obtain and maintain CALEA accreditation. According to CALEA Standards for Law Enforcement Agencies, CALEA
Accreditation “strengthens the agency’s accountability through a continuum of standards that clearly define authority, performance and responsibilities and can limit an agency’s liability and risk exposure because it demonstrates that internationally recognized standards for law enforcement have been met.”

**Recommendation**

Review departmental policies as outlined in the UPD Policy Manual and update as necessary. Train all employees on established procedures and monitor to ensure compliance.

**Management's Response**

The UPD Policy Manual will be reviewed and updated as necessary including the items discussed below.

- **Evidence room spot checks** are now performed by a staff member independent of evidence property and are unannounced. Evidence room inventory procedures will be reviewed for consistency with CALEA standards and modified as needed. This will include a full inventory of money, jewelry, drugs, and weapons. Target date: February 28, 2012.

- **The external complaint log format** has been updated to record the dates investigations were completed and date of notification of disposition to the complainant and is in use. The policy manual will be modified to reflect current processes. Target date: December 31, 2011.

- **Outside employment forms** have been completed for fiscal year 2012. An annual notification will be sent to employees to submit requests for the new fiscal year and as a reminder to submit throughout the year for changes. Target date: Complete.

- **Training records** for security and administrative employees will be reviewed annually. This portion of the policy manual will be reviewed and updated to reflect current procedures. Target date: May 31, 2012.

- **Training or communication of updates** and areas warranting additional compliance efforts will be provided. Target date: May 31, 2012.
5. Firearm Repairs

Observation

UPD does not have a formal process in place for monitoring firearm repairs. Firearms are inspected annually and at each weapons qualification session that typically occurs quarterly. The annual inspection includes a full break-down of the weapon, and the quarterly inspection consists of ensuring the weapon is functioning properly. Inspections of handguns are documented; however, rifle and shotgun inspections are not documented.

According to management, deficiencies noted during inspections are typically corrected at the time of the inspection; however, without consistent documentation of the inspections and subsequent repairs, there is no record to document that repairs were made. Additionally, if an officer determines that his/her firearm is in need of repair, there is no formal process in place for him/her to request to have it repaired. Management indicated that the officer is required to take the firearm needing repair to the Weapons Coordinator or an authorized firearms instructor for inspection. The department did not have any documentation of these types of inspections and repairs.

Lack of documented inspections and repairs increases UPD’s risks should a gun malfunction and it be determined to be in need of repair. According to the UPD Policy Manual, a record will be maintained of each firearm that will include the last date of inspection as well as any notes regarding the firearm.

Recommendation

Establish a formal process for requesting/initiating and monitoring a firearm repair. Document the chain of custody of the firearm and any notes about the repair as well as the time it took from notification to completion of the repair. Maintain documentation of repairs along with annual and range inspections for each firearm in inventory at UPD.

Management’s Response

A web-based process is being developed to request and maintain firearm repairs. The online process will document the date the repair is requested, notes about the repair, and date of completion. Chain of custody of the firearm will also be documented.
5. Firearm Repairs (cont.)

A form similar to the handgun inspection form currently in use has been developed to document rifle and shotgun inspections. Use of the form will begin January 1, 2012. Target date: January 31, 2012.

6. Disaster Recovery Planning

Observation

There is no disaster recovery plan in place for the UPD CAD/RMS databases.

The department has not created a disaster recovery plan for the CAD/RMS (Computer Automated Dispatch/Record Management System) databases which contain the mission-critical information UPD needs to maintain operations on a daily basis. Texas Administrative Code (TAC) 202.24 addresses requirements for business continuity planning including specific elements of a disaster recovery plan. Texas A&M University Standard Administrative Procedure 29.01.M1.32, Information Resources - Disaster Recovery Planning, requires a documented disaster recovery plan be maintained for all mission-critical resources. Failure to properly prepare for the loss of mission-critical IT services can result in excessive downtime and costs that negatively affect the department’s ability to fulfill its responsibilities.

Recommendation

Establish a departmental disaster recovery plan for mission-critical information systems as part of the departmental business continuity plan. The disaster recovery plan should be documented, tested and updated on a periodic basis and approved by the Chief or his designated representative.

Management’s Response

UPD has recently added a position of a Senior Information Technology Professional II. The position is expected to be filled in January 2012. This position will assist in preparing a disaster recovery plan for the CAD/RMS databases. The plan will be documented, include measures for periodic testing and updating, and be approved by UPD management. Target date for plan completion: April 30, 2012.
7. Clery Act Responsibilities

Observation

<table>
<thead>
<tr>
<th>UPD has not identified a backup for Clery Act responsibilities.</th>
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<tbody>
<tr>
<td>UPD does not have an identified backup for performing Clery Act responsibilities when the primary person is unavailable. According to the Code of Federal Regulations 34CFR668.46 the institution must log in information within two business days of the report to the campus police unless that disclosure is exempted. The Handbook for Campus Safety and Security Reporting also suggests that the institution have more than one person responsible for making entries in the log in case of personnel changes or work absences. Without a backup for Clery Act responsibilities, UPD risks noncompliance with reporting requirements if the responsible officer is out for more than two consecutive days. Additionally, information on the UPD website was outdated and contained non-Clery Act reports that may be perceived as Cleary Act information by a reader.</td>
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Recommendation

| Identify and train a backup person for Clery Act reporting. Periodically monitor the UPD web site to ensure that information published is up-to-date. For clarity, consider grouping all Clery Act-related items on the UPD website in a similar location. |

Management’s Response

| A backup position for Clery Act reporting has been assigned and trained. To remain current on departmental procedures, the backup position will perform Clery Act duties once a month. Target date: Completed. Non-Clery Act reports have been removed from the website. If additional reports are added in the future, they will be grouped separately from Clery Act items. Target date: Completed. |

8. Contract for Basic Police Academy Assistance

Observation

<table>
<thead>
<tr>
<th>No formal agreement is in place for UPD’s assistance with the TEEX Basic Police Academy.</th>
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<tbody>
<tr>
<td>Currently there is no written agreement between Texas Engineering Extension Service (TEEX) and UPD documenting each party’s deliverables, responsibilities and liabilities with regard to UPD’s assistance in providing teaching services to TEEX’s</td>
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Project #20110221
8. Contract for Basic Police Academy (cont.)

Basic Police Academy. UPD provides officers to serve as instructors for the academy. The officers teach during their regular work hours and as a result, they do not receive additional compensation from TEEX nor does the UPD assess a fee to TEEX for the officers’ time.

Texas A&M University Rule 25.07.M1, Contract Administration, states “Written contracts shall be executed whenever Texas A&M University enters into a binding agreement with another party that involves any stated or implied consideration.” Management was unaware that a contract needed to be in place because the current understanding with TEEX, which also includes other law enforcement agencies within the Brazos Valley, has been in place for several years.

In addition, UPD does not track the number of officers or hours spent teaching at the academy. Management was unaware that UPD officers were being requested to teach at the academy more frequently than officers at other Brazos Valley law enforcement agencies. If the terms of the agreement are not stated explicitly, there is an increased risk for disagreements and misunderstandings.

Recommendation

Ensure a written agreement is in place between UPD and TEEX outlining duties and responsibilities of each with regards to the Basic Police Academy. UPD should monitor the number of officers and hours spent teaching at the academy to ensure compliance with provisions of the agreement.

Management’s Response

A memorandum of understanding will be put in place between UPD and TEEX to outline the respective parties’ duties and responsibilities regarding the Basic Police Academy. Compliance with the agreement provisions will be monitored. Target date for completion of the memorandum of understanding: January 31, 2012.

9. Disclosure of Conflicts of Interest

Observation

Annual conflict of interest disclosures are not required by management.

UPD does not have a formal process in place to require annual conflict of interest disclosures from employees so that management can manage any conflicts which may exist. There
are several married couples within the department as well as other related parties such as siblings and cousins. Currently, disclosure of internal conflicts is up to the employee. Management stated they manage the conflicts through scheduling to ensure that related parties do not supervise one another. However, in some cases, the highest ranking officer on duty for a particular shift may not typically be a supervisor. In these situations, the highest ranking officer has indirect supervision over all functions of the department such as police, dispatch and security. While this indirect supervision does not include the ability to affect an employee’s pay or performance, there can be other departmental issues related to a perceived act of preferential treatment.

Management works with University Human Resources any time a question arises about supervision and related parties, but has not considered the risk of indirect supervision without the ability to affect pay or performance. Ensuring unbiased actions, in fact and appearance, are important in maintaining the integrity of UPD and its staff.

Recommendation

Implement a formal process for obtaining employee disclosures of conflicts of interest. These disclosures should be updated annually.

Management’s Response

To ensure that management is aware of related parties and potential conflicts of interest, a form will be developed for employees to disclose related parties and potential conflicts of interest. The form will be updated annually. Target date for completion of form by department personnel: March 31, 2012.
BASIS OF REVIEW

Objective

The objective of this audit was to review the processes and controls in place within the University Police Department to determine if resources are used efficiently and effectively to provide a safe environment for students, faculty, staff and visitors. Also, determine if Department operations are in compliance with laws, policies, regulations and rules.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System; the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act; the Commission on Accreditation for Law Enforcement Agencies (CALEA) Standards; the Treadway Commission’s Committee of Sponsoring Organization’s Internal Control – Integrated Framework (COSO); and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The University Police Department (UPD) is the primary police authority for Texas A&M University. It provides law enforcement and security services to all components of Texas A&M University including the academic campus and a variety of satellite facilities throughout Brazos County. The mission of UPD is to provide a safe and secure environment through education, the cooperative spirit of all University community members, and the enforcement of laws and regulations.
The Department has 133 authorized positions including 70 state-certified police officers, 42 security officers, 13 communication officers and 8 administrative support personnel. The fiscal year 2011 annual budget was $6.7 million. The Department maintains a fully staffed investigations division, a crime prevention unit, a recruiting unit, a training division, and an Emergency Communications Center.
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PROJECT SUMMARY

Overview

Texas A&M University – Corpus Christi is in the process of transitioning their research administration program to ensure that research activities are conducted in compliance with laws, policies, regulations and rules. During the audit period, the University was significantly noncompliant in the post-award administration areas of time and effort reporting, facilities and administrative costs, cost sharing, and project closeout. Noncompliance also extended to research compliance with respect to human subject protocols. Although the error rates were high, the University has made great strides over the past several months to put themselves in position to strengthen their compliance with applicable laws, policies, regulations and rules going forward.

