QUALITY ASSURANCE REVIEW ADVISORY COMMITTEE FOR THE OFFICE OF THE INSPECTOR GENERAL AND OFFICE OF THE INDEPENDENT POLICE MONITOR

REPORT REVIEWING ACTIVITIES FOR 2014

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Executive Summary

As called for in the City statute creating the Office of the Inspector General (OIG), this report of the Quality Assurance Advisory Committee (Committee) assesses the written work product of the OIG. Our Committee conducted a full review of the public work product of the OIG during 2014 including public letters and investigations, audits and reviews, follow-up reports, and inspections and evaluations. It is important to note that the OIG performs many other functions not included in our review mandate.

In general, the Committee found the OIG to be extraordinarily productive in producing the documents we reviewed. The written work products of the OIG addressed some of the most important issues facing the City of New Orleans

In each area of our review we offer several observations and comments. Regarding the public letters and investigations, we note their potential to greatly impact public policy and political practice due to the wide audience they receive. Overall, the public letters and investigations were timely and effective interventions. The methodologies employed in the investigations were data-driven in nature and revealed serious problems regarding reporting, lying, and theft. The recommendations and observations to combat the uncovered problems contained therein were appropriate and reflected common sense judgment.

Additionally, the Committee reviewed seven audits and two follow-up reports compiled by the OIG. The audits, like the investigations, again showed the OIG to be meticulous in its comprehensive methodologies. The majority of the findings revealed in the performance audits were violations of established codes, policies, or practices and could be solved by simply

enforcing compliance. The follow-up reports displayed responsiveness to the OIG's recommendations and implementation of the recommended corrective actions.

The OIG conducted four evaluations and inspections of City operations focusing on the New Orleans Police Department's staffing and organization, the Electronic Monitoring Program administered by the Orleans Parish Sherriff's Office, and a follow-up evaluation regarding the City's life insurance. These turned up important findings that the City will need to address in the following years.

Overall, our Committee believes the reports of the OIG provided a valuable service to the City of New Orleans. The written work we have reviewed meets high standards of quality. These reports have also opened up important areas for reform and debate for the citizens of New Orleans.

The Committee also reviewed the written work-product of the Office of the Independent Police Monitor (OIPM) for the year 2014. In 2014 the OIPM produced three written works: 1) an analysis of the New Orleans Police Department's Retaliation Policy, Pattern, and Practice and an evaluation of NOPD's newly proposed retaliation policies; 2) an advocacy piece entitled "Hurricane Katrina: The Remaining Legacy, A Story of Uninvestigated Police Shootings and Human Rights Deprivations;" and 3) the OIPM 2014 Annual Report. In reviewing the above works individually, the committee reached both positive and negative conclusions regarding the work of the OIPM.

First, the Committee found the analysis of the New Orleans Police Department's Retaliation Policy, Pattern and Practice to include questionable conclusions based on data collected. The OIPM's inferences of widespread retaliation against civilian complainants and

intradepartmental whistleblowers within the New Orleans Police Department (NOPD) suffered from insufficient investigative techniques, and lacked reliable data and documentation. On the other hand, the OIPM's evaluation of NOPD's newly proposed retaliation policies and recommendations offered sound, thoughtful additions and clarifications to the new policies which, if adopted, would materially enhance the efficacy of those policies.

With regard to the advocacy piece, the Committee found that the OIPM overreached the duties and responsibilities allocated to the OIPM. This advocacy paper's unabashedly partisan and sensationalist assertion that inadequate investigation of several officer involved shootings during Hurricane Katrina created a human crisis that exponentially expanded the destruction of the storm, lacked evidentiary support and the reporting of the events cited was not done in an objective manner, nor did it project an independent attitude and appearance. The paper's open endorsement and promotion by third party advocacy organizations and community activists further compromised the mandated impartiality of the OIPM.

Lastly, in reviewing the OIPM's annual report, the Committee commended the OIPM on the depth and scope of activities covered and generally on the professional judgment exercised by the OIPM throughout its report.

I. The Role of the Advisory Committee and the Scope of This Report

The City Code in Section 2-1120(16) (a) calls for the appointment of and specifies the duties of the Quality Assurance Review Advisory Committee for the OIG. This three-person committee—whose members are appointed representatives of the City Council, the Ethics Review Board, and the Office of the Mayor—is charged with reviewing the "completed reports of audits, inspections, and performance reviews, and public reports of investigation" for overall quality. The representative chosen by City Council serves as chair of the committee.

The role of this Committee is limited to reviewing the completed and published material produced by the OIG during 2014. Ongoing investigations are not included, but presumably would be reviewed in future years when the investigations are completed. A full list of the material that the committee reviewed is contained in the Appendix to this report.

It is of note that the OIG performs other important duties not included in our review mandate. The OIPM is also part of the OIG, and this report does review its published activities as well.

This is the third report of the Quality Assurance Review Committee. First, this report discusses the public letters produced by the OIG, followed by a section reviewing audits conducted by the OIG. We next turn to a series of inspections and evaluations completed by the OIG and then move to review the office's investigations. Finally, the Committee reviews the work of the OIPM. The report concludes with our overall assessment of the written work produced by the OIG and OIPM.

The Committee has strived to reach its conclusions in as objective a manner as possible and in strict conformity with The Principles and Standards for Offices of Inspector General

(Association of Inspectors General, May 2004). While, as noted above, the role of this Committee is limited to providing an objective assessment of the work product of the OIG and OIPM in accordance with those standards, it is important to point out that the underlying tensions between these two offices and their highly publicized disputes may impede the public's perception of this report's objectivity.

The OIG and OIPM were designed and chartered, in large part, to restore public confidence in local governmental agencies, confidence which historically had been eroded by an acute perception of corrupt practices and a lack of transparency. Unfortunately, public debate surrounding these issues, rightly or wrongly, often devolved into racially charged rhetoric which only furthered the racial divide within the community.

Regrettably, these same influences have impacted the community's perception of the OIG and OIPM. Without attributing fault, the inescapable fact is that the public dispute between these offices regarding their respective lines of authority has fostered confusion and misunderstanding in the public arena of their respective roles. The lack of clear lines of demarcation in theory and in practice between their respective roles has only heightened the pre-existing atmosphere of racial tension and community mistrust in which these offices were created. The result has been a dysfunctional relationship between the offices culminating in the recent decision to formally separate the two offices. Much of the 2014 work product this Committee has been asked to review was produced during the apex of this intra-office dysfunctionality.

The Committee is mindful of, and sensitive to, community stakeholders' potential reaction to a report generated amidst the circumstances described above. Despite these

challenges, the Committee performed its function in an open, transparent, and collaborative manner and sought to reach conclusions that were objectively derived and fair to all concerned.

II. PUBLIC LETTERS

During 2014, the OIG issued six public letters. A letter issued in 2010 to then Mayor-Elect Landrieu is also included in this section. Public letters are especially important due to the wide attention they garner from the press and their tendency to set the tone for the office as a whole. In this section, we review the public letters.

The OIG sent two letters to Norman Foster, Chief Financial Officer for the City of New Orleans. After the OIG issued the *New Orleans Police Department (NOPD) Grants Performance Audit*, which compared grant expenditures made during the testing period to the financial records, the Inspector General sent the first letter to Norman Foster in May of 2014. In the letter, the Inspector General informed Foster that certain expenditures from 2012 were posted in error to the 2011 financial records. This resulted in the 2012 financial records not matching the grant funds reported to the grantor. The Inspector General recommended that the City develop a process to ensure that expenditures are posted in the proper period in compliance with Generally Accepted Accounting Principles (GAAP) and grant reporting. This recommendation was an appropriate and common sense suggestion by the Inspector General.

After the OIG issued *Follow-up Report: The Payroll Internal Control Performance Audit*, the Inspector General wrote Foster an additional letter in regard to user access controls for the payroll system. The Inspector General recommended that the City strengthen the policies over modifying and terminating users' access rights after discovering that the City's informal IT policy was not followed and that terminated and transferred employees' access was not being revoked in a timely manner. Secondly, after learning that as of November 1, 2013, the City had three payroll checks totaling $2,695, issued prior to July 1, 2012, that had not been escheated to the state as required by Policy Memorandum No. 117 and Louisiana State Law due to the new ERP system, the Inspector General recommended that the

City escheat all checks, regardless of any updates to the system. The Committee sees both recommendations as appropriate. The first recommendation properly attempts to limit access to the payroll system to those employees currently approved, and the second simply recommends that the City comply with Policy Memorandum and state law standards.

In response to a performance audit conducted by the Office of the Inspector General (OIG) of the NOPD's Uniform Crime Reporting of Forcible Rape from June 1, 2010 to May 31, 2013, the Inspector General sent a letter to Stephen Gordon, Executive Director of the Orleans Parish Communication District (OPCD), regarding three conditions noted during testing that pertained to the OPCD. First, the NOPD's Computer Aided Dispatch System (CAD) was unable to generate a listing of the initial signal for each call for service, which resulted in the NOPD being unable to report all calls for service. The Inspector General recommended that the OPCD develop the coding to query the CAD system to generate a list of the initial signals and its corresponding final signal for all calls for service. Second, after OIG discovered that users of CAD were not prompted to change passwords after the original password was created and that the CAD system did not have an automatic timeout feature, the Inspector General recommended that OPCD develop password procedures and timeout procedures to ensure proper authentication and access related to CAD. The Inspector General recommended implementing a policy requiring that passwords be changed periodically, be more complex, and have a minimum length. In our view, the Inspector General properly raised concern regarding the CAD system's inability to generate an initial signal listing and regarding the CAD system's security. Both recommendations were aimed at making CAD more reliable and secure.

