



UNITED STATES ENVIRONMENTAL PROTECTION AGENCY
WASHINGTON, D.C. 20460

SEP 19 2012

THE INSPECTOR GENERAL

MEMORANDUM

SUBJECT: Proposed Fiscal Year 2012 Management Challenges and Internal Control Weaknesses for the Chemical Safety and Hazard Investigation Board

TO: The Honorable Rafael Moure-Eraso
Chairperson and Chief Executive Officer
Chemical Safety and Hazard Investigation Board

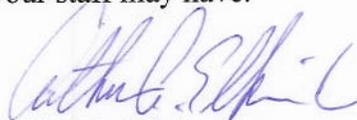
The Office of Inspector General (OIG) is providing its recommended fiscal year (FY) 2012 management challenges and internal control weaknesses for consideration as part of the Chemical Safety and Hazard Investigation Board (CSB) Federal Managers' Financial Integrity Act review. We identified two management challenges and two internal control weaknesses for FY 2012 (attachment). We previously provided you a draft of this document, and we considered your comments in finalizing these management challenges and internal control weaknesses.

The Reports Consolidation Act of 2000 requires our office to report what we consider the most serious management and performance challenges facing CSB. We used audit and evaluation work, as well as additional analysis of CSB operations, to arrive at the two management challenges and two internal control weaknesses. Additional challenges and weaknesses may exist in areas we have not yet reviewed, and other significant findings could result from additional work.

The Government Performance and Results Act Modernization Act of 2010 (GPRA 2010) requires agencies to include the management challenges prepared by their Inspectors General (IGs) in their Annual Performance Plans. It also requires agencies to identify planned actions to address challenges; performance goals, performance indicators, and milestones to measure progress toward resolving the challenges; and the agency official responsible for resolving the challenges. In addition, Office of Management and Budget (OMB) Circular A-136, *Financial Reporting Requirements*, dated October 27, 2011, requires agencies' performance and accountability reports to include a statement prepared by the IG summarizing what the IG considers to be the most serious management and performance challenges facing the agency and to briefly assess the agency's progress in addressing those challenges. Comments by the agency head should follow the IG's statement and address each IG challenge, but the agency head may not modify the IG statement.

GPRA 2010 provides a new government-wide definition for major management challenges. According to GPRA 2010, major management challenges are “programs or management functions, within or across agencies, that have greater vulnerability to waste, fraud, abuse, and mismanagement, wherein a failure to perform well could seriously affect the ability of an agency or the federal government to achieve its mission or goals.” Internal control weaknesses are deficiencies in internal control activities designed to address and meet internal control standards. In FY 2011, we identified two management challenges and one internal control weakness. Based on your responses to our prior audit recommendations, we have decided to carry over the challenges and weakness to FY 2012. We have also included an additional internal control weakness on the audit follow-up process.

Further details on CSB’s management challenges and internal controls weaknesses the OIG has identified are provided in the attachment. We would be pleased to discuss these matters with you and address any questions you or your staff may have.



Arthur A. Elkins, Jr.

Attachment

***Proposed Management Challenges and
Internal Control Weaknesses***

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Clarifying CSB's Statutory Mandate

CSB is not investigating all accidents that fall within its legal jurisdiction. CSB has an investigative gap between the number of accidents that it investigates and the number of accidents that fall under its statutory responsibility to investigate. CSB believes it is operating according to its statutory mandate and cites a lack of resources to investigate the additional accidents cited. CSB should request that Congress clarify its statutory mandate as it relates to investigating chemical accidents.

Created under the Clean Air Act (CAA) Amendments of 1990,¹ CSB began operating in 1998 as an independent federal government organization. The board that governs CSB consists of five members appointed by the President and confirmed by the Senate. One of the board members serves as the chairperson and chief executive officer. As of July 31, 2012, there were 3 appointed board members, including the chairperson, and a professional staff of 38.

CSB's mission is to enhance the health and safety of the public, workers, and the environment by determining the root causes of accidental chemical releases, and using these findings to promote preventive actions by the private and public sectors. CSB's investigations examine all aspects of chemical accidents, including physical causes such as equipment failures, as well as inadequacies in safety management systems that define safety culture and adherence to government regulations. The board makes safety recommendations to plants, industry organizations, labor groups, and regulatory agencies. Safety recommendations are suggestions for actions to prevent accidents based on lessons learned from each investigation or study.

