2025 QARAC ANNUAL REVIEW REPORT

OFFICE OF THE INSPECTOR GENERAL

CITY OF NEW ORLEANS

EXECUTIVE SUMMARY

Section 2-1120(16)(a) of the City of New Orleans Municipal Code (Code) provides that a third-party Quality Assurance Review Advisory Committee (QARAC) shall be appointed to conduct annual quality assurance reviews of the yearly audits, inspections, and performance reviews and public reports of investigation completed by the New Orleans Office of Inspector General (OIG). Section 2-1120(16)(a)(1) of the Code further provides that the QARAC shall include a representative appointed by the city council, who shall serve as chair of the committee; a representative appointed by the office of the mayor; and a representative appointed by the ethics review board. This QARAC being duly appointed in accordance with Section 2-1120(16)(a) of the Code, now presents this 2025 QARAC Annual Review Report (Report).

In accordance with the items identified for review in Section 2-1120(16)(a) of the Code, the QARAC reviewed the below listed audits, inspections, performance reviews, and public reports of investigation completed by the OIG for the 2024 calendar year:

- Audit: New Orleans East Hospital Credit Card Audit
- Audit: Orleans Parish Sheriff's Office Off-Duty Detail and Mardi Gras Pay
- Evaluation: Sewerage and Water Board of New Orleans Water Loss Control
- Evaluation: Fuel Dispensing Follow-Up Report
- Report: Traffic Signals Maintenance
- Report: Orleans Parish Communications District Hexagon Contract
- ROI: Failure to Follow Contract Requirements While Using Wisner Trust Funds
- ROI: Mayor's Office of Youth and Families Was Directing Monies to Forward Together New Orleans

At the outset, the QARAC notes that the above-listed items provide a summary of the purpose of the OIG review, the methodology used, a background history summary, key findings, conclusion statements, recommendations for remediation, and (in some instances) copies of the documents reviewed and memoranda of interviews conducted in connection with the assessments. Some of the reports indicate that the City has implemented certain of the OIG's recommendations as to the particular program, audit, or investigation, but we are unaware of the OIG's continued efforts to ensure that the

implementation was completed and/or maintained, as more fully described in this Executive Summary. For those instances in which the OIG simply offered recommendations but gave no indication whether the City actually implemented any of the offered recommendations, the QARAC has no information or indication as to whether the OIG conducted any type of follow up as to the status of any such recommendation. As indicated in the below reports, while on the one hand, this shows the importance of the OIG and the power of making recommendations to City departments and agencies, it also shows that the integrity of the inspection reporting process may be undermined by a lack of a proper follow up by the OIG. Moreover, as noted in the below assessments, the OIG has not indicated in its public-facing reports any sort of threshold that it employs when identifying matters for audit, evaluation, review, or investigation. It would be important to understand the cost-benefit analysis applied for each of the matters considered so that the QARAC can better understand and assess the resource allocations. Therefore, to ensure that these audits, evaluations, reports, and investigations are given proper weight, to enhance the accountability of the City departments and agencies, and to provide the citizens of Orleans Parish transparency and some comfort that their City government is striving for greater compliance and governance efforts, the QARAC recommends the OIG create a detailed follow-up schedule to ensure the recommendations with the biggest impacts get implemented timely and remain implemented, and to further provide a more transparent vetting process for considering the matters included in its yearly reports.

Additionally, QARAC was unable to obtain the full scope of non-public documentation supporting some facts provided in the OIG's report due to the confidential nature of the OIG's workpapers. Sec. 2-1120 (16)(a) reads in part: "Completed reports of audits, inspections and performance reviews, and public reports of investigation, shall be subject to an annual quality assurance review by a third-party advisory committee, known as the quality assurance review advisory committee for the office of inspector general." The QARAC believes the performance of a proper quality assurance review necessitates access to non-public work papers, however, the longstanding interpretation of this language has been that the QARAC only has access to public documents.

At the outset of our review, QARAC made what it believes were very reasonable requests for information to the OIG which were subsequently denied. When it became abundantly clear that the OIG would not give us any more information than what is publicly available to us on their website, the QARAC stopped requesting additional information from the OIG. In a subsequent call, the staff of the OIG stated their concerns that we had not been in communication with them and that we should feel free to ask more questions. The QARAC proceeded to ask questions relating to our concerns about the ability to follow-up on reports and asked if it could obtain the policies relating to follow-ups. The OIG's staff became

somewhat combative and told us that policies relating to follow up are not within the scope of QARAC's review and initially stated they would not send more documents or policies relating to when and how they determine follow up reports. Following the call, however, the OIG staff provided us with the following documents: OIG Inspections & Evaluations Division Operational Manual, 2025 Annual Work Plan, and OIG Audit Division Operational Manual. These documents set forth the general process for how the OIG office conducts its reviews, and includes follow-up protocols; however, the QARAC is unaware of any documentation evidencing any actual follow-up and confirmation of the completion or status of the recommended action items as described in this Report. Moreover, in contravention of the commitment to the transparency of the OIG's work, the QARAC did not find any inclusion of the consideration thresholds, cost-benefit analysis, or any other analytics modeling employed by the OIG in its investigation of the various matters included in this Report or the conclusions reached.

Finally, the OIG issued a number of public letters over the course of the past year. The QARAC did not review these letters as a whole because they are not "reports". The OIG staff indicated that letters are used when timeliness is a large factor in the issuance of findings. OIG staff indicated that producing letters in lieu of formal reports allows the office to bypass many of the strict timelines required in formal audits such as engagement letters on the front end of an investigation and response periods from the departments being looked at. In short, the letters allow the OIG's office to maintain flexibility to respond quickly to new or changing information. The QARAC believes the tradeoffs between having a streamlined process to release critical information are important and necessary given the OIG's critical oversight role. However, OIG staff also stated that the production of letters "does not impact the number of reports released". The OIG staff also indicated their lack of ability to produce follow up reports is largely due to resource constraints. It is difficult to understand how the OIG's office can be both significantly resource constrained and that the production of eight public letters following all of the thorough research and investigation of a typical report does not impact the number of full reports issued.