A significant improvement made by the University was addressing the high turnover of staff in both the research administration and research compliance areas. New and recent appointments include the Associate Vice President for the Office of Research and Scholarly Activity and Graduate Studies (Research Office), Director of Research & Scholarly Activity, Assistant Director for Post-award Administration, and Research Compliance Officer. Another effective step was providing specialized training and guidance to research administration staff and principal investigators by peers from other A&M System institutions. The Research Office has also developed and begun to implement new procedures governing the research area which should improve compliance once fully implemented.

Texas A&M University - Corpus Christi had over 250 proposals submitted during fiscal year 2010 with 135 of those being awarded. Total research expenditures for fiscal year 2010 were $13.7 million. Post-award and research compliance activities at the University are administered through the Research Office. The pre-award administration of sponsored projects has been outsourced.
Summary of Management's Response

The University agrees with the results of the audit and will move expeditiously to address the issues raised.

Scope

The review of research administration focused on activities for the period September 1, 2010 through May 31, 2011. Areas reviewed included facilities and administrative costs, cost sharing, expenditures, time and effort reporting, and project closeout for all research projects administered by the University. Additionally, we reviewed areas related to human subject research including protocol submission and review, overall processes and procedures, and organization of the Institutional Review Board. Fieldwork was conducted from June to August, 2011.
OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. Time and Effort Reporting

Observation

The University is not in compliance with time and effort reporting requirements.

For six of the 13 (46%) state and federally funded projects tested, the proposal budgets were approved without inclusion of required minimum effort for the principal investigator (PI) and no documentation existed that effort was ever allocated. Office of Management and Budget (OMB) Circular A-21, as clarified by Memorandum M-01-06, specifies that most federally funded research programs should have some level of committed faculty effort. Additionally, for nine of the 19 (47%) budgeted employees working on those 13 projects, their time and effort certifications were not completed within 45 days from the close of the certification period as required by System Regulation 15.01.01, Administration of Sponsored Agreements-Research and Other.

Prior research administration management had not enforced the OMB Circular A-21 requirements on minimum PI effort. Current research administration employees are aware of this requirement and have identified it as an area that needs improvement. Researchers at the University are adjusting to the new time and effort system that was implemented by the University. Subsequent to our onsite visit, the Research Office brought in an employee from another A&M System institution to provide university-wide training on the time and effort system.

Recommendation

Enforce minimum PI effort requirements in accordance with OMB Circular A-21.

Ensure that time and effort reports are certified within the 45 days as required by System Regulation 15.01.01. Certifications should be monitored by the Research Office for compliance. Provide training on the time and effort system throughout the year as new research personnel and staff are added.
Management’s Response

1. Time and Effort Reporting (cont.)

In January 2011 and in accordance with OMB A-21 Circular Memorandum M-01-06, the Research Office began working with the Texas A&M Research Foundation in the proposal development stage to ensure minimum PI effort is included in the budget or documented as cost share (mandatory/voluntary committed). Beginning January 2011, the Research Office monitors and ensures that PIs and department administrators report time & effort and certify within the 45-day timeframe established by Texas A&M University System regulation.

In July 2011, a new training session for researchers and department administrators was organized by the Research Office and presented by a member of the Texas A&M University staff. University-wide training sessions will continue to be offered twice a year (fall and spring) with the objective of increasing the understanding and importance of timely effort certification. These have been implemented and in process as of July 2011.

2. Facilities and Administrative Costs

Observation

Fourteen of the 20 (70%) sponsored research projects tested had Facilities and Administrative (F&A) rates that were not at the stated rates negotiated with the Department of Health and Human Services (51% rate for fiscal year 2009 and 53% for fiscal years 2010 and 2011). Four of the projects reviewed utilized a 25% rate, four utilized a 15% rate, and six did not have a rate listed in the Sponsored Research module of the Financial Accounting Management Information System. The project files did not contain a statement of explanation or Chief Executive Officer approval for the reduced rates as required by System Regulation 15.01.01.

System Regulation 15.01.01 requires a statement of explanation indicating the benefits to the A&M System and the State of Texas that justify cost sharing a portion of the approved F&A rates. Any reductions must have the Chief Executive Officer or designee approval. In some instances, certain sponsors will not pay the full F&A rate, and in others PIs are either not aware of the regulation or agree to lower rates due to the competitive nature of the grants. In either case, the University was approving proposals without ensuring that proper documentation and approvals were obtained for F&A rates lower than the approved rate.
Recommendation

2. Facilities and Administrative Costs (cont.)

Develop procedures that require a statement of explanation for the exception to the use of the negotiated Department of Health and Human Services’ F&A rate. These exceptions should be approved by the Chief Executive Officer or designee. Monitor and retain documentation as part of the sponsored award file. Provide training for PIs and other relevant staff on F&A cost procedures that comply with System Regulation 15.01.01.

Management’s Response

The Research Office follows System Regulation 15.01.01, 10.3 by ensuring sponsored agreement terms are established according to the approved Department of Human & Health Services negotiated rate and emphasize the importance of obtaining approval if an exception applies.

A new F&A online request process has been in place since April 2011 for PIs to submit a request for waiver and/or reduction of F&A costs. This request serves as a statement of explanation indicating the benefits to the A&M System and the State of Texas. The waiver reduction in costs must be approved by the Associate Vice President for Research. This process ensures proper documentation and approval is obtained for F&A rates lower than the approved rate. This request becomes a record in the project file. In addition, the Associate Vice President for Research has been meeting with new faculty instructing them on the importance of abiding by the negotiated F&A rate.

3. Cost Sharing

Observation

The University’s processes for cost sharing were not in compliance with System Regulation 15.01.01. If cost sharing was required, it was listed on the proposal routing sheet, and the costs were tracked outside of the accounting system in a stand-alone database. Cost sharing was not documented and identifiable in the University’s accounting system through the use of a separate account as required by regulation. Although the Financial Accounting Management Information System (FAMIS) Sponsored Research module has the capability of accounting for cost sharing, it was not being utilized by the University for this purpose until January 2011.
3. Cost Sharing (cont.)

Recently, the Research Office has had a large amount of staff turnover. Since hiring new staff, it has developed procedures to be in compliance with the System regulation and began implementing this new process. However, during fieldwork, none of the projects reviewed had been started under the new processes, so the effectiveness of the processes could not be verified.

Recommendation

Continue with the implementation of new cost sharing procedures and processes that are in compliance with System Regulation 15.01.01. Provide training for PIs and other relevant staff on the University’s cost sharing procedures.

Management’s Response

In compliance with System Regulation 15.01.01, 11.5.1, the University has established a process in April 2011 for new awards that document, track, and identify mandatory and voluntary committed cost sharing in the University’s accounting system.

The University attempts to keep voluntary cost sharing to a minimum and has procedures to document when a cost sharing obligation occurs. Both mandatory and voluntary committed cost sharing contained in proposals are now part of the review and approval process by the PI’s department chair, dean/director, fiscal office, and Associate Vice President for Research. A new cost sharing request process has been implemented since April 2011 for PIs to submit a justification and detailed explanation if cost sharing is not required by the sponsor.

As of January 2011, the Research Office staff has been working with Accounting Services to set up both the project and cost sharing accounts simultaneously at the time of award. In addition, the Research staff works with Payroll in creating and revising EPAs to ensure mandatory/voluntary cost sharing is documented for the salary portion of each project.

Furthermore, the Research Office continues to utilize the FAMIS Sponsored Research module to monitor and document voluntary and mandatory cost sharing. Finally, the Research Office will work on establishing a series of training sessions for PIs and Business Coordinators on cost sharing procedures by March 2012.
4. Project Closeout

Observation

Projects are not closed in a timely manner.

Ten of 12 (83%) projects reviewed with ending dates during the audit period were not closed out in a timely manner. The University’s post-award Administration’s Standard Operating Procedure 14.00, Project Closeout, states that financial closeout will be completed within 90 days from the project end date and that physical files will be closed within 180 days from the project end date. For the projects reviewed, the following project closeout tasks were not completed:

- For three projects, the final invoice was not sent within 90 days after the project end date, and the final payment from the sponsor was not received in a timely manner.
- For one project, the encumbrances were not liquidated, the final financial report to the sponsor was not completed within 90 days, and residuals were not removed from the account within 180 days.
- For seven projects, the FAMIS account was not marked as frozen and deleted within 180 days.
- For ten projects, the project files were not closed within 180 days as required by departmental procedures.
- For eight projects, the project checklist was not present and/or completed.

The office handling post-award research administration has experienced high staff turnover in the last year, which contributed to the inability to closeout projects on a timely bases. Research administration staff has recently been focused on bringing this area into compliance with a goal of closing out all projects within the stipulated period. Failure to closeout projects in a timely manner, including the submission of final invoices, can lead to loss of revenue, residual income not being utilized, and charges being made to a project after the end date.