The CAA Amendments direct CSB to investigate (or cause to be investigated), determine, and report to the public in writing the facts, conditions, and circumstances, and the cause or probable cause, of any accidental chemical release resulting in a fatality, serious injury, or substantial property damage. The CAA Amendments also require CSB to issue periodic reports to Congress; federal, state, and local agencies concerned with the safety of chemical production, processing, handling, and storage; and other interested persons. These reports should recommend measures to reduce the likelihood or the consequences of accidental releases, and propose corrective steps to make chemical production, processing, handling, and storage as safe and free from risk of injury as possible. CSB must also establish, by regulation, requirements that persons report accidental releases into the ambient air subject to the board's investigatory jurisdiction. The CAA Amendments further state, "In no event shall the Board forego an investigation where an accidental release causes a fatality or serious injury among the general public, or had the potential to cause substantial property damage or a number of deaths or injuries among the general public."

In 2004, the U.S. Department of Homeland Security (DHS) OIG identified an investigative gap, defined as the difference between the number of accidents the CSB investigates and the number of accidents that fall under CSB's statutory responsibility to investigate. DHS OIG recommended that CSB develop a plan to describe and address the investigative gap and include the information in future budget submissions to Congress and OMB.²

¹ 42 U.S. Code (U.S.C.) Section 7412(r) (6).

² DHS OIG, *A Report on the Continuing Development of the U.S. Chemical Safety and Hazard Investigation Board*, OIG-04-04, January 7, 2004, pp. 30–31.

In FY 2008, the U.S. Government Accountability Office (GAO) found that CSB had not fully responded to the DHS OIG recommendations to address the investigative gap. GAO recommended that CSB develop a plan to address the investigative gap and request the necessary resources from Congress to meet its statutory mandate or seek an amendment to its statutory mandate.³

To implement GAO’s recommendation, CSB examined its existing approach to investigating serious chemical accidents and defined a new investigatory methodology to close the gap. The board’s traditional model focused exclusively on deployments to major chemical process accident sites, resulting in full investigations lasting more than 1 year. In 2010, CSB investigators began assessing smaller accidents with significant consequences and generating internal reports outlining the details of the accident. Also in 2010, the board initiated three short, focused safety bulletins and case studies on critical issues facing the chemical and petrochemical industries. Using this model, CSB is able to target high-risk industries using data collected from assessments as well as data in the incident-screening database.⁴

CSB believes it is operating according to its statutory mandate, but cites a lack of resources to investigate more than a portion of the accidents that fall within its legal jurisdiction. In FY 2011, CSB recorded 46 fatal accidents, resulting in the deaths of 52 people—either people employed where the accidents took place or members of the public—for which CSB was unable to deploy investigators.⁵ In FY 2010, CSB recorded 32 fatal accidents, resulting in the deaths of 38 people.⁶ The totals for FYs 2009–2011 are in table 1 below, and the table shows an increase each year in number of accidents with fatalities and accidents not investigated.

Table 1: Percent of accidents with fatalities investigated by in FYs 2011, 2010 and 2009

Fiscal year	Accidents and investigations with fatalities			Percent investigated
	Initiated ⁷	Not initiated	Total ⁸	
2011	6	46	52	12%
2010	11	32	43	26%
2009	8	25	33	24%

Sources: CSB budget justification for FYs 2011 and 2012; CSB performance and accountability reports for FYs 2009 and 2010; CSB FY 2011 Non-Deployed Fatal Incidents and other supporting data.

CSB noted in response to the draft management challenges that, during this period, incident screening procedures have improved so that more fatal incidents are likely being recorded. Also, by June 2010, CSB was seriously overcommitted in terms of open investigations, with an unsustainable, record-high level of 22 open cases, which necessitated a temporary reduction in

³ GAO, *Chemical Safety Board—Improvements in Management and Oversight Are Needed*, GAO-08-864R, August 22, 2008, p. 11.

⁴ *Final Budget Justification, Fiscal Year 2012*, February 2011, pp. 3–4.

⁵ *CSB FY 2011 Non-Deployed Fatal Incidents, and other supporting data*, pp. 2-5.

⁶ *Final Budget Justification, Fiscal Year 2012*, February 2011, pp. 8–10.

⁷ *CSB FY 2011 Non-Deployed Fatal Incidents, and other supporting data*, pp. 2-5; *CSB Performance and Accountability Report for Fiscal Year 2010*, November 2010, p. 13; and *CSB Performance and Accountability Report for Fiscal Year 2009*, November 2009, p. 12.

