

OFFICE OF THE STATE INSPECTOR GENERAL

FISCAL YEAR 2016
ANNUAL REPORT TO THE GOVERNOR
& THE GENERAL ASSEMBLY OF VIRGINIA

OCTOBER 2016



JUNE W. JENNINGS, CPA
STATE INSPECTOR GENERAL
REPORT No. 2016-ADM-001



COMMONWEALTH OF VIRGINIA
Office of the State Inspector General

June W. Jennings
State Inspector General

Post Office Box 1151
Richmond, Virginia 23218

Telephone (804) 625-3255
Fax (804) 786-2341
www.osig.virginia.gov

October 4, 2016

The Honorable Terence R. McAuliffe
Governor of Virginia
Patrick Henry Building, Third Floor
1111 East Broad Street
Richmond, VA 23219

Members of the Virginia General Assembly
General Assembly Building
1000 Bank Street
Richmond, VA 23219

Dear Governor McAuliffe and Senators and Delegates of the Virginia General Assembly:

It is an honor to present the Annual Report of the Office of the State Inspector General (OSIG) for the Commonwealth of Virginia. This report provides an overview of key accomplishments and activities for the fiscal year ending June 30, 2016.

Since 2012, the Office of the State Inspector General has established itself as the primary outlet for state employees and citizens to report wrongdoing within the Executive Branch of state government. The office also serves as a resource to assist government officials in improving the efficiency and effectiveness of operations.

During fiscal year 2016, OSIG conducted performance reviews, inspections, and investigations of executive branch agencies. OSIG provided agencies with recommendations for enhancing internal procedures and processes and preventing fraud, waste, and abuse in state government. All of our published reports can be found on the OSIG website at www.osig.virginia.gov.

Sincerely,

June W. Jennings, CPA
State Inspector General

CC: Paul Reagan, Chief of Staff for Governor McAuliffe
Suzette Denslow, Deputy Chief of Staff for Governor McAuliffe

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FY 2016 HIGHLIGHTS

In accordance with Title 2.2 [Chapter 3.2](#) (§§ 2.2-307 through 2.2-313) of the Code of Virginia, the Office of the State Inspector General (OSIG) is responsible for:

- [Investigating](#) complaints alleging fraud, waste, abuse, or corruption by an executive branch state agency, non-state agency or officers, employees, or contractors of those agencies;
- Administering the [Fraud and Abuse Whistle Blower Reward Fund](#);
- Overseeing the [State Fraud, Waste and Abuse Hotline](#);
- Conducting [performance reviews](#) of state agencies;
- Providing training and coordination of standards for the state's [internal audit](#) functions;
- Performing inspections and making policy and operational recommendations for [Behavioral Health and Developmental Services](#) facilities and providers; and
- Reviewing operations of the Virginia Tobacco Region Revitalization Commission.

Consistent with these responsibilities, OSIG completed the following activities during fiscal year 2016:

- Performance Review Services
 - Published seven performance reviews.
 - Made 67 performance review recommendations.
 - Performed three follow-up reviews.
 - Conducted one special project review.
- Behavioral Health & Developmental Services
 - Published three unannounced inspections reports.
 - Conducted three special projects.
 - Of 79 total complaints received, reviewed 24 complaints in-house, referred 51 complaints to the Department of Behavioral Health and Developmental Service, and referred four to other agencies/organizations.
- Investigative Services
 - Partnered with federal and/or state organizations on two major investigations, which resulted in two federal grand jury indictments and guilty pleas by four defendants.
 - Opened 11 investigations related to executive branch agencies.
 - Investigated allegations of fraud, conflict of interest, misappropriation, procurement violations, and ineffective management.
 - Referred nine cases to the Office of the Attorney General.
- State Fraud, Waste & Abuse Hotline

- Assigned 494 cases for investigation.
- Of cases closed, determined that 20 percent were substantiated; 51 percent were unsubstantiated; 13 percent were referred to other agencies; and made recommendations to improve internal controls or policies in 16 percent of unsubstantiated cases.
- Investigated 25 cases in-house, because allegations involved an agency head, an agency internal audit employee, or an “at-will” employee.
- Completed five follow-up investigative reviews for compliance with recommendations.
- Conducted three agency work paper reviews to ensure investigations completed on behalf of OSIG were in compliance with Hotline Policies and Procedures.
- Audit Training Services
 - Initiated a staffing study of internal audit departments at universities.
 - Conducted one Quality Assurance Review.
 - Offered 14 training courses to 443 individuals
 - Determined that OSIG training resulted in savings of \$199,868 over comparable course offerings from private vendors.
 - Completed and implemented a findings database for analysis of internal audit department activities.
- Education and Outreach
 - Made presentations before 10 state and national organizations.
 - Developed brochures and information sheets about OSIG, the Performance Review Process, and the State Fraud, Waste and Abuse Hotline.
 - Produced and distributed four news releases.

DASHBOARD – WHAT HAS OSIG DONE?

Below is a snapshot of OSIG’s work between July 1, 2015, and June 30, 2016.