Recommendation

Continue efforts to catch up on project closeout tasks. Develop additional procedures to notify PIs about project closeout requirements to ensure projects can be closed in a timely manner.
Management’s Response

4. Project Closeout (cont.)

Protocol reviews were not consistently documented and continuing reviews were not timely.

A new procedure as of June 2011 has been established to complete the backlog of project closeout tasks. The Research Office reviews a monthly Business Objects report on projects expiring within the following 30 to 90 days. A formal notification is emailed to the PI and Business Coordinator. This notification indicates the expiration date for the project and a list of tasks to be completed by the PI and/or department prior to the expiration date, if no extension is needed on the project. If an extension is needed, PIs are asked to contact the Research Office to officially begin the process of preparing and submitting the extension request to the sponsor.

Closeouts for all expired projects and those that have exceeded the 90-day period will be finalized prior to June 2012.

5. Human Subject Research Protocols

Observation

While procedures appear to be in place to ensure that new protocols involving human subject research are generally processed in a timely manner and that required materials are submitted by the PIs to the Compliance Office and the Institutional Review Board (IRB), improvements are needed in the documentation of the protocol review process by the Compliance Office. Documentation was lacking for the following:

- Five of the five (100%) protocols receiving expedited reviews had incomplete documentation of the review.

- Ten of the 15 (67%) total protocols reviewed had incomplete or no documentation of the administrative review.

- Four of the ten (40%) total protocols submitted for review after January 1, 2011 had no documentation in the protocol file to indicate that required human subject research training was completed. The University did not require human subject research training prior to that date.

Additionally, improvements are needed to ensure timely reviews are conducted for protocols that are being continued beyond their original duration. Both of the protocol continuations reviewed were not approved prior to the original protocols’ expiration and there was no documentation showing whether the continuing review expiration and notification procedures were followed. An email was sent out in January 2011 by the Compliance Office to disseminate some of the
new procedures for amendments and continuations, which addresses this issue.

A new research compliance officer was appointed during the fiscal year to establish a more comprehensive compliance program. Many of the improvements have only recently been developed and implemented and therefore would not have been utilized on many of the projects reviewed. Failure to properly document human subject protocol reviews or to review continuations in a timely manner can result in noncompliance with University procedures, System regulations and federal laws.

**Recommendation**

Ensure that the new procedures for human subject research protocols are documented and fully implemented. Strengthen procedures over continuations to ensure that work is not being performed on an expired protocol. Documentation over all aspects of the protocol review and approval process, including the monitoring of training, needs to be improved in order to ensure compliance with all laws, policies, regulations and rules.

**Management’s Response**

*Procedures have been in place since January 1, 2011 to ensure that new protocols involving human subject research are processed in a timely manner and that required materials are submitted by the PIs to the Compliance Office and the IRB. The Compliance Office has implemented checklists customized to fully document the review process of various protocol categories.*

*The Research Office is also ensuring that the new procedures for human subject research protocols are documented, fully implemented, and that work is not being performed on expired protocols. Documentation over all aspects of the protocol review and approval process, including the monitoring of training, will continue to be strengthened in order to ensure compliance with all laws, policies, regulations and rules.*

*Training requirements are also in place for all amendments, continuations, and protocols submitted after January 2011. Revised forms, procedures, and documentation techniques to more accurately review, document, and track protocols were put in place as of January 2011. A complete revision to the standard operating procedures is in process to more fully document IRB procedures. This will be completed by February 29, 2012.*
BASIS OF REVIEW

Objective

The objective of this audit was to review research administration at Texas A&M University – Corpus Christi to determine if resources are used efficiently and effectively and in compliance with laws, policies, regulations and rules.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The duties of the University’s Office of Research and Scholarly Activity and Graduate Studies are divided between research activities and graduate studies. The Office of Research and Scholarly Activity provides services including research development, post-award administration, research compliance, comprehensive resources including required forms and documents, training opportunities, and coordination with the research centers and institutes and the various colleges. The pre-award administration of sponsored projects has been outsourced. The University had over 250 proposals submitted during fiscal year 2010 with 135 of those being awarded. Total research expenditures for fiscal year 2010 were $13.7 million.
AUDIT TEAM INFORMATION

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First Quarter Report for Fiscal Year 2012

TARLETON STATE UNIVERSITY

Review of Environmental Health, Safety and Security Operations

Catherine A. Smock, C.P.A.
Chief Auditor

Project #20110404
PROJECT SUMMARY

Overview

Tarleton State University has developed processes over environmental health, safety and security operations to provide reasonable assurance that a safe environment exists for students, faculty, and staff and that the University is in compliance with relevant laws, policies, regulations, and rules. However, the implementation of these processes has not been fully achieved due to control weaknesses in the areas of laboratory safety inspections, employee safety training, and long-term management of chemical storage. The University has strengthened its processes and controls to promote complete and accurate Clery Act reporting.

Environmental health and safety is under the responsibility of the Risk Management & Safety Office while security is under the responsibility of the University Police Department. The Risk Management and Safety Office has four full-time employees and a fiscal year 2011 operating budget of approximately $322,000. The University Police Department has 13 full-time employees and a fiscal year 2011 operating budget of approximately $782,000.

Summary of Management’s Response

Tarleton State University values the review that has been performed and feels that improvement has been achieved in many areas of environmental, health, safety and security since the previous audit. The Office of Risk Management and Safety (RMS) has taken preliminary actions to implement processes to improve in the areas of laboratory safety inspections, employee safety training, and chemical storage and management as documented as observations by the audit team. RMS staff will continue to foster its current
relationships with applicable academic and non-academic departments to ensure this improvement is achieved.

Scope

The review of environmental health, safety and security operations at Tarleton State University focused on the areas of fire and life safety, laboratory safety inspections, student and employee safety training, Clery Act reporting, chemical administration, University-sponsored camps, student activities, and student and faculty international travel. Transactions and activities related to these areas were reviewed for the period March 1, 2010 through May 31, 2011. Fieldwork was conducted from June 2011 to August 2011.
1. Laboratory Safety Inspections

Observation

The University laboratory safety inspection process requires improvement to ensure that teaching and research laboratories remain safe and that all laboratory safety issues are identified and addressed in a timely manner. Comprehensive safety inspections of the University’s teaching laboratories were not carried out by the Risk Management and Safety Office during the audit period to monitor compliance with safety protocols. In addition, University departments were not performing self-inspections of their labs nor reporting results to the Risk Management and Safety Office in accordance with University laboratory safety program procedures. This situation has been largely due to the year-long vacancy of the environmental safety technician position which conducts these lab safety inspections. This safety technician position has been vacant at times during three out of the last six years. The lack of an effective laboratory safety inspection process could lead to serious injuries and property damage as potential hazards and risks are not detected and corrected in a timely manner. A&M System Regulation 24.01.01 states that each component with identified harmful exposures is to develop a monitoring program that includes the evaluation and written communication of results, with appropriate corrective actions.

Prior to the environmental safety technician vacancy, the Risk Management and Safety Office met with departments to reinforce good laboratory safety practices. In lieu of formal laboratory safety inspections, the Risk Management and Safety Office included some lab inspection coverage in its fire and life safety inspections. However, there was no formal follow-up of the inspections to ensure that deficiencies identified were addressed in a timely manner. It should be noted that the safety technician vacancy was filled just prior to the start of the audit and steps were underway during the audit to strengthen the inspection process.

Recommendation

Strengthen the laboratory safety inspections process by:
1. Laboratory Safety Inspections (cont.)

- Developing a risk-based laboratory safety inspection schedule for the various laboratories, shops, and related facilities. Determine the inspection frequency necessary to ensure a safe working environment. Establish and adhere to a schedule for the performance of these inspections. In scheduling and staffing the inspection process, factor in contingencies for staff turnover so that inspections are consistently carried out.

- Strengthening procedures for documenting inspection results and providing reports to appropriate personnel including the respective department head, dean (as necessary) and University management.

- Ensuring that departments carry out self-inspections of laboratories and report results to the Risk Management and Safety Office in accordance with University laboratory safety program procedures.

- Implementing a follow-up inspection process that includes formal tracking and monitoring of the implementation of inspection report recommendations to ensure appropriate steps are taken to correct the identified deficiencies in a timely manner.

- Tracking safety deficiencies to identify trends and areas of additional safety training needs.

Management’s Response

Tarleton’s Office of Risk Management and Safety (RMS) will develop a comprehensive risk-based review process to identify the appropriate inspection level of applicable laboratories, shops and related facilities. This process will include the development and implementation of a uniform inspection checklist to be used for academic self-inspections and, additionally, by RMS personnel. This process will be developed and implemented no later than May 31, 2012.

Documented RMS and self-inspections will be forwarded to the applicable department head, director, and/or manager with discrepancies and follow-up inspections submitted to the dean of the respective academic college, and to the vice president as warranted.

Beginning spring 2012, web-based tracking tools of the inspection process will be explored, and an appropriate system identified and purchased, which will serve as the formal tracking mechanism.
Applicable inspections performed following the revised process will be completed by May 31, 2012.

The laboratory inspection program will be a collaborative effort between the key departments (Chemistry, Biology, Environmental and Agricultural Management, and RMS) to ensure consistency and to sustain efforts during staffing and organizational changes.