The Inspector General also wrote to Orleans Parish Sheriff Marlin Gusman to express concern related to the procurement of professional medical and mental health services. Proposals from $8 million to $14 million had been received, and the selection board was set to meet behind closed doors to select a contractor. Due to the selection of contractors in private being a "large red flag" to

procurement auditors, the Inspector General recommended that the selection board open their meetings to the public to assure citizens the process was fair. The Committee views the recommendation of allowing citizens to observe and scrutinize the procurement process to be aligned with the Inspector General's goal of promoting transparency in government, and feels it was an appropriate suggestion.

Finally, after the NOPD purchased body cameras for the use of its officers, the Inspector General wrote to commend Mayor Landrieu and his administration on their decision. Citing a report from the United Kingdom that found that officers without body cameras were more than twice as likely to use force as those with body cameras, the Inspector General wrote he believed that the decision to purchase the cameras would result in a great investment in improving police-community relations. The Committee agrees with the Inspector General in his commendation and support in this effort.

In April of 2010 the Inspector General wrote to the then Mayor-Elect Landrieu regarding practices for awarding professional service contracts. At Landrieu's request, the OIG had reviewed charter provisions, ordinances, and procedures involving the procurement of professional service contractors and consults for City departments, and had compiled a comparative analysis of the procurement practices adopted by the State of Louisiana with those of the cities of Baton Rouge, Chicago, Houston, New York, and San Francisco. The letter serves to compare the City of New Orleans' practices with those aforementioned cities and additionally with the City of Atlanta. The Inspector General recommended that New Orleans adopt practices for awarding professional services that conform to more modern standards that aim to minimize the influence of politics and to ensure fair competition for professional service contract opportunities. The Inspector General offered to review and comment on any proposed legislation to achieve these goals. The Committee views the OIG's suggestions regarding modernizing the City's procedure for awarding professional service contracts to be sensible and again aimed at achieving transparency in government.

III. AUDITS

In this section, the Committee considers the performance audits, reviews, and follow-up reports completed by the OIG. In 2014, the OIG issued reports of six performance audits, two follow-up reports, and one review. Of the six performance audits, five concerned the NOPD and one concerned the Bureau of Revenue's Internal Controls in the compliance division. The first follow-up report revisited the performance audit of the New Orleans Aviation Board's month-to-month contracts; the second follow-up report revisited the City of New Orleans Payroll Internal Control. Included in this section is a brief review of the OIG's findings in each, followed by general comments and observations.

Performance Audit of the New Orleans Police Department's Uniform Crime Reporting of Forcible Rapes

The performance audit of NOPD's Uniform Crime Reporting[1] ("UCR") of forcible rapes, conducted from June 1, 2010 through May 31, 2013, emphasized ten findings and three observations.[2] The objective of the audit was to determine whether NOPD properly classified and reported forcible rapes to the UCR Program.

The OIG reported six UCR findings related to NOPD practices and policy violations: (1) 43% of UCR offenses were misclassified by NOPD as sexual battery or miscellaneous rather than forcible rape; (2) offenses were misclassified to a miscellaneous offense instead of unfounded ("UNF"); (3) the NOPD did not provide the reason for the signal and/or disposition change on an incident or supplemental report; (4) the NOPD incident reports were not completed by officers prior to ending their tour of duty; (5) NOPD supervisors did not review incident and/or supplemental reports in a timely manner; (6)

[1] The Federal Bureau of Investigation's ("FBI") Uniform Crime Reporting Program ("UCR Program") is a voluntary nationwide, cooperative statistical effort of city, county, state, tribal, and federal law enforcement agencies reporting data on crimes brought to their attention. The UCR Program's objective is to generate reliable information for use in law enforcement administration, operation, and management. "Crime in the United States, 2009" U.S. Department of Justice – Federal Bureau of Investigation; September 2010. www.fbi.gov.

[2] Forcible rape was selected for testing based on the FBI's 2012 published crime statistics, which revealed that forcible rape in New Orleans was 43% lower than 24 other cities with the highest crime rates.

certain evidence was not remitted to Central Evidence & Property ("CE&P"). Additionally, the OIG reported four findings related to the NOPD's compilation of its UCR data: (7) the NOPD did not report the highest offense on the hierarchy list to the UCR program; (8) the NOPD did not maintain supporting documentation for 2010 and 2011 Part I offenses causing the data to be unable to be audited[3]; (9) the NOPD excluded forcible rapes with a disposition of "Report to Follow" ("RTF") in its UCR data; and (10) the NOPD excluded forcible rapes with a disposition of UNF from its UCR data. The report found that the NOPD violated UCR data quality guidelines provided by the FBI to maximize the quality, objectivity, utility, and integrity of the information.

The OIG's observations are as follows: (1) the NOPD lost its ability to report arrest data involving Part II offenses to the UCR Program; (2) the NOPD discontinued its practice of posting quarterly UCR data on its website after the website was consolidated into a city-wide website; and (3) the NOPD backdated two supplemental reports instead of using the date the report was written.

Performance Audit of the New Orleans Police Department's Uniform Crime Reporting of Robbery

In its performance audit of NOPD's UCR of robbery, the OIG highlighted six findings: (1) the NOPD misclassified 37% of the offenses tested to a miscellaneous offense rather than a robbery; (2) the NOPD misclassified 40% of the offenses tested to miscellaneous offense instead of assigning a disposition of UNF; (3) the NOPD did not report all robberies with a disposition of UNF to the UCR program; (4) the NOPD did not report known robbery offenses when the victim refused to cooperate; (5) the NOPD did not corroborate signal changes with supporting documentation; and (6) the NOPD did not submit evidence to CE&P. The audit was conducted over the period of June 1, 2010, through May 31,

[3] For UCR reporting purposes, criminal offenses are divided into two major groups: Part I and Part II. Part I offenses are serious offenses that occur with regularity and are more likely to be reported to police. There are eight Part I offenses: murder, non-negligent manslaughter, forcible rape, robbery, aggravated assault, burglary, larceny-theft, motor vehicle theft, and arson. For Part II offenses, participating law enforcement agencies only provide arrest data. NOPD UCR Reporting-Forcible Rape Performance Audit, 2013, p. 6 of 30.

2013. The objective of the report was to determine whether Part I robbery offenses were properly classified and reported to the UCR Program.[4] Like the report involving UCR of forcible rape, this report found that the NOPD violated UCR data guidelines provided by the FBI.

Performance Audit of the New Orleans Police Department Central Evidence & Property Section (CE&P)

Ten findings and eleven observations were reported in the OIG's performance audit of the NOPD CE&P section. While the auditors noted improvements made to CE&P policies and procedures, the OIG found a high risk of theft or misplacement of evidence and property in CE&P custody if inventories, audits, and disposals are not conducted in accordance with NOPD policies and best practices.

Five findings were reported relating to annual inventories, audits, and disposals: (1) the CE&P section did not purge evidence for which all statutes of limitations had expired; (2) the CE&P section did not conduct inventories on an annual basis in compliance with policy; (3) the CE&P section did not conduct inventories when there was a change in key-holding personnel in the CE&P facility; (4) annual audits of the CE&P section were not performed in compliance with NOPD policy; and (5) NOPD policy did not specify the personnel that should perform the annual audit of the CE&P section, nor did it outline the audit procedures to be performed. Five additional findings were issued regarding inventory testing: (6) evidence and property recorded in BEAST evidence management tracking system[5] was no longer in the custody of CE&P or was in a different storage location than listed; (7) currency exhibits were still listed at their original amounts even though the actual amounts had been altered; (8) currency

[4] Robbery was selected for testing based on the FBI's 2012 published crime statistics, which revealed that robbery in New Orleans was 46% lower than 24 other cities with the highest crime rates.
[5] Bar Coded Analysis Statistical Tracking ("BEAST") software, manufactured by Porter Lee, was used by NOPD to track all evidence and property exhibits submitted to CE&P.

exhibits investigated by PIB[6] were not timely deposited or transferred out of CE&P custody once the exhibits were no longer required to be held for investigation; (9) CE&P did not maintain a balance of currency on hand from its records of currency entering the facility and leaving for deposit; and (10) property and evidence exhibits in the custody of CE&P did not have the corrected storage location reflected in BEAST.

The OIG submitted three observations involving the BEAST evidence management tracking system: (1) CE&P's wireless barcode scanners used for inventories were not functional; (2) CE&P management was unable to generate a report of the entire inventory in the facility; and (3) the CE&P section did not utilize the BEAST capability to provide a count of currency on hand. Six more observations were provided relating to the CE&P policies and procedures: (4) NOPD policy did not require complete inventories for sensitive evidence areas where there was a change in key-holding personnel; (5) copies of the Verification Cash Count Sheet[7] maintained by CE&P did not consistently have a supervisor's signature; (6) one narcotics exhibit selected for testing had $200 of currency commingled with it; (7) several evidence tags lacked the signature of the submitting officer; (8) narcotics exhibits did not have the total packaged weight recorded on the evidence tag in accordance with CE&P policy; and (9) NOPD policy for notifying the public of unclaimed property via the internet was not compliant with Louisiana state law. Finally, the OIG included two observations in connection with CE&P leases: (10) the city leased the CE&P facility at a rate in excess of fair market value; and (11) NOPD leased a secure storage unit to house narcotics exhibits for which all statutes of limitations had expired.

New Orleans Police Department Grants Performance Audit

[6] NOPD Public Integrity Bureau ("PIB"). Following Hurricane Katrina, CE&P operations were housed in FEMA trailers. After CE&P management failed to locate several currency exhibits, the NOPD PIB began an investigation in 2007. The PIB investigation was expanded in 2008 as a result of the additional revelation of tampering and misappropriation.

[7] The "Verification Cash Count Form" for each department was to be signed by both the Valuables Control Officer and the supervisor who reviewed the documentation. This step evidenced a supervisor's review and approval of support for each deposit in accordance with procedures in the CE&P Procedures Manual.