For all of these reasons, the QARAC recommends that New Orleans City Council clarify the language and allow QARAC members to access to OIG workpapers and internal policies and procedures for the sole purpose of a more fulsome and substantive quality assurance review for the betterment of the citizens of the City of New Orleans. To satisfy any concerns either the City Council or the OIG would have as to confidentiality, the QARAC is ready to work with both entities to implement various guardrails to support confidentiality assurances including, but not limited to, creating penalties in the event a QARAC member inappropriately shares the documents with non-QARAC members.

EVALUATION: FUEL DISPENSING FOLLOW-UP REPORT

Methodology

The Office of Inspector General (OIG) conducted a follow-up evaluation of its June 2016 "Fuel Dispensing" report to assess the extent to which the City of New Orleans implemented recommended improvements to its fuel dispensing process. The scope included all records of fuel dispensed from City fueling stations in 2022. The methodology comprised interviews with staff from the Equipment Maintenance Division (EMD), the New Orleans Fire Department (NOFD), and the City's fuel station contractor; analysis of fuel transaction data; review of active fuel cards and PINs; examination of manual fuel logs; and surveys of department vehicle coordinators (DVCs). The evaluation was conducted according to the Principles and Standards for Offices of Inspector General for Inspections, Evaluations, and Reviews.

Key Findings

The City of New Orleans spends significant public resources on fuel—over $3.6 million in 2022 for more than 1.2 million gallons dispensed. The follow-up report found that while the City partially implemented each of the five recommendations from the 2016 report, deficiencies persisted:

1. **Fuel Card Management:** The City reissued most, but not all, fuel cards and did not develop an effective mechanism to inventory and deactivate unused or obsolete fuel cards. Nearly half of active fuel cards were not used during 2022, suggesting many were tied to vehicles no longer in service.

2. **PIN Management:** The City did not reissue all PINs and failed to reliably identify and deactivate PINs for former employees. Over 600 PINs associated with terminated, retired, or deceased employees remained active.

3. **Transaction Controls:** Although policy was amended to require accurate odometer readings, over 36% of fuel transactions in 2022 contained unreasonable odometer readings. Furthermore, gallons-per-transaction limits were not implemented for all vehicles; a significant number retained excessively high limits.

4. **Training and Oversight:** Initial training and guidance for DVCs were provided after the 2016 report, but ongoing training was lacking. Many DVCs did not consistently review fuel use reports or investigate suspicious transactions.

5. **Manual Fuel Logs (NOFD):** While fuel dispensing counters were repaired and NOFD completed fuel logs, this information was not analyzed or entered into the automated fuel dispensing system, limiting oversight and analysis.

Recommendations

The report emphasizes the importance of fully implementing the original recommendations to strengthen fuel dispensing controls and reduce the risk of waste, fraud, and abuse. The key recommendations are:

1. **Reissue and Inventory Fuel Cards:** The City should complete the reissuance of all fuel cards and develop a robust mechanism to regularly inventory and promptly deactivate cards tied to decommissioned vehicles or equipment.
2. **Reissue and Deactivate PINs:** All authorized fuel user PINs should be reissued, with effective procedures established for identifying and deactivating PINs associated with departing employees. Integration with Human Resources is recommended to ensure PINs are deactivated upon employee termination.
3. **Enforce Accurate Transaction Data and Limits:** Employees must be held accountable for entering accurate odometer readings. The City should implement realistic gallons-per-transaction limits for all vehicles, matching actual fuel capacities, to prevent excessive or inappropriate dispensing.
4. **Strengthen DVC Training and Accountability:** Institutionalize regular training for DVCs, ensure they receive necessary guidance and transaction data, and enforce accountability for failure to perform oversight duties, including investigation of suspicious transactions.
5. **Integrate and Analyze Manual Fuel Logs:** The City should develop mechanisms to track and analyze NOFD fuel use data, incorporating it into the automated fuel dispensing system to facilitate ongoing analysis and oversight.

Conclusion

While the City of New Orleans made policy changes and some improvements following the initial 2016 report, many of these were not fully implemented or sustained. The lack of consistent controls and oversight continues to pose risks to the effective management of public resources. The OIG recommends that the City prioritize full implementation of the above recommendations, provide ongoing training and accountability, and ensure comprehensive data integration and analysis to safeguard taxpayer funds.

QARAC Review

Throughout the review process, the QARAC has had many conversations regarding the need for the OIG to produce more follow-up reports. This report serves as evidence of that assertion. Based on the report, the City did implement several of the recommendations from the original report, however, as time passed many of the recommendations that were only

partially implemented became deprioritized. On the one hand, this shows the importance of the OIG and the power of making recommendations to city agencies. On the other hand, it shows that lacking the proper follow up the OIG's recommendations may be undermined. Therefore, QARAC recommends the OIG create a detailed follow-up schedule to ensure the recommendations with the biggest impacts get implemented timely and remain implemented.

AUDIT: NEW ORLEANS EAST HOSPITAL CREDIT CARD AUDIT

Introduction

The City of New Orleans Office of Inspector General (OIG) conducted a performance audit of New Orleans East Hospital (NOEH), focusing on credit card usage. The audit aimed to determine whether NOEH credit card purchases complied with relevant policies, best practices, and state law, and whether those purchases were business-related.

Methodology

- **Scope:** All NOEH credit card transactions from January 1, 2022 to December 31, 2022.
- **Data Collection:** The audit reviewed transactions from five credit cards (one Visa, one Home Depot, three Shell fuel cards), totaling 927 transactions and $68,043. After excluding 42 refunds and other adjustments, the population for testing was 885 transactions totaling $68,043.
- **Sampling:** Auditors tested all 15 high-value transactions ($29,616) and randomly sampled 51 additional transactions ($12,305), for a total of 66 transactions valued at $41,921.
- **Procedures:** The team conducted interviews with NOEH staff, reviewed credit card policies for alignment with best practices, verified supporting documentation, and assessed compliance with both internal policy and Louisiana law.
- **Standards:** The audit was conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS) and Principles and Standards for Offices of Inspector General.