2. Employee Safety Training

Observation

A review of training records for newly hired Physical Facilities employees indicated that three of eight (38%) employees did not receive timely hazard communication training. Two employees were hired in late 2010 and subsequently after auditor inquiry in June 2011, the training was completed. The third employee was trained approximately 10 weeks after hire. Physical Facilities supervisors did not consistently require employees to attend training. The Risk Management and Safety Office was not sufficiently monitoring the process to ensure that employees with potential exposure to hazardous chemicals and/or blood borne pathogens received timely training. The lack of an effective process to identify and provide hazard communication training results in the increased risk of personal injury and property damage. The University’s Hazardous Communication Program requires departments with jobs where hazardous chemicals are routinely used or handled to provide and/or make available chemical training sessions to employees at least annually. In addition, the department is to provide training to new or newly assigned employees prior to their working with or in a work area containing hazardous chemicals.

Recommendation

Enhance monitoring controls of the employee safety training to ensure that those employees who could be potentially exposed to hazardous chemicals and/or blood borne pathogens, receive safety training in a timely manner (prior to initial exposure to these chemicals and/or pathogens).

Use the A&M System TrainTraq training system to provide hazard communication and blood borne pathogen training to enhance the University’s ability to monitor and track employee safety training for timely completion. For instance, determine a specific time period (e.g. within two days of hire date, etc.) for hazard communication and blood borne pathogen training to be completed following a new employee’s hire date, and enter the corresponding due dates for
2. Employee Safety Training (cont.)

training in TrainTraq so that employees receive reminders for training and past due reports can be generated to monitor compliance.

Management’s Response

Tarleton’s Office of Risk Management and Safety will implement a process to monitor employee changes to ensure applicable new employees receive timely training through a collaborative effort between RMS and the Department of Human Resources.

The Computer Help Desk will notify RMS by email as a work request for network access is completed by their department. This action will provide a timely notification so that applicable training can be assigned to the employee by RMS.

RMS will be notified by Human Resources on a frequent basis (weekly and/or monthly) as new employees begin their employment at Tarleton as an additional monitoring process. This listing will include full-time, non-budgeted, adjunct instructors and student employees. A reminder will be sent to employees that have not completed the training by the specified timeframe along with RMS and the applicable supervisor being notified so that appropriate follow-up measures can take place.

This change is currently implemented and being monitored to ensure that various employee classifications are captured by this process.

RMS has initiated discussions with Human Resources to assign applicable hazard communications and blood borne pathogens training to employees through TrainTraq. By May 31, 2012, Tarleton will have implemented the necessary changes to ensure the stated training is deployed to all applicable employees.

3. Chemical Storage

Observation

Chemical storage processes within the University require improvement to ensure hazardous chemicals are properly stored and maintained. A review of the Chemistry Department's chemical storage facilities (particularly, the Chemistry Stockroom in the Science Building) indicated that large amounts of possibly excess and unused chemicals were being stored. These facilities included chemicals stored in containers with missing or faded labels, chemicals in deteriorated containers, and chemicals that
3. Chemical Storage (cont.)

were old and had not been used in several years. Management does not have a formal plan for the long-term management of stored chemicals including tracking the age and most recent use of chemicals, and ensuring the timely disposal of old or unused chemicals. Inadequate chemical storage processes increase the risk of injury to students, faculty, and staff and place the University in potential noncompliance with federal and state requirements. The University’s chemical safety program states that chemicals should be properly sealed, labeled, and stored in compatible containers.

Recommendation

Strengthen the management of stored chemicals by:

- Reviewing all stored chemicals (especially those located in the Chemistry Department storage areas) to ensure they are maintained in appropriate containers with proper labeling, including date of purchase or most recent use to assist in determining timely disposal.

- Require all departments with large volumes of chemicals (especially Biology and Chemistry) to annually review inventories and carry out appropriate disposal of old, unused chemicals.

Management’s Response

By May 31, 2012, Tarleton’s Office of Risk Management and Safety will implement a process to perform a risk review of key departments such as Chemistry, Biology, Agricultural Science, etc. and establish criteria to evaluate chemical inventories annually in an effort to minimize the volume of chemicals stored and to improve safety within the laboratories.

Risk Management and Safety will request each applicable department to perform an annual internal evaluation of their chemical inventories, no later than August 31, 2012. Inventoried chemicals will be evaluated and identified for disposal based on the following criteria:

- Age of chemical (20 years or older)
- Condition of container
- Label condition (missing or illegible)
3. Chemical Storage (cont.)

- Need (Is the chemical needed for future lab course offerings or research activities within the next 2 years?)
- Is chemical substitution an efficient and viable approach to an existing, more hazardous chemical?
- If efficient, can micro-scale chemistry techniques be incorporated for certain laboratory activities?
- Can mercury-based equipment, such as thermometers, be replaced with alcohol or petroleum filled devices?
- Has the shelf life of the chemical been exceeded?

Once the chemical inventories have been evaluated each department will forward a completed Waste Disposal Form to RMS for processing and subsequent disposition.
BASIS OF REVIEW

Objective

Review and assess the University’s controls and processes over campus safety and security to ensure that they provide reasonable assurance that a safe environment exists for students, faculty, and staff. Also, determine that the University is in compliance with laws, policies, and regulations relevant to campus safety and security.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System; Tarleton State University Rules and procedures; the Treadway Commission’s Committee of Sponsoring Organization’s Internal Control – Integrated Framework (COSO); and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Tarleton State University is committed to a campus environment that protects the safety and environment of the students, employees, and visitors. The Risk Management & Safety Office and University Police Department comprise the two most significant elements of the environmental health, safety and security operations at Tarleton State University. The mission of the Risk Management & Safety Office is to provide a safe and healthy environment through programs designed to ensure the safety of employees, protection of property, and compliance with state and national regulations and standards. The mission of the University Police Department is to provide a safe and secure learning, living, and working environment through the delivery of professional police service.
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First Quarter Report for Fiscal Year 2012

PRAIRIE VIEW A&M UNIVERSITY

Review of the Owens-Franklin Health Center

Catherine A. Smock, C.P.A.
Chief Auditor
PROJECT SUMMARY

Overview

Overall, the controls and processes at Prairie View A&M University’s Owens-Franklin Health Center provide reasonable assurance that operations are conducted in compliance with laws, policies, regulations, and rules. However, management has not developed a viable plan to address its staffing shortage to ensure that resources are used in an effective and efficient manner. In addition, the risks associated with providing medical services to non-student patients need to be addressed. Compliance with the Center’s requirement for student worker confidentiality statements also needs to be improved.

In fiscal year 2010, the Center had 5,842 patient visits which represented at 12.5 percent increase from the prior year. The Center has approximately 14 staff and an annual operating budget of $1.5 million.

Summary of Management’s Response

Management appreciated the System Internal Audit Department’s efforts to identify issues needing improvement and steps necessary to ensure improvement is achieved. We are committed to satisfactorily addressing these issues and have developed and enhanced procedures to address these issues.

Scope

The review of the Owens-Franklin Health Center focused on the areas of technology, staffing levels, medical records, pharmacy operations, revenue management and performance measures for the period September 1, 2009 to January 31, 2011. Fieldwork was conducted from February to April 2011.
OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. Resource Management

Observation

The Center’s resources are not being used in an efficient and effective manner.

Management has not developed a viable plan to address staffing shortages created by the prolonged vacancies of several key positions, and the general lack of flexibility within the Center’s operating budget. The lack of a plan has resulted in some practices that do not ensure the Center’s staff, equipment, and revenues are used in the most efficient and effective manner, as identified in the following:

- The practices put into place to address the Center’s prolonged staffing shortages do not promote the efficient use of current staffing resources. Center management indicated that since four of the Center’s key positions became vacant in 2007 the rest of the staff has had to take on extra duties to cover these vacancies. However, the manner in which the extra duties are assigned does not always allow for the most effective use of staff time. For example, the Center administrator currently also functions as the health information coordinator, counselor, and sometimes as the front desk receptionist. In the last two years, the administrator has also assumed the responsibility for the receipt and tracking of the recent state-required bacterial meningitis immunization documentation. These extra duties are taking more of the administrator’s time, leaving little opportunity to perform her managerial duties. During this audit it was noted that the administrator spent a significant amount of her time filling in as the front desk receptionist, and seemed to operate in a “fire-fighting” mode. The prolonged under-staffing elevates the risk of staff burnout and that critical duties, such as strategic planning, may be neglected which could, in turn, create more problems. Further, the shortages have increased patient turnaround time to more than 80 minutes. In addition, with little time available to pursue grants, the Center is not able to take advantage of potential grant funding opportunities. Management indicated the inability to replace key staff positions is largely due to budget constraints.

- The Center’s x-ray equipment was out of service from December 2010 through March 2011, leaving the Center without radiology services. Center management indicated it could not bring the
1. Resource Management (cont.)

- The Center’s revenue management processes do not ensure receipts are deposited timely, in accordance with A&M System Regulation 21.01.02. Thirty-three percent (7 out of 21) of the receipts reviewed had not been deposited within three business days. The delays ranged from one to ten days late. Management indicated the Center does not always have the staff to deliver the deposit to the University’s fiscal office in a timely manner.

The lack of resources, both staff and funding, were cited by management in the Center’s 2010 Annual Report as challenges to achieving several performance measures. Management indicated during this review that they were anticipating an increase in Center fees in fiscal year 2012, which could help to alleviate some of their financial needs and enable them to hire needed staff.

Recommendation

Develop a plan for the Health Center that ensures the Center’s funding matches with its operational goals and expectations so that staff are more effective and efficient in carrying out their job duties. Center management should seek permission to use reserves to fund the delivery of important services. Ensure receipts are deposited timely in accordance with System regulations.