The OIG conducted an audit of the NOPD's grant expenditures between January 1, 2011, and December 31, 2012. The objective was to test grant control and grant compliance, as well as to search for waste or abuse. The OIG reported three primary findings: (1) the NOPD incorrectly billed overtime grants on its STEP grant;[8] (2) an NOPD officer submitted fictitious tickets on the STEP grant;[9] and (3) the NOPD was unable to locate a computer purchased under its COPS Technology grant.[10]

New Orleans Police Department Payroll Performance Audit

From December 30, 2012 through April 6, 2013 the OIG conducted an audit of the NOPD's payrolls. The audit's objective was to evaluate the operating effectiveness of payroll, overtime, and paid detail processes specifically related to daily working limits and controls that are unique to NOPD.[11] Five findings were made relating to general NOPD payroll: (1) seventeen NOPD officers worked more than the allowed 16 hours and 35 minutes a day;[12] (2) fourteen officers worked more than 32 hours of overtime in a week, violating the NOPD Operations Manual; three officers worked more than 24 hours of overtime in a week without required approval; (4) twenty-two NOPD officers tested did not approve their time in the Beat Book;[13] and (5) fourteen NOPD officers' Beat Books were not available for audit.

[8] The 2011 Police Traffic Services ("STEP") grant was a sub-grant of the Louisiana Highway Safety Commission designed to reduce fatal and injury crashes on Louisiana roadways. The STEP grant centered on issuing citations for speeding, drunk driving, seat belt violations, and underage drinking. The grant provided funding for the officers tow work overtime patrols between October 1, 2010 and September 30, 2011. The STEP grant provided for overtime in addition to the officer's regularly scheduled tours of duty.

[9] The officer has since retired. The matter was referred to the U.S. Department of Transportation's Office of Inspector General.

[10] A $654, 710 U.S. Department of Justice COPS awarded to purchase equipment. This grant began in December 2007 and ended in December 2013. The NOPD purchased mobile video units, DVD burners, computers, and other technology related equipment.

[11] Paid detail refers to the off-duty employment, for compensation, of any employee of the Police Department by another individual, business, establishment, or organization where the employee is performing the duties of a police officer or a function of the police department. NOPD Operations Manual, 22.8.

[12] NOPD Operations Manual Chapter 13.15 – Overtime.

[13] The Beat Book is a compilation of the daily beat roll printouts for each unit of the NOPD. The Beat Roll Printouts refer to a daily printout for each unit of NOPD, which indicated each employee's working status and hours for the given day. The commanding officer was required to maintain the Beat Books for the unit.

Furthermore, four additional findings were reported by the OIG involving paid details: (6) NOPD officers failed to enter paid details into the paid detail database;[14] (7) three NOPD officers worked a total of four paid details while also working their tour of duty;[15] (8) twelve NOPD officers worked 50 paid details without a break between the tour of duty and the paid detail; and (9) NOPD officers worked paid details without the knowledge or approval of their supervisors.

Lastly, two observations were noted: (1) pursuant to the NOPD operations manual, NOPD officers were able to work up to 106 hours and 55 minutes per week; and (2) one NOPD officer split his work shifts eight times to perform a traffic escort detail.[16]

Performance Audit of the Bureau of Revenue's Internal Controls – Compliance Division

The OIG conducted an audit of the internal controls of the post-audit processes of the Bureau of Revenue's Compliance Division from January 1, 2011, through December 31, 2012.[17] The OIG auditors reported six findings: (1) the Bureau of Revenue lacked internal written policies and procedures for its auditors to enforce timely collection of unpaid tax assessments; (2) the City of New Orleans Revenue System did not have the capabilities necessary for the Bureau of Revenue to collect taxes expeditiously; (3) the Bureau of Revenue did not maintain complete audit files; (4) the Bureau of Revenue did not complete audits in a timely manner; (5) the Bureau of Revenue did not update it Formal

[14] When officers worked a detail, one member of the detail was required to call the Orleans Parish Communication District ("OPCD") to check in before commencement of the detail. Then OCPD issues an item number for the detail, which is entered into the paid detail database by each officer. The paid detail database provided information needed to check the number of the detail hours an officer worked in a given period.
[15] NOPD Operations Manual Chapter 22.8: Paid Details states, "Officers or other employees authorized to work paid details may perform or engage in authorized paid details only during those times when they are off-duty.
[16] NOPD policies prohibit an officer from splitting work shifts within a scheduled tour of duty. Splitting a work shift is defined as clocking out and back in without using approved leave (sick, annual, etc.) for the work interruption.
[17] The Bureau of Revenue is a component within the Department of Finance within the City of New Orleans that is responsible for administering and enforcing ordinances pertaining to the collection of various taxes, such as sales taxes, hotel-motel taxes, and other taxes in accordance with the City Code.

Assessment letter in a timely manner[18] to be in compliance with Louisiana State Law;[19] and (6) taxpayer bank accounts were not levied as required by the Bureau of Revenue's informal policy.[20]

Four observations were also included in the OIG's report: (1) the engagement letter sent to taxpayers referenced a Louisiana Revised Statute that did not exist; (2) audit reports and exit conference memos were not dated or were dated after the exit conference was held; (3) staffing was not sufficient to perform assigned tasks in a timely manner; and (4) taxpayers did not have an exit conference, and no evidence was maintained documenting the taxpayer's decision to waive the exit conference.

Review of the New Orleans Firefighters' Pension and Relief Fund Credit Card and Expense Reimbursement Transactions

From January 1, 2010, through December 31, 2012, the OIG oversaw a review of the New Orleans Firefighters' Pension and Relief Fund (NOFFPRF) policies and procedures for credit card transactions and expense reimbursements.[21] Seven findings were reported: (1) the NOFFPRF policy was ambiguous, incomplete, and contrary to best practices;[22] (2) NOFFPRF employees and board members made credit card purchases that were determined unallowable;[23] (3) NOFFPRF accepted a credit card customer copy which only contained the total amount charged to the card instead of requiring a "voucher or receipt for each expenditure;" (4) the board did not enforce its policy relating to written

[18] The Formal Assessment letter is the third step in the Compliance Division's unpaid tax collection procedure.
[19] Louisiana law determines how much time a taxpayer is granted to pay their taxes. Prior to January 2011, taxpayers were granted 60 days to pay the taxes assessed. On January 1, 2011, the Louisiana Legislature revised the statute to reduce the time allotted to 30 days. The Formal Assessment letters have not been updated to reflect this impactful revision.
[20] The Bureau of Revenue levied a taxpayer's bank accounts if he did not pay or settle his taxes after a Demand Payment Notice deadline. By not levying 23% of the bank accounts tested, the Bureau of Revenue reduced its ability to collect tax liabilities from taxpayers.
[21] The City of New Orleans was responsible for providing funding to the New Orleans Firefighters' Pension and Relief Fund. The NOFFPRF was created, pursuant to the Louisiana Revised Statute 11:3361, for the purpose of providing retirement allowances and other benefits for the firefighters of the City of New Orleans.
[22] The policy did not define unallowable expenses, require an itemized receipt, require a written explanation for credit card transaction, and was silent on a time frame for reimbursement.
[23] Of the sixty credit card transactions tested, 30% were not allowable under the "Basis and Items of Reimbursement" section of the NOFFPRF policy.

explanations for expenses incurred; (5) the board did not review and approve the required support for each credit card transaction and expense reimbursement prior to payment; (6) unallowable expenses were not reimbursed by the cardholders in a timely manner; and (7) most board members, an administrative employee, and two individuals unrelated to the fund had unlimited access to NOFFPRF credit cards.

Four further observations were reported: (1) in December 2012, the Louisiana Board of Ethics filed charges against a NOFFPRF board member; (2) the board did not provide a complete listing of reimbursements made to NOFFPRF employees and board members; (3) NOFFPRF employees and board members were permitted a ten dollar per day telephone reimbursement when traveling; and (4) a board member was reimbursed twice for the same expense.

Follow-up Report: A Performance Audit of the New Orleans Aviation Board Month-to-Month Contracts

The OIG conducted a follow-up report in response to its performance audit of the New Orleans Aviation Board ("NOAB") to determine if NOAB implemented the corrective actions indicated in the 2013 report. In four follow-up findings, the OIG concluded that the NOAB implemented its corrective actions. The findings reported that NOAB successfully: (1) monitored month-to-month contracts to ensure that they were renewed and/or procured in a timely manner; (2) reviewed selective invoices and verified that the invoices were in compliance with the contract terms prior to approving the invoice for payment; (3) properly supported and documented invoices tested; and (4) received approval from the Board of Directors on all tested capital project invoices greater than $15,000 prior to payment. In its only follow-up observation, the OIG noted that the NOAB staff successfully maintained work previously outsourced to an outside vendor.

Follow-up Report: The Payroll Internal Control Performance Audit

In response to a 2011 performance audit relating to the internal controls involved in the payroll

process, the OIG issued a follow-up report to determine if the City implemented its corrective actions and if such actions were operating effectively. The OIG reported that the City fully implemented four of its recommendations, partially implemented five of its recommendations, and failed to implement three of its recommendations.[24] Overall, the follow-up report found that the City had clearly made progress in its payroll controls, but that more work is necessary to fully correct the findings of the original report.[25]

General Comments

Overall, the Committee views the OIG's audits to be thorough both in methodology and in written work product. For every audit, review, or report, the OIG meticulously identified the condition, cause, and effect of each individual finding. The process involved is as important as the results provided, and we find the OIG's procedures to be comprehensive and conscientious. Many of the findings revealed in the performance audits seem to be solvable solely by enforcing compliance with established codes, practices, and policies. The follow-up reports encouraged the committee in their responsiveness to OIG recommendations and corrective actions they displayed. By addressing the issues raised in each audit, the Committee finds that the respective departments will avoid future, more serious abuses.

