POLICE & CRIME COMMISSIONER FOR LEICESTERSHIRE JOINT AUDIT, RISK & ASSURANCE PANEL

PAPER MARKED

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Report of	**CHIEF CONSTABLE**
Subject	**INTERNAL AUDIT PROGRESS REPORT**
Date	**TUESDAY 27 APRIL – 10.00 A.M.**
Author :	**MR MARK LUNN, MAZARS**

Purpose of Report

1. This report summarises the work that Internal Audit has undertaken in progressing the Operational Plan for the year ended 31st March 2021

2. Internal audit provides the Police and Crime Commissioner and Chief Constable with an independent and objective opinion on governance, risk management and internal control and their effectiveness in achieving the organisation's agreed objectives. Internal audit also has an independent and objective advisory role to help line managers improve governance, risk management and internal control. The work of internal audit, culminating in our annual opinion, forms a part of the OPCC and Force's overall assurance framework and assists in preparing an informed statement on internal control.

Recommendation

3. The Panel is recommended to discuss the contents of the report.

Background

4. None

Implications

Financial: none.
Legal: none.
Equality Impact Assessment: none.
Risks and Impact: as per individual reports.
Link to Police and Crime Plan: as per audit plan

List of Attachments / Appendices

Leicestershire Police and OPCC IA Progress Report – Apr 21

Background Papers

None

Officer to Contact

Paul Dawkins – Assistant Chief Officer (Finance & Resources): Leicestershire Police and Temporary Chief Finance Officer: Office of Police and Crime Commissioner for Leicestershire – 0116 248 2244

Police and Crime Commissioner for Leicestershire
Internal Audit Progress Report 2020/21

Joint Audit, Risk and Assurance Panel

April 2021

Presented to the Panel: 27th April 2021

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Disclaimer

This report ("Report") was prepared by Mazars LLP at the request of Leicestershire Police and the Office of the Police and Crime Commissioner (OPCC) for Leicestershire and terms for the preparation and scope of the Report have been agreed with them. The matters raised in this Report are only those which came to our attention during our internal audit work. Whilst every care has been taken to ensure that the information provided in this Report is as accurate as possible, Internal Audit have only been able to base findings on the information and documentation provided and consequently no complete guarantee can be given that this Report is necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required.

The Report was prepared solely for the use and benefit Leicestershire Police and the Office of the Police and Crime Commissioner (OPCC) for Leicestershire and to the fullest extent permitted by law Mazars LLP accepts no responsibility and disclaims all liability to any third party who purports to use or rely for any reason whatsoever on the Report, its contents, conclusions, any extract, reinterpretation, amendment and/or modification. Accordingly, any reliance placed on the Report, its contents, conclusions, any extract, reinterpretation, amendment and/or modification by any third party is entirely at their own risk. Please refer to the Statement of Responsibility in Appendix A1 of this report for further information about responsibilities, limitations and confidentiality.

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01 Summary

The purpose of this report is to update the Joint Audit, Risk and Assurance Panel (JARAP) as to the progress in respect of the Operational Plan for the year ended 31st March 2021, which was considered and approved by the JARAP at its meeting on 25th April 2020.

The Police and Crime Commissioner and Chief Constable are responsible for ensuring that the organisations have proper internal control and management systems in place. In order to do this, they must obtain assurance on the effectiveness of those systems throughout the year and are required to make a statement on the effectiveness of internal control within their annual report and financial statements

Internal audit provides the Police and Crime Commissioner and Chief Constable with an independent and objective opinion on governance, risk management and internal control and their effectiveness in achieving the organisation's agreed objectives. Internal audit also has an independent and objective advisory role to help line managers improve governance, risk management and internal control. The work of internal audit, culminating in our annual opinion, forms a part of the OPCC and Force's overall assurance framework and assists in preparing an informed statement on internal control.

Responsibility for a sound system of internal control rests with the Police and Crime Commissioner and Chief Constable and work performed by internal audit should not be relied upon to identify all weaknesses which exist or all improvements which may be made. Effective implementation of our recommendations makes an important contribution to the maintenance of reliable systems of internal control and governance.

Internal audit should not be relied upon to identify fraud or irregularity, although our procedures are designed so that any material irregularity has a reasonable probability of discovery. Even sound systems of internal control will not necessarily be an effective safeguard against collusive fraud.