Management’s Response

*We agree with your recommendations. Health Center management has added a new Health Center fee which will increase more resources in the fall. A plan will be developed to ensure funding matches with its operational goals and expectations so that staff are more effective and efficient in carrying out their job functions. Health Center management will explore the possibility of using reserves to fund the delivery of important services. Health Center management will ensure receipts are deposited efficiently in accordance with System regulations.*

*This process will be implemented by May 31, 2012.*
2. Non-Student Patients

Observation

Providing medical services to non-student patients creates risk for the Center and the University.

The Center does not effectively manage the billing and collection processes associated with treating non-student patients, as discussed in the following issues:

- The Center has not billed Medicare for services provided to its non-student patients since March 2010, and as of the date of this review had accumulated Medicare receivables of approximately $4,000. Beginning in March 2010, Medicare requires all claims to be filed electronically. The Center's automated patient management system, Medicat, was not able to electronically process Medicare claims without additional software. Center management indicated that, until recently, it did not have the financial resources to acquire this software, and are now in the process of acquiring the software and expects to be able to file Medicare claims in late 2011. Medicare requires claims to be filed within two years.

- The Center has not performed a review of its billing rates for its non-student patients in more than ten years. A comparison of the Center’s rates for an office visit found the rates to be significantly lower than those of local community healthcare providers. The Center charges a $35 fee per office visit, while the rate in the community for a clinic appointment appears to be in the $90 range. Over the last several years, the Center has seen an increase in the number of non-student patients. In fiscal year 2010 non-student patient visits accounted for 810 of the 5,842 (14%) total patient visits at the Center. This is an increase from fiscal year 2003 when approximately 10 percent of the total patient visits were non-students (483 of 4,599).

When the Center is unable to collect on health care charges for non-student patients, or is undercharging for non-student medical services, these costs are likely being paid by student Health Center fees. The Center is the only health center in the A&M System that regularly treats non-student patients (faculty, staff, and Waller County residents). While the Center has a long standing practice of treating non-student patients, they need to be able to manage the additional risks associated with treating this group of patients. As discussed in the previous section of this report, the Center has very limited financial resources, and not collecting the full costs of treating non-student patients presents additional financial problems. In addition to the financial risks mentioned above, there are compliance risks with federal health
2. Non-Student Patients (cont.)

Improved compliance is needed in signed student worker confidentiality statements.

care laws that must also be managed. The Health Information Portability and Accountability Act (HIPAA), which addresses the privacy and security rules associated with patient information, applies to the non-student patients but not to the student patients whose privacy is covered under another federal law, the Family Educational Rights and Privacy Act (FERPA).

Recommendation

Center management should make arrangements to resume Medicare billing as soon as possible. University management should re-evaluate the need to continue treating non-students. If management decides to continue this service, the Center should analyze the rate structure charged to non-students to determine that they cover the full cost of this medical care in order to avoid subsidizing these medical services with income from Student Health Center fees.

Management's Response

We agree with your recommendations. Health Center management will make arrangements to resume Medicare billing. Although management believes cutting services for non-students does not impact goals or objectives, the University management will re-evaluate the need to continue treating non-students. Health Center management will analyze the rate structure charged to non-students.

This process will be implemented by May 31, 2012.

3. Confidentiality Statements

Observation

Current practices do not ensure compliance with the Center’s requirements for student worker confidentiality statements. Three of eleven student workers (27%) reviewed in the Center did not have signed confidentiality statements on file. A lack of management oversight contributed to this situation. It is important to have students recognize that they may have access to confidential information as part of their work, and to sign a confidentiality statement acknowledging that fact and their responsibility to not divulge this confidential information.
3. Confidentiality Statements (cont.)

Recommendation

Improve compliance with Center requirements that student workers sign confidentiality statements when hired.

Management’s Response

We agree with your recommendations and we are implementing formal processes to ensure the following:

Health Center management will ensure student workers sign confidentiality statements at the time of hire.

This process will be implemented by January 31, 2012.
BASIS OF REVIEW

Objective

The overall objective was to review and assess the University’s controls and processes over the Owens-Franklin Student Health Center’s services to determine if resources are used efficiently and effectively and in compliance with laws, policies, regulations, and rules.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The Owens-Franklin Health Center provides medical health care to students, faculty, staff, and community residents of Waller County. It has approximately 14 full-time staff, including a full-time physician, and an annual operating budget of approximately $1.5 million. The Center had 5,842 patient visits in fiscal year 2010.
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First Quarter Report for Fiscal Year 2012

TEXAS A&M UNIVERSITY

Review of Payroll

Catherine A. Smock, C.P.A.
Chief Auditor
PROJECT SUMMARY

Overall, financial and management controls at Texas A&M University provide reasonable assurance that payroll expenditures are accurate and complete and in compliance with laws, policies, regulations, and rules. Opportunities for further improvement include increased monitoring and controls over certain departmental payroll expenditures that are not processed through the normal monthly budgeted payroll processes including supplemental pay and payroll corrections. The University should continue working to increase the efficiency and effectiveness of payroll operations such as further reducing the number of manual payroll transactions including both supplemental pay and payroll corrections. The University processes approximately 380,000 payroll transactions totaling $800 million annually.

OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. Payroll Monitoring and Controls

Observation

Payroll monitoring and controls need to be strengthened in certain areas.

Testing of all of the University's departmental payroll transactions for the first nine months of the fiscal year using data analysis techniques indicated that payroll transactions were generally accurate and in compliance with laws, policies, regulations, and rules based upon supporting departmental payroll documentation. We noted some instances of noncompliance along with areas where controls could be further improved as follows:

- Approval dates were missing from 8 of 12 (67%) dual employment supplemental pay documents tested and thus evidence of advanced approval required by University procedures was not available. University Standard Administrative Procedure 31.01.99.M0.02 related to supplemental pay for dual employment requires advanced approval of the head of both departments when the payment involves more than one department.
1. Payroll Monitoring and Controls (cont.)

- Payroll transactions indicating an excessive number of hours worked were identified for one department and were the result of employees receiving supplemental pay for being on-call during regular working hours which is not appropriate. These transactions were also not in compliance with departmental procedures which indicate these payments should be made only for hours other than normal working hours in which a person is on-call.

- Job duties of some University payroll staff include approvals of certain payroll activities for all University employees. However, three of these payroll staff members have related individuals that work for other departments at the University. As a result, there is a potential risk for actual or perceived conflict of interest related to these approvals. Texas A&M System Policy 33.03, Nepotism, states that departments or comparable administrative units may employ individuals who are related as spouse, as parent-child, or as sibling provided that neither relative has responsibility for direct or indirect supervision of the other, or authority over any term or condition of the other’s employment, including salary or wages. Although these approvals are secondary to departmental approvals and no unusual behavior was noted in the audit period, the ability to approve payroll activities and access payroll data for related individuals should be further evaluated and monitored to ensure no conflict of interest exists or could be perceived as one.

- Approval forms and procedures for supplemental pay related to extra work performed such as continuing education, work unrelated to current duties, and work at greater than 100% effort do not include a requirement for ensuring that appropriate leave is taken by the employee in accordance with relevant University leave requirements while performing additional work. In addition, supplemental pay approval forms do not always include use of a signature block which makes it difficult to determine the actual approver. Use of the signature block would better facilitate and ensure proper approvals.

Payroll transactions and approvals are currently handled at the department level with only limited monitoring of these transactions outside of the departments. Additional monitoring would provide greater assurance that payroll expenditures are accurate and in compliance with laws, policies, regulations, and rules. This is especially important given the magnitude of payroll transactions and payroll-related expenditures at the University which total approximately 380,000 and $800 million annually.
1. Payroll Monitoring and Controls (cont.)

The Committee of Sponsoring Organization’s Internal Control Integrated Framework states that internal control systems need to be monitored to ensure that they continue to operate effectively. Given the large number of payroll transactions processed, a risk-based monitoring approach using data analysis tools may be the most effective and efficient method to provide additional oversight and monitoring of these transactions.

Recommendation

Implement additional risk-based monitoring processes to further ensure departmental payroll expenditures are accurate and complete and in compliance with laws, policies, regulations, and rules. For instance, employ various data analysis techniques to identify areas of risk related to departmental payroll transactions and perform additional monitoring such as spot checks of payroll documentation and approvals in these areas. Address the specific instances of departmental noncompliance noted above.

Review existing payroll processes for actual or perceived conflict of interest such as situations where a Payroll Services’ employee may have the potential to approve payroll documents or have access to sensitive payroll information for related individuals. Evaluate the related risk based on management’s knowledge of operations and develop a monitoring strategy.

Develop and implement a process to ensure that proper leave is taken as required in situations where non-faculty employees are receiving supplemental pay for extra work performed. A statement to this effect could be added to current supplemental pay approval forms as evidence that this leave verification has been performed during the supplemental pay approval process. Document this process within University payroll procedures. Consider updating supplemental pay approval forms to also include signature blocks for all required approvals.

Management’s Response

We will evaluate and implement additional risk-based monitoring processes, including those specific items listed, by February 28, 2012 to further ensure departmental payroll expenditures are accurate, complete, and in compliance. This will be an ongoing process and additional processes will be put in place as needs are identified.

Existing payroll processes will be reviewed for actual or perceived conflict of interest with a monitoring process in place by May 31, 2012.
Opportunities exist for further automation of payroll processes.

1. Payroll Monitoring and Controls (cont.)

A statement will be added to existing forms for certification that proper leave was taken when paying non-faculty employees by February 28, 2012.

An approval statement will be added to the supplemental pay approval forms for all required approvals by February 28, 2012.