[24] One corrective action was unable to be tested because the new payroll system was not fully functional at the time of follow-up testing.

[25] For example, the original report found that 597 employees of the City's employees, or 18%, exceeded the maximum overtime limit per year. The follow-up review found that only 201 employees exceed 416 hours. Additionally, the follow-up report found 285 outstanding payroll checks, and the follow-up review found only three payroll checks outstanding.

IV. INSPECTIONS AND EVALUATIONS

During 2014, the OIG conducted four Inspections and Evaluations. Two of the Inspections and Evaluations focused on two aspects of the City's Electronic Monitoring Program, and the remaining two focused on the New Orleans Police Department's staffing and development, and a follow-up on the City's employee life insurance. This section reviews this portion of the OIG's work. Like most of the written work product from the OIG, the evaluations are data driven in nature. The timely evaluations contained evidence that met the standards for competence, sufficiency, and relevance. This section reviews each of the individual inspections or evaluations and then provides some general comments regarding the quality of each report.

Evaluation of the City's Electronic Monitoring Program Administered by the Orleans Parish Sheriff's Office

The OIG conducted an evaluation of the City's Electronic Monitoring Program (EMP) administered by the Orleans Parish Sheriff's Office (OPSO). The EMP allows defendants who might otherwise be detained to avoid detention while awaiting trial by agreeing to wear a monitoring device (i.e. ankle bracelet) that uses tracking technology to locate and monitor their movements. The goals of the evaluation were to identify the goals of the EMP program, to identify and assess the program's performance measures, to review the program's annual budget allocation and expenses, and to examine alerts and OPSO responses in April 2013. Part one of the OIG's evaluation, presents findings and recommendations related to EMP budget and billing practices. Part two of the OIG's evaluation provides administrative and programmatic findings and recommendations as to implementation and supervision of the program.

I. Budget and Billing

Part one of the OIG's evaluation presents five major findings related to budget allocations and other expenditures: (1) OPSO's reported expenditures for EMP exceeded program revenues by over $100,000 in 2011 and 2012; (2) OPSO reported indirect costs for EMP that could not be verified or were miscalculated, including over $140,000 per year in rent; (3) EMP deputies' schedules included regularly scheduled overtime, which raised personnel costs by more than $100,000 over base salaries, the equivalent to two monitoring deputy positions in 2012; (4) the daily rate per person OPSO charged the City for electric monitoring was more than it initially proposed, more than it charged an EMP grant, and more than the per diem of a program administered by a comparable law enforcement agency in another city; and (5) OPSO overbilled the City by approximately $23,000 due to billing errors and billed the City over $65,000 for post-conviction monitoring, and the City did not identify these errors.

Based on the findings, the OIG also made three recommendations related to budget and billing practices. The first recommendation urged the OPSO to improve fiscal controls and keep a separate running account of the EMP budget separate from its General Fund. By maintaining a monthly accounting of revenues generated and itemized expenditures, the OPSO could engage in ongoing budgetary review and prevent budget overruns. The OIG purported that monitoring spending on a regular basis could maximize available resources. For example, OPSO could have funded at least two additional monitoring deputies with the amount spent on overtime pay in 2012.

In its second recommendation, the OIG suggested that the City renegotiate the cost per unit per day to include a fixed indirect cost rate. To accomplish this, the OIG first recommended that the City establish an acceptable indirect cost rate for externally managed programs such as the EMP to ensure that city funding does not support miscalculated and/or inflated program costs. Secondly, to reach the end of a fixed lower cost per unit per day, the OIG stated that the City should improve its fiscal oversight of the EMP by requiring a more detailed program accounting. In doing so, the City could expand the number of program participants without increasing its budgetary allocation for the EMP.

In its third and final recommendation, the OIG advised that the City and OPSO should increase financial controls and oversight of the billing processes to ensure that invoices sent to the City are both accurate and include billing only for those defendants that the program is intended to serve. As discussed in finding five, OPSO erroneously charged the City in more than one capacity. Due to a lack of sufficient financial oversight, the City was also responsible for unidentified billing errors, and because of this, failed in fulfilling their obligation to taxpayers to ensure that taxpayer funds were used appropriately. The OIG suggested OPSO review its billing protocol and improve oversight of its billing process.

II. Implementation and Supervision

In part two of its evaluation of the City's Electronic Monitoring Program (EMP) administered by the Orleans Parish Sheriff's Office (OPSO), the OIG's objectives were to examine EMP operations, review the program's protocols, assess how the monitoring deputies responded to alerts, and determine whether adequate performance measures were set up to gauge the effectiveness of the program. The OIG reported six major findings: (1) EMP

defendant records were incomplete and inaccurate; (2) monitoring deputies entered in exclusion zones in the Omnilink monitoring system for only two of 37 defendants with judicial stay away orders;[26] (3) OPSO protocols for responding to alerts were neither detailed nor comprehensive enough to provide adequate instruction for monitoring deputies; (4) alerts notifying deputies that defendants had left the geographic area that they were ordered to remain in were left active for more than 30 minutes and evaluators could not determine what, if any, action was taken in response; (5) monitoring deputies tagged only two percent of the total alerts generated in April 2012; and (6) the City did not establish program objectives or performance measures to assess OPSO's implementation of the EMP and the overall effectiveness of the program, and data that OPSO provided to the City had very little useful information for measuring program performance.

In general, the corresponding recommendations suggested abiding by established protocol and enforcing policies to reprimand violations thereof. Recommendation one urged EMP supervisors to more carefully review EMP records and to hold the staff assigned to monitor participants accountable for accurate and complete file maintenance. In response to problems with the "stay away" orders, recommendation two simply requests that prohibited addresses pursuant to such orders be entered as exclusion zones in the electronic monitoring system.

[26] Judges often rely on "stay away" orders to prevent a defendant from gaining access to victims, places of business, and co-defendants. In the system, monitoring deputies could enter in "exclusion areas," specific geographic areas the defendant was prohibited from entering – if the defendant entered the exclusion area, the monitoring deputy would receive an alert.

With regards to problems with responding to alerts, the OIG recommended developing effective policies and procedures and then providing supervision to secure personnel compliance. Recommendation three proposed that the City and EMP contractor provide specific information about the actions monitoring staff should take in response to alerts, including time thresholds for graduated responses, and that the EMP supervisor provide sufficient oversight to ensure EMP personnel comply with the policy. Recommendation four similarly prompted monitoring staff to detain defendants who violate curfew or house arrest orders as soon as valid inclusion alerts are confirmed and stated that instructions to this effect should be codified in the EMP statement of policies and procedures. Additionally, the OIG recommended that monitoring staff tag all alerts and document actions taken in response to verified alerts.

In its final recommendation, the OIG urged the EMP contractor and the City to develop meaningful performance measures for judges, City administrators, and the City Council to effectively evaluate the EMP. The OIG suggested that the measures designed should be able to determine whether the program is reducing costs as an alternative to pretrial detention, enhancing public safety by reducing recidivism, appropriately enrolling defendants in accordance with established eligibility criteria, and meeting program goals for defendants' compliance with program requirements.

Evaluation of New Orleans Police Department Staffing and Development: Meeting the Demand of Citizen Calls for Service with Existing Resources

The OIG conducted an evaluation of New Orleans Police Department's (NOPD) force structure, focusing on the department's staffing and deployment to answer citizen-generated calls for service. The evaluation's objectives were to record and assess the efficiency and effectiveness of the organization of personnel to carry out the department's mission "to provide professional police services to the public."[27] Eleven findings and corresponding recommendations are included in the report.

Step one of the OIG's evaluation examined the distribution of citizen-generated calls for service, and step two examined the types and prioritization of citizen-generated calls for service. Here, the OIG's first finding was that NOPD classified 22 percent of calls for service as "complaint other," making it difficult for supervisors to implement calls-for-service data to inform NOPD staffing and deployment needs. In response, the OIG recommended that NOPD reduce its use of non-descriptive calls-for-service classifications and instead use call classifications that provide qualitative information about the nature of the calls for service.

Finding two stated that NOPD used three main categories to prioritize citizen-generated calls for service, significantly limiting information available to the officer about the nature and urgency of the call and reducing the department's ability to prioritize responses to calls for service effectively and efficiently. The OIG recommended that NOPD implement calls-for-service priority codes with descriptive information and specific instructions to guide the officer's response.

Step three of the evaluation involved determining how long a call takes from the initial response to final paperwork, which is essential for calculating the minimum number of officers

[27] New Orleans Police Department, *Policy Manual*, 2012.

needed per shift. Within this step, OIG evaluators found that Platoon supervisors held calls for service in queue at shift change, creating a backlog of calls waiting to be dispatched at the beginning of the next shift. This resulted in a backlog of calls within the first hour of the shift, and the data suggests the officers rarely caught up to the demand for service. The OIG recommended that NOPD should adjust Platoon shift times to alleviate the need to hold calls for service in queue. One possibility would be to stagger the starting and ending times of shifts for some officers.

In finding four, the evaluation noted that evaluators were unable to determine response times or on-scene times, because officers did not enter arrival times for 13 percent of calls for service. Response times are an indicator of police performance, about which the citizens are concerned. Police supervisors and policy makers would have difficulty in managing citizens' expectations when they lack reliable response time data. Here, the corresponding recommendation was that NOPD supervisors should require officers to provide arrival times when responding to calls for service.

In step four of the evaluation, the OIG attempted to calculate the shift relief factor. The shift relief factor is used to estimate the number of officers needed to meet the workload demands for each shift. Step five focused on deciding how much time should be devoted to calls for service, and step six provided staffing estimates. In its fifth finding, the OIG observed that in May 2013 most platoons did not have sufficient manpower to meet the demand of citizen-generated calls for service at 50 and 40 percent time answering calls for service; at 30 percent time answering calls for service, none of the platoons were sufficiently staffed to meet

the demand. [28] The fifth recommendation was for NOPD to increase the number of officers assigned to handle calls for service while simultaneously pursuing options to reduce the demand.