Key Findings

1. **Compliance with Policy and Law**
    - All tested credit card purchases appeared business-related and allowable under NOEH policy and state law.
    - All tested purchases were supported by itemized original receipts and documentation of business purpose.
2. **Purchase Approval Deficiencies**

- For 18 out of 66 transactions tested (27%), totaling $15,914, NOEH employees did not receive written approval prior to the issuance and use of NOEH credit cards, as required by policy and best practices. Written approval was sometimes replaced by verbal approval, with written documentation provided after the fact.

3. **Credit Card Issuance Controls**
    - NOEH did not maintain written logs to account for the issuance and return of its credit cards (Visa, Home Depot, Shell fuel cards), which is inconsistent with recommended best practices. This omission increased the risk of unauthorized use or misuse.
4. **Policy and Procedure Strengths**
    - NOEH policies clearly defined allowable and prohibited purchases (e.g., personal use, cash advances, alcohol/tobacco, prescriptions, donations).
    - The hospital reconciled monthly credit card statements to submitted receipts, and no misuse of cards was detected during testing.

Recommendations

1. **Employee Training and Compliance**
    - NOEH should provide regular training to employees regarding credit card issuance and use, emphasizing the need for written approval prior to card usage. Employees should sign an acknowledgement of policy understanding after each training session.
2. **Maintenance of Written Logs**
    - NOEH should maintain written logs for each credit card, documenting the chain of custody, including dates/times of issuance and return, business purpose, and signatures of both the custodian and the employee. Logs should comply with best practices and be updated as policies evolve.

Conclusion

The audit found that NOEH's credit card purchases were business-related and compliant with policy and law, but identified weaknesses in pre-approval documentation and card

custody tracking. Implementing the recommended controls—regular training and written logs—will help ensure compliance with best practices, reduce risk, and strengthen internal controls over credit card usage.

QARAC Review

The audit was prompted by prior concerns from external auditors who found missing documentation of business purpose and inadequate review/approval for some credit card statements. The scope of the audit was one year's worth of credit card transactions totally less than $100,000. While the audit did lead to quality recommendations for NOEH's credit card policies, the OIG should conduct a cost-benefit analysis when taking on these types of audits. It is likely the cost to produce the report was higher than the amount of dollars in question and the opportunity cost of producing this report is certainly higher when you compare it to the audits the OIG could have engaged in instead.

REPORT: ORLEANS PARISH COMMUNICATIONS DISTRICT HEXAGON CONTRACT

Methodology:

The Office of Inspector General (OIG) of the City of New Orleans conducted an evaluation of the Orleans Parish Communication District's (OPCD) Hexagon contract covering the period January 2020 through September 2023. The evaluation sought to assess the OPCD's compliance with procurement laws and internal policies, review the expenditure of public funds, and determine whether the Hexagon OnCall Records system was suitable for meeting organizational needs.

OIG staff employed a multi-faceted methodology that included:

- Reviewing financial records related to the contract and project expenditures.
- Examining video recordings of OPCD board meetings and internal email communications.
- Analyzing state laws, OPCD internal policies, federal consent decrees, and public procurement best practices.
- Interviewing current and former employees of OPCD, the City's Office of Information Technology and Innovation, and the New Orleans Police Department (NOPD). The evaluation was conducted in accordance with the Association of Inspectors General's "Quality Standards for Inspections, Evaluations, and Reviews."

Key Findings:

1. **Non-Transparent Procurement Process:**
   The OPCD obligated more than $6 million through the Hexagon contract using a process that violated its own internal purchasing policy. Required documentation—such as quotes from multiple vendors—was absent from the contract file, and the contract was approved outside the established requisition system. This undermined transparency and accountability in the procurement process.
2. **Product Did Not Meet Organizational Needs:**
   The Hexagon Records Management System (RMS) did not satisfy mandatory requirements outlined in a draft RFP, including operational experience in similarly sized jurisdictions and technical specifications crucial to NOPD's needs. Post-contract assessment by NOPD IT staff found that approximately 24% of evaluated requirements were unmet or undemonstrated. The system's limitations included insufficient support for federal consent decree compliance, crime reporting standards, and practical police operations.

3. **Weak Internal Controls and Board Governance:** The former executive director signed the Hexagon contract without prior board approval and altered a board resolution to secure project financing, circumventing proper governance procedures. The OPCD's policies lacked clear guidelines on contract approval authority and processes for collaborative agreements with other agencies. This contributed to ineffective oversight and financial exposure.

Financial Impact:
By the time of cancellation, the Hexagon contract resulted in over $3.75 million in public expenditures without delivering a functional RMS/JMS. The OPCD and the City of New Orleans incurred significant costs, including payments for software, consulting, and staff time, with ongoing financial obligations from the financing agreement.

Recommendations:
The OIG made several recommendations to address identified deficiencies:

- Revise procurement policies to strengthen documentation and approval controls.
- Adopt a formal evaluation process for competitive procurements, including written criteria and committee review.
- Clearly define board and executive director roles and responsibilities, and establish formal procedures for collaborative agreements with other governmental entities.

1. Revise Procurement Policies to Include Internal Controls for Documentation and Approval

The OIG found that OPCD's procurement of the Hexagon contract lacked transparency and failed to follow internal purchasing policies. Specifically, OPCD did not maintain documentation of competitive quotes or use its requisition system as required for purchases exceeding $10,000. The OIG recommends that OPCD review procurement procedures from other governmental entities and adopt stronger policies that require competitive processes for large purchases. Recommended actions include:

- Establishing clear monetary thresholds for competitive procurement.
- Requiring all professional services acquisitions above a set threshold to undergo a Request for Proposals (RFP) or Request for Qualifications (RFQ) process.
- Mandating documentation of all proposals received and evaluation processes in the contract file.
- Implementing internal controls such as checklists, multi-step approval processes, and requisition system safeguards to ensure compliance.

- Educating staff about their rights under whistleblower protection statutes to promote reporting of irregularities.