⁸ *CSB Budget Justification, Fiscal Year 2011*, February 2010, pp. 11–12.

new deployments. In addition, CSB agreed to initiate an investigation requested by Congress that was unprecedented in terms of scale and cost. CSB communicated to Congress that taking on a large-scale investigation would necessitate “certain extraordinary measures,” including possible termination of cases, reassignment of personnel from existing cases, and requesting significant supplemental funds from Congress. Although no supplemental funds were provided, the CSB’s commitment to this massive case remains.

CSB stated that it needed to seek additional guidance from OMB and Congress before it commits to a long-term plan of action, and agreed to work with Congress to clarify its statutory mandate. In a letter dated November 5, 2009, CSB requested that Congress clarify CSB’s statutory mandate as it relates to investigating chemical accidents.⁹ To date, there has been no response from Congress. Since the issuance of its letter to Congress, CSB has not taken any further action to clarify its statutory mandate. In our draft challenges, we recommended that CSB follow up with the relevant congressional committees on the status and resolution of this issue.

CSB provided the following comments on the draft management challenge:

The issue is whether language in the original text of the Clean Air Act of 1990 directing the CSB to investigate “any” accidental chemical release causing death, serious injury, or substantial property damage should be interpreted as requiring the CSB to investigate *all* such accidents, of which there are hundreds each year. Since its inception in 1998, the CSB has taken the position that the language in the Clean Air Act allows the agency to exercise discretion in investigating chemical accidents (unless a member of the public is killed or seriously injured). Thus, we focus our extremely limited resources on the most serious accidents, like the Macondo well blowout in the Gulf, the Tesoro Anacortes refinery explosion, and the Donaldson Enterprises fireworks explosion in Hawaii, to name a few current cases.

We believe both Congress and the Office of Management and Budget support the CSB’s approach. No appropriations bill or report language has ever suggested that the CSB should dilute its modest \$11 million per year budget among hundreds of different accidents. We also believe it is unrealistic to suggest that the CSB, an agency of fewer than fifty people, must persuade Congress to re-open the Clean Air Act for the sake of changing a single word whose meaning is at best ambiguous. We note that we are not aware of any external stakeholder from industry, labor, community, or environmental organizations who has ever publicly taken the position the CSB is compelled to investigate all chemical releases. Certainly, no one has ever sought to force the CSB to investigate an accident using this questionable rationale, and thus no federal court has had the opportunity to pass judgment on the CSB’s interpretation of its statutory language on this point. The CSB’s position mirrors that of the much-larger NTSB (National

⁹ Letter from the CSB Chairperson to the Chairperson and Ranking Member of the Subcommittee on Superfund, Toxics, and Environmental Health, Committee on Environment and Public Works, United States Senate, and the Chairperson and Ranking Member of the Subcommittee on Energy and Environment, Committee on Energy and Commerce, U.S. House of Representatives, November 5, 2009.

Transportation Safety Board), which exercises discretion in committing agency resources to transportation-related disasters.

Further, we believe that since the OIG itself raised this issue to Congress last year in its “Management Challenges” report – and Congress has again shown no interest and taken no action on the matter – this issue should now be dropped from the list of challenges.

CSB should seek to close its investigative gap between the number of accidents that it investigates and the number of accidents that fall under its statutory responsibility to investigate. CAA Amendments clearly state that CSB should not “... forego an investigation where an accidental release causes a fatality or serious injury among the general public, or had the potential to cause substantial property damage or a number of deaths or injuries among the general public.” Therefore, we continue to report this issue as a management challenge for CSB.

Promulgating a Chemical Incident Reporting Regulation

CSB has not published a chemical incident reporting regulation as envisioned in the CAA Amendments. In 2008, GAO recommended that CSB publish a regulation requiring facilities to report all chemical accidents. In 2009, CSB notified the public of a proposed reporting regulation. CSB has not yet published the regulation.