OSIG Listens:

- In FY16 — 1,209 total Hotline calls with 494 assigned for investigation *(and since July 1, 2012, when OSIG began, a total of 6,160 Hotline calls, with 2,704 assigned for investigation).*
- In FY16 — 436 total citizen inquiries *(since July 1, 2012, a total of 1,070 citizen inquiries).*

OSIG Identifies Potential Cost Savings:

- In FY16 — \$81,877,567 in potential cost savings reported to Agency Heads and Cabinet Secretaries *(since July 1, 2012, a total of \$95,476,783 reported in potential cost savings).*

OSIG Makes Government Better:

- In FY16 — 157 recommendations to improve controls, efficiency, and effectiveness *(since July 1, 2012, a total of 849 recommendations to improve controls, efficiency, and effectiveness.)*

THE MISSION, VISION & VALUES OF THE OFFICE OF THE STATE INSPECTOR GENERAL

OSIG'S MISSION

On behalf of the citizens of the Commonwealth, the Office of the State Inspector General (OSIG) serves as a catalyst for positive change by:

- Facilitating good stewardship of resources;
- Deterring fraud, waste, abuse, and corruption;
- Advocating efficiency and effectiveness; and
- Promoting integrity and ethical conduct.

OSIG'S VISION

OSIG's vision is to maximize the public's confidence and trust in state government by promoting the highest level of integrity, efficiency, effectiveness, and economy.

OSIG'S VALUES

In its work and with each other, OSIG pledges to uphold the following core values:

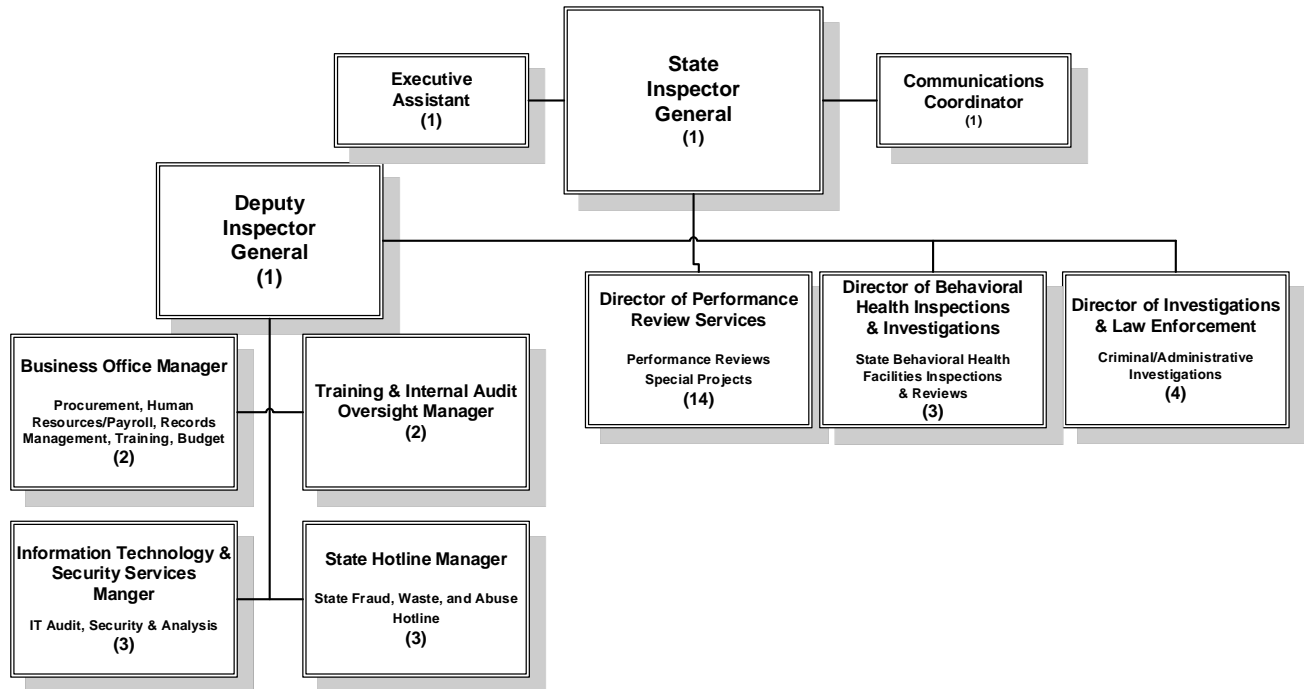
- Integrity, trust, and ethical behavior;
- Dedication, objectivity, and innovation;
- Cohesive and collaborative communications and operations; and
- Courage, accountability, and respect.

DIVISIONS WITHIN THE OFFICE OF THE STATE INSPECTOR GENERAL

The organizational structure of OSIG is designed to accomplish statutory mandates through four divisions:

- Performance Review Services
- Behavioral Health and Developmental Services
- Investigations and Law Enforcement Services
- Administrative Services

OFFICE OF THE STATE INSPECTOR GENERAL



Revised: 9/6/2016

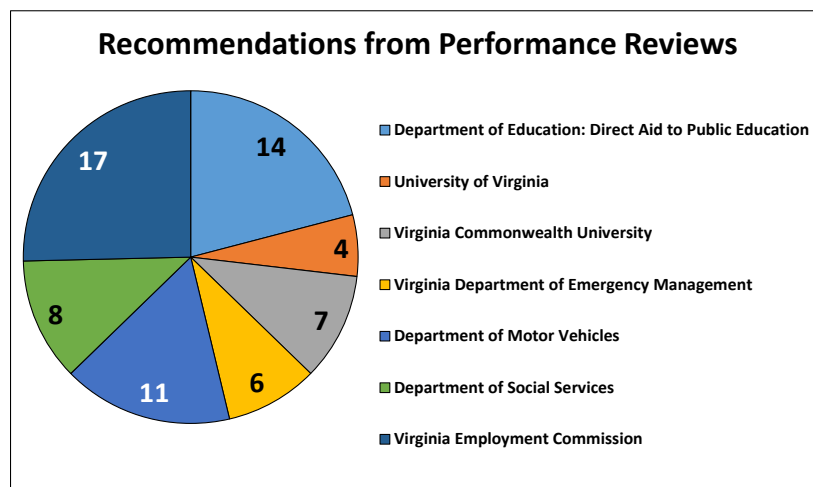
PERFORMANCE REVIEW SERVICES

OSIG's Performance Review Services legislative mandates are delineated in *Code* § [2.2-309\[A\]\(10\)](#) and § [2.2-309.2](#) and include:

- Conducting performance reviews to assess the efficiency, effectiveness, and economy of executive branch agencies' programs and operations.
- Assessing the condition of the accounting, financial and administrative controls of state and non-state agencies as necessary.
- Reviewing the condition of the Tobacco Region Revitalization Commission's accounting, financial, and administrative controls.

ISSUED REPORTS

During FY 2016, OSIG published seven performance reviews and made 67 performance review recommendations.



Department of Motor Vehicles

- Review focused on these areas: citizen satisfaction; performance measurement and reporting; cash control; strategic planning; inventory/assets; procurement; employee training/competency; and budgeting and forecasting.
- The report included 11 observations and recommendations.
- For details, see the March 17, 2016, [report](#).

University of Virginia

- Review focused on these areas: general-fund appropriations; accounting and financial reporting; investment in science, technology, engineering, and math (STEM) fields; AccessUVA; and faculty retention, recruitment, and compensation.

- The report included four observations and recommendations, and two commendations.
- For details, see the August 14, 2015, [report](#).

Virginia Commonwealth University

- Review focused on these areas: investment in science, technology, engineering, mathematics, and health (STEM-H); faculty start-up packages; transfer and return of collected revenues; administrative functions; facility usage; and strategic planning and performance measures to promote student success.
- The report included seven observations and recommendations.
- For details, see the June 7, 2016, [report](#).

Virginia Department of Education: Direct Aid to Public Education

- Review focused on these areas: data collections, minimum funded positions, and state grant requests from localities.
- The report included 14 observations and recommendations.
- For details, see the January 27, 2016, [report](#).

Virginia Department of Emergency Management

- Review focused on these areas: providing assistance to localities and state agencies following a disaster situation; the hiring and training plan for vacant positions in the Finance Division; and VDEM's implementation of Cardinal.
- The report included six observations and recommendations. Of particular note was a recommendation to consult with surrounding states that were more efficient in project close-outs.
- For details, see the June 23, 2016, [report](#).

Virginia Employment Commission

- Review focused on these areas: revenue; workforce services; records management; performance measurement and reporting; social media; and third-party administrator/contract management.
- The report included 17 observations and recommendations.
- For details, see the February 2, 2016, [report](#).

Virginia Department of Social Services

- Review focused on these areas: human resources management; training of state and local employees; the availability of information technology systems; and oversight of local departments of social services.
- The report included nine observations and eight recommendations.
- For details, see the July 21, 2015, [report](#).

SPECIAL PROJECT

During FY 2016, one special project review was conducted and 15 recommendations were made.

Department of Corrections: Agribusiness Program

- The request, by the General Assembly, focused on the following five areas: costs and benefits of offender labor; collaboration with universities; cost of food; comparison with other states' Agribusiness programs; and potential efficiencies, cost savings, and productivity improvements.
- The report included 15 observations and recommendations.
- For details, see the September 17, 2015, [report](#).

FOLLOW-UP REVIEWS

During FY 2016, three follow-up reviews were conducted to determine the status of the 30 original recommendations.

Journey House Roanoke

- The original report included six recommendations.
- The November 25, 2015, follow-up report indicated that Journey House Roanoke adequately addressed all six recommendations in the original report.

Tobacco Region Revitalization Commission

- The original report included 15 recommendations.
- The November 3, 2015, follow-up report indicated that the Tobacco Region Revitalization Commission (formerly the Tobacco Indemnification and Community Revitalization Commission) adequately addressed 11 observations in the original report.
- Four observations remain open.

Virginia Department of Transportation

- The original report included nine recommendations.
- The April 12, 2016, follow-up report indicated the Virginia Department of Transportation (VDOT) adequately addressed all nine recommendations in the original report.

ONGOING PERFORMANCE REVIEWS

During FY 2016, reviews were initiated for the following agencies:

- College of William & Mary
- Department of Aging & Rehabilitative Services: Disability Determination Services
- Department of Alcoholic Beverage Control

- Department of General Services
- Department of Rail & Public Transportation
- Department of Taxation
- Virginia Department of Health
- Virginia Information Technologies Agency
- Virginia Polytechnic Institute and State University

BEHAVIORAL HEALTH & DEVELOPMENTAL SERVICES

OSIG's Behavioral Health and Developmental Services legislative mandates are delineated in *Code* § [2.2-309.1](#) and include:

- Conducting annual unannounced inspections of the 14 state facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS).
- Inspecting, monitoring, and reviewing the quality of services at the state-operated facilities and providers of behavioral health and developmental services.
- Ensuring that the General Assembly and the Joint Commission on Health Care are fully and currently informed of significant problems, abuses, and deficiencies.
- Investigating specific complaints of abuse, neglect, or inadequate care.
- Reviewing, commenting on, and making recommendations about, as appropriate, any reports prepared by DBHDS and the critical incident data collected by DBHDS.

