AGENDA

FLORIDA GULF COAST UNIVERSITY BOARD OF TRUSTEES

Audit and Compliance Committee
Conference Call Meeting

Thursday, August 17, 2017 1 p.m. to (estimated) 2 p.m.
CALL WILL ORIGINATE FROM EDWARDS HALL ROOM #309
FLORIDA GULF COAST UNIVERSITY

NOTE: Indicated times within the agenda are approximate and are subject to change. Agenda items may be taken out of order at the call of the Chair and with the concurrence of the Committee.

Committee Members:
Trustee Joseph Fogg III – Chair
Trustee Darleen Cors
Trustee Leo Montgomery
Trustee Kevin Price

1 p.m. Call to Order, Roll Call, and Opening Remarks – Chair Joseph Fogg III

1:05 p.m. Consent Agenda (Includes Public Comment) – Chair Joseph Fogg III
- Minutes of May 15, 2017 (TAB #1)

1:10 p.m. Action Items (Includes Public Comment):
- 2016-2017 Internal Audit Annual Report – Director of Internal Audit William Foster (TAB #2)
- 2017 Internal Audit Quality Assurance Review – Director of Internal Audit William Foster (TAB #3)
- 2017-2018 Internal Audit Work Plan – Director of Internal Audit William Foster (TAB #4)
- 2016-2017 Compliance and Ethics Office Annual Report – Chief Compliance and Ethics Officer Stacey Chados (TAB #5)
1:30 p.m. **Information Item:**
   - **Discussion of Whistleblower Procedures** – Chair Joseph Fogg III (TAB #6)

1:50 p.m. **Old Business** – Chair Joseph Fogg III

1:55 p.m. **New Business** – Chair Joseph Fogg III

2 p.m. **Closing Remarks, and Adjournment** – Chair Joseph Fogg III

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Florida Gulf Coast University Board of Trustees
Audit and Compliance Committee
August 17, 2017

SUBJECT: Minutes of May 15, 2017

PROPOSED COMMITTEE ACTION

Approve minutes

BACKGROUND INFORMATION

The Audit and Compliance Committee met on May 15, 2017. Minutes of the meeting were kept as statutorily required.

Supporting Documentation Included: Minutes of May 15, 2017

Prepared by: Transcription Experts, and Assistant Director of Board Operations Lauren Schuetz

Legal Review by: N/A

Submitted by: Vice President and Chief of Staff Susan Evans
FLORIDA GULF COAST UNIVERSITY BOARD OF TRUSTEES

AUDIT AND COMPLIANCE COMMITTEE

Monday, May 15, 2017

MARIEB HALL, ROOM #402
Florida Gulf Coast University

Minutes

Members:
Present: Trustee Joseph Fogg III, Chair; Trustee Leo Montgomery; Trustee Darleen Cors (by telephone); and Trustee Kevin Price (by telephone starting at 1:13 p.m.).

Others:
Trustees: Trustee J. Dudley Goodlette (by telephone starting at 1:12 p.m.); and Trustee Shawn Felton.

Staff: President Wilson Bradshaw; Vice President and Chief of Staff Susan Evans; Vice President for University Advancement and Executive Director of FGCU Foundation Chris Simoneau; Vice President and General Counsel Vee Leonard; Chief Compliance and Ethics Officer Stacey Chados; Director of Internal Audit Bill Foster; Executive Assistant to the Vice President and Chief of Staff Tiffany Reynolds; and Project Manager Danielle O’Brien

Item 1: Welcome and Opening Remarks
Chair Joseph Fogg called the meeting to order at 1:03 p.m. Roll call was taken with three of the four members present, thus meeting quorum requirements. Trustee Kevin Price joined the meeting through conference call at 1:13 p.m. making the attendance four.

Item 2: Audit and Compliance Resources (See Tab #1)
Chair Fogg asked President Bradshaw to present information concerning Audit and Compliance resources.