Reference: See pages 10–12, Office of Inspector General IE-23-004, Hexagon Contract Final Report.

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2. Adopt an Evaluation Process for Competitive Procurements Consistent with Best Practices

The OIG identified that OPCD did not have a formal process for evaluating proposals or selecting vendors, which resulted in the purchase of a product that did not meet mandatory requirements. To remedy this, the OIG recommends:

- Establishing written evaluation criteria and an evaluation plan prior to the solicitation of bids or proposals.
- Forming a selection committee comprising subject matter experts and relevant stakeholders to review proposals.
- Ensuring that all evaluation scorecards, meeting minutes, and related documentation are preserved and attached to the requisition file.
- Reviewing best practices from sources such as the Federal Acquisition Regulation (FAR), the National Association of State Procurement Officials (NASPO), and the City of New Orleans Bureau of Purchasing.

These measures are intended to ensure transparency, accountability, and alignment of purchased products with organizational needs.

Reference: See pages 18–19, Office of Inspector General IE-23-004, Hexagon Contract Final Report.

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3. Clearly Define Board and Executive Director Roles and Establish Formal Processes for Interagency Partnerships

The evaluation revealed ambiguities in OPCD's governance, with the former executive director signing contracts without clear board approval and altering board resolutions. To address this, the OIG recommends:

- Developing policies and procedures that clarify the responsibilities and authority of the Board of Commissioners and the executive director.

- Explicitly authorizing the executive director to sign contracts below a specified threshold, with contracts above this threshold requiring board approval.
- Creating standing committees for governance, finance, and audit to strengthen oversight.
- Instituting formal procedures for entering into collaborative partnerships with other governmental entities, including individually drafted Cooperative Endeavor Agreements (CEAs) that specify public benefits and each party's obligations.
- Reviewing resources such as the United States Government Accountability Office's Standards for Internal Control in the Federal Government ("Green Book"), the OIG's Model Board Manual, Model Administrative Procedures, and guidance from the Louisiana Legislative Auditor.

These recommendations aim to ensure sound governance, reduce risks of fraud or abuse, and clarify organizational accountability.

QARAC Review

In this report the OIG does a good job of reviewing the gaps in accountability and oversight which led to the questionable procurement of Hexagon and the several missteps made along the way. The OIG also made several strong recommendations about updates to policies and procedures which could help prevent multi-million dollar contracts to be executed prior to board approval and with required documentation. However, the OIG failed to address some simple questions:

- Why was the OPCD procuring IT solutions for NOPD and OPSO without sufficient input from the respective entities? The report states that NOPD paid for the RFP to be drafted, but that OPCD actually released the RFP, however, no analysis was done that explains why that occurred.
- For future joint procurement projects how can outside entities ensure the selected vendor can meet organizational needs?
- Does OPCD utilize BRASS and if not would that be a solution to many of the issues mentioned in the report?

Furthermore, the report seems to include a significant amount of extraneous information which may be confusing to readers. For instance, on page 8 the report states "Prior to 2022 this body of law required public entities to advertise and award contracts to the lowest responsible bidder for all purchases of materials and supplies above $30,000." However, the first sentence of the next paragraph states that the law previously discussed does not pertain

to the Hexagon contract. In fact, the OPCD was not required by law to "advertise, receive bids or engage in competitive negotiations" for the Hexagon contract. Therefore it is unclear why the OIG felt the need to cite laws not applicable to the situation at hand.

Additionally, the OIG appears to narrowly construe criteria or words in such a way to render them near meaningless and/or impossible. When gauging the "jurisdictions of comparable size and characteristic as the City of New Orleans" the OIG chooses to narrowly construe those words in a way that appears to severely restrict the qualifying bids to potentially render it impossible for any respondent. The OIG appears to believe "comparable size and characteristic" means both the same size of police force and frequency of crimes. That would mean maybe about 10 comparable cities exist in the United States. When discussing an IT solution if those were legitimate concerns by the OIG the OIG should have explained why the differences in a 500 member police force and a 1,000 member police force or a violent crime rate of 2 per 1,000 residents or 6 per 1,000 residents is a material impact to the system. Obviously we should not compare to Vidalia, LA or New York City, but greater leeway should be given to what can count as a comparable jurisdiction.

Conclusion

The OIG produced a good report, however, the report should strive to be more streamlined and simple. The inclusion of immaterial legislation as well as nit-picking the meanings of specific words could have been left out entirely and created an easier to understand report. Furthermore, the OIG should follow up within a relatively short time period to ensure the Board and the new Executive Director are implementing the needed changes. Finally, the OIG should look into the issue of why the OPCD ultimately issued an RFP for other governmental entities and recommend ways to ensure that does not happen and issue more guidance and best practices for when it makes sense to issue joint RFPs.

EVALUATION:

SEWERAGE AND WATER BOARD OF NEW ORLEANS WATER LOSS CONTROL

The April 2024 evaluation of the Sewerage & Water Board of New Orleans (SWBNO) identified significant deficiencies in the agency's water loss control practices, including persistently high non-revenue water loss, gaps in industry-standard control frameworks, and failure to comply with statutory reporting obligations.

Key Findings

Water Loss Performance

- **Exceptionally High Water Loss:** SWBNO experienced non-revenue water levels averaging approximately 73% from 2008 through 2017—well above industry norms (~45.5%). Non-revenue water remained at 75% in 2021 and 64% in 2022.
- **Multiple Causes Identified:** Water losses were attributed to both physical infrastructure weaknesses and metering or billing errors.

Policy & Framework Deficiencies

- **Lack of Best Practice Program:** The evaluation found that SWBNO had not adopted a comprehensive water loss control framework consistent with recommendations from the U.S. EPA or American Water Works Association (AWWA).
- **No Annual Water Audits:** Audits essential for operational planning and evaluation were missing. SWBNO lacked capacity to conduct these evaluations or collect the necessary data.

Statutory Reporting Failures

- **Non-Compliance with Reporting Requirements:** SWBNO failed to report water loss statistics to the New Orleans City Council as required by Louisiana Revised Statute 33:4091.