ISSUED REPORTS

During FY 2016, OSIG published three unannounced inspections reports.

Adult Behavioral Health Facilities & Hiram Davis Medical Center FY 2015 Unannounced Inspections

OSIG conducted unannounced inspections of Virginia's adult behavioral health facilities and the Hiram Davis Medical Center (HDMC). The purpose of these inspections was to assess the impact of *Code* § [37.2.809.1](#)[B], also referred to as "the safety net law." While OSIG determined that the safety net law has ensured individuals meeting temporary detention criteria are able to be admitted to a hospital bed, the implementation of the law has had a profound impact on the state-operated adult behavioral health facilities, HDMC, and the staff and individuals served in these settings. Recommendations were identified in four key areas:

- Programming and scope of services across the system.
- Facility Master Staffing Plans.
- Impact of safety net law on patient safety.
- Current and future role of HDMC and other facilities for patients requiring specialized care.

For details, see the May 5, 2016, [report](#).

Commonwealth Center for Children & Adolescents FY 2015 Unannounced Inspection

OSIG conducted an unannounced inspection of the Commonwealth Center for Children and Adolescents (CCCA). In addition to assessing the impact of the safety net law, the inspection also allowed for follow up on open findings and recommendations from previous OSIG reports.

Overall, OSIG found that the impact of the safety net law was less significant for CCCA than other behavioral health facilities operated by DBHDS. Recommendations were identified in four key areas:

- Adequacy of Virginia’s system of community-based services and supports serving children and adolescents.
- Impact of CCCA’s physical plant and unit design on the treatment needs of the diverse populations it serves.
- Staff overtime hours and costs, high turnover rates, position vacancies, and increased incidents of aggression by patients.
- Staff training.

For details, see the January 12, 2016, [report](#).

Virginia Center for Behavioral Rehabilitation FY 2015 Unannounced Inspection

OSIG conducted an unannounced inspection of the Virginia Center for Behavioral Rehabilitation (VCBR). OSIG reviewed the modified resident-complaint process approved by the State Human Rights Committee — through variances to the Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the DBHDS (Human Rights Regulations —and authorized by the DBHDS Commissioner are consistent with program objectives. OSIG determined that while the exemptions as applied to residents at VCBR are consistent with program objectives, the complaint and appeal process should be brought in line with other DBHDS-operated facilities and Human Rights Regulations by ensuring an impartial and independent review of resident complaints. Recommendations were identified in three key areas:

- Membership of the VCBR complaint-process Appeals Committee.
- DBHDS organizational structure.
- Availability and role of the VCBR Human Rights Advocate.

For details, see the January 21, 2016, [report](#).

SPECIAL PROJECTS

In addition to annual unannounced inspections in FY 2016, three special projects were conducted related to behavioral health and developmental services.

Hampton Roads Regional Jail Investigation of Critical Incident

OSIG conducted an investigation of behavioral health services provided to an individual incarcerated — and who subsequently died — at the Hampton Roads Regional Jail (HRRJ). It included a review of processes related to referral and admission of HRRJ inmates to Eastern State Hospital; a review of the March 16, 2016, DBHDS Office of Internal Audit Investigation Report; identification of potential risk points; and recommendations for systemic improvement in order to prevent similar events in the future. Recommendations were identified in five key areas:

- The process for transferring inmates from Hampton Roads Regional Jail to ESH.
- The process for developing and ensuring the accuracy of the ESH Jail Transfer Waiting List.
- Recommendations of the DBHDS Transformation Team for the Justice Involved.
- The DBHDS investigation of the death at HRRJ.
- Management of HRRJ contract providers.

For details, see the April 5, 2016, [report](#).

Juvenile Correctional Centers & Juvenile Detention Centers Review of Mental Health Services

OSIG conducted a review of the mental health services in Virginia's Juvenile Correctional Centers (JCCs) and Juvenile Detention Centers (JDCs) to gain an understanding of how JCCs, JDCs and Community Services Boards (CSBs) identify and address the needs of youth in the correctional system with mental illness. Overall, OSIG found that JDCs and JCCs were operating in accordance with current clinical standards relevant to identification and engagement of youth offenders with mental health treatment needs, and all CSBs funded to provide mental health services in JDCs were doing so in some manner. Recommendations were identified in four key areas:

- JCCs and JDCs policies and practices supporting consistent identification and engagement of youth with mental health service needs in treatment services.
- Services provided by Virginia's juvenile corrections system identifying and meeting the mental health treatment needs of youth during and after their residency.
- Effectiveness of Department of Juvenile Justice (DJJ) policies and practices in connecting youth with community-based services when they leave DJJ residential settings and return to their communities.
- Methodology to accurately determine total annual costs of providing mental health services in JCCs and JDCs.

For details, see the December 29, 2015, [report](#).