President Bradshaw said Chair Fogg previously had asked about the adequacy of resources in the Compliance and Internal Audit departments. President Bradshaw stated he had spoken with the directors, Ms. Chados and Mr. Foster, in both of those divisions, and they assured him there currently were adequate resources.

Trustee Fogg called for discussion. He asked if in the future there was a change in this status, the directors would inform the Committee.
Trustee Montgomery asked Director of Internal Audit Bill Foster if there was a plan in place for the next three years. Mr. Foster responded that generally an Audit Work Plan was completed, and it was currently being developed under Risk Assessment procedures. This process was completed annually as opposed to three years.

Trustee Montgomery suggested that maybe some areas could be assessed every year and maybe some could be assessed every three years. Mr. Foster responded that this currently was being done.

President Bradshaw explained the process where he meets with key personnel and the Chair of the Board’s Audit and Compliance Committee, and together they create an Audit Work Plan. Then, the Plan would come to the Audit and Compliance Committee for recommended approval before going to the full FGCU Board of Trustees (BOT). He said the Plan would be submitted to the FGCU BOT in September, and to the Committee prior to that time.

**Item 3: Audit and Compliance Committee’s Responsibilities regarding Florida Gulf Coast University's Direct Support Organizations (DSOs) (See Tab #2)**

President Bradshaw announced Mr. Bill Foster as the now permanent Director of Internal Audit, with the removal of “Interim” from his title. Congratulations were expressed.

Chair Fogg called on Vice President and General Counsel Vee Leonard to present this item.

Ms. Leonard pointed out there were three areas that governed universities’ Direct Support Organizations (DSOs): 1) Statute Section 1004.28; 2) Board of Governors Regulation 9.011; and 3) FGCU Board of Trustees Regulation 1.005. These provide a basis for how to create DSOs and how to manage the business of the organization. Ms. Leonard said the Office of Internal Audit and the Office of Compliance and Ethics would interact with the DSOs. She stated the Board of Governors (BOG) would like the universities to take a more active role in the auditing of the DSOs. She said, therefore, these two departments would work with the DSOs for their financial statements and operating procedures, and bring to the Audit and Compliance Committee any concerns. She added the statute and regulations mentioned provided a broad range of responsibilities, and the University’s Regulation was derived from the BOG Regulations and the statute as related to how the University would utilize and exchange property, and personal services. Ms. Leonard stated she had spoken with the Inspector General of the BOG, and he confirmed there would not be independent actions going to the Audit and Compliance Committee, but actions would come to the Director of Internal Audit or the Chief Compliance and Ethics Officer. She said the Audit and Compliance Committee would provide more specificity than what was mentioned in the statute and regulation.
Chair Fogg stated there were two FGCU DSOs, (1) the Financing Corporation, and (2) the Foundation. He said the Financing Corporation had an independent outside auditor, and the Foundation has an audit committee and an independent outside auditor. He asked Ms. Leonard how FGCU now will be involved in this process.

Ms. Leonard responded the Internal Auditor and the Compliance and Ethics Officer would be more intimately involved with the DSOs. When the Foundation’s audit committee meets with the external auditor, Mr. Foster would be at that meeting to make sure there was nothing in the audit that he saw as problematic.

Chair Fogg suggested the Audit and Compliance Committee schedule at least one meeting a year with a specific agenda item for reports on the DSOs audits. He asked Mr. Foster and Ms. Chados to suggest the meeting where that would concur. Ms. Leonard agreed.

President Bradshaw asked what the current cycle was for the Foundation and the Financing Corporation audits.

Vice President for University Advancement and Executive Director of FGCU Foundation Chris Simoneau said the Foundation runs on a fiscal year through the end of June. He said last week was the entrance meeting with the independent auditor.

Chair Fogg asked if Mr. Foster was present at that meeting, and Mr. Simoneau’s response was he was not, as he was not aware of the interpretation for Mr. Foster to be there.