Observation

Over the last few years, great strides have been made to automate many payroll processes; however, some payroll transactions at the University continue to be manually processed especially related to supplemental pay and payroll corrections. During testing we noted approximately 20,000 supplemental pay transactions and 13,000 payroll corrections during the first nine months of fiscal year 2011 which accounted for 12% of all payroll transactions during that period. These transactions are manually processed and included payroll processing issues such as changes to funding accounts and work study funding for student financial aid which represented a large portion of the payroll corrections noted during the audit. These manual processes are less efficient and increase the likelihood for clerical and processing errors.

The University has been working with the A&M System Business Computing Services (BCS) staff to further automate supplemental pay transactions and payroll corrections in the A&M System’s Budget, Payroll, and Personnel (B/P/P) system. Additional analysis to identify areas most prone to payroll corrections as well as their corresponding cause would further assist in preventing and thus reducing the number of manual payroll corrections. A key performance measure for the University’s Division of Finance, which includes the Payroll Services department, is cost savings/efficiencies. This measure focuses on quantifying savings and avoidance of both hard and soft costs which serves to connect performance excellence to the bottom line of the business operations.

Recommendation

Continue working with the A&M System BCS staff to further automate supplemental pay transactions and payroll corrections in the B/P/P system.

Perform additional monitoring and analysis of payroll corrections to identify common areas where payroll corrections are most prevalent and their corresponding cause. Implement corrective actions to eliminate the need for the payroll corrections in these areas as feasible and/or provide additional training as needed.

Management's Response

We will continue working with the A&M System BCS staff to further automate payroll transactions. A meeting will be scheduled with BCS staff to determine the priority and develop a timeline for initiating efforts to further automate payroll transactions. It is estimated that the timeline will be received by February 28, 2012.

We will monitor and analyze payroll corrections to identify common areas where these occur and work with those areas to eliminate or minimize the need for corrections. We will have a process in place for this and will have worked with at least two of the top areas that are identified by May 31, 2012. We will work with those areas we identify on an ongoing basis.
BASIS OF REVIEW

Objective and Scope

The overall objective was to review the financial and management controls over payroll operations to determine if the University has processes in place to ensure the completeness, integrity and accuracy of wages and salaries paid to staff and faculty, and that the University is in compliance with laws, policies, regulations, and rules.

Payroll transactions for the first nine months of fiscal year 2011 at Texas A&M University were analytically reviewed using fiscal year 2011 payroll data. The review consisted of using computer-assisted data analysis to subject all payroll data to various tests. These tests were designed to correlate risks within the payroll process, focusing on the identification of unauthorized or inappropriate transactions, and the efficiency and effectiveness of the processes. The parameters of the tests were defined based upon compliance with laws, policies, and regulations, as well as, expected relationships indicative of the integrity and reasonableness of transactions.

Through a review of supporting payroll documentation and discussion with personnel, we tested a sample of transactions inconsistent with individual test parameters. In addition, we reviewed processes for recovering and restoring critical payroll functions that have been either partially or completely interrupted as the result of a disaster or other extended disruption and account management controls over access to confidential payroll data in the University’s imaging system. Fieldwork was conducted from June to August, 2011.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System; Texas A&M University rules and standard administrative procedures; the Committee of Sponsoring Organization’s Internal Control Integrated Framework; and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain
sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Many of the payroll processes at the University are initiated and approved at the department level. Payroll Services, an administrative unit operating within the University's Division of Finance, serves as the primary resource for payroll processing for the University. There are three sections within Payroll Services: Payroll Processing; Distribution, Imaging and Employment Verifications; and Tax which are staffed by twenty-three employees. The Payroll Processing section is responsible for review and processing of Employee Payroll Actions (EPA), monthly and biweekly time and effort reporting and required employment documentation in accordance with established laws, rules and regulations for Texas A&M University. The Distribution, Imaging and Employment Verifications section is responsible for printing and distributing payroll-related reports, checks, and earnings registers as well as digital imaging of payroll documents and maintenance of online payroll reports. The Tax section is responsible for a variety of services with regards to tax matters as they relate to payments made to employees, vendors or students. The University processes approximately 380,000 payroll transactions annually for over 18,000 individuals totaling $800 million.
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First Quarter Report for Fiscal Year 2012

TEXAS A&M UNIVERSITY

Review of Service Centers

Catherine A. Smock, C.P.A.
Chief Auditor
PROJECT SUMMARY

Texas A&M University has established processes to provide assurance that University service centers’ rate studies are reviewed annually for compliance with laws, policies, regulations and rules. However, these processes were not effective in ensuring the timely submission and approval of all required service center rate studies. The University delegated responsibility for monitoring compliance with applicable federal and A&M System regulations to the Office of Cost Analysis within the Division of Finance, but several service centers were delinquent in submitting accurate and complete rate studies and appropriate levels of management were not involved to ensure prompt compliance with the University’s reporting and rate review requirements.

The University has 47 services centers, with combined annual expenditures of approximately $112 million.

OBSERVATION, RECOMMENDATION, AND RESPONSE

Annual Rate Studies

Observation

Procedures were not in place to ensure timely submission and approval of annual rate studies in compliance with A&M System regulations and University rules. Fifteen of 47 (32%) service centers reviewed did not submit annual rate studies to the Office of Cost Analysis in compliance with A&M System Regulation 21.01.05 and University Rule 21.01.05.M1. The service centers either did not submit an annual rate study to the Office of Cost Analysis by August 31, 2011, or the rate study submitted was incomplete or inaccurate. Combined total expenditures of these 15 centers were approximately $19.5 million. Previously, the Office of Cost Analysis had primarily communicated directly with the person actually performing the rate study or the department head to which the center reports. The applicable dean or vice president responsible for the review and approval of the service center rates was not notified of late or inaccurate rate studies. Since supervisors were not notified, they could not assist with resolving problems and providing necessary
support and resources to ensure that rates were developed in accordance with System regulations and federal guidelines.

Not conducting annual reviews of service center rate studies increases the University’s risk of noncompliance with allowable rates that can be charged to federal projects.

**Recommendation**

Ensure rates are reviewed by the Office of Cost Analysis in a timely manner. Establish procedures that provide periodic reports of noncompliance to a higher level of management for greater accountability of rate study requirements.

**Management’s Response**

*The Division of Finance management agrees with the observation and the recommendation provided above. The Office of Cost Analysis will create a process to monitor and track rate study due dates. A process will also be established to monitor rate study compliance with applicable System regulations and University rules. Each of these processes will include a written notification for any delinquent or non-compliant rate study submissions. The notification process will include a tiered distribution methodology to ensure higher levels of management are included on notifications as the level of delinquency and noncompliance of the rate study increases. Target date for implementation is August 2012.*
BASIS OF REVIEW

Objective and Scope

The objective of this audit was to review the financial and management controls over service centers to determine if processes are in place to ensure service center rates are accurate and in compliance with laws, policies, regulations and rules. The review of service centers was limited to the review of rate study submissions to the Office of Cost Analysis and the rate study review and approval process performed by the Office of Cost Analysis. The audit period focused primarily on activities from September 1, 2010 to August 31, 2011. Fieldwork was conducted from September to October, 2011.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors' "International Standards for the Professional Practice of Internal Auditing."

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Service centers are units within the University that provide goods and services at approved rates primarily to University and other A&M System users. University service centers are subject to federal laws and regulations including the Federal Office of Management and Budget Circular A-21 that has specific requirements for rates that can be charged to federal projects. The Office of Cost Analysis reports to the Vice President for Finance and is tasked with review and approval of service center rates. They also assist service centers during preparation of the annual rate studies by offering guidance for accurate and timely completion of the rate study.
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First Quarter Report for Fiscal Year 2012

PRAIRIE VIEW A&M UNIVERSITY

Review of Financial Management Services

Catherine A. Smock, C.P.A.
Chief Auditor

Project #20110505
PROJECT SUMMARY

Overview

Overall, Prairie View A&M University has processes and controls in place to provide reasonable assurance that financial management services operations are performed effectively and efficiently and in compliance with laws, policies, regulations and rules. Opportunities for improvement exist in the areas of payroll, contract administration, and reconciliations.

The Office of Business Affairs provides a wide range of support including accounting, budgeting, fixed asset, payroll, procurement card, purchasing, reconciliation, travel, and treasury services.

Summary of Management’s Response

Management appreciates the System Internal Audit Department’s efforts to identify issues needing improvement and steps necessary to ensure improvement is achieved. We are committed to satisfactorily addressing these issues and have developed and enhanced procedures to address the recommendations in the report.

Scope

The review of financial and management controls within the University’s Office of Business Affairs focused on the areas of accounts receivable, bank reconciliations, contract administration, customer service, deposits, payroll, property management, purchase and travel vouchers and working funds. Transactions and activities were reviewed primarily for the period of March 2010 to February 2011. Fieldwork was conducted from May to August 2011.
OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. Payroll

Observation

Current controls over payroll functions do not include a strong monitoring process to identify overtime payments to exempt employees and untimely approval of supplemental payments. The following exceptions were identified:

• Five University employees classified as exempt in the payroll system received overtime pay totaling approximately $6,000 during the audit period. According to System Regulation 31.01.09, Overtime, exempt employees are not eligible for overtime payment. These payments would have been more appropriately processed as supplemental payments. Payments were supported by approved payroll adjustment forms and time card reports for janitorial and security services, as well as extra time worked due to staff shortages.

• The request for supplemental pay form was not signed prior to commencement of work for seventeen of twenty-one (81%) supplemental payments reviewed. Signatures necessary for approval were obtained one to sixty days after work began. University Administrative Procedure 27.04.99.P0.05, Supplemental Payroll Payments requires that “the requesting department must complete the request for supplemental pay form and obtain the required approvals before authorizing the employee to perform the work.”

Weak controls over payroll processes increase the risk that unearned and unauthorized payments will be made to employees, resulting in lost revenue and noncompliance with A&M System regulations and University administrative procedures.