Technology & Capacity Limitations

- **Delayed Projects for Improvement:** While SWBNO had initiated projects like an Advanced Metering Infrastructure (AMI) program and Enterprise Asset Management

plans, these lacked alignment with a formal water loss control framework and would not be fully operational until 2025 or later.

Assessment and Areas for Improvement

While the evaluation provides a clear summary of SWBNO's water loss issues and policy deficiencies, several areas could be strengthened:

Comprehensive Root Cause Analysis

Though the report notes capacity challenges, it does not fully explore underlying organizational or cultural factors that allowed chronic high water loss to continue. **Recommendation:** Investigate governance, decision-making, budget allocation, and leadership engagement to determine why water loss was not prioritized earlier.

Impact Quantification

Raw percentages are useful, but the evaluation does not convert water loss figures into monetary terms or quantify the financial burden. **Recommendation:** Translate non-revenue water estimates into estimated cost of lost revenues or wasted treatment costs (e.g. an estimated $19 million in unbilled water during 2021–2022).

Corrective Action Plan (CAP)

The report offers recommendations (e.g. adopt best practice frameworks, conduct annual audits, improve data collection) but lacks specific assignments, deadlines, or performance indicators.
Recommendation: Require a formal CAP with named responsibilities, time-bound milestones, and progress metrics.

Follow-Up and Monitoring

There is no documented mechanism or timeline for reassessment of SWBNO's implementation of recommendations. **Recommendation:** Schedule future audits or status reports to verify progress and sustained compliance.

Emphasis on Urgency

Despite the long duration of water loss issues, the report does not convey the urgent need for rapid implementation of foundational controls. **Recommendation:** Include stronger language or timelines to drive immediate action, especially given ongoing infrastructure developments.

Conclusion

The evaluation effectively highlights critical weaknesses in SWBNO's management of water loss, linking persistent operational losses to missing control systems, lack of audits, and statutory reporting failures. It offers foundational recommendations to realign SWBNO with industry standards.

To maximize the impact of the evaluation, the following enhancements are recommended:

- In-depth root cause examination
- Financial quantification of water loss
- Structured corrective action planning
- Commitment to follow-up and accountability
- Emphasis on urgency in remedying identified issues

These steps will strengthen the report's role as a catalyst for meaningful and sustained reform in SWBNO's water loss control program.

REPORT: TRAFFIC SIGNALS MAINTENANCE

Purpose and Methodology

The Office of Inspector General for the City of New Orleans (OIG) conducted an inspection of the City's traffic signal maintenance. The purpose of this inspection was to determine whether the City conducted traffic signal maintenance in an efficient and effective manner. Originally, the OIG intended to compare New Orleans traffic signal repair times to best practices and to the performance of other jurisdictions, but data limitations prevented this analysis. The report also sought to identify any obstacles to timely and effective maintenance.

As part of this inspection, OIG staff reviewed best practices regarding traffic signal maintenance and compared New Orleans' maintenance practices with those of other jurisdictions. OIG evaluators also interviewed personnel from the Department of Public Works (DPW) and the Orleans Parish Communication District (OPCD). In addition, OIG evaluators analyzed the City's 311 data and reviewed DPW policies and procedures, procurement documents, contracts, and cooperative endeavor agreements related to traffic signal maintenance, as well as a sample of available maintenance records. The evaluation was conducted according to the Principles and Standards for Offices of Inspector General for Inspections, Evaluations, and Reviews.

Key Findings

Of the 462 signalized intersections in New Orleans, DPW had responsibility for maintaining the 298 intersections under the City's jurisdiction. The Louisiana Department of Transportation and Development (DOTD) was responsible for the remaining 164 signalized intersections. However, pursuant to a cooperative endeavor agreement (CEA) between the City and the DOTD, the DOTD paid the City to maintain these signals as well. Nevertheless, DPW employees indicated major projects at these intersections were still performed by the DOTD:

1. **Lack of Effective Data Management and No Implementation of Performance Measures:** DPW failed to regularly update traffic signal data and further failed to produce or implement any performance measures for effective management of traffic signal maintenance, which is at odds with industry best practices specific to benchmarking traffic signal operations as set forth by the National Operations Center of Excellence (NOCoE), and which completely prohibited DPW from providing citizens with expected repair timelines. DPW also did not routinely update the status of 311 service requests. In addition, the City Council charged DPW with creating and launching a publicly available online dashboard to increase transparency and provide maintenance and repair update information. While DPW developed this

dashboard, it pulled its data from the potentially flawed 311 dataset, raising questions as to the accuracy and reliability of the dashboard information. Finally, DPW also lacked a comprehensive internal case management system to track traffic signal repairs and maintenance (used white boards and handwritten logs only). DPW staff indicated that they were in the process of collecting data to support this effort; however, low levels of resources and staffing shortages within the traffic signal shop limited the department's ability to focus on long-term best practices, which situation was further exacerbated by the resignation of the department's Chief Traffic Engineer.

2. **Insufficient Staffing:** DPW lacked adequate staffing to ensure necessary repairs and maintenance occurred in a timely manner; in fact, the level of staffing within DPW was substantially below that which was recommended by the Manual on Uniform Traffic Control Devices (MUTCD) and the NOCoE. For jurisdictions responsible for more than 150 signals, the Federal Highway Administration (FHWA) recommended ideal staffing ratios of 75-100 signals per engineer and 30-40 signals per technician. The 2019 NOCoE report found that the average number of staff performing traffic signal work in responding agencies was 20.9 people for entities with 150-450 signals, and 43.5 people for entities responsible for 450-1,000 signals. For the City's 462 signalized intersections, its 2024 budget approved four employees within the traffic signal shop, one more than was included in the 2023 budget, which prevented staff from performing any proactive routine maintenance work. DPW also faced a considerable risk of losing institutional knowledge, since its only traffic signal specialist planned to retire in the near future, and no policies or standard operating procedures documenting traffic signal maintenance operations. DPW relied on contractors to perform much of the traffic signal repairs and maintenance, but the last contract for routine maintenance and repairs expired in 2021. Although the department issued emergency contracts to complete some repairs since that time, the City did not have a non-emergency contract for signal repairs in place until summer of 2024.