Ms. Leonard stated the Board of Governors had most recently directed Internal Audit to be included in the business, operating, and financial audits of the DSOs. She said her interpretation is that Mr. Foster would be included at both the entrance and exit conferences of the audit.

Chair Fogg said he did not know if including Mr. Foster at the Foundation audit’s entrance meeting could be corrected after the fact or just to make sure in the future he would be included.

Mr. Foster stated he could make a phone call to the auditor and obtain any appropriate notations and that would be sufficient for the current year. When the exit conference occurred, he would attend the meeting to make sure he was apprised of anything needing to be brought forward.

Chair Fogg asked when would be an appropriate time for Mr. Foster to come back to report to the Committee. Mr. Foster said it would depend on the timing of the audit.

Mr. Simoneau stated the preliminary work would start next week, and the plan was to have the audit done approximately the first or second week of October and have a
close-out meeting with the Foundation Audit Committee mid-October. Then the
Foundation would bring the report to the January 9 FGCU Board of Trustees meeting.

Chair Fogg said to schedule this report for review at the December 8 Audit and
Compliance Committee meeting. All were in agreement of this date.

Chair Fogg asked Ms. Leonard what Ms. Chados’ role should be in this process.

Ms. Leonard responded it would be appropriate for Ms. Chados and Mr. Foster to work
together as she was sure there would be some compliance issues as it related to
operations, but neither Direct Support Organization (DSO) had any employees, so there
would not be employee issues. However, she stated that did not mean there would not
be any operational issues that might need to be addressed.

Chair Fogg said Ms. Chados and Mr. Foster needed to work with Ms. Leonard to come
up with a clear idea as to what their roles should be with the DSOs. He said there was
a greater level of expectation at the Board of Governors level, which needed a
response.

Ms. Leonard said she, Ms. Chados, and Mr. Foster could certainly meet together on a
regular basis.

Chair Fogg suggested adding a report on the DSO audits from Ms. Chados and Mr.
Foster to the December 8 meeting agenda. Mr. Simoneau said the Committee also
would need to review and recommend the DSO audits to the FGCU Board of Trustees
(BOT) for approval in January.

Trustee Montgomery said if this Committee had the responsibility for approving the
audit, then it should be keenly aware of the planning process. He asked Mr. Foster if
his internal audit function included any part of the operations of the DSOs during the
year.

Mr. Foster responded he was required to consider DSOs in Risk Assessment this year,
and it had been included.

Ms. Leonard laid out a proposed timeline where after the Financing Corporation’s audit
was completed and Mr. Foster reviewed it, he also would be included in the
Foundation’s Audit Committee meeting, and from that meeting, the audit would come to
the Audit and Compliance Committee meeting for recommendation to the FGCU BOT.
It would be a recommendation, and the FGCU BOT would give final approval.

Mr. Simoneau stated the Foundation’s Board of Directors would give its approval in
December before it came to the FGCU Board of Trustees. This was so the FGCU BOT
did not receive an audit that was not approved by the Foundation Board of Directors.
Chair Fogg said the Financing Corporation has a similar type of process, except the Financing Corporation Board of Directors must approve the audit as it did not have an audit committee.

Trustee Darleen Cors asked if the item should be moved to the Committee’s January meeting.

Chair Fogg responded the FGCU Board of Trustees meet in January, and so the report would have to be reviewed by the Audit and Compliance Committee at the December meeting. He asked if the charters for these departments needed to be revised to include these issues.

Ms. Leonard stated the charters included language related to the DSOs. Chair Fogg stated this needed to be verified as to adequacy. Ms. Leonard said she would do so.

Chair Fogg said it was unclear what role the Office of Compliance and Ethics played in the process.

Ms. Chados said her impression was that through the University’s Hotline, anyone could come forward with any type of allegation of wrongdoing occurring at the University. She said certainly the same thing could occur through the Foundation or the Financing Corporation and if anyone observed something inappropriate, he or she could either come directly to her, Mr. Foster, or to any entry point to bring his or her concern. She then would handle the intake of the allegation and refer it to the appropriate department for review.