Recommendation

Ensure the University community is aware of University Administrative Procedure 27.04.99.P0.05, Supplemental Payroll Payments, and the requirement that the request for supplemental pay form must be completed prior to the start of work. Ensure payments to exempt employees for duties performed outside their normal work hours or course of work are processed as
1. Payroll (cont.)

supplemental payments. Monitor for compliance with these requirements.

Management’s Response

We agree with your recommendation.

Financial Services management will ensure the University is aware of University Administrative Procedure 27.04.99.P0.05. This procedure is being revised to more fully describe the supplemental payroll process. The revised procedure will be distributed via campus announcement and periodic training sessions will be provided.

Payroll adjustment forms will be submitted for supplemental payments and only specific payments will be processed via this form. All payroll adjustment forms will be monitored for compliance, which will require appropriate authorized signatures with supporting documentation attached prior to processing for payment.

This process will be implemented by May 31, 2012.

2. Contract Administration

Observation

Three of ten (30%) contracts reviewed were not fully approved prior to the contract execution date. Delay periods ranged from approximately 6 to 90 business days. A total of 242 contracts were in place during the audit period.

Timely routing of contracts can prove to be challenging as it is a manual process. A&M System Policy 25.07.01, Contract Administration Procedures and Delegations, and University Administrative Procedure 25.07.01.P0.01, Contracting Delegations, require all contracts to be processed in accordance with the President’s delegation of authority. If contracts are not routed for required approvals in an efficient manner, the University could be bound to a contract which does not serve the best interest of the institution.

Recommendation

Ensure employees involved with contract administration procedures are aware of the importance in fully executing a contract prior to its start date. Develop a contract routing form to be used with each
2. Contract Administration (cont.)

Reconciliations were not consistently dated by the reconciler resulting in the inability to determine timeliness of the reconciliation process.

Management’s Response

We agree with your recommendations.

Financial Administration management will ensure employees involved with contract administration procedures are aware of the importance in fully executing a contract prior to its start date. The procedure will be distributed via campus announcement and monthly training sessions will be provided.

A contract routing form has been developed and implemented by management, which includes the contract execution date as well as signatures required and dates signatures are received.

This process will be implemented by February 29, 2012.

3. Reconciliations

Observation

Of fifteen reconciliations reviewed, six (40%) did not include the date the reconciliation was performed. Timeliness of reconciliations could be determined by reviewing either the reconciler or reviewer’s date for eleven of fifteen reconciliations reviewed; of these eleven, five (45%) were not performed timely ranging from three to forty-one days after the allowable thirty-day period. For the four remaining reconciliations, timeliness could not be determined as the review date was outside the thirty-day period and the reconciled date was not provided. As of audit test work the University was utilizing eleven local banks and forty State Comptroller accounts.

According to the University Reconciliations Office Procedures, both the preparer and reviewer are required to initial and date the reconciliations. Compliance with this process would facilitate management’s monitoring efforts to determine accountability and timeliness of reconciliations. Performing and reviewing bank reconciliations in an untimely manner reduces the effectiveness of the reconciliation as an internal control and increases the risk of impropriety.

University management has made several changes to improve the reconciliation process including the establishment of a reconciliation entity within the Office of Business Affairs and a
3. Reconciliations (cont.)

reconciliation report listing all banks in use, status of the most recent reconciliation, and number of outstanding items. This report is provided to the Vice President for Business Affairs for regular review.

Recommendation

Continue efforts in ensuring timely completion and review of bank reconciliations. Ensure those performing and reviewing reconciliations both sign and date the reconciliation as required by University procedures.

Management’s Response

We agree with your recommendations.

Financial Administration management will continue its efforts in ensuring timely completion and review of bank reconciliations. We will ensure those performing and reviewing reconciliations sign and date the reconciliations as required by University procedures.

This process will be implemented by March 31, 2012.
BASIS OF REVIEW

Objective

The objective of the audit was to review the financial and management controls over the University’s financial management services' operations to determine if resources are used efficiently and effectively, assets are safeguarded, and compliance is achieved with applicable laws, policies, regulations, and rules.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System, Prairie View A&M Administrative Procedures, and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The Office of Business Affairs at Prairie View A&M University strives to further the University’s mission by efficiently and effectively serving students, faculty, staff, and outside constituents. Business Affairs is divided into 11 units, which includes Financial Administration and Financial Services. These units provide many services including accounting, budgeting, contract review, payroll, procurement, and fixed asset management. There are approximately twenty employees in Financial Administration and Financial Services.
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First Quarter Report for Fiscal Year 2012

PRAIRIE VIEW A&M UNIVERSITY

Review of the University’s NCAA Athletic Rules Compliance Program

Catherine A. Smock, C.P.A.
Chief Auditor

Project #20110506
PROJECT SUMMARY

Prairie View A&M University has taken actions to improve its rules compliance program and provide greater assurance that the University’s intercollegiate athletics are operating in compliance with applicable National Collegiate Athletic Association (NCAA) regulations. A new director of athletic compliance was hired last year and more recently the University hired an athletic compliance officer. The newly staffed Athletics Compliance Office has provided additional resources to better oversee and monitor athletic activities. In addition, there appears to be greater accountability of coaches and athletic staff for rules compliance based upon the support provided by the Athletic Director and executive management. This includes having the Director of Athletics Compliance report directly to the President. A separate athletic foundation was also recently established to better manage and control athletic booster donations and activities. Additionally, the three remaining recommendations from prior NCAA rules compliance audits have been successfully implemented.

Although, no compliance issues were noted, additional improvements are needed in regard to certain rules compliance procedures and documentation, along with continued focus and management support for strong monitoring processes and accountability systems. All of this is important to demonstrate an effective NCAA rules compliance program in the future.

Summary of Management’s Response

Management appreciates the System Internal Audit Department’s efforts to identify issues needing improvement and steps necessary to ensure improvement is achieved. We are committed to satisfactorily addressing these issues and have developed and enhanced procedures to address these issues.
OBSERVATIONS, RECOMMENDATIONS, AND RESPONSES

1. Rules Compliance Procedures

Observation

The University has developed policies and procedures for their NCAA rules compliance program. However, these rules compliance procedures have not yet been updated to reflect new and revised compliance processes implemented by the Athletics Compliance Office. As a result, rules compliance procedures do not agree with actual practices as follows:

- Current processes for evaluating allegations and conducting investigations including who would undertake the investigation differ from the procedures documented in the University’s NCAA Athletics Compliance Manual.

- Procedures related to rules education contain outdated position titles and indicate at least two rules compliance training sessions will be held annually that all coaches and assistant coaches are required to attend. This does not agree with the current rules education process for coaches in which separate rules education sessions are provided to paid coaches in each of the four major sports groups as well as one-on-one meetings with head coaches.

In addition, there are no documented procedures to address NCAA rule interpretations or athletic booster access to student-athletes on the sidelines during athletic contests. The University’s athletic website also contains multiple procedure manuals with overlapping information. This can make it confusing for users to find information as well as difficult for athletic and compliance staff to maintain these manuals to ensure they are consistent. Policies and procedures form the foundation of the University’s NCAA rules compliance program. Without comprehensive procedures that are properly maintained and updated there is a greater risk of noncompliance with NCAA bylaws.

Recommendation

Update existing procedures to better reflect actual rules compliance processes in place, especially areas where new or revised rules compliance procedures have been implemented, such as those listed above. Develop additional procedures to
address NCAA rule interpretations and athletic booster access to the sidelines during athletic contests. Consider combining current athletic procedure manuals into a combined manual and making it more readily available by including it in the University’s official online policy library.

Management’s Response

We agree with your recommendations.

The Athletics Compliance management will review its existing procedures and ensure they accurately reflect the actual rules compliance processes. Additional procedures will be developed to address NCAA rule interpretations and athletic booster access to the sidelines during athletic contests. The Athletics Compliance management in conjunction with the Athletics Department management will consolidate the current athletic procedures manuals and ensure the manual is in the University’s official online policy library.

This process will implemented by May 31, 2012.

2. Rules Compliance Documentation

Observation

Other than investigations actually reported to the NCAA in 2008, there was little documentation available of previous allegations or investigations of rules violations at the University. In addition, no documentation was available of rules education materials provided by coaches to graduate assistants, volunteer coaches, and student-athletes in their respective sports. Rules interpretations are documented primarily in the email system. Documentation of NCAA rules compliance efforts are important to demonstrate the University’s due diligence and overall institutional control related to rules compliance which could result in reduced NCAA penalties in the event of future rules violation.

The University’s NCAA rules compliance procedures do not provide adequate guidance on documentation and retention requirements in the above areas. The Athletic Compliance Office is currently in the process of implementing the NCAA’s Compliance Assistance software. This software is provided by the NCAA to member institutions and includes features for preparing and retaining documentation for various rules compliance processes such as providing a documentation format and storage location for alleged rules violations and investigations and the corresponding reports.
Recommendation

Develop and implement documentation and retention requirements for the rules compliance areas listed above to better ensure these processes are adequately documented and provide evidence of compliance efforts in these areas. Add these documentation requirements to the University’s Athletics Compliance Manual.

Include graduate assistants and volunteer coaches in the rules education training sessions attended by the head coaches and assistant coaches for each sport to the extent possible. Otherwise have the Athletics Compliance Office provide the rules education materials to these individuals directly to better ensure this process is occurring as intended and is properly documented.

Complete the implementation of the NCAA’s Compliance Assistance software including utilization of the software features available for documenting rules compliance efforts.

Management’s Response

We agree with your recommendations.