The CAA Amendments mandated that CSB establish by regulation a requirement for reporting accidental chemical releases to CSB or to the National Response Center. The CAA Amendments specifically state:

Establish by regulation requirements binding on persons for reporting accidental releases into the ambient air subject to the Board’s investigatory jurisdiction. Reporting releases to the National Response Center, in lieu of the Board directly, shall satisfy such regulations. The National Response Center shall promptly notify the Board of any releases that are within the Board’s jurisdiction.¹⁰

CSB understood that the purpose of the reporting regulation was to inform CSB of major incidents so that it could deploy investigators. However, in its 2008 report, GAO suggested that the reporting regulation offered additional value. GAO stated that the rule would “better inform the agency of important details about accidents that it may not receive from current sources.” GAO also suggested that the information obtained through the reporting rule could improve CSB’s ability to “target its resources, identify trends and patterns in chemical incidents, and prevent future similar accidents.” GAO recommended that CSB “publish a regulation requiring facilities to report all chemical accidents, as required by law, to better inform the agency of important details about accidents that it may not receive from current sources.” GAO believed a reporting rule would improve surveillance of chemical accidents.¹¹

¹⁰ 42 U.S.C. Section 7412(r) (6) (c) (iii), p. 27.

¹¹ GAO, *Chemical Safety Board - Improvements in Management and Oversight Are Needed*, GAO-08-864R, August 22, 2008, pp. 4, 11, 38, 59.

On June 25, 2009, CSB published an advance notice of proposed rulemaking in the Federal Register, seeking comments and information in advance of drafting a proposed regulation to implement the accidental release reporting requirement.¹² In the advance notice of proposed rulemaking, from the federal register, CSB identified some general approaches for implementing the statutory requirement:

1. A comprehensive approach would require the reporting of information on all accidental releases subject to the CSB's investigatory jurisdiction. CSB expressed concerns that this approach might be unnecessarily broad in scope, duplicative of other federal efforts, and may not be necessary for CSB to learn about most significant incidents that would justify an on-site investigation.
2. A targeted approach would require the reporting of basic information for incidents that met significant consequence thresholds. Such an approach would be consistent with that taken by several other federal agencies.
3. A third approach would require owners and operators to report to CSB more extensive information on chemical incidents in their workplaces when notified by CSB. CSB would continue to rely on existing sources to learn initially about chemical incidents, but would follow up on a subset of the incidents to gather additional information through a questionnaire or online form that the reporting party would be required by regulation to complete and submit to CSB.
4. A fourth approach to a reporting requirement could be based upon the presence or release of specified chemicals and specified threshold amounts. However, CSB investigations have shown that serious consequences may and do result from the release of relatively small amounts of chemicals that may not meet threshold amounts and from chemicals that are not likely to be listed.¹³

CSB should consider other chemical incident reporting requirements, the impact such a requirement will have on its resources, and the cost effectiveness associated with using an existing chemical incident reporting system.

CSB has not taken steps to publish a proposed rule. In our draft memorandum on CSB's management challenges and internal control weaknesses, we recommended that CSB follow up by consulting with Congress to clarify its statutory requirement to publish a chemical incident reporting regulation. CSB provided us the following comments when responding to the draft management challenge:

Since 1998 when CSB began its operations, the CSB has not promulgated a chemical incident reporting regulation as envisioned in the CSB enabling legislation. On this matter, we respectfully restate our position from last year. Our position has been that the need for a reporting regulation to notify CSB of major accidents has been overtaken by events. Specifically, the requirement for

¹² Federal Register, Volume 74, No. 121, June 25, 2009, Proposed Rule, pp. 30259 - 62.

¹³ *Ibid*, page 30262.

this regulation dates back to the 1980's, prior to internet search engines and alerts that notify the CSB in almost real time of incidents. However, as a result of a FY 2008 GAO recommendation, the CSB agreed to publish a request for information, which took the form of an advanced notice of proposed rulemaking in FY 2009. Most public stakeholders who responded to the request for comment contended that a rule requiring reporting incidents to the CSB would be duplicative, burdensome, and/or unnecessary.

Due to continued staffing limitations – and absent any resources or direction from Congress for promulgating a reporting rule – the CSB has taken no further action to develop such a rule. During 2012, we do intend to develop a written questionnaire that could be sent to sites that experience accidents, and will augment our already robust incident screening process, which you commended in a prior report. Depending on the usefulness of the questionnaire, we will consider whether it is appropriate to adopt it as part of a future reporting rule.

CSB's entire incident screening program consists of two employees, both of whom have collateral investigation duties in addition to screening. Even if the CSB had already adopted a reporting rule, the agency would have essentially no capacity to collect or interpret much of the data it received, or seek enforcement action against any non-reporters. Under these conditions, enacting a reporting rule would run afoul of the spirit of recent Executive Orders 13563 (January 18, 2011) and 13610 (May 10, 2012), which direct agencies to reduce regulatory burdens by identifying "rules that may be outmoded, ineffective, insufficient, or excessively burdensome, and to modify, streamline, expand, or repeal them in accordance with what has been learned."