Chair Fogg stated the Office of Internal Audit had a proactive role and the Office of Compliance and Ethics had a reactive role.

Ms. Leonard said that was true; however, the Chief Compliance and Ethics Officer can be proactive in deterring any inappropriate behavior. Ms. Chados may recommend a policy or regulation she sees needed at the University.

**Item 4: 2017-2018 Schedule for Audit and Compliance Committee** (See Tab #3)

Chair Fogg asked for discussion of the proposed schedule for 2017-2018.

Vice President and Chief of Staff Susan Evans commented the schedule was developed with the input of Mr. Foster and Ms. Chados as to when certain items would be completed. She said she also had considered the schedule of the FGCU Board of Trustees meetings. The schedule provided a conference call meeting on August 17 at 1:00 p.m. Ms. Evans stated Mr. Foster would bring the proposed 2017-2018 Internal Audit Work Plan to this meeting for review and recommendation for the full Board. Ms. Evans stated this meeting would provide items to be reviewed and recommended to the FGCU Board of Trustees meeting scheduled on September 12, 2017.
Ms. Evans said on December 8, the Compliance Plan, Regulation for the Code of Conduct, and the reports on the Foundation Audit and the Financing Corporation Audit would be on the agenda. She said the Committee would have action items to recommend for the FGCU BOT January 9 meeting. Ms. Evans added the starting time for the December 8 and other BOT meetings was 8:30 a.m. The time for the Audit and Compliance Committee meeting would be five minutes after the FGCU BOT meeting ended.

Ms. Evans explained on the February 20 limited agenda FGCU BOT meeting, there was a timing issue related to the Data Integrity Audit required by the BOG. Ms. Evans said outside auditors complete the audit, and Mr. Foster said it should be ready in time for this meeting. She said on this date, the Audit and Compliance Committee would meet before the FGCU BOT meeting to review and recommend the audits. The FGCU BOT meeting would follow the Committee meeting.

Ms. Evans stated for the April 10 FGCU BOT meeting, a separate Audit and Compliance Committee meeting had not been scheduled, but if a need arose, one would be scheduled.

Ms. Evans said if needed, the Audit and Compliance Committee would meet on May 1, following the FGCU BOT meeting. Ms. Evans added the times listed on the schedule would depend on the length of the FGCU Board of Trustees meetings.

Chair Fogg asked if the Committee members concurred with the schedule as presented, and they indicated they did.

**Item 5: Approval of the Minutes of the April 27, 2017 Meeting** (See Tab #4)

Chair Fogg asked for a motion to approve the minutes of the April 27 Audit and Compliance Committee meeting.

Trustee Montgomery made a motion to approve the minutes of the April 27, 2017 meeting. Trustee Cors seconded the motion. Chair Fogg called for discussion.

Chair Fogg asked if the meetings were recorded. Ms. Evans responded they were recorded. The recordings were then sent out to a company to be transcribed, and then the minutes were reviewed by her office for accuracy.

Chair Fogg asked if the approved minutes or the recording were the official record. Ms. Evans said the minutes were the official record. He asked if the recordings were kept. Ms. Evans said yes, and the recordings were public record.

There was no public comment. The vote was unanimous in favor of the motion.
Item 6: Audit and Compliance Committee Charter (See Tab #5)

Chair Fogg said this item was the Charter for the Audit and Compliance Committee, as opposed to the two charters for the two departments that recently were approved. He asked for a motion for this action item.

Trustee Cors made a motion to approve the Charter for the Audit and Compliance Committee. Trustee Montgomery seconded the motion.

Chair Fogg called for discussion of this item.

Chair Fogg directed attention to Page 2, the fifth bullet point under – “The Committee is authorized to” -- which states, “Receive updates on matters of substantial import from external, state, and regulatory auditors, as well as other independent consultants.” Chair Fogg pointed out that the Committee should receive the report first and then receive updates. He asked Ms. Chados and Mr. Foster to revise the language.