Our work is delivered is accordance with the Public Sector Internal Audit Standards (PSIAS).

02 Current progress

Since the last meeting of the JARAP we have issued two final report in respect of the 2020/21 audit plan, these being in regard to Wellbeing & Vetting. Further details are provided in Appendix A3. Moreover, we have also issued one final report in respect of 2019/20 with this being in regard to Collaboration Business Continuity.

The impact of the Covid-19 lockdown(s) has posed several challenges to the internal audit process and the move to remote auditing has caused some initial delays in setting dates when the audits will be carried out. Both parties have worked hard to ensure the audits could be completed and Mazars have regularly communicated with the Force and OPCC, which has enabled us to make good progress against the plan to date.

As noted in our last progress report whilst, we have worked hard to ensure completion of the 20/21 plan by year end, due to the impacts of stating the plan late due to Covid-19 this means that two audit have been scheduled to take place in April – these being in regards to Medium Term Financial Planning and Payroll Provider.

At the time of writing fieldwork has largely been completed for the other outstanding audits – IT GDPR, IT Security Vetting, Risk Management, Victims Code of Practice and Workforce Planning and with timely responses from the Force it is anticipated these draft reports will be issued by the time the JARAP meets.

The finalisation of the Collaboration Business Continuity Audit from 19/20 completes the most outstanding audit to date. We are pleased to say that draft reports for the two Collaboration Audits in 20/21 have now been issued.

We have attended the regional Chief Finance Officers' meeting to discuss the Collaboration Audits for 2021/22 and it has been agreed that a more focused approach will be taken to collaboration audits and internal audit are working with the Collaboration Manager to produce a proposed plan of work to the next regional Chief Finance Officers' meeting. It is envisaged with a more focused approach this should result in the delivery of these audits in a timelier manner. Audit will keep the JARAP informed of progress moving forward.

Summary table of work to date:

Leicestershire 2020/21 Audits	Report Status	Assurance Opinion	Priority 1 (Fundamental)	Priority 2 (Significant)	Priority 3 (Housekeeping)	Total
Procurement	Final	Satisfactory	-	-	2	2
Estates Management	Final	Satisfactory	-	3	2	5

Payroll	Final	**Significant**	-	-	2	2
Core Financials	Final	**Significant**	-	-	1	1
Wellbeing	Final	**Satisfactory**		1	2	3
Vetting	Final	**Satisfactory**		1	2	3
Collaboration: Budget Control	Draft					
Collaboration: Workforce Planning	Draft					
		Total		**5**	**11**	**16**

03 Performance

The following table details the Internal Audit Service performance for the year to date measured against the key performance indicators that were set out within Audit Charter.

Number	Indicator	Criteria	Performance
1	Annual report provided to the JARAP	As agreed with the Client Officer	N/A
2	Annual Operational and Strategic Plans to the JARAP	As agreed with the Client Officer	Achieved
3	Progress report to the JARAP	7 working days prior to meeting.	Achieved
4	Issue of draft report	Within 10 working days of completion of final exit meeting.	100% (6/6)
5	Issue of final report	Within 5 working days of agreement of responses.	100% (6/6)
6	Follow-up of priority one recommendations	90% within four months. 100% within six months.	Achieved
7	Follow-up of other recommendations	100% within 12 months of date of final report.	N/A
8	Audit Brief to auditee	At least 10 working days prior to commencement of fieldwork.	100% (11/11)
9	Customer satisfaction (measured by survey)	85% average satisfactory or above	100% (2/2)

A1 Plan overview

Audit area	Proposed Dates	Draft Report Date	Final Report Date	Target JIAC	Comments
Procurement	Q1/2	Aug 2020	Aug 2020	Oct 2020	
Workforce Planning	Q2			Mar 2021	Awaiting meeting with management prior to issue of draft report.
Estates Management	Q2	Nov 2020	Dec 2020	Jan 2021	
Core Financials	Q3/Q4	Dec 2020	Jan 2021	Jan 2021	
Payroll	Q3	Oct 2020	Nov 2020	Jan 2021	
Wellbeing	Q3	Jan 2021	Mar 2021	Mar 2021	
Vetting	Q4	Feb 2021	Feb 2021	Mar 2021	
Risk Management	Q4			Jul 2021	Awaiting meeting with management prior to issue of draft report.
IT Security	Q4			Jul 2021	Fieldwork Completed, draft reports to be issued Apr 21
GDPR	Q4			Jul 2021	Fieldwork Completed, draft reports to be issued Apr 21
Victims Code of Practice	Q4			Jul 2021	Fieldwork Completed, draft reports to be issued Apr 21
Payroll Provider	Q4			Jul 2021	Fieldwork proposed to commence 9th Apr 21
Medium Term Financial Planning	Q4			Jul 2021	Fieldwork proposed to commence 19th Apr 21