The Athletics Compliance management will develop and implement documentation and retention requirements for the rules compliance areas and these requirements will be incorporated into the University’s Athletics Compliance Manual.

The Athletics Compliance management will ensure graduate assistants and volunteer coaches are trained at the time of employment. We will ensure these individuals receive the required trainings, newsletters, and hot topics.

The Athletics Compliance management will complete the implementation of the NCAA’s Compliance Assistance software and utilize software features for documenting rules compliance efforts.

This process will be implemented by May 31, 2012.
BASIS OF REVIEW

Objective and Scope

The objective was to review and assess the adequacy of the University’s NCAA rules compliance program for selected compliance areas. This review was performed to fulfill the NCAA requirements that each Division I member have its rules compliance program evaluated at least every four years by an authority outside the Athletic Department. Compliance areas are reviewed on a four-year rotating basis for Prairie View A&M University. This review focused on the compliance areas of camps and clinics, rules education, investigation and self-reporting of rules violations, extra benefits related to athletic boosters, and certification of compliance forms. The audit period focused primarily on activities from September 2010 through July 2011, although some activities outside this time period were examined as necessary. Fieldwork was primarily conducted from June to August 2011.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System; the 2010-11 National Collegiate Athletic Association Division I Manual; the University’s Athletics Compliance Manual; the University’s athletic department policies, procedures and student athlete handbook; and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Prairie View A&M University participates in intercollegiate athletic competition as a Division I member of the NCAA Football Championship Subdivision. In fiscal year 2011, the University’s athletics program consisted of 18 intercollegiate athletic sports as follows:
The University has an Athletics Compliance Office which is staffed with two full-time individuals and reports directly to the University’s president. The mission of this office is to provide a comprehensive compliance and monitoring program that promotes knowledge of and adherence to NCAA, Southwestern Athletic Conference, and institutional rules and regulations among members of the athletic department, Prairie View A&M University personnel and members of the athletics community, thereby reducing infractions.

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<td>Track &amp; Field - Outdoor</td>
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Prairie View A&M University: Review of the University’s NCAA Athletic Rules Compliance Program

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Texas A&M University System Internal Audit Department

First Quarter Report for Fiscal Year 2012

Texas A&M University – Corpus Christi

Review of the University’s NCAA Athletic Rules Compliance Program

Catherine A. Smock, C.P.A.
Chief Auditor

Project #20111507
PROJECT SUMMARY

Overall, the controls established over the National Collegiate Athletics Association (NCAA) rules compliance program at Texas A&M University - Corpus Christi are effective in providing reasonable assurance that the University is operating in compliance with NCAA regulations related to those compliance areas included in this review. Improvement is needed in the documentation of the timely notification to student-athletes of their annual financial aid scholarship renewals.

OBSERVATION, RECOMMENDATION, AND RESPONSE

Notification of Scholarship Terms and Conditions

Observation

For 16 of 28 (57%) student-athletes sampled, their records lacked evidence that they were notified of the University’s final decision to renew their athletically-related scholarships on or before the July 1 deadline established by the NCAA. Departmental procedures stipulate that the student-athlete will be asked to come to the Compliance Office to sign their award letter that has been approved by both the Athletic Department and the Financial Aid Office. If the student-athlete is not on campus, the award letter is to be mailed or emailed. The sixteen award letters were not signed before the deadline and notification emails that may have been sent by the former compliance officer were not available for review. Failure to notify student-athletes of their athletically-related financial aid status in a timely manner can hinder their decisions related to which school they will attend in the upcoming academic year.

Recommendation

Ensure that all student-athletes whose scholarships are being renewed are notified of the renewals on or before July 1 in
accordance with NCAA bylaws. This notification should be documented.

Management’s Response

The University agrees with the recommendation and will make improvements in the administration and oversight of the Notification of Scholarship Terms and Conditions.

The Athletic Compliance Office is conducting a review of all scholarship renewals for the 2010-11 and 2011-12 academic years in order to determine exactly how many student-athletes were not properly notified of their renewals pursuant to NCAA legislation.

The Athletic Department (starting in summer 2011) now uses the ACS InControl system in order to track all correspondence, including notifications, with student-athletes (telephone calls, texts, e-mails, etc.). By using this system, the Athletic Compliance Office is able to track all notifications (texts, e-mails, etc.) and is able to view the date and time in which the student-athlete has received and opened the notification.

BASIS OF REVIEW

Objective and Scope

The objective of the audit was to review and assess the adequacy of the University’s NCAA rules compliance program for selected compliance areas. This review focused on financial aid administration and playing and practice seasons. Financial aid administration includes general financial aid, terms and conditions and maximum limits. This audit period focused primarily on activities from September 1, 2010 to June 30, 2011. Fieldwork was conducted from June to August 2011.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System; the 2010 National Collegiate Athletics Association’s Division I Manual; the University’s Athletic Compliance Manual; and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.”
Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Texas A&M University – Corpus Christi is a member of the National Collegiate Athletics Association and competes at the Division I level. During the 2010-2011 academic year, the University had approximately 200 student-athletes participating in 14 intercollegiate sports as follows:

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<td></td>
<td>Cross Country</td>
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</tbody>
</table>

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First Quarter Report for Fiscal Year 2012

TEXAS A&M UNIVERSITY

Review of the Education Research Center

Catherine A. Smock, C.P.A.
Chief Auditor

Project #20120202
PROJECT SUMMARY

Texas A&M University has processes in place to provide reasonable assurance that the Education Research Center is in compliance with state and federal laws related to the interagency agreement between Texas A&M University, the Texas Higher Education Coordinating Board (THECB), and the Texas Education Agency (TEA). The Education Research Center operated within its contractual requirements. The University also implemented the recommendation in our prior report, Review of the Education Research Center, which was issued in December 2010, by improving the management of project accounts.

The Education Research Center, established in July 2007, is one of three Education Research Centers in Texas created to maintain a warehouse of student data and conduct research using this data. The Education Research Center received initial funding of $1,050,000 to establish the center and perform certain research projects and is in the last year of a five-year agreement. Expenditures from the initial grant totaled approximately $60,000 in fiscal year 2011 and there is a remaining balance of just over $150,000. Several other grants have been received since its inception which provide funding for further education research projects.

BASIS OF REVIEW

Objective and Scope

The objective of the audit was to assess the University’s compliance with the contract terms and state and federal laws related to the interagency agreement between Texas A&M University, the Texas Higher Education Coordinating Board, and the Texas Education Agency to establish the Education Research Center at the University. The interagency agreement with the THECB and TEA requires Texas A&M University to obtain an audit of the Education Research Center annually. The review of the Education Research Center focused primarily on expenditures and contract compliance. Our review did not include a detailed review of data security or a penetration test as the Education Research Center arranged to be included in a controlled
penetration test performed by the Texas Department of Information Resources for the THECB. The audit period was September 1, 2010 through August 31, 2011. Fieldwork was conducted during September 2011.

Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors' "International Standards for the Professional Practice of Internal Auditing."

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The interagency agreement between Texas A&M University, the Texas Higher Education Coordinating Board, and the Texas Education Agency provided the University with $1,050,000 in 2007 to create and operate a research center for a period of five years. The State of Texas Education Research Center at Texas A&M University studies major issues in education reform and school governance in order to improve policy and decision-making in P-16 education. The Education Research Center's interdisciplinary team of researchers investigates the nature and impact of school resources and educational practices that affect students' learning and close the achievement gap. In support of its mission, the Education Research Center conducts research in three areas: educator preparation; school finance, resources, and facilities; and curriculum and teaching methods.
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Texas Transportation Institute

Review of ISO Accreditation

Catherine A. Smock, C.P.A.
Chief Auditor
PROJECT SUMMARY

The Texas Transportation Institute’s (TTI) Proving Ground’s Research Facility testing documentation is in compliance with its quality management system developed to comply with testing services identified in the International Standard ISO 17025. Overall, it appears the Agency management system developed to document policies, systems, programs, procedures and instructions to assure the quality of tests and results is compliant with ISO 17025. In addition, TTI implemented the recommendations in our prior report, Review for ISO Accreditation, which was issued in March 2011. Improvements were made to project test file documentation and the project test quality survey form.

The Proving Grounds and Research Facility located at TTI’s Riverside campus conducts testing procedures in accordance with ISO 17025 standards, and must go through an external accreditation process periodically to recognize their compliance status with ISO 17025. This review is a part of this process. Multiple types of testing are performed at the Proving Grounds and Research Facility including crash, pendulum, static, and bogie testing with just over 100 tests performed during fiscal year 2011.

BASIS OF REVIEW

Objective and Scope

Review the TTI Proving Grounds quality assurance program, including testing procedures, for ISO 17025 accreditation purposes. Our review of the Proving Ground’s management system and testing activities focused on compliance with the Agency’s quality management system testing procedures and International Standard ISO 17025 General Requirements for the Competence of Testing and Calibration Laboratories requirements. Activities and documentation related to these tests focused primarily on activities from September 17, 2010 through August 31, 2011. The review was conducted September through October 2011.
Criteria

Our audit was based upon standards as set forth in the System Policy and Regulation Manual of the Texas A&M University System and other sound administrative practices. This audit was conducted in conformance with the Institute of Internal Auditors’ “International Standards for the Professional Practice of Internal Auditing.” The requirements of ISO 17025 were also used as criteria for this review.

Additionally, we conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The Texas Transportation Institute has been in existence since 1950, and during this time has partnered with universities, communities, and industries to address a broad range of transportation issues. The TTI Proving Grounds and Research Facility conducts testing procedures in accordance with ISO 17025 standards, and must go through an external accreditation process periodically to recognize their compliance status with ISO 17025. This review is a part of this process.
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