Ms. Chados stated the Charter was not talking about reports, but rather something coming up prior to a report. She said the language could be changed to “be briefed on matters” rather than “updates.”

Chair Fogg suggested simply changing the word “updates” to “reports.” Ms. Chados agreed.

Ms. Leonard asked if the report would be written or could it be verbal. Chair Fogg responded it could be either.

Ms. Chados stated “informational briefings” would work, as she did not see the referenced reports as something written.

Chair Fogg suggested “informational briefings and reports.” All agreed this language would work well.

Chair Fogg stated the Charter if approved, would then go to the Board for final approval.

Trustee Price made a motion to approve the Charter as amended. Trustee Montgomery seconded the motion. The vote was unanimous in favor of the motion.

Item 7: Old Business

There was no old business for discussion.

Item 8: New Business

Chair Fogg asked what role the Audit and Compliance Committee played, if any, in the Whistleblower program.
Ms. Leonard answered it depended on the type of whistleblower. She stated if it was a local issue, the report would come first to this Committee. She said there was a Board of Governors regulation which handles allegations against the President or the Board, and those would be addressed at the level of the Board of Governors.

Chair Fogg asked when the Committee would be notified of an allegation.

Ms. Leonard responded it would depend on how the notice was received. If the allegation came through the Hotline, Ms. Chados would determine the course of action. If she wished, she may call Chair Fogg and inform him.

Chair Fogg asked what part of the process was exempt from the Sunshine Laws.

Ms. Leonard said the identity of the whistleblower is exempt from the Sunshine Laws. She said the Committee as a whole would not be informed an investigation was taking place.

Ms. Chados said she intended always to keep someone informed of any issues from the Hotline. She said she would always let Chair Fogg know of any allegations.

President Bradshaw asked if the President should be informed of any allegations, except if they were related to him.

Ms. Chados said she also would inform the President.

**Item 9: Chair’s Closing Remarks & Meeting Adjournment**

Chair Fogg adjourned the meeting at 1:45 p.m.

Minutes prepared by Transcription Experts, and reviewed by Danielle O’Brien, Project Manager.

**Agenda Items:**

A. See Tabs

**Attachment:**

A. Record of Votes
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<td>Trustee Darleen Cors</td>
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<td>4</td>
<td>Trustee Joseph Fogg</td>
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Florida Gulf Coast University Board of Trustees
Audit and Compliance Committee
August 17, 2017

SUBJECT: 2016-2017 Internal Audit Annual Report

PROPOSED COMMITTEE ACTION
Accept the 2016-2017 Internal Audit Annual Report, and recommend its acceptance by the FGCU Board of Trustees.

BACKGROUND INFORMATION
To comply with Board of Governors Regulation 4.002 (State University System Chief Audit Executives), “each university shall have an office of chief audit executive as a point for coordination of and responsibility for activities that promote accountability, integrity, and efficiency in the operations of the university.” FGCU’s chief audit executive is the Director of Internal Audit who “shall prepare a report summarizing the activities of the office for the preceding fiscal year.”

The same regulation requires that, “by September 30th of each year, the report shall be provided to the president, board of trustees, and the Board of Governors.”

Supporting Documentation Included: 2016-2017 Internal Audit Annual Report

Prepared by: Director of Internal Audit William Foster

Legal Review by: N/A

Submitted by: Director of Internal Audit William Foster
This annual report provides information on the benefits and effectiveness of the FGCU Office of Internal Audit (IA) during the 2016-2017 fiscal year. The primary objective of our office is to assist management at all levels of the University including members of the FGCU Board of Trustees in the effective discharge of their duties.
MESSAGE FROM THE DIRECTOR OF INTERNAL AUDIT

It is my pleasure to provide the Annual Report for the year 2016-2017. This year was filled with many interesting events. The Board of Governors (BOG) increased their emphasis on audit and compliance functions by passing four (4) Regulations which became effective November 3, 2016. Then, to provide a comprehensive set of investigative standards, the State University Audit Council (SUAC), which is composed of the Chief Audit Executives of the 12 State Universities in Florida, adopted “Standards for Complaint Handling and Investigations for the State University System of Florida”, as a supplement to the BOG Regulations. At the end of November, our former Director retired after 13 years with FGCU, and I am her successor.