Virginia Acute Psychiatric & Community Services Board Bed Registry Review

OSIG conducted a review of the Virginia Acute Psychiatric & Community Services Board Bed Registry to determine the utility of the registry as a tool for CSBs' emergency services staff to facilitate the identification and designation of facilities for the temporary detention and treatment of individuals. The review included the registry's successes, challenges, and efficiencies, as well as look at the impact of current registry-related operations on CSBs, state-operated facilities, private inpatient-psychiatric facilities, public and private residential crisis-stabilization units, DBHDS, and individuals served. While OSIG found that the registry operates in substantial compliance with statutory requirements, it was noted that registry updates are not always being made by providers in accordance with *Code* requirements. Recommendations were identified in two key areas:

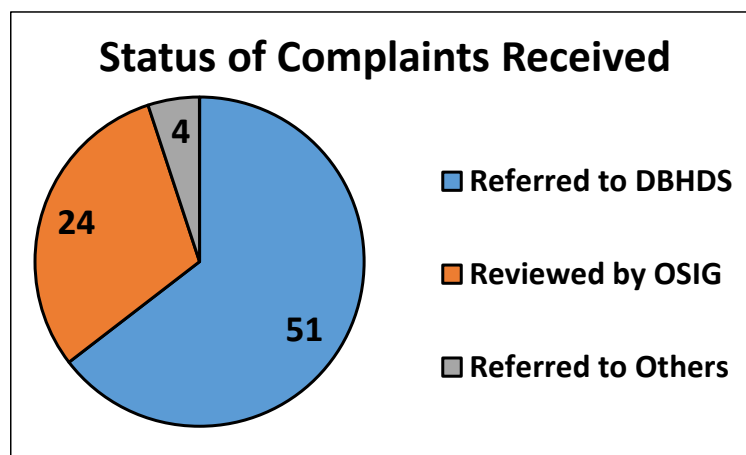
- Provider compliance with *Code* § [37.2-308.1](#)[D].
- DBHDS analysis of high risk cases.

For details, see the January 28, 2016, [report](#).

MONITORING ACTIVITIES

Seventy-nine complaints were received in FY 2016:

- 51 of the complaints were reviewed and referred to DBHDS for investigation
- 24 were reviewed and/or investigated by OSIG
- 4 were referred to others:
 - 2 to the facilities' Human Rights Advocates
 - 1 to the Virginia Department of Health
 - 1 to the Pennsylvania State Inspector General



DBHDS has developed processes for facility and community providers to document death and serious physical injuries to individuals served and has permitted access to that information to support OSIG's *Code* responsibilities of monitoring and reviewing the quality of services at the state-operated facilities and providers of behavioral health and developmental services. OSIG utilizes information made available by DBHDS to identify and analyze significant events and patterns, to identify trends, and to develop an annual work plan.

The Office of the Chief Medical Examiner (OCME) — pursuant to § [32.1-283](#) of the *Code of Virginia* — investigates the death of any patient or resident of a state mental health facility. In FY 2016, OSIG received copies of 34 autopsies regarding patients in DBHDS facilities from OCME.

ONGOING REVIEWS

During FY 2016, the following activities were initiated:

- Unannounced Inspections of Behavioral Health Facilities,
- Unannounced Inspections of Training Centers & Specialty Facilities,

- Review of Licensed Behavioral Health Programs in Department of Corrections Facilities,
- Follow up to the February 2014 Department of Behavioral Health & Developmental Services Discharge Assistance Performance Review.

INVESTIGATIVE SERVICES

OSIG's Investigative Services legislative mandates are delineated in *Code* § [2.2-309](#)[A](3-6) and § [2.2-309.2](#) and include:

- Investigating the management and operations of state agencies, non-state agencies, and independent contractors of state agencies to determine whether acts of fraud, waste, abuse, or corruption have been committed or are being committed by state officers, employees or independent contractors of state agencies or any officers or employees of non-state agencies.
- Investigating allegations of fraudulent, illegal, or inappropriate activities concerning disbursements from the Tobacco Indemnification and Community Revitalization Endowment and the Tobacco Indemnification and Community Revitalization Fund.

In addition, the State Fraud, Waste and Abuse Hotline, through the authority of [Governor's Executive Order 52 \(2012\)](#), provides state employees and citizens a confidential method to report suspected occurrences of fraud, waste and abuse in State agencies and institutions, and authorizes OSIG to investigate allegations to determine their validity, and, when appropriate, make recommendations that serve to eliminate future occurrences.

INVESTIGATIONS STATISTICAL SUMMARIES

During FY 2016, OSIG opened investigations regarding the following Executive Branch agencies:

- Department of Corrections
- Department of Environmental Quality (2 cases)
- Department of Historic Resources
- Virginia Department of Agriculture & Consumer Services
- Virginia Department of Emergency Management
- Virginia Department of Health (3 cases)
- Virginia Economic Development Partnership
- Virginia State University

Of the 11 cases that were opened in FY 2016, the types of allegations were as follows:

- Fraud — 6
- Conflict of Interest — 2
- Misappropriation — 1
- Procurement Violations — 1
- Ineffective Management — 1

The chart below reflect the numbers of cases conducted by OSIG during the FY 2016.

INVESTIGATIONS DIVISION CASE SUMMARY FY16	
Open cases carried over from FY15	25
Cases opened in FY16	11
Cases closed in FY16	4
Cases resulting in corrective action recommendations in FY16	5
Cases referred to Office of the Attorney General in FY16	9
Cases open at end of FY16	32

SIGNIFICANT CASES FOR FY 2016

Department of Mines, Minerals & Energy

A company received approximately \$500,000 in federal stimulus funds to start a biomass recycling center in Richmond. The principal reported the purchase of a John Deere Excavator at \$209,475, and a 2004 Mack Tractor Truck at \$30,109. Both purchases were allowable by the federal program in which the federal funds were administered by the Department of Mines, Minerals and Energy. The assets were unlawfully sold, and the proceeds were misdirected. A joint investigation by the US Department of Energy-Office of Inspector General and OSIG resulted in a federal grand jury indictment being issued in October 2015.