3. **No Asset Management System:** DPW had no asset management system in place, which would not only document routine and preventive maintenance, but would also help DPW to inventory assets, assess their performance and condition, determine when assets should be taken out of service, and identify risks. DPW did not keep any useful maintenance or repair records, and the traffic signal shop did not have any formal inventory process for spare parts. Moreover, the traffic signal shop lacked readily available inventory, which increased the risk of delayed repairs, as much of their existing inventory of spare parts consisted of old traffic signal parts salvaged from roadwork projects undertaken by the State of Louisiana. At the time of the OIG's

review, the traffic signal shop was housed in post-Katrina Federal Emergency Management Agency (FEMA) trailers, which were in considerable disrepair and had little space for storage of parts and equipment. DPW staff noted issues related to theft, lack of storage, and equipment damage due to exposure. OIG evaluators observed that most of the signal shop's assets were stored outside in a minimally secured lot near the signal shop, with anything that might be damaged by rain covered with tarps.

Recommendations

The report emphasizes the importance of fully implementing the recommendations to enhance and maintain a more robust, transparent, and reliable traffic signals program to support a healthy quality of life in New Orleans, as a failure to do so creates a dangerous threat to public safety and negatively impacts the transportation infrastructure of the City. The key recommendations are:

1. **Additional Staff Procurement and Retention; Implementation of SOPs:** The City and DPW should ensure the traffic signal shop has sufficient staff to improve traffic safety and the quality of life in the city, and should identify and act to remedy barriers to hiring signal shop employees with the appropriate level of experience needed to successfully perform routine and preventive maintenance on traffic signals. Additionally, the DPW should adopt standard operating procedures for traffic signal maintenance and repair, which should include provisions for timeliness of traffic signal repair and processes that should be used to regularly update the status of all service requests, and which should further align with industry best practices.

2. **Asset Management System Adoption:** DPW should adopt a system of asset management that incorporates routine and preventive maintenance, inventory assessments, and asset protection. Further, the City should ensure that DPW has adequate funds to implement a comprehensive asset management program. The City indicated that it was in the process of contracting for asset management software; however, the OIG found that the system itself will not solve all of DPW's problems and recommended that adequate policies, procedures, and internal controls are in place to optimize the benefit of this software. OIG also recommended that the City and DPW work together to determine whether the current facility and level of security presently practiced are appropriate to the needs of the department and its employees.

Conclusion

In assessing DPW's traffic signal maintenance program, OIG found several weaknesses, which led to increased concerns about public safety and traffic congestion if signals are not maintained properly:

1. The City lacked reliable data and performance goals that would facilitate effective management of traffic signal maintenance.
2. DPW's traffic signal maintenance efforts were also hampered by the lack of adequate staffing to make necessary repairs in a timely manner.
3. In addition, DPW did not have an effective asset management program, including preventive maintenance, maintenance records, sufficient inventory, and protection of assets.

To combat these issues, the OIG recommended that the City and the DPW work together to determine the minimum number of staff needed to ensure traffic signals are maintained and repaired in an efficient manner. This includes a review of the positions and qualifications necessary, and the compensation that would be needed to attract skilled workers. Further, DPW should also adopt formal policies with standard provisions that detail how and when staff should conduct preventive and routine maintenance, document repairs, and manage the department's assets.

QARAC Review

Throughout the review process, QARAC has made many requests of the OIG to produce more follow-up reports as well as any other documentation, including, working papers and follow-up inspection reports, that could support QARAC's fulsome assessment of the traffic signals maintenance program. To date, OIG has not provided any additional documentation. Moreover, QARAC is unaware of, and was not provided with, any follow-up information to determine whether any of the recommendations have been implemented and the data underlying the effectiveness of such implementation. While the OIG's report shows the importance of the OIG and the power of making recommendations to city agencies, it also shows the lack of proper follow by the OIG. Therefore, QARAC recommends the OIG create a detailed follow-up schedule to ensure the recommendations with the biggest impacts get implemented timely and remain implemented.

AUDIT: ORLEANS PARISH SHERIFF'S OFFICE OFF-DUTY DETAILS AND MARDI GRAS PAY

Orleans Parish Sheriff's Office Off-Duty Details and Mardi Gras Pay Audit — November 12, 2024

The November 2024 audit of the Orleans Parish Sheriff's Office (OPSO) identified several significant findings, particularly related to the administration of off-duty details and the handling of Mardi Gras overtime pay.

Key Findings

Off-Duty Details

- **Documentation Deficiencies:** OPSO failed to maintain required documentation for off-duty details. Specifically, 45.2% of Detail Coordinator's Forms and 34.4% of Off-Duty Detail Authorization Forms were missing from the sampled records.
- **Policy Non-Compliance:** Authorization forms were frequently incomplete or lacked the appropriate supervisory approval, suggesting systemic non-adherence to established protocols.
- **Incomplete Records:** OPSO's recordkeeping did not fully capture all off-duty details worked by deputies. Even existing records often lacked critical information, impeding effective oversight.
- **Policy Gaps:** The policies and procedures governing secondary employment were misaligned with best practices, resulting in inconsistencies and operational vulnerabilities.

Mardi Gras Overtime Pay

- **Overpayment Issues:** OPSO used premium supplemental Mardi Gras pay when calculating regular overtime rates, leading to a projected overpayment of $259,758.
- **Holiday Pay Miscalculations:** Some employees were credited with holiday pay before the holiday occurred, resulting in an additional projected overpayment of $21,407.
- **Excessive Work Hours:** Instances were found where employees worked more than 15 consecutive hours without the required written authorization, violating labor policies and raising safety concerns.

The audit used a statistically valid random sampling methodology, which added credibility to its findings. The report was also effective in presenting its conclusions clearly, supported by detailed percentages and financial estimates.