A2 Reporting Definitions

Assurance Level	Control Environment
Significant Assurance:	There is a sound system of internal control designed to achieve the Organisation's objectives.
Satisfactory Assurance:	While there is a basically sound system of internal control, there are weaknesses which put some of the Organisation's objectives at risk.
Limited Assurance:	Weaknesses in the system of internal controls are such as to put the Organisation's objectives at risk.
No Assurance:	Control processes are generally weak leaving the processes/systems open to significant error or abuse.

Recommendation Priority	Description
1 (Fundamental)	Recommendations represent fundamental control weaknesses, which expose the Organisation to a high degree of unnecessary risk.
2 (Significant)	Recommendations represent significant control weaknesses which expose the Organisation to a moderate degree of unnecessary risk.
3 (Housekeeping)	Recommendations show areas where we have highlighted opportunities to implement a good or better practice, to improve efficiency or further reduce exposure to risk.

A3 Summary of Reports

Below we provide brief outlines of the work carried out, a summary of our key findings raised, and the assurance opinions given in respect of the final reports issued since the last progress report in respect of the 2019/20 Internal Audit Plan:

Collaboration: Business Continuity

Assurance on adequacy and effectiveness of internal controls	
EMSOU SOC	Limited
EMSOU FS	Satisfactory
EMCHRS OHU	Satisfactory
EMCJS	Satisfactory

Recommendation Priorities	
Priority 1 (Fundamental)	-
Priority 2 (Significant)	3
Priority 3 (Housekeeping)	4

Our audit considered the following area objectives:

Roles and Responsibilities

Roles and responsibilities in respect of Business Continuity across the unit are clearly defined, with officers and staff having a full understanding and accountability for associated processes.

Policies and Procedures

Effective policies and procedures are maintained and regularly reviewed to ensure a consistent and effective approach to Business Continuity is applied across the unit.

There is clear identification of critical functions within the unit.

Plans

There are effective Business Continuity Plans to ensure that incidents are effectively escalated, and emergency action is mobilised where required.

Business Continuity Test Plans

The Business Continuity Plans are subject to regular testing to ensure they remain fit for purpose

Continuous Improvement and Lessons Learnt

The delivery of testing plans, associated outcomes and unplanned events is monitored with systems embedded to drive continuous improvement and lessons learnt. Where issues are identified these are appropriately escalated.

Monitoring and Reporting

There is regular monitoring and reporting of business continuity processes and there is opportunity for effective challenge and scrutiny.

We raised three priority 2 (Significant) recommendations where the control environment could be improved upon. The finding, recommendation and response from the report is detailed below:

Recommendation 1 (Significant)	The EMSOU SOC & EMCHRS OHU should formally document where responsibility for business continuity lies within the unit. The Collaboration Units should consider adopting their own business continuity policy that align to the Forces in the region and including the roles and responsibilities within this. Alternatively, they could adopt a Force Policy and amend the responsibilities for the unit.
Finding	At each of the Forces in the region, a Business Continuity Policy sets out the Force's approach to BCM and documents the roles and responsibilities for business continuity. The collaboration units that audit visited for this review found that policies and procedures for business continuity were not in place, (either a separate policy or adopting one of the Forces). Therefore, in some instances (EMSOU SOC & EMCHRS OHU, it was not clearly stated who has responsibility for business continuity. Risk: Lack of ownership and oversight of Business Continuity. Business Continuity Plans are not properly maintained and are therefore ineffective during an adverse event.
Response	EMSOU: The Business Continuity Policy has been written and approved by Notts BC Manager. It will now be added to EMSOU Policy register and regularly reviewed. OHU: The plan owner and plan manager are specified within the OH BC Plan. These are the ACO with OH in their portfolio and the Head of OH.
Timescale	Completed