Two defendants entered guilty pleas in federal court to making false material statements and representations. They were each sentenced to 10 years' probation.

Virginia Department of Health

A non-profit entity misappropriated funds for personal gain by submitting falsified records. The funds, disbursed by the US Department of Agriculture (USDA) through the Virginia Department of Health Summer Food Service Program exceeded \$300,000. A joint investigation by the Virginia State Police, USDA-Office of Inspector General, and OSIG resulted in federal grand jury indictments.

In late January and early February 2016, two defendants pleaded guilty to a federal indictment in Norfolk. Pleas included the fact of misappropriation of more than \$150,000. One defendant received 12 months and one day in federal prison and restitution of \$249,000. The other defendant was ordered to serve 15 months — with three years' supervised probation upon release — and restitution of \$249,000.

OTHER ACTIVITIES

Point Of Contact Initiative

OSIG's Point of Contact (POC) Initiative is designed to foster professional and collaborative relationships between OSIG's Investigations and Law Enforcement Services Division and

counterparts within executive branch agencies, usually the Internal Audit Director or other senior manager. The POC Initiative promotes exchange of information with executive branch agency officials regarding pertinent activities within OSIG, as well as relevant issues within agencies. Each OSIG Special Agent and Investigator is assigned as the POC Liaison representative for several state agencies. The POC Liaison representatives are tasked to meet with assigned agency POC counterparts annually.

Law Enforcement Liaison & Intelligence Resource Partnerships

The Investigations and Law Enforcement Services Division has partnered with the following agencies on cases of mutual interest during FY2016:

- Virginia State Police
- Federal Bureau of Investigation
- US Department of Homeland Security
- US Department of State
- Offices of Inspector General of the U.S. Department of Agriculture, the US Department of Energy, and US Department of Labor.

OSIG maintains a formal Memorandum of Agreement with both the Auditor of Public Accounts and the Virginia State Police.

OSIG participates in regularly scheduled meetings or collaborates with the following law enforcement and professional criminal justice affiliated entities:

- Central Virginia Chief Law Enforcement Executives Association
- Federal Bureau of Investigation
- Internal Revenue Service — Criminal Investigations Division
- US Secret Service & US Postal Inspections Service – Financial Crimes Task Force
- Virginia Association of Chiefs of Police
- Virginia State Police, Bureau of Criminal Investigations

OSIG maintains membership in the following criminal intelligence and investigative resource organizations:

- National White Collar Crime Center
- Regional Organized Crime Information Center

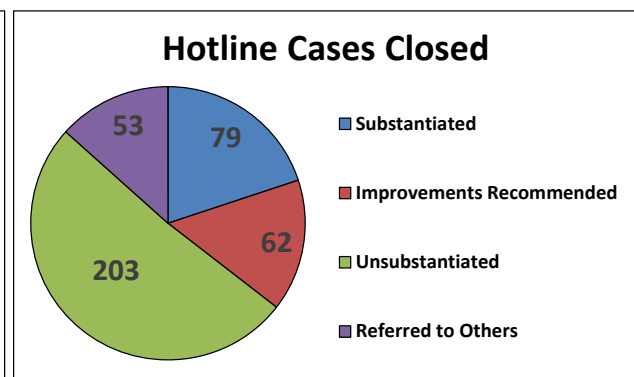
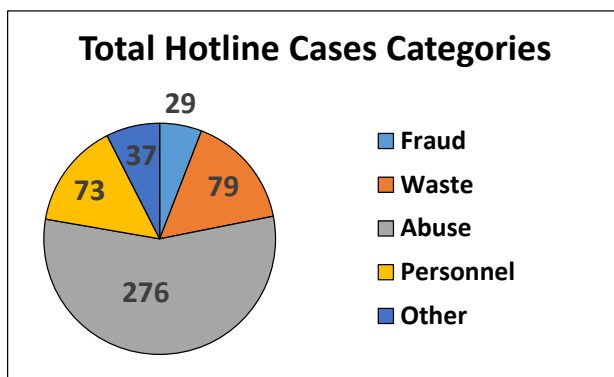
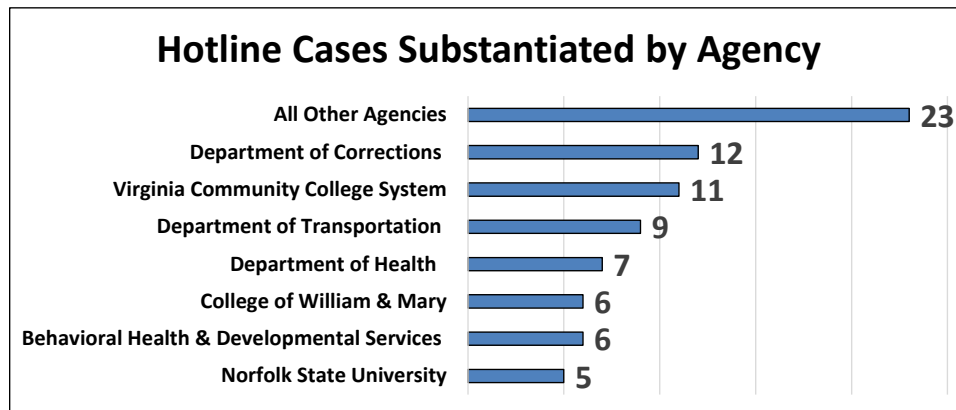
OSIG observes the professional education and training requirements of the following:

- Association of Certified Fraud Examiners
- Association of Inspectors General [Note: One special agent serves on a “peer review” team]
- Crater Criminal Justice Academy
- Department of Criminal Justice Services

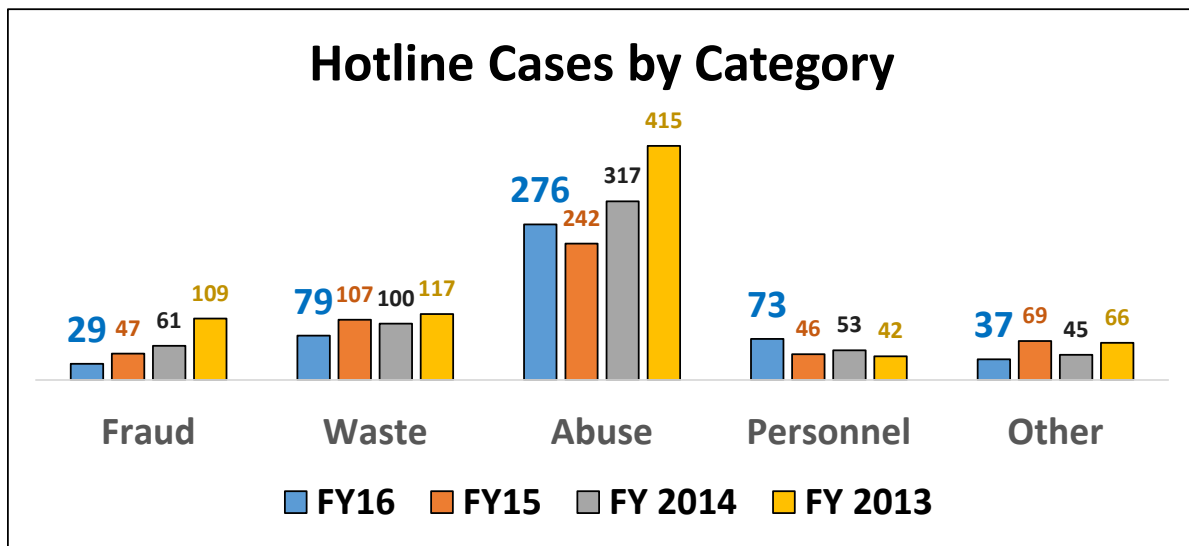
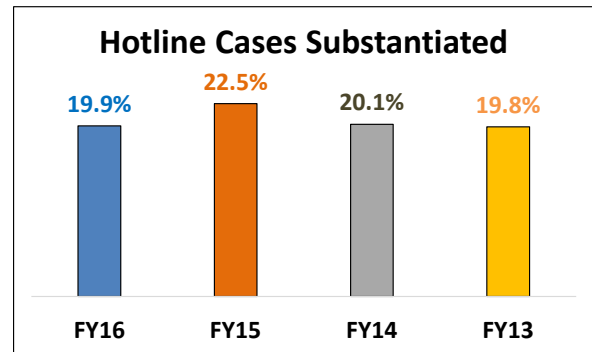
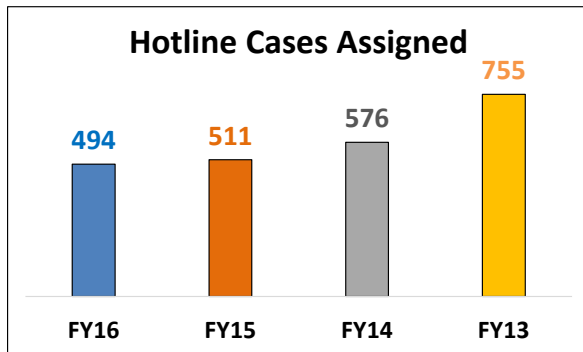
STATE FRAUD, WASTE & ABUSE HOTLINE

FY 2016 Hotline Statistics

- Of the calls received, 494 were determined to meet the criteria for fraud, waste, and abuse and required a formal investigation. This number reflects a drop from the previous three fiscal years: 511 in 2015; 576 in 2014; and 749 in 2013.
- Leave abuse, waste of agency/state resources, and misuse of state-owned vehicles continue to represent the most common cases.
- Of the Hotline cases closed, 20 percent were determined to be substantiated; 51 percent were unsubstantiated; 13 percent were referred to other appropriate entities; and in 16 percent of the cases — while an occurrence of fraud, waste, or abuse was not found — recommendations were made to improve and strengthen internal controls or policies were made.
- Twenty-five Hotline calls were investigated by OSIG Hotline staff because they involved allegations regarding an agency head, an agency internal audit employee, or an “at-will” employee.



Hotline Statistical Comparisons



Hotline Investigative Reviews

- Five follow-up investigative reviews were completed for agencies with previous Hotline cases to ensure that agency management complied with OSIG recommendations to improve internal controls or policies.
- Three agency work paper reviews were completed to ensure that investigations completed on behalf of OSIG — by agency Internal Audit Departments or Hotline Coordinators — were performed in compliance with the Hotline Policies and Procedures Manual and that the conclusions reached were supported in the investigative work papers.