Assessment and Areas for Improvement

While the report successfully highlights procedural failures and offers several recommendations, it lacks a deeper analysis of the underlying systemic and cultural causes behind the findings. Specifically:

Comprehensive Root Cause Analysis

It is recommended that the OIG conduct a more thorough investigation into the systemic issues contributing to documentation lapses and policy non-compliance. The OPSO cited a lack of human and technological resources as a root cause, and the report appropriately acknowledges that increased staffing and system upgrades, along with additional training and oversight, could help address these challenges.

However, the report stops short of exploring more fundamental questions, such as:

- Why were so many employees unable or unwilling to complete relatively simple forms?
- Why did the Detail Department prioritize processing payment requests over verifying their appropriateness?

Understanding the behavioral and organizational factors behind these widespread compliance issues would better inform the design of future procedures and training.

Detailed Corrective Action Plan

We commend the OIG for its timely intervention in resolving the dispute between the City and OPSO regarding the Mardi Gras pay structure. The swift facilitation of a Cooperative Endeavor Agreement (CEA) helped clarify expectations and prevent further misuse of city funds.

However, a similar level of urgency appears to be lacking in response to longstanding administrative issues in off-duty detail management. While the OIG recommends increasing resources and providing training and annual policy reviews, the absence of a structured implementation timeline is notable—particularly given that these issues have reportedly persisted since at least 2017.

If OPSO lacks the financial resources to outsource these responsibilities, as suggested, then a more clearly defined internal plan with deadlines and accountability checkpoints is essential. Without this, the risk of continued inefficiencies and policy violations remains high.

Conclusion

The audit effectively identifies serious administrative shortcomings and recommends broad corrective measures. To build on this work, future reviews should emphasize:

- Deeper exploration of root causes
- Greater urgency in response to longstanding failures
- More concrete timelines and accountability mechanisms

These enhancements would better support OPSO in implementing sustainable improvements, ensuring both financial integrity and public trust.

ROI: FAILURE TO FOLLOW CONTRACT REQUIREMENTS WHILE USING WISNER TRUST FUNDS

Purpose and Methodology

The Office of Inspector General for the City of New Orleans (OIG) conducted this inspection based on an anonymous complaint received that alleged that Wisner Trust funds were being mismanaged by the City of New Orleans (City) through a December 14, 2021 Cooperative Endeavor Agreement (CEA) with the Center for Employment Opportunities (CEO) for a grass-cutting, lot maintenance, and re-entry workforce training program. Specifically, the complainant alleged that very few individuals were actually hired to perform the work under the CEA, that the maximum amount payable by the CIty of $1,000,000, per the CEA, could not be spent in the allotted one-year time frame, and that any money not spent would not be properly accounted for by the City. The City Code Enforcement Department oversaw and administered the CEA. Article I of the CEA required CEO to submit monthly invoices to the City via its Budget, Requisition, and Accounting Services System (BRASS), and further required CEO to submit photographic evidence of all work performed through the City's Land Management Software (LAMA). The purpose of the OIG investigation was to evaluate the veracity of the claims included in the anonymous complaint.

As part of the investigation, OIG Investigators reviewed LAMA and BRASS records for invoices paid by the City related to the CEA and interviewed various City and CEO personnel.

Key Findings - Investigative Notes

City personnel reported to the OIG that LAMA and BRASS showed only limited data of work being completed by CEO per the CEA and that, in fact, the LAMA system was insufficient and unable to manage the program under the CEA.

City personnel further reported the decision was made to pay quarterly, as opposed to monthly per the CEA, as they viewed the monty as a grant and that the City could claw back funds if CEO could not meet its contractual obligations.

City personnel also reported that CEO's accounting lacked detail and that invoices were either not submitted timely or not submitted at all. CEO claimed that certain City personnel advised them not to worry about submitted any invoices. This was corroborated by the City personnel interviewed as part of this investigation.

Key Findings - Potential Violations of the CEA

1. **The City Did Not Verify Services Rendered by CEO Before Making Payment:** The CEA required the City to track work order assignments and keep accurate records of all cuts and other completed services, reports, invoices, and payments. The City did not comply with these requirements.
2. **The City's Payment Schedule Did Not Comply with the CEA:** The CEA did not authorize the City's quarterly payments of $250,000.00 to CEO, but rather set forth a clear possess for monthly payments after verification of services rendered. The City made two improper $250,000.00 quarterly payments without verification. A third payment of $250,000.00 was rescinded once the City learned that OIG questioned the expenditures.
3. **CEA Contained Impossible Obligations:** Despite the City knowing that LAMA would not be able to track the work performed under the CEA, prior to entering the agreement, the CEA was still drafted to contain the language that LAMA would be utilized for billing and proof of work, which created an accountability problem for both the City and CEO.

Key Findings - Potential Violations of the Louisiana Constitution

1. **Non-Compliance with Article VII, Section 14:** Article VII, Section 14(A) prohibits the donation of public funds. Article VII, Section 14(C) requires formal cooperative

endeavor agreements clearly identifying a "public purpose" for the expenditure of public funds. While the City may enter cooperative endeavor agreements, it must follow the terms thereof when making payments, which the City did not do. The City also failed to keep records to sufficiently verify that the expenditure of the public funds was for a public purpose, and not gratuitous. The City attempted to verify the work after the fact, but that provided almost impossible, and resulted in CEO having to repay a certain amount of unaccounted payments to the City.

Recommendations

The Louisiana Attorney General uses the "Cabela's test," which requires all three of the following elements be met for an expenditure of public funds to be permissible under the Louisiana Constitution: (1) the expenditure must be for a public purpose; (2) the expenditure, taken as a whole, does not appear to be gratuitous; and (3) evidence must demonstrate that the public entity has a reasonable expectation of receiving a benefit or value at least equivalent to the amount expended. Based on this test, the OIG recommended:

1. **CEA Expense Review Process:** The City implement a review process to ensure all expenses incurred as apart of cooperative endeavor agreements are permissible under Article VII, Section 14(A) of the Louisiana Constitution. This review process should include: (1) verify that invoiced expenses meet the Cabela's test; and (2) verify that payments for work performed comply with the terms of the CEA as written.
2. **Services Verification Process:** The City verify in advance that any systems included in CEAs are sufficient to provide transparency and manage programs per the terms of the agreement.
3. **Maintain CEA Compliance Records**: The City should only transfer funds to an entity after services are provided, and should maintain complete and accurate record for cooperative endeavor agreements to ensure that the services were provided in accordance with the CEA and that all payments were permissible under the Louisiana Constitution.