Recommendation 2 (Significant)	EMSOU should ensure that BC Plans across the unit are in place and up to date. Once the Plans are up to date the unit should ensure that they are regularly reviewed and updated, it should be considered that the Risk, Assurance & Compliance Meeting are provided with oversight to ensure that the review and updates take place.
Finding	At the time of the audit visit, discussion with staff at EMSOU confirmed that they were in the process of reviewing and updating all of the BC Plans because it had been identified that they were outdated. The Unit does have a governance forum that oversees Business Continuity and therefore this forum should be kept up to date with the status of the BC plans across the unit moving forward. Risk: Business Continuity Plans are not fit for purpose.
Response	BC Plans have now been written and approved by Notts BC Manager. A tabletop exercise now needs to take place to test these (being planned) and once this is done the plans can be published within EMSOU.

Timescale	Completed.

Recommendation 3 (Significant)	EMSOU SOC, EMCJS and EMCHRS OHU should carry out testing/exercising of all Business Continuity Plans on a regular basis to ensure they remain fit for purpose. Consideration should be given for the Force BC Managers to assist all the collaboration units with appropriate tests of their plans e.g. desktop-based exercises.
Finding	The aims of testing, business continuity plans, is to ensure that in the event they need to be activated they are effective and are able to restore critical function as quickly as possible. Form our previous reviews of business continuity at each Force in the region we note all have some form of BC Plan testing in place. Audit noted that at EMSOU SOC and EMCHRS OHU there were no planned tests of business continuity plans. For the Force owned EMCJS plans it was unclear if business support would carry out testing or the Forces' BC Managers. Risk: Where business continuity plans are not subject to appropriate testing, they maybe not up to date or fit for purpose.
Response	EMSOU: We intend to introduce BC testing once our plans have been updated. The EMSOU Support Manager will coordinate the testing for EMSOU SOC in consultation with Notts Police. The frequency of testing will also be consistent with Notts police Discussions are ongoing about the best form for a test to take. It is hoped to carry this out within a few weeks
Timescale	Completed

In addition to the above we raised four priority 3 recommendations of a more housekeeping nature relating to:

Business Continuity Support – it was noted that not all the units were invited to the regional east midlands business continuity meeting.

Monitoring & Oversight of Business Continuity (OHU) – it was noted Business Continuity was not a standing agenda item at Management Board meetings.

Lessons Learned – A recommendation was raised to ensure a review of actions taken during the pandemic takes place at each unit.

Future Considerations – it was noted the approach to business continuity differs at each unit, with not all having their own defined plans. In light of the impacts of the pandemic each unit should consider holding their own plans that cover loss of staff.

For each recommendation agreement was made for each unit with appropriate management response confirmed by the regional CFO's meeting. All recommendation were noted as completed.

Below we provide brief outlines of the work carried out, a summary of our key findings raised, and the assurance opinions given in respect of the final reports issued since the last progress report in respect of the 2020/21 Internal Audit Plan:

Vetting

Overall Assurance Opinion	Satisfactory

Recommendation Priorities	
Priority 1 (Fundamental)	-
Priority 2 (Significant)	2
Priority 3 (Housekeeping)	1

Our audit considered the following area objectives:

Governance

- Governance arrangements for Vetting are clearly defined, including roles and responsibilities, risk management processes, decision making and reporting arrangements.
- There are clearly documented procedures in place that support the processing of vetting requests and are aligned with the relevant Codes and any other relevant legislation and good practice.

Processing of Vetting Requests

- Vetting requests are accurately recorded and there are effective processes for securing and holding information to support the requests.
- Vetting requests are correctly assessed in terms of level of security clearance required and are dealt with in accordance with the relevant legislative and procedural requirements.
- There is a robust appeals process which is communicated to those requesting vetting when informed of the outcome of the request.
- Vetting requests are processed in a timely manner, in accordance with any relevant SLAs.
- There is an agreed scale of fees for administering vetting requests and income from such.

APP Implementation

- The Force has assessed the impact of the introduction of the revised APP on Vetting and considered this in the context of the Force.
- The Force has implemented / action plans in place to ensure alignment with the Forces processes to the APP.

Monitoring

- Robust performance information is produced that enables the Force to effectively manage the vetting process.
- Performance data that is calculated is accurate and supported by source data.
- The Force ensure that Officer Vetting is renewed sufficiently prior to expiry, through regular review and reconciliation.