The evaluators found several options in which NOPD could use existing resources to increase the number of officers available to answer calls for service. In finding six, the OIG noted that NOPD Districts have sworn officers assigned to tasks that reduce districts' capacity to answer calls for service. Recommendation six suggested that NOPD attempt to maximize its capacity to answer citizen calls for service by ensuring that the most effective and efficient use is made of trained law enforcement personnel. The OIG found that best practices suggest that officers currently assigned to desk duties, vehicle maintenance, and building maintenance service should be reassigned to patrol duty and NOPD should make alternative arrangements for non-law enforcement needs.

In finding seven, the evaluators pointed out inconsistency and noted a lack of clear department-wide expectations regarding the deployment of sworn officers resulting in differing deployment and practices among the eight NOPD districts. Here, the OIG recommended that NOPD provide greater oversight and guidance on the way in which commanders use district resources while continuing to support NOPD's decentralized district management.

The OIG noted in finding eight that NOPD had a high ratio of sworn to non-sworn staff; more than 100 of its sworn positions met the International Association of Chiefs of Police Criteria for duties that can be performed by civilians. To improve efficiency and cost-

[28] Percent time refers to the percentage of time during a shift that an officer is required to spend answering calls for service.

effectiveness, recommendation eight suggested that NOPD hire more non-sworn staff to perform non-law enforcement duties and redeploy sworn officers to respond to calls for service. In general, the evaluation said a position should be sworn only if it requires the powers, skills, and abilities of a police officer (e.g. the authority to make arrests). Non-sworn staff can often perform tasks previously designated for a police officer at a significantly lower cost and with less training. The OIG emphasized that sworn officers should only perform services that require a trained officer to perform. For example, the OIG noted that, while a police officer might be very good at fixing cars, the City incurs an opportunity cost by using a sworn officer in this capacity.

The OIG contended that one of the key issues in police organization and strategy is span of control or the number of subordinates reporting to each supervisor. Finding nine stated that NOPD had a higher ratio of sergeants to officers than the recommended average. In response the OIG recommended that NOPD widen the span of control by reducing the number of supervisors and commanding officers in accordance with best practice and operational needs.

Findings ten and eleven concerned wasted time. Finding ten dealt with reducing calls for service due to false alarms, observing that in 2012, a significant amount of NOPD resources were wasted responding to 36,691 burglar alarms. False alarms are a waste of valuable police resources and a problem that many law enforcement agencies struggle to combat. Recommendation ten stated that the City should make revisions to City Code designed to reduce calls for service due to burglar alarms, and subsequently NOPD should adopt a new policy and procedure that reflects those changes. Other cities have responded to this issue with

approaches that rely on registering alarm companies and regulating the behavior of consumers and alarm companies by enforcing monetary penalties and offering education.

In its last finding, the OIG found that NOPD patrol officers spent a significant amount of time investigation traffic incidents that did not require the training and expertise of a law enforcement officer. Traffic accidents and hit and run calls totaled at seven percent of all citizen-generated calls for service. In recommendation eleven, the OIG urged the City to include in its state legislative agenda changes to state law the permit alternative responses to traffic accidents and result in the most efficient and effective use of law enforcement resources. Additionally, the OIG stated that NOPD should also adopt new policy and procedure to develop and implement alternative responses.

Follow-up Report: Evaluation of City Employee Life Insurance

The OIG conducted a follow-up to its Evaluation of City Employee Life Insurance issued in February of 2012. Six major findings were discussed in the follow-up report: four of which were resolved, one of which was partially resolved, and one of which was not resolved.

The follow-up report stated that of the original findings two, four, five, and six were resolved. The City resolved finding two by obtaining a new life insurance provider, resulting in $8,000 savings each year. By issuing a policy memorandum to reaffirm the responsibility of all personnel to preserve and safeguard public records, the City resolved finding four. Additionally, the City resolved finding five by providing employees with information about coverage claims and procedures under the group life/AD&D policy. Finally, finding six was resolved by

developing a procedure to identify deceased employees and send claims information to designated beneficiaries.

In its original evaluation, the OIG found that City had overpaid for life insurance due to failed calculations in the Risk Management Division. The follow-up report found that, by shifting responsibility of the group life policy to the Employee Benefit's Division, the City partially resolved the finding. The OIG noted that additional adjustments were required because the City continued to make errors in calculating monthly premium payments.

The follow-up report found that the OIG's original recommendation three, for the City to make and approve vendor payments through the City's electronic purchasing system, was not resolved. The City rejected this suggestion and continued to use the Request for Payment Voucher method for generating premium payments to group life insurance providers. This topic was the subject of subsequent OIG report issued in October 2012.

General Comments

In all of the inspections and evaluations reviewed by the Committee, the OIG's recommendations were plainly and logically related to the findings resulting from the quantitative and qualitative evidence gathered. The information was presented in a manner that detailed its sources and sufficiently supported its conclusions. Emphasizing the importance of accountability and enhanced supervision, the recommendations for the EMP, if followed, appear to be appropriately tailored to make the EMP a more successful program.

In its evaluation regarding NOPD's staffing and development, the OIG focused its recommendations on maximizing both NOPD's resources and effectiveness. The data of the report is presented objectively and often in reader friendly charts and graphs, making the

report accessible and meeting the organizational standards for the OIG's evaluations. Again, the findings are data-driven and thoroughly supported, and the recommendations have an apparent logical relation to the findings. Citizen safety seems to be the OIG's priority.

Finally, the City employee life insurance follow-up was timely and determinative as to the corrective measures taken. Surely, successful follow-up reports such as this further the OIG's objective: to ensure that problems initially identified are properly addressed and necessary corrective action is taken.[29]

[29] For information regarding the applicable standards see Principles and Standards for Offices of Inspector General, Quality Standards for Investigations and Quality Standards for Inspections, Evaluations, and Reviews, Association of Inspectors General, p 33-35 (May 2004)("OIG Quality Standards").

V. INVESTIGATIONS

During 2014, the OIG conducted three Investigations. The Investigations focused on allegations of neglect of duty and gross negligence by the Deputy Director of the Taxicab Bureau in the Department of Safety and Permits, a report regarding the documentation of sex crime investigations by five Detectives in the Special Victims Section of the NOPD, and allegations of neglect of duty and gross negligence by Larry Bishop, Airport Service Manager, Ground Transportation, New Orleans Aviation Board. In this section, we will comment on this aspect of the OIG's performance. General comments follow an individualized summary of each investigation.

Allegations of Neglect of Duty and Gross Negligence by Deputy Director, Taxicab Bureau, Department of Safety and Permits

Based on a request from the First Deputy Mayor and Chief Administrative Officer (CAO), Andrew Kopplin, the OIG conducted a comprehensive review of the Taxicab Bureau's (TCB) operations. The Investigation included a review of more than 1,200 files, including personnel files and Certificate of Public Necessity and Convenience (CPNC) files; interviews with TCB employees, City Hall employees, Taxicab Drivers, CPNC owners; a review of applicable policies and procedures; and a review of the requirements as set forth in Chapter 162 of the New Orleans City Code.

The OIG made two findings. First, that the failure to properly maintain files, documents, and public records was due to Deputy Director (DD) Malachi Hull's neglect of duty. Second, that DD Hull was grossly negligent in not providing proper oversight and in not ensuring that his personnel were properly trained. DD Hull's alleged negligence led to at least two instances of employees using excessive force and directly impacted public safety. In connection with the two findings, the OIG issued a referral for administrative action to CAO Kopplin.

The first finding dealt with DD Hull's alleged neglect of duty in regards to effectively maintaining files, document, and public records. The TCB was established for the purpose of overseeing daily operations of taxi service within New Orleans and enforcing the requirements as set forth in the New Orleans City Code. The TCB accumulates hundreds of documents every day; thus, it is imperative that said documents are cohesively organized and well managed. In their review of approximately 500 CPNC files, OIG investigators found that 400 CPNC owners (80%) paid lesser (incorrect) amounts in fees and fines owed to the City. OIG investigators found that the City did not collect the correct amount of fees and fines in the areas of CPNC fees, inspection fees, and drivers' fees, which resulted in a loss of revenue. For example, an OIG investigator discovered that a CPNC owner owed the City $62,370 in transfer fees.

Additionally in their first finding, OIG investigators found that most of the CPNC files reviewed were not complete and important documents were missing. The CPNC documents were located under and behind desks, behind file cabinets, in the storage room, in multiple recycling bins, in the employee break room, and were filed in the wrong CPNC files. DD Hull was notified by OIG investigators numerous times between September 2011 and February 2012 regarding the collection of money owed to the City and was made aware of the file maintenance problems numerous times; however, he never acted to address the situation. The OIG concluded that DD Hull was in violation of CAO policy memorandum No. 83(R); particularly, "*Each employee, because of the job assignment has certain required duties and must assume certain responsibilities… Failure to perform these duties or take the responsibilities is neglect of duty."* The OIG referred DD Hull for administrative action to CAO Kopplin.

The OIG's second finding was that DD Hull was grossly negligent in failing to ensure public safety and manage personnel, and that he lied to the OIG. Two incidents occurred under DD Hull's supervision where TCB Investigators used excessive force. The first incident occurred in the presence of DD Hull when a TCB investigator physically assaulted a Tour Guide Operator, twisting her arm behind her back

and forcing her body onto a parked vehicle. The second involved a TCB investigator spraying pepper spray into the face of a Taxicab Driver. In an interview with OIG investigators, DD Hull stated that he thought the TCB investigators were operating within their normal course of duties; that he assumed they had training for physical confrontations; and that he believed that Chapter 162 of the Ordinance gave his investigators "arrest powers." OIG investigators were also informed by DD Hull that there was no operations manual for TCB Investigators, and that DD Hull did not write one because he "did not have time."