Conclusion

The OIG determined that the City did not comply with the CEA with CEO and that, as a result, the public funds paid by the CIty to CEO may have violated the Louisiana Constitution.

QARAC Review

Throughout the review process, QARAC has made many requests of the OIG to produce more follow-up reports as well as any other documentation, including, working papers and follow-

up inspection reports, that could support QARAC's fulsome assessment of the Wisner Trust CEA investigation. To date, OIG has not provided any additional documentation. Moreover, QARAC is unaware of, and was not provided with, any follow-up information to determine whether any of the recommendations have been implemented as part of the City's general cooperative endeavor development, maintenance, and administration process. While the OIG's report shows the importance of the OIG and the power of making recommendations to city agencies, it also shows the lack of proper follow up by the OIG. Therefore, QARAC recommends the OIG create a detailed follow-up schedule to ensure the recommendations with the biggest impacts get implemented timely and remain implemented.

ROI: MAYOR'S OFFICE OF YOUTH AND FAMILIES WAS DIRECTING MONIES TO FORWARD TOGETHER NEW ORLEANS

Purpose and Methodology

The Office of Inspector General for the City of New Orleans (OIG) conducted this inspection after it received an anonymous complaint that the Mayor's Office of Youth and Families (OYF) was directing the disbursement of monies donated to the private non-profit Forward Together New Orleans (FTNO), the transition committee for Mayor-elect LaToya Cantrell, from April 19, 2022 through June 26, 2023. On April 27, 2022, the City Council of New Orleans (Council) made an additional request, pursuant to Council Resolution No. R-22-203, for the OIG to investigate FTNO's receipt and use of City funds through one-year cooperative endeavor agreement(s). The purpose of the OIG investigation was to evaluate the veracity of the claims included in the anonymous complaint.

As part of the investigation, OIG Investigators reviewed former FTNO employee Shaun Randolph, obtained an Affidavit from Dr. Kathleen Kennedy, and reviewed various relevant news articles and press releases, including those issued on nola.gov and the Mayor's website and the FTNO website, FTNO organizational documents, the Professional Services Agreement between the City and UHC, certain CEAs to which FTNO was a party, relevant social media postings (Twitter (now X) and Facebook), relevant emails with the Mayor's office, as well as relevant City memos and payment receipts.

Investigation

The OIG investigation revealed that beginning in April 202, FTNO received several donations from certain City contractors (such as UHC) and other benefactors, but later transferred those funds to OYF, who would then direct the spending of those funds. The new Executive Director of FTNO, Shaun Randolph, raised questions as to the seeming co-dependency of FTNO and the City and opined that FTNO should be a separate entity. Mr. Randolph's concern centered around the seeming magnitude of influence over FTNO by City employees. Mr. Randolph has since been terminated from his role with FTNO.

Conclusion

The initial allegation regarding FTNO's receipt of donations from entities conducting business with the City (like UHC) demonstrated a potential conflict of interest for a City employee to solicit or accept donations from such an organization, particularly if that City employee is a board member, board liaison, or an individual who determines where and how monies received by FTNO will be spent. According to the OIG, the entities having a contractual relationship with the City were likely "prohibited sources" under La. Rev. Stat. 42:1115. As such, FTNO could not accept funds from UHC, a City contractor, while a City

employee was on the FTNO board as that City employee could have influenced the selection of City contractors while she had a duty to do so impartially and for the benefit of the City and, by contrast, as a board member of FTNO, that City employee had a duty to solicit and accept gifts from any and all donors. Similarly, other City employees at OYF likely could not direct expenditures of funds by FTNO when those funds included donations from a City contractor such as UHC. OYF employees may have had a conflict of interest because they were obligated to impartially award contracts for the benefit of the City, but their decision-making might have been influenced by the knowledge of City contractors' or potential contractors' donations to FTNO.

Key Findings

1. FTNO's receipt of donations from a City contractor demonstrated a potential conflict of interest for a City employee who was also a FTNO board member.
2. A City employee at OYF directed the expenditure of funds donated to FTNO. This also demonstrated a potential conflict of interest because those funds included donations from a City contractor.
3. FTNO's Former Executive Director expressed concern and objected to a City employee's direct involvement with FTNO and its daily operations, ultimately attempting to operate FTNO independently in a direction contrary to the FTNO board. As a result of those attempts, he was terminated from FTNO.

Recommendations

1. Non-profits and other charitable organizations must ensure that expenditures of City funds provided in accordance with a CEA are properly characterized and expended. The City must maintain sufficient documentation to confirm that City funds provided to non-profits and other charitable organizations are properly characterized, expended, and utilized in a manner consistent with the agreed-upon terms outlined within a Cooperative Endeavor Agreement (CEA).
2. The City should add a section to its current financial disclosure form requiring City employees to disclose any service they provide to non-profits or other charitable organizations that receive funds from the City. If there is any uncertainty or ambiguity regarding the disclosure requirements, it is advisable to seek an Advisory Opinion from the Louisiana Board of Ethics.

QARAC Review

While the OIG's report shows the importance of the OIG and the power of making recommendations to city agencies, it also shows the lack of proper follow up by the OIG or

any documentation of the City's efforts to comply with and implement the OIG's recommendations as to this, or as to any other of its cooperative endeavor agreements and similar arrangements as was at issue here. QARAC is, in fact, unaware of, and was not provided with, any follow-up information to determine whether any of the recommendations have been implemented as part of the City's general cooperative endeavor development, maintenance, and administration process. Therefore, QARAC recommends the OIG create a detailed follow-up schedule to ensure the recommendations with the biggest impacts get implemented timely and remain implemented.