Follow Up

- Previously identified weaknesses have been addressed.

We raised three priority 2 (Significant) recommendations where the control environment could be improved upon. The finding, recommendation and response from the report is detailed below:

Recommendation 1 (Significant)	The Force should review both the appeals guidance that is published on the external website and the appeals flowchart used internally by the Vetting team to ensure that there is consistency with that which is advised to candidates. Performance information for appeals should be monitored and reported on, further noted within recommendation 4.3.

Finding	An appeals guide is published on the Force external website, which states that following investigation, a full and final response will be made in writing within 14 working days An internal flowchart for appeals is in place, where it is stated that applicants are to be informed of the decision within 14 calendar days on receipt of the appeal. There are therefore contradictory timescales for completion of appeals cases within internal and external guidance. Audit performed a sample test of five appeals, where it was noted that in one instance the response was made to the candidate in 17 working days / 23 working days. This is outside of the timescale as set out within the Appeals guidance document and the internal flowchart. Through discussion with management, it has been noted that this is an internally set timescale that is not directed or governed by the College of Policing guidance. Risk: The Force internal appeals process is not adhered to. External and internal guidance is not aligned.
Response	Update is required of the external HR website to provide clarity and distinguish between the HR Appeal response timeframe and the Vetting Appeal response timeframe. Timeframe for Vetting appeal responses to be extended to 14 working days.
Timescale	Completed (March 21)

Recommendation 2 (Significant)	The Force should ensure that performance information is produced for Vetting, with consideration made to enhancing the data that is included within the performance indicators. The vetting performance information that is produced should be presented at the Professional Standards Department (PSD) Senior Management Team (SMT) meetings. Examples of further indicators that will enhance the reporting are: - The number of cases received in the month - The number of cases processed in the month - The % of renewals processed prior to the expiry date - Exception reporting on significant outliers in cycle / touch time - The proportion of each type of vetting case received within the month - The turnaround time on vetting appeals that are processed.
Finding	Since February 2020, no performance data has been produced for the area of Vetting due to no analyst being in post. Audit performed a review of the most recent indicators used at January 2020, where it was noted that there was insight on the following areas: • how long the cycle of each case takes. • the average time worked on a case by the Vetting team, the number of

	cases in progress. • and the number of outstanding cases. Audit have identified processes which are not subject to performance reporting, or review through use of indicators, such as the actual volume of cases received in to the area, the timeliness of processing renewals, any cases which required a significant amount of time that skews overall averages, and consideration over the type of each vetting processed by the team. Risk: The Force are unaware of performance of the Vetting team. Management are unable to monitor and assess performance.
Response	Currently, MI reporting responsibility sits outside of the Vetting unit and therefore is not within the direct control of the Security Vetting Manager. 1) Outstanding PSD performance reports for March 2020 – January 2021 have been obtained since the draft audit report was received (08/02/2021) 2) In line with the audit recommendations, the reporting categories and KPI's are to be reviewed by the Security Vetting Manager who will act as Subject Matter Expert to the SSD Performance Analyst lead, for the development of a Strategic and Operational Vetting dashboard.
Timescale	1) Completed (March 21) 2) March 2022

In addition to the above we raised one priority 3 recommendations of a more housekeeping nature relating to:

Internal Vetting Guidance – At the time of the audit, there was no formally documented guidance in place for staff, to support them in the processing of vetting cases. However, a new system is due to replace the existing one and therefore on implementation of the new vetting system, the user guide should be completed by the Force.

The above was agreed with an estimated timescale for completion of February 2022.

Wellbeing

Overall Assurance Opinion	Satisfactory

Recommendation Priorities	
Priority 1 (Fundamental)	-
Priority 2 (Significant)	1
Priority 3 (Housekeeping)	2

Our audit considered the following risks relating to the area under review:

- Clearly defined Governance arrangements are not in place resulting in ineffective and inefficient arrangements.
- There is an inconsistent line of reporting between the four individual boards and the Wellbeing Leadership Board resulting in ineffective decision making.
- The Wellbeing Strategy and Policies & Procedures are not aligned with strategic aims and do not provide clear direction.
- Implementation plans are not robust, aligned with strategic objectives and take into account future need.
- Robust recording, monitoring and analysis processes of Wellbeing data are not in place resulting in ineffective action plans and feedback shared at governance meetings; and,
- Issues are not identified promptly and are not evaluated appropriately leading to repeated issues in Wellbeing projects/works.