In reviewing the TCB Investigators' personnel files, OIG inspectors found that no applicable training had been documented nor was there any reference to applicable training. Moreover, the OIG investigators reported that DD Hull lied regarding when he first learned of TCB investigators' lack of training in October 2013. OIG investigators located an email from June 2011, in which DD Hull emailed the Superintendent of the NOPD and requested training for his Investigators. NOPD eventually advised DD Hull that they could not provide the training because TCB personnel did not have the requisite enforcement powers. The OIG investigators discovered at least five failed attempts made by DD Hull to obtain training for his personnel. In conclusion, the OIG found that DD Hull failed in his duty and responsibility to ensure that the TCB investigators had proper training, direction, and supervision, and that his gross negligence in this matter led to two separate physical assaults by TCB investigators. Additionally, in lying to the OIG investigators, the OIG noted in its investigation DD Hull violated City Code Section 2-1120 (20)(a), "*It shall be the duty of every city officer and employee… to cooperate with the Office of the Inspector General in any investigation, audit, inspection, performance review, or hearing pursuant to this chapter."*

Report of Inquiry into Documentation of Sex Crime Investigations by Five Detectives in the Special Victims Section of the New Orleans Police Department

Based on information gathered by the Audit Division of the OIG in its May 2014 *Audit of NOPD's Uniform Crime Reporting of Forcible Rapes*, the OIG initiated this investigation. The Investigations Division of the OIG conducted a review of the randomly selected 90 sex crime related reports that were cited by auditors in their report.[30] Investigators identified 23 reports out of the 90 that aroused significant concerns with regard to the documentation of the investigations. Six reports were actually created on a later date than the date written on the report; seven reports did not contain any supplemental reports documenting any follow-up or further investigative efforts; and four reports included information that was materially different from related medical reports. In the course of that review, the OIG also identified five detectives in the Special Victims Section of the New Orleans Police Department (NOPD) as failing to provide documentation of the investigative efforts and findings, or providing questionable documentation in some of their investigations of sex crimes. These discrepancies led the Investigations Division to conduct a comprehensive review of every case that the five detectives were assigned from January 1, 2011 to December 31, 2013.

The investigators then requested that NOPD's Public Integrity Bureau (PIB) identify every sex crime related call for service that was assigned to the five detectives during the three-year period. PIB provided 1,290 calls for service that had been assigned to one of the five detectives to investigate. Due to ongoing investigations at the time of the OIG's report, the OIG did not name the five detectives, and instead referred to them as Detectives A-E. The true identities of the detectives were provided to PIB separately. The OIG's report contains examples of the questionable documentation by these five

[30] *See "*Performance Audit of the New Orleans Police Department's Uniform Crime Reporting of Forcible Rapes." May 14, 2014. www.nolaoig.org.

detectives, but omits information that could lead to the identification of any victims, i.e. names, dates, locations, etc.

OIG investigators reviewed the 1,290 calls assigned to the five detectives. Of the 1,290 calls, 840 (65%) were designated Signal 21 or Miscellaneous, and no reports were written and no comments were included in the Incident Recall Report. [31] Due to this total lack of information, the investigators were unable to analyze 65% of the sex crime related calls for service assigned to the five detectives. OIG investigators analyzed the remaining 450 calls designated as sex crime signals.[32] For each call there is an initial report, which contains very little information.[33] OIG Investigators found that in the majority of the initial reports associated with the 450 calls for service, the detectives indicated that additional information would be provided in a supplemental report. Unfortunately, the OIG found that the detectives followed through only 40% of the time, providing a total of only 179 supplemental reports among the five detectives. The OIG's Investigation found these 179 supplemental reports represented the entirety of the written work product documenting investigative efforts during the three-year period. The OIG recommended that the 271 cases designated as a sex crime signal but lacking any supplemental reports be investigated by the NOPD and a final determination made.

Additionally, the OIG's report contained an individual analysis of each of the five detectives. First, OIG Investigators found, for example, that Detective A was assigned 13 cases of potential sexual or physical abuse involving juveniles wherein the juvenile victims potentially were still in the same house where the alleged abuse occurred. Out of these 13 cases, the report noted that 11 had no supplemental

[31] A sex crime related call for service might be originally classified as Signal 21 (Miscellaneous) when there is not enough information to designate it, as for example Signal 42 (Rape) or Signal 43 (Simple Rape). It is entirely with in the discretion of the NOPD whether to reclassify a Signal 21 to a signal that indicates criminal behavior.
[32] Sex Crime Signals include: Signal 42, Rape; Signal 43, Simple Rape; Signal 80, Indecent Behavior with a Juvenile.
[33] The initial reports are purposefully brief to protect the victim's identity. For example, a typical initial report of a sex crime might say, "a known female was sexually assaulted at a known location. Additional information will be provided via supplemental report."

reports documenting any investigative effort beyond the initial report. Due to potential safety concerns regarding the children, the OIG investigators provided these cases to NOPD.

Secondly, among other observations, the OIG investigators found that Detective B was assigned three separate cases wherein the Louisiana State DNA Laboratory identified DNA evidence. However, none of the cases documented any follow-up investigation. The OIG investigators noted that for 11 simple rape cases, Detective D did not file reports documenting any effort beyond the initial report. Finally, the OIG Investigators found it noteworthy that both Detectives C and E created reports three years after their reported date in response to a request for the missing reports from the OIG.

In conclusion, the OIG's Report observed widespread failure to submit supplemental reports as well as discrepancies between reports and other factual documentation. The OIG found this to mean that there was no effective supervision of these five detectives over a three-year period, nor any effective supervision of the supervisors, nor any review of the outcome of the cases assigned to the five detectives.

Allegations of Neglect of Duty and Gross Negligence by Larry Bishop, Airport Service Manager, Ground Transportation, New Orleans Aviation Board

The OIG initiated this investigation of Larry Bishop because of a complaint received by the City of New Orleans that stated that "unfair practices" were taking place within the New Orleans Airport Ground Transportation Department. Prior to contacting the OIG, the complainant had spoken with Larry Bishop multiple times regarding the complaints. The complainant alleged that since the Airport began the use of "Airport Taxicab decals," multiple drivers were using the same decal in violation of the rules and that Bishop was accepting monetary payments in exchange for not enforcing the rules and was not following nor enforcing the Code of Ordinances for issuance of the Airport Taxicab Decals. Through its investigation, the OIG determined that Bishop was in violation of Policy Memo No. 83(R), Standards of

Behavior for City Employees, and City Code Section 2-1120(20)(a). The OIG found that Bishop lied to the OIG, neglected his duty, acted with gross negligence, failed to ensure public safety, lacked accountability, created false documents, and failed to collect revenue for ground transportation. The OIG made a referral for administrative action to Aviation Director, Iftikhar Ahmad.

In September 2014, OIG Investigators contacted Bishop who voluntarily provided the Investigators with information and answered questions. Here, the OIG reports that Bishop lied to investigators regarding the enforcement of the Ordinances and Rules as applied to Taxicab Decals when he claimed that all paperwork and applications for taxicabs to operate at the Louis Armstrong New Orleans International Airport (LANOIA) were fully executed in a complete manner. Additionally, the OIG's report states that Bishop said he would not and "has never" approved an incomplete application. The OIG also interviewed three LANOIA employees who all said that Bishop authorized the issuance of decals in the past, despite the applications being incomplete or not existing. Bishop's statements were also contradicted by those of the LANOIA employees when he told the OIG that he has never allowed anyone to obtain a decal without the required paperwork, including the background check. Four employees informed the OIG that Bishop ordered them to issue decals when the application was not complete or the applicant was ineligible to receive a decal. The OIG also found Bishop's statement that he had approval to issue Special Event Decals to cabs that did not possess a Certificate of Public Necessity Convenience (CPNC) to be false. In the course of its report, the OIG randomly selected 45 out of 900 decal files for review. All 45 files contained expired or incomplete information in the applications. Both current and former LANOIA employees informed the OIG that most of applications were incomplete because Bishop ordered the employees to issue the decals despite the incomplete application.

The OIG also found that Bishop failed to ensure public safety by not requiring "short line"[34] cabs to obtain a current Airport Taxi Use Decal, which is a direct violation of LANOIA rules and regulations. LANOIA rules and regulations state: "*Every person desiring to operate a taxicab from LANOIA shall first obtain a current Airport Taxi Use Decal to be issued by LANOIA."* Both Michelle Wilcut, Deputy Director of Human Resources, and Walter Krygowski, Deputy Director (DD) of LANOIA informed the OIG that they did not and would not approve of allowing taxis to operate in the "short line" without being registered with the LANOIA. Bishop also failed to ensure public safety when he created fraudulent airport decals with no security features.

Due to LANOIA employees' reports of Bishop leaving the office regularly for several hours in the middle of the day with no notice to his staff, the OIG also found that Bishop lacked accountability. The staff reported that when they attempted to contact Bishop via phone, he would not take their calls. The staff recalled four specific incidents in the Fall of 2014 where Bishop left work in the middle of the day, without notice, and did not answer or return any of the staffs' attempts to contact him.

LANOIA employees also informed the OIG that Bishop ordered them to issue decals to taxicab drivers/transportation companies that requested one, despite not having proof of a CPNC. The employees knew this to be against LANOIA rules and regulations and demanded that Bishop obtain a statement from Jefferson Parish stating that a CPNC was not required. The OIG discovered that Bishop created a false document in January of 2014 wherein he pretended to be a Jefferson Parish official waiving the CPNC requirement.