If enacting an incident reporting rule is not in accordance with the Executive Orders 13563 and 13610, CSB should submit a preliminary plan to OMB noting its determination that such a rule should be repealed to make the agency's regulatory program more effective, streamlined and less burdensome in achieving its objectives. We will continue to report this issue as a management challenge until CSB addresses the regulation requirement with OMB as required in the executive order.

Establishing Internal Controls Related to Program Operations

CSB has not established and implemented a management control program to evaluate and report on the effectiveness of program operation controls. OMB Circular A-123, *Management's Responsibility for Internal Control*, states that internal controls "include program, operational, and administrative areas as well as accounting and financial management."¹⁴ CSB should develop and implement a comprehensive internal control program encompassing systems and processes for program, operational, administrative, accounting, and financial management functions.

¹⁴ OMB memorandum, "Revisions to OMB Circular A-123, Management's Responsibility for Internal Control," December 24, 2004, p. 4.

In FY 2011, OIG determined that CSB should develop and implement a management control plan to address prior audit recommendations and to improve the board's system of management controls.¹⁵ CSB did not take timely corrective actions to address 34 audit recommendations from 3 OIGs and from GAO.¹⁶ In four instances, it took CSB 4 years beyond the agreed-upon corrective actions date (or report date) to implement corrective actions. CSB's actions to address 13 recommendations were not completely effective and required additional corrective actions, and 7 recommendations were not yet completed.¹⁷

In FY 2012, OIG concluded that CSB did not consistently achieve its goals and standards, as outlined in its current strategic plan, for timely implementation of its safety recommendations. As of December 2010, CSB had issued 588 safety recommendations, of which 218 were open while actions were in progress to resolve them. Of the 218 recommendations, 54 were open for more than 5 years. The Government Performance and Results Act of 1993 require federal agencies to have strategic plans, and OMB Circular A-123 requires policies and procedures to ensure effective and efficient internal controls to achieve program results. Although CSB does not have enforcement authority, and implementation of some of its recommendations may face lengthy regulatory processes, CSB has not established or maintained sufficient internal controls and processes related to safety recommendations. Without effective controls and efficient processes, there is an increased likelihood that recipients will not timely implement CSB safety recommendations and, as a result, chemical accidents may not be prevented to the greatest extent possible.¹⁸

Information security is an important part of program operations. The OIG identified control weaknesses in its FY 2011 audit of CSB's compliance with the Federal Information Security Management Act. Unpatched devices significantly elevate CSB's risk of system and data compromise by unauthorized users, which could lead to altered or deleted critical data and degraded system performance. Also, maintaining an inventory that contains a large number of excess information technology devices could allow for the misuse or loss of data, or the disclosure to the public of sensitive data.¹⁹

In its FY 2011 performance and accountability report, the CSB chairperson acknowledged that the Federal Managers' Financial Integrity Act requires an annual evaluation of its management controls to identify any material weaknesses. The chairperson further acknowledged that the

¹⁵ EPA OIG, *Chemical Safety and Hazard Investigation Board Did Not Take Effective Corrective Actions on Prior Audit Recommendations*; Report No. 11-P-0115, February 15, 2011, p. 3.

¹⁶ In FY 2004, Congress designated EPA OIG to serve as the IG for CSB. As a result, EPA OIG has the responsibility to audit, evaluate, inspect, and investigate CSB's programs, and to review proposed laws and regulations to determine their potential impact on CSB's programs and operations. This includes an annual audit of CSB's financial statements. Prior to FY 2004, the IGs for the Federal Emergency Management Agency and the U.S. Department of Homeland Security served as the IG for CSB.

¹⁷ EPA OIG, Report No. 11-P-0115, *op. cit.*, p. 4.

¹⁸ EPA OIG, *U.S. Chemical Safety and Hazard Board Should Improve Its Recommendations Process to Further Its Goal of Chemical Accident Prevention*, Report No. 12-P-0724, August 22, 2012, p.3/22.

¹⁹ EPA OIG, *Evaluation of U.S. Chemical Safety and Hazard Investigation Board's Compliance with the Federal Information Security Management Act (Fiscal Year 2011)*, Report No. 12-P-0363, March 21, 2012, p. 2-3.

requirement applies to all CSB programs and administrative functions.²⁰ However, according to CSB, the assurance statement in its performance and accountability report addresses controls over CSB's financial management operations and not the organization's mission-related program operations.