In reviewing the above risks, our audit considered the following areas:

- Governance.
- Strategy & Policies.
- Implementation Plans.
- Feedback and Monitoring; and,
- Lessons Learned

We raised one priority 2 (Significant) recommendations where the control environment could be improved upon. The finding, recommendation and response from the report is detailed below:

Recommendation 1 (Significant)	The Force should ensure that data, outlined on each working group's Plan on a Page, is being reviewed regularly and that any data analysis requested is being carried out effectively and shared with all relevant governance bodies.
Finding	Thematic Data Wellbeing Groups, covering the four thematic areas, meet bi-monthly to discuss current initiatives and ideas for increasing awareness and activity in their wellbeing area, in line with their Terms of Reference. Each group also has a Plan on a Page, which outlines their Goals for the year, Evidence, Benefits, Performance Indicators and Development Areas. Therefore, it would be reasonable to discuss Performance Indicators (and their underlying data sources) on a regular basis to ensure that objectives are on track. Performance Indicators are usually linked to Management Information that is provided by external providers but is also generated internally from the HR

	Gateway and covering the thematic areas. Examination of minutes and agenda packs for all Wellbeing Groups and the Wellbeing Leadership Board has found that the regular review of Management Information or the underlying data, is not carried out. Where Management Information is discussed, this is one-off analytics that have been requested within one Wellbeing Group and is not more widely shared. Data Analysis Our review has identified three distinct data analysis exercises (in contrast the thematic data above, were the data is extracted but not transformed for analysis). These related to an analysis of Long-Term Sickness (LTS) absences specifically limited to mental health absences; a Training Needs Assessment that was noted by Management; and, a Working from Home (WfH) survey carried out through the year. For greater efficiency, the LTS review could have been carried out over all LTS absences and reported to all Wellbeing Groups for review/discussion and, subsequently, the Wellbeing Leadership Board. Additionally, we noted that the review of the LTS at the Mental Health Wellbeing Group was not included in reports to the Wellbeing Leadership Board. Similarly, the WfH Survey and the Training Needs Assessment do not appear to have been reviewed/discussed at either the Wellbeing Groups and/or the Wellbeing Leadership Board. Risk: Initiatives and actions recommended by Wellbeing Groups and the Wellbeing Leadership Board are not guided by the latest data and are not effective. Data analysis exercises are too limited in scope and/or reporting to be impactful and good value for money.
Response	The 5 Wellbeing Boards are developing data analysis against their plans and to also incorporate the benefits assessment of initiatives and working practices alongside a more developed wellbeing assessment of the Force.
Timescale	December 2021

In addition to the above we raised two priority 3 recommendations of a more housekeeping nature relating to:

Review of Policy and Procedures – As previously noted a number of HR procedures were out of date and due for review. This is already subject to tracking at the SORB, but it's been raised as pertinent to this particular audit.

The above was agreed with an estimated timescale for completion of December 2021

Oscar Kilo Blue Light Framework – This framework was developed as a self-assessment tool by the college of policing, it was noted through our review that the OHU element for Leicestershire was incomplete.

The above was agreed with an estimated timescale for completion of July 2021.

A4 Statement of Responsibility

We take responsibility to Leicestershire Police and the Office of the Police and Crime Commissioner for Leicestershire for this report which is prepared on the basis of the limitations set out below.

The responsibility for designing and maintaining a sound system of internal control and the prevention and detection of fraud and other irregularities rests with management, with internal audit providing a service to management to enable them to achieve this objective. Specifically, we assess the adequacy and effectiveness of the system of internal control arrangements implemented by management and perform sample testing on those controls in the period under review with a view to providing an opinion on the extent to which risks in this area are managed.

We plan our work in order to ensure that we have a reasonable expectation of detecting significant control weaknesses. However, our procedures alone should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify any circumstances of fraud or irregularity. Even sound systems of internal control can only provide reasonable and not absolute assurance and may not be proof against collusive fraud.

The matters raised in this report are only those which came to our attention during the course of our work and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Recommendations for improvements should be assessed by you for their full impact before they are implemented. The performance of our work is not and should not be taken as a substitute for management's responsibilities for the application of sound management practices.

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