Additionally, the OIG found that by not enforcing the rules and regulations for short line taxicab drivers, Bishop did not collect any revenue for short line cabs. The OIG determined that in failing to

[34] The term short line refers to vehicles that transport passengers to locations close to LANOIA, while the long line refers to vehicles that transport passengers to Orleans Parish.

collect a background fee of $50 per applicant and a decal fee of $200 per applicant for 2012, 2013, and 2014, Bishop cost the department a loss of $325,000.

In conclusion, the OIG found that, as the Manager of the Ground Transportation, Larry Bishop failed in his duty and responsibility to ensure that all the Taxicab files were organized and properly maintained. Bishop lied multiple times about the enforcement of the Ordinances and Rules as applied to the decals. Bishop failed to ensure public safety by not enforcing LANOIA's rules and regulations, such as by not requiring mandatory background checks and by issuing decals to applicants even though they did not meet eligibility requirements. Based on the above information, the OIG found that Bishop was in violation of CAO Policy Memorandum No. 83(R), particularly, "*Each employee, because of the job assignment has certain required duties and must assume certain responsibilities. Each employee has a job to do and must do that job. Failure to perform these duties or take these responsibilities is neglect of duty*." By lying to the OIG investigators, Bishop violated City Code Section 2-1120(20)(a), "*It shall be the duty of every city officer, employee, department, agency, board, commission… to cooperate with the Office of Inspector General in any investigation*." Due to these violations, the OIG made a referral for administrative action to Aviation Director, Iftikhar Ahmad.

General Comments

The reports reviewed by the committee employed sound methodology and thorough documentation that meets the applicable standards for investigations by the OIG.[35] The evidence appears to have been gathered in an objective manner with clearly reported data supporting each finding. Through meticulous evidence collection, the OIG's findings uncovered instances of dishonesty, lack of accountability and of supervision, and deficiencies regarding the organization and storage of

[35] See Principles and Standards for Offices of Inspector General, Quality Standards for Investigations and Quality Standards for Inspections, Evaluations, and Reviews, Association of Inspectors General, p. 25-31 (May 2004)("OIG Quality Standards").

important information. Each finding appears logically related to the information gathered and presented in the reports and deserves the attention of the City and those with supervisory roles within the organizations investigated.

VI. OFFICE OF THE INDEPENDENT POLICE MONITOR

This section of the QAR report reviews the written work-product of the Office of the Independent Police Monitor (OIPM) for the year 2014. The OIPM is a civilian police oversight agency operating within the Office of Inspector General. In 2014 the OIPM produced the following three written works: 1) an analysis of the New Orleans Police Department's Retaliation Policy, Pattern, and Practice; 2) an advocacy piece entitled "Hurricane Katrina: The Remaining Legacy, A Story of Uninvestigated Police Shootings and Human Rights Deprivations;" and 3) the OIPM 2014 Annual Report. Each of these work-products is separately assessed below.

New Orleans Police Department's Retaliation Policy, Pattern, and Practice

As a result of a federal Consent Decree, the New Orleans Police Department (NOPD) was required to implement a retaliation policy to address feared or actual retaliation from NOPD in retaliation for filing complaints against officers or cooperating in the investigation of such complaints. In a report dated July 30, 2014, the OIPM set forth its findings after a review of NOPD's then newly proposed retaliation policy as well as NOPD's pattern and practice regarding retaliation.

This OIPM report consists of two general components. The first section is an investigative report of complaints of retaliation by both civilians and NOPD personnel between 2011 and 2013. The second section is an evaluation of NOPD's newly proposed retaliation policies. Since

this report has both investigative and evaluative components, each component will be reviewed under the respective quality standards applicable to investigations and evaluations.[36]

Regarding civilian complaints, the OIPM, in a section entitled "*Civilian Retaliation*," reports that it "received 63 contacts involving an element of retaliation or fear of retaliation from [civilians]"[37] between 2011 and 2013. These "contacts" consisted of formal complaints, communications with individuals who subsequently abandoned the complaint process, and inquiries from civilians, some of which were anonymous.[38] These "contacts" included allegations by civilians of various claimed or feared forms of retaliation including: harassment; threats; retaliatory police action; and discouragement from filing a complaint or interference with the complaint process.[39] The remainder of this section of the report consists of a series of charts detailing the number of each type of claimed or feared retaliation, racial and gender demographics of the complainants and accused police personnel, rank of police personnel involved, and departments in which the accused police personnel worked.[40]

Regarding complaints by NOPD personnel, the OIPM, in a section entitled "*Intradepartmental/Whistleblower Retaliation*," reports alleged retaliation or fear of retaliation being taken against NOPD personnel who cooperated in investigations. The OIPM reports that it "received 26 contacts involving an element of retaliation or fear of retaliation…from NOPD

[36] See Principles and Standards for Offices of Inspector General, Quality Standards for Investigations and Quality Standards for Inspections, Evaluations, and Reviews, Association of Inspectors General, p. 25, 33 (May 2004)("OIG Quality Standards").
[37] Letter dated July 24, 2014 from OIPM to Director, Public Integrity Bureau, NOPD, at p.5.
[38] *Id.*
[39] *Id.*
[40] *Id*. at 7-8.

personnel"[41] between 2011 and 2013. These "contacts" include complaints and "information."[42] Of these 26 contacts, 13 actual complaints were filed, seven of those were anonymous, and two failed to file actual complaints after initiating contact with the OIPM.[43] The most common forms of alleged or feared retaliation include: retaliatory complaints being filed against the NOPD employee, intimidation, reassignment or threat of reassignment; interference with the complaint investigation; refusal to receive or investigate; and harassment or unprofessional conduct directed toward the complainant.[44] The remainder of this section of the report consists of a series of charts detailing racial and gender demographics of the complainants and accused NOPD personnel, rank and department location of complainants and accused, and disposition of the complaints by NOPD's Public Integrity Bureau.[45]

The Committee finds several questionable aspects of the OIPM's report. First, the opening sentence of the report prefaces a request to collaborate with NOPD's Public Integrity Bureau in investigating retaliation with a reference to a highly publicized 20 year old incident in which a former rogue NOPD officer arranged the retaliatory killing of a civilian who had reported police misconduct. This incident occurred prior to the creation of NOPD's Public Integrity Bureau and before other reforms were subsequently implemented by NOPD to encourage civilian reporting of police misconduct. The Committee, therefore, agrees with the NOPD's response to the OIPM that this reference, by innuendo, "immediately mischaracterizes

[41] *Id*. at 9.
[42] *Id.*
[43] *Id*. at 10-11.
[44] *Id.* at 9.
[45] *Id*. at 11-13.

the current operation and efforts of the NOPD and is not necessary to request collaboration with PIB."[46]

Secondly, it is difficult to discern whether the data presented confirm the suggestion of widespread retaliation they were seemingly intended to convey. The use of the term "contacts" is vague and potentially misleading since it includes other equally ill-defined encounters such as inquiries, expressions of concern, and anonymous communications, each of which have little probative value. Moreover, the OIPM does not indicate the number of contacts involving claimed retaliation versus fear of retaliation or the number of contacts involving multiple concerns regarding the same incident. Sources of investigative techniques should be documented in sufficient detail to provide a basis for assessing its reliability.[47]

The fact that only a small fraction (4.24%) of civilian allegations of retaliation had been sustained by the PIB as of the OIPM's report, could signal an inflationary quality to the data presented by the OIPM. Similarly, of the 26 contacts regarding intradepartmental retaliation, only 13 actual complaints were filed and seven of those were anonymous, leaving only 6 actual complaints over a two year period. The data, as presented, simply do not support the OIPM's inferences of rampant retaliation throughout the NOPD. Reliance upon inherently unreliable anonymous complaints, in particular, seems misplaced.

[46] Letter dated September 22, 2014 from Michael Harrison and Arlinda Westbrook, New Orleans Department of Police, to Susan Hutson, Independent Police Monitor.
[47] OIG Quality Standards, pg.29.

Thirdly, the above referenced deficiencies reflect questionable methodology used to compile the data. Accordingly, the committee questions whether the data gathered were accurately interpreted and logically presented.[48]

The OIPM report next reviews the new retaliation policies of NOPD. The OIPM overall commends the NOPD for drafting the policies and opines that the policies are a strong, positive first step in preventing retaliation and complying with the mandates of the federal Consent Decree. The report then critiques certain select policies regarding the definition and prohibition of retaliation, prompt resolution of grievances, mandatory reporting of misconduct, and disciplinary consequences for retaliation.

The OIPM then offers a series of recommendations based on reviews of other Police Department policies that have already been implemented and law journal and law enforcement publications regarding police retaliation. The OIPM's recommendations include: prevention of retaliation through training; enhanced supervisory responsibility; clarified definitions of "retaliatory conduct" and "protected activities;" detailed procedures for the timely reporting of misconduct and providing notice to the accused officer; and allocation of sufficient resources to prevent retaliation and assist the complainant.[49]

The Committee found these recommendations to be sound, thoughtful additions and clarifications to NOPD's new retaliation policies. If adopted, the OIPM's recommendations would materially enhance the efficacy of those policies.

[48] *Id.*
[49] *Id*. at 18-23.