CSB has not completed its management control plan in accordance with OMB Circular A-123 to address program operations and improve accountability. We recommended that this internal control weakness remain in 2012 until a management control plan is completed. CSB provided the following comments on the draft internal control weakness:

We agree on the usefulness of a management control plan; a plan has been drafted and will be put into effect this fiscal year, in coordination with the approval of a new four-year Strategic Plan, which is now before the Board for a vote.

Implementing an Audit Follow-Up Process²¹

CSB and its OIG do not have an agreed-to follow-up process to ensure prompt implementation of audit recommendations. In an FY 2011 audit, *Chemical Safety and Hazard Investigation Board Did Not Take Effective Corrective Actions on Prior Audit Recommendations*,²² we reported that CSB did not take timely corrective actions to address 34 audit recommendations from 3 OIGs and from GAO.²³ In four instances, it took CSB 4 years beyond the agreed-upon corrective actions date (or report date) to implement corrective actions. CSB's actions to address 13 recommendations were not completely effective and required additional corrective actions, and seven recommendations were not yet completed.²⁴ The FY 2011 report resulted in seven recommendations, and one of the seven has five detailed recommended actions for CSB to address. As of February 2012, CSB had implemented the agreed-to corrective actions for two of the seven audit recommendations and two corrective actions for one other recommendation. CSB is up to a year past the agreed-to date on fully implementing three of the remaining four audit recommendations. Our review of CSB's FY 2012 status report showed that CSB changed or updated its response to two of four unimplemented recommendations. For the other, CSB noted that the recommendation should be closed but kept it open with a revised corrective action date because activities were planned to be completed in April 2012. Those activities remained unimplemented as of May 2012.

The need for an agreed-to process to follow up on audit recommendations had been overlooked by OIG and CSB senior management because there was no formal process established when the EPA OIG was given responsibility to serve as the IG for the CSB. CSB does not have a

²⁰ CSB, U.S. Chemical Safety and Hazard Investigation Board Performance and Accountability Report, FY 2011, November 15, 2011, p.4

²¹ Memorandum: Finding Outline: Audit Follow-up Process Needed for the Chemical Safety and Hazard Investigation Board, May 3, 2012.

²² EPA OIG, *Chemical Safety and Hazard Investigation Board Did Not Take Effective Corrective Actions on Prior Audit Recommendations*; Report No. 11-P-0115, February 15, 2011.

²³ In FY 2004, Congress designated EPA OIG to serve as the IG for CSB (see footnote 18 for details).

²⁴ EPA OIG, Report No. 11-P-0115, *op. cit.*, p. 4.

documented tracking system to ensure the prompt and proper resolution and implementation of audit recommendations, as required by OMB Circular A-50, *Audit Followup*.

The IG Act of 1978, as amended, emphasizes the importance of the audit follow-up process. Section 2(3) states that one purpose of IGs is “to provide a means for keeping the head of the establishment and the Congress fully and currently informed about problems and deficiencies relating to the administration of such programs and operations and the necessity for and progress of corrective action.” OMB Circular A-50, Section 5, states, “[a]udit follow-up is an integral part of good management, and is a shared responsibility of agency management officials and auditors. Corrective action taken by management on resolved findings and recommendations is essential to improving the effectiveness and efficiency of Government operations. Each agency shall establish systems to assure the prompt and proper resolution and implementation of audit recommendations. These systems shall provide for a complete record of action taken on both monetary and non-monetary findings and recommendations.” GAO’s *Standards for Internal Control in the Federal Government* state that internal control is a major part of managing an organization and should provide reasonable assurance that the objectives of the agency are being achieved.

OIG determined that an agreed-to follow-up system as required by OMB Circular A-50, which at a minimum includes a policy and a CSB tracking system, would help CSB ensure it is achieving its objectives, efficiently and effectively using its resources, and complying with the circular. By not having an agreed-to follow-up process between the OIG and CSB, controls over promoting efficiency and effectiveness within CSB’s operations are weakened. During a May 2012 meeting, CSB and the OIG discussed implementing a policy and a tracking system. Both offices agreed on an interim process that includes continuing to update the OIG’s spreadsheet for the status of unimplemented recommendations.

CSB provided the following comments on the draft internal control weakness:

The CSB looks forward to developing such a process in partnership with the OIG, as your staff recently offered at a meeting with CSB personnel. The draft report correctly notes that neither organization had such a process to date.