To meet the recommendations of the BOG, the Board of Trustees established a separate Audit and Compliance Committee, with the following Trustees: Chair Joseph Fogg III, Darlene Cors, Kevin Price and Leo Montgomery. This committee adopted a charter and we updated our Internal Audit Charter to conform to best practices and the BOG requirements. These charters were approved by the Board of Trustees June 13, 2017.

To meet professional standards, our office had a Quality Assurance Review with External Validation, and we are pleased to report, we earned the highest rating possible, of “generally conforms to the International Standards for the Professional Practice of Internal Auditing”, issued by the Institute of Internal Auditors.

Of significance, this was the third year the BOG required a Data Integrity Audit, of the data submission processes that support the University’s Performance Funding Metrics. As we have done in the two (2) prior years, for enhanced appearance of independence, we engaged the accounting firm of Mauldin and Jenkins to perform agreed upon procedures. Our office oversaw the engagement and participated to the extent we were able to offer an unqualified opinion on the integrity of the data submission processes to the BOG.

Our team is committed to providing independent, objective assurance services. Within this report, we intend to demonstrate that the internal auditing function is operating as intended. Based on the program of work completed during the year, we have the following representations:

- All audits were performed in accordance with the Institute of Internal Auditors International Standards for the Professional Practice of Internal Auditing.
- The work plan and each individual audit were risk-driven.
- All significant observations were reported.
- We received cooperation from management and staff in performing our work.

The dedication and professionalism of the members of the Office of Internal Audit led to the success our office had this year. I thank them for their efforts.

William D. Foster, MBA, CPA, CIA, CGAP, CFE, CRMA, CCSA
Director, Internal Audit
ABOUT OUR DEPARTMENT

Our Internal Audit Charter defines the purpose, authority, and responsibility of the internal audit activity. The Charter is consistent with the Definition of Internal Auditing, the Code of Ethics, and the Standards mandated by the International Professional Practices Framework (IPPF) of the Institute of Internal Auditors. We have updated the Charter according to the latest guidance from the Institute of Internal Auditors. An updated Charter was approved at the June 13, 2017 Board of Trustees meeting.

The Institute of Internal Auditors professional standards require that our Office possess the knowledge, skills, and other competencies needed to perform our responsibilities. Our staff has 27 years of cumulative auditing experience (Director, 17 years; Internal Auditor, 7 years; and, Staff Auditor, 3 years). The auditors hold a total of 6 certifications. During 2016-2017, each staff member spent at least 40 hours improving internal auditing skills and knowledge of higher education issues through continuing professional education.

QUALITY ASSURANCE AND IMPROVEMENT PROGRAM

BOG Reg. 4.002(6)(e) and the Institute of Internal Auditors professional standards require that our Office report on the results of the quality assurance and improvement program. The quality assurance and improvement program must include both internal and external assessments. Our office has established a Quality Assurance and Improvement Program (QAIP) Policy and conducts periodic QAIP meetings to ensure compliance with the Standards.

Internal Assessments

According to the Standards, internal assessments must include ongoing monitoring of the performance of the internal audit activity and periodic self-assessments. Internal Audit conducts a variety of internal assessments during the course of its routine audit processes. The Internal Audit Director provides supervision over IA staff during the course of audit work. After the completion of each audit, another Internal Audit staff member reviews the audit materials. In addition to our Operations Manual and Charter, guidelines have been established to provide a framework so that all necessary elements of the audit process are completed and documented.