Advocacy Paper Entitled, "Hurricane Katrina: The Remaining Legacy, A Story of Uninvestigated Police Shootings and Human Rights Deprivations"

This work product is a 15 page advocacy paper that purports to be "A response to the United Nations Committee Against Torture Periodic Report of the United States of America" and is endorsed by a number of civil rights organizations and community activists. The paper's central thesis is that federal, state, and local authorities exponentially expanded the destruction of Hurricane Katrina, creating a human rights crisis by "ignoring the United States Constitution and depriving civilians of their constitutional rights."[50] More specifically, the OIPM asserts that lack of adequate investigation into several officer involved shootings during Hurricane Katrina and its aftermath has eroded public trust in the New Orleans justice system.[51] The OIPM gratuitously offered this unsolicited paper as a so-called "shadow report" to supplement the official U.S. response to the Fifth Periodic report of the United Nations Committee Against Torture, which included two paragraphs related to New Orleans.[52]

The OIPM then makes two recommendations. The first recommendation is to reopen a 2006 investigation conducted by the U.S. Senate Committee on Homeland Security and Governmental Affairs into the emergency response to Hurricane Katrina.[53] This recommendation is made based on the OIPM's belief that the Senate Committee report should

[50] *Hurricane Katrina: The Remaining Legacy, A story of Uninvestigated Police Shootings and Human Rights Deprivations, A Response to the United Nations Committee Against Torture Periodic Report of the United States of America*, New Orleans Office of the Independent Police Monitor (2014) at pg. 2.
[51] *Id*. at 3.
[52] *Id.*
[53] *Id*. at 3-5.

have addressed the alleged suspension of constitutional rights and officer involved shootings related to the storm. The recommendation is followed by a brief description and purported update of several highly publicized officer involved shootings.[54] Such a recommendation is beyond the jurisdictional purview of the OIPM. While the OIPM is authorized to request the reopening of internal NOPD investigations, recommending that a U.S. Senate Committee reopen a 9 year old investigation is not within the OIPM's charge.

The second recommendation by the OIPM is to adequately fund police monitoring by local civilian monitoring agencies and the Department of Justice Civil Rights Division on a regular basis and during national emergencies.[55] The OIPM's rationale for this recommendation is that the OIPM lacks sufficient staff to perform this function and the OIPM's assertion that the NOPD is either unable or unwilling to do so.[56] The recommendation for funding civilian monitoring agencies does not identify any such local agencies equipped with the requisite expertise, independence, and impartiality to reliably perform the proposed monitoring functions such as collecting complaints, auditing police work, and monitoring crime scenes. Even if such organizations exist, these recommended oversight functions appear to be overly intrusive, unrealistic on a practical level, and could impede or even conflict with the same functions being performed by OIPM. Furthermore, if the purpose of this recommendation is to supplement the resources of an allegedly understaffed OIMP, it is difficult to envision how this could be implemented in the absence of legislative action.

[54] *Id*. at 5-12.
[55] *Id.* at 3, 13-15.
[56] *Id*. at 13.

As for the recommendation to adequately fund the DOJ Civil Rights Division to investigate civil rights violations, there was no showing by the OIPM or otherwise that DOJ lacks the resources to do so or that the alleged failure to adequately investigate NOPD officer involved shootings was caused by lack of DOJ funding. Consequently, the recommendation rings hollow.

The Committee considers an advocacy piece such as this to be highly inappropriate and well beyond the duties and responsibilities of the OIPM as delineated in the enabling ordinance creating the office.[57] While those duties include monitoring use of force and in-custody deaths, the reporting of those events should be done in an objective manner and should project an independent attitude and appearance. Conversely, this paper is unabashedly partisan and strident in its insistence that each and every one of the enumerated officer involved shootings was either not investigated or inadequately investigated, despite the fact that most were federally prosecuted or investigated by the F.B.I. Dissatisfaction with the outcomes, such as the level of offenses charged by the prosecutor, acquittal of the officer involved, the length of the sentence imposed, or a decision by the U.S. Attorney not to prosecute, provides scant support for the sensationalized conclusions reached in this paper.[58] Moreover, advocating such positions, even if well founded, with the endorsement of third party advocacy organizations and individual community activists, is not the job of the OIPM. Doing so also compromises the mandated impartiality of the office and vitiates the other work product of the OIPM.

[57] *See* New Orleans City Code Sec. 2-1121(3).
[58] For example, this paper is rife with histrionic suggestions of widespread "NOPD violence and misconduct," "suspension of constitutional rights," "human rights crisis," and "cover ups."

Another repeated theme that permeates this paper, and which reappears in the OIPM's Annual Report (discussed below), is the OIPM's assertion that the office is severely understaffed and underfunded. Notwithstanding the questionable propriety of this frequent refrain throughout the work product, if resources are indeed so scarce, the use of OIPM assets to engage in partisan advocacy seems even more ill-advised.

OIPM 2104 Annual Report

The OIPM's 2014 Annual Report provides a comprehensive and detailed account of all the office's activities during the past year. The 2014 activities described include the following:

1. The year in review
2. Major incidents and actions
3. Community-police mediation program
4. Complaint intake activities
5. Disciplinary actions
6. Critical incident response and use of force monitoring activities
7. Use of force incidents
8. Commendations
9. Community engagement

The majority of these activities involved either factual reporting of statistics detailing the actions or incidents involved or an explanation of the process being described. In each case, the information was presented in an objective manner with impressive detail. The depth and scope of the activities covered was thorough, seemingly prepared in a diligent and complete manner, and sufficiently documented.

Certain other aspects of the report, by their nature, implicated the exercise of professional judgment in the conclusions reached. This occurred primarily in the sections describing the year's disciplinary actions, the critical incident response and use of force monitoring activities, and the use of force incidents. For example, in the disciplinary actions section, the OIPM opined that, based on its observation of 11 NOPD disciplinary hearings and using a preponderance of the evidence standard, nine of NOPD's decisions in those cases were supported by the evidence while two cases were not. This committee finds that such conclusions were within the sphere of proper discretionary judgment given the police oversight functions of the OIPM and the OIPM's presence at the disciplinary hearings.

However, several other discretionary conclusions were problematic. The OIPM's conclusions regarding the monitoring of critical incident response and use of force lacked sufficient factual support or suffered from poor methodology. The OIPM reached several conclusions after collecting "information"[59] from the involved officers and, where applicable, the civilian; the investigative procedures utilized; and the crime scene. In some cases the OIPM did not attend the crime scene because of allegedly untimely notice or the crime scene was not preserved, in which case the OIPM only "attended the hospital where the involved civilian was transported."[60]

Based on this unidentified information, the OIPM raised several "questions and concerns,"[61] including the legality of the involved officer's initial stop of the suspect,[62] the

[59] 2014 Annual Report (Annual Report), Office of the Independent Police Monitor, pg. 52.
[60] *Id*.
[61] *Id.*
[62] *Id*. at 56.

propriety of the officers drawing their weapons,[63] the endangerment of bystanders caused by the use of force,[64] improper control of access to the scene of an officer involved shooting,[65] and improper sequestration and monitoring of the involved officer.[66]

Some of these conclusions lacked sufficient factual support, called for legal conclusions, or seem to be well beyond the professional expertise of the OIPM. The OIPM fails to specify the "information" upon which each of these conclusions is reached. It also bases some conclusions upon equally vague, unspecified information garnered solely from visiting some of the civilians involved in the hospital. In the Committee's opinion, relying exclusively on such witnesses who have a vested interest in the outcome, without more, is an inappropriate methodology for some of the conclusory opinions of alleged wrongdoing reached by the OIPM.

Other conclusions such as the constitutionality of the initial stop and the excessive degree of force used by the responding officers are legal determinations more appropriately made by a legal tribunal after considering all the available evidence. Even preliminary findings of this gravity should only be proffered after a thorough investigation by a qualified investigative body equipped with sufficient resources to conduct a comprehensive investigation.[67] The OIPM's premature, sweeping inferences of impropriety regarding such complex constitutional legal issues without the benefit of a thorough investigation are hopelessly speculative, unreliable, and deeply flawed.

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[63] *Id*. at 58.
[64] *Id.*
[65] *Id*. at 62.
[66] *Id*. at 63.
[67] By its own assertions, the OIPM complains that" [d]ue to the lack of sufficient resources, the OIPM estimates it is unable to perform at least half of its [required] functions." *Hurricane Katrina: The Remaining Legacy,* pg. 13.

VII. CONCLUSION

This report of the Quality Assurance Advisory Committee assesses the written work product of the Office during 2014. This committee conducted a full review of the product of the Office of the Inspector General ("OIG") during 2014, including public letters, audits, inspections and evaluations, investigations, and the work of the Office of the Independent Police Monitor. It is important to note that the OIG performs many other important duties not included in our review mandate.

Our Committee found the OIG to be productive in producing the documents we reviewed. The reports were clearly written and provided a glimpse into the operation of government for the residents of New Orleans.

This report offers a number of comments and observations. Public letters and results of investigations reach much of the public and have great potential impact on policy and political practice. Overall, the public letters and investigations were very effective and reasonable interventions.

The audit section includes performance audits, reviews, and follow-up reports completed by the OIG. This committee found that each audit, review, and report was thoroughly organized and competently completed; each product identified the condition, cause and effect of each finding. Additionally, the follow-up reports highlight responsiveness to the OIG's recommendations and a commitment to implementing suggested corrective actions.

During 2014, the OIG conducted four in-depth inspections and evaluations of City

operations in a wide variety of programs. These inspections turned up many important findings that the City has indicated it will address over the next several years. Like most of the OIG's work product, the evaluations are data driven in nature and the recommendations made were supported by the findings detailed in each document. The evaluations reflect the OIG's dedication to resourcefulness and efficiency.

Next, three investigations were published by the OIG in 2014. Careful evidence collection led the OIG to uncover instances of dishonesty, lack of accountability and of supervision, and issues with the organization and storage of important information. Each report clearly meets the applicable standards for investigations by the OIG.

Finally, the Committee reviews the written work-product of the OIPM. While this section's evaluation led to some negative conclusions, especially implicating issues with professional judgment, the Committee was nonetheless impressed by the depth and scope of activities covered in the OIPM's annual report.

In closing, our Committee finds that, on balance, the reports of the OIG and OIPM provided a truly valuable service to the City of New Orleans through their written work. These reports have highlighted important areas for improvement and drawn attention to needed areas of reform that are of value to both policymakers and the citizens of New Orleans.