Hotline Marketing Materials

- A two-page State Fraud, Waste and Abuse Hotline fact sheet — with answers to frequently asked questions — was produced for distribution to state employees and made available for downloading and printing on the OSIG website.
- A State Fraud, Waste and Abuse Hotline logo and flier were designed for distribution to all Executive Branch agencies.

ADMINISTRATIVE SERVICES

INTERNAL AUDIT & TRAINING SERVICES

OSIG's Internal Audit and Training Services Unit legislative mandates are delineated in the *Code* § [2.2-309](#)[A](10-12) and include:

- Coordinating and requiring standards for those internal audit programs in existence as of July 1, 2012.
- Coordinating and requiring standards for other internal audit programs in state agencies and non-state agencies as needed in order to ensure that the Commonwealth's assets are subject to appropriate internal management controls.
- Assisting agency internal auditing programs with technical auditing issues and coordinating and providing training to the Commonwealth's internal auditors.

Staffing Study

During fiscal year 2016, the Internal Audit and Training Services Unit contacted two university professors about conducting a staffing study of internal audit departments at Virginia universities. The professors had previously conducted a survey to determine effective sizing for internal audit departments in colleges and universities, and their study was published by the Institute of Internal Auditors.

The professors updated their assessment instrument and scoring software to accommodate changes in the university audit environment. They are working with the board members of the Association of Colleges and University Auditors for support in distributing their survey to university audit departments in Virginia as well as in other states.

They plan to benchmark and validate the results to ensure accuracy and to publish the results. They also hope to develop a similar instrument that can be used to determine effective sizing for internal audit departments in state government.

Findings Database

A findings database was completed in FY 2016 to help analyze activities in the executive branch agencies that have internal audit departments. Information from FY 2015 has been entered into the database to allow analysis of various findings categories, follow-up on completion of findings, audit plan completion, risk assessment, and submission of audit charters. The database will also allow reports to be created and provided to the internal audit departments for their use in planning their future audits. Information from FY 2016 will also be entered into the database for similar analysis.

Quality Assurance Reviews

All internal audit programs which adopt the Institute of Internal Auditors Standards are required to have a Quality Assurance Review (QAR) completed once every five years. OSIG monitors compliance with these standards and provides a cost effective alternative through the use of the Quality Assurance Review Committee to conduct QARs. For FY 2016, OSIG completed one QAR.

DEPARTMENT OF MOTOR VEHICLES

The report was issued on August 20, 2015. The internal audit program received an overall rating of “generally conforms,” which is the highest achievable rating.

Training Statistics

In FY 2016, 443 individuals attended 14 OSIG training courses. This was a 33 percent increase in attendance over FY 2015. Training attendees were primarily from state agencies while some attendees were from local government and the private sector. OSIG training courses are offered at a fraction of the cost versus training from a private vendor. An analysis of comparable course offerings determined that the individuals attending OSIG training saved more than \$199,868.



Agency Risk Management & Internal Control Standards

In FY 2016, OSIG completed the Agency Risk Management and Internal Control Standards (ARMICS) implementation project and created an agency ARMICS program in compliance with

the Department of Accounts (DOA) ARMICS standard. This includes the agency control environment/overall risk assessment and the financial controls assessment. ARMICS test work programs and work paper templates were developed for the agency to document current and future years test work under the standard.

ARMICS requirements were completed by DOA's September 30 deadline and recommendations were approved by OSIG management. Overall, it was determined that OSIG has a strong internal control program. OSIG is currently updating the ARMICS process for FY 2016 compliance, and implementing new requirements issued by DOA.

SharePoint

In FY 2016, OSIG expanded access to the Chief Audit Executives (CAE) SharePoint site to a second individual in each Commonwealth internal audit department. The CAE SharePoint site is used to share audit documents that exemplify best practices in internal auditing. This site includes a blog function to allow CAEs to discuss important issues or concerns.

EDUCATING OTHERS ABOUT OSIG

In a continuing effort to inform and educate others about the mission and activities of OSIG, staff made presentations and participated in panel discussions before a number of organizations and groups in FY 2016 including the following:

- Association of Government Accountants
- Better Government Association
- Chief Audit Executive Roundtable
- Central Virginia Chapter of the American Society for Public Administration
- College and University Auditors of Virginia
- Joint Subcommittee to Study Mental Health Services in the 21st Century
- Virginia Association of School Boards
- Virginia General Assembly Senate New Member Orientation
- Virginia Local Government Auditors Association
- US Department of Defense Office of the Inspector General's Third Annual Hotline Worldwide Outreach

In FY 2016, OSIG developed a brochure to provide an overview and to explain OSIG's mission, authority, and operations. Additionally, information sheets — with frequently asked questions and answers — were also created concerning OSIG, the Performance Review Process, and the State Fraud, Waste, and Abuse Hotline. All are available on the OSIG website.

OSIG produced and distributed to more than 130 media outlets, the following four news releases in FY 2016:

- OSIG Releases Report to Governor McAuliffe: Investigation of Critical Incident at Hampton Roads Regional Jail Now Available
- Whistle Blower Protection Act Encourages Commonwealth Citizens to Report Fraud, Waste & Corruption in State Government
- State Fraud, Waste & Abuse Hotline: Anonymously Report State Government Allegations with Toll-Free Call
- State Inspector General Elected to National Board: Association of Inspectors General Select June W. Jennings to Serve.