At the conclusion of each audit, the Office of Internal Audit solicits feedback from each unit that was audited through a Post Audit Feedback Survey. The survey highlights areas that relate to pre-audit engagement activities, the audit process, the closing meeting and the reporting of observations. Internal Audit utilizes the feedback to help us continue to improve our processes. For the 2016-2017 audits, our office received a 100% favorable rating from the audited departments.

External Assessments

External Assessments must be conducted at least once every five years. A Quality Assurance Review (QAR) was conducted this year, 2016-2017. The QAR was a self-assessment with independent validation done by the Monica Moyer, Director of Internal Audit at Saint Leo University. Her professional activities include serving ACUA as annual conference director for 2014-17, and as an international ambassador of the IIA.

We were assessed as a department that “generally conforms to the International Standards for the Professional Practice of Internal Auditing,” the highest rating available.
In order to maintain compliance with the Standards, our next external assessment will be conducted in 2021-2022.

INTERNAL AUDIT ACTIVITY

The Internal Audit work plan for 2016-2017 included four audits, and a required Quality Assurance Review of our office. Three of the four audits have been completed successfully, with the fourth scheduled to be completed in the first quarter of 2017-2018.

The scheduled audits and projects completed during 2016-2017 were:

- Accident Procedures Audit: A limited-scope audit of accident procedures used by Florida Gulf Coast University Environmental Health and Safety Department (EH&S) during the Spring, Summer and Fall 2016 Semesters.
- Athletic Camps: A limited-scope audit of compliance and revenue collection processes for Athletic Camps operated on campus from the Summer and Fall 2015 semesters, through the Spring 2016 semester.
- Quality Assurance Review: An assessment of the internal audit activity’s conformance to The Institute of Internal Auditors’ (IIA’s) International Standards for the Professional Practice of Internal Auditing, including evaluation of the internal audit activity’s effectiveness in carrying out its mission, and an opportunity to identify opportunities to enhance its management and work processes, as well as its value to Florida Gulf Coast University.
- Performance Measures Data Integrity Audit: the Florida Board of Governors required each Board of Trustees to direct its Internal Audit Director to perform, or cause to have performed by an independent audit firm, an audit of the processes that ensure data submissions to the Florida Board of Governors, that support the performance funding metrics, are complete, accurate and timely.
ADDITIONAL ASSURANCE COVERAGE FROM PROCUREMENT SERVICES

Procurement Services, in the Administrative Services Division, has a Purchasing Card Administrator who continuously audits purchasing card activity by cardholder. Because Trustees have indicated an interest in this activity, we present the following information for 2016-2017 that was provided by Procurement Services.

During 2016-2017 there were 397 purchasing card audits performed. The audits were rated according to compliance with FGCU purchasing card procedures. Before employees are issued a purchasing card, they must undergo training and sign an agreement to abide by FGCU procedures. The 2016-2017 audits rated employees’ purchasing card compliance as follows:

- Excellent – 184
- Good – 184
- Fair – 27
- Poor – 2

No purchasing card privileges were revoked during this period.
2017-2018 AUDIT WORK PLAN

In conformance with BOG Reg. 4.002(6)(d), the Office of Internal Audit’s 2017-2018 Audit Work Plan was developed based on the results of a periodic risk assessment, and is being presented at the August 2017 Audit and Compliance Committee meeting for recommendation to approve at the September 2017 Board of Trustees meeting.

For comparative purposes, listed below is a three year history of audits by division:

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<td>Performance Measures Data Integrity</td>
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AUDIT FOLLOW-UP

As required by the Institute of Internal Auditors Standards, and BOG Reg. 4.002(6)(c), the chief audit executive must establish and maintain a system to monitor the disposition of results communicated to management. Additionally, the chief audit executive must establish a follow-up process to monitor and ensure that management actions have been effectively implemented or that senior management has accepted the risk of not taking action.

As a part of the audit process, management issues a response to each audit recommendation. Internal Audit requests that the management response include any proposed actions, a responsible party and the proposed implementation date. After the implementation date has passed, we ask management to provide an update of their progress. Follow-up inquiries are not made for reviews and audits with no observations.

Management responsible for the Office of Student Conduct Audit has implemented the recommendations stated in the 2015-2016 audit report. The recommendation included updating the Office of Student Conduct Procedural Manual and processes to reflect consistency with FGCU Regulations.

Management responsible for the Housing Maintenance Equipment and Supplies Audit have taken steps to improve their inventory count and reconciliation system in response to the 2015-2016 audit report.

Management from the Athletics department has updated their written procedures to consistently document any differences in employees’ recorded hours and to ensure employees are not assigned work responsibilities until Human Resource requirements have been met. They are also working with the Office
of Internships and Cooperative Program to meet the requirements for interns working in Athletics, as noted in our report.

The follow up process for the audits in the 2016-2017 year will be reported in the 2017-2018 Annual Report once the departments have had the opportunity to implement the recommendations in their respective audit reports.

PROFESSIONAL ACTIVITIES

The Institute of Internal Auditors professional standards require that our Office possess the knowledge, skills, and other competencies needed to perform our responsibilities. Members of our Office hold memberships in the following professional organizations to increase our knowledge to better serve FGCU and to pass our knowledge to others:

- Institute of Internal Auditors (IIA)
- Association of College and University Auditors (ACUA)
- Information Systems Audit and Control Association (ISACA)
- Association of Certified Fraud Examiners (ACFE)
- American Institute of Certified Public Accountants (AICPA)
- Florida Institute of Certified Public Accountants (FICPA)
- State University Audit Council (SUAC)

Currently, two (2) members of our office serve as Treasurer and President of the Southwest Florida Chapter #226 of the IIA. In October, 2016, I gave a 2 hour presentation to the IIA Chapter on “Self-Audit Techniques and Approaches” as part of a program of Continuing Professional Education (CPE). During 2016-2017, each staff member spent at least 40 hours improving their internal auditing skills and knowledge of higher education issues through CPE.

MANDATORY DISCLOSURES

Institute of Internal Auditors standards and BOG Reg. 4.002(5) require that Internal Audit regularly disclose the following information about its activities to the FGCU Board of Trustees and Senior Management.

Organizational Independence

The Office of Internal Audit (IA) confirms to the Board, at least annually, its organizational independence. IA reports administratively to the President and functionally to the Chair of the Audit and Compliance Committee of the FGCU Board of Trustees. Reporting to the Board helps promote the independence necessary for IA to perform its organizational function.

Impairments to Independence or Objectivity

If independence or objectivity is impaired in fact or appearance, the details of the impairment must be disclosed. IA had no impairments to independence or objectivity for any engagements performed during the 2016-2017 fiscal year.

Disclosure of Nonconformance

Occasionally circumstances require the completion of projects or engagements in a manner that is not consistent with Institute of Internal Audit standards. When this occurs, IA must disclose the nonconformance
and its impact to Senior Management and the Board. During the 2016-2017 fiscal year, there were no such instances.

**Resolution of Management’s Acceptance of Risks**

Each audit engagement can potentially produce items that may pose risks to university operations. Some items will require management’s attention while others may be situations in which management decides to accept the risk associated with continuing the current practice. This is normal and is often due to cost/benefit constraints. IA is required to disclose to Senior Management and the Board any situations in which it is believed University personnel have accepted a level of residual risk that may not adequately reduce or mitigate the risk of loss. There were no such instances during the 2016-2017 fiscal year.
Florida Gulf Coast University Board of Trustees
Audit and Compliance Committee
August 17, 2017

SUBJECT: 2017 Internal Audit Quality Assurance Review

PROPOSED COMMITTEE ACTION

Accept the 2017 Internal Audit Quality Assurance Review Report, and recommend its acceptance by the FGCU Board of Trustees.

BACKGROUND INFORMATION

To comply with Board of Governors Regulation 4.002(6)(e) and the International Standards for the Professional Practice of Internal Auditing, the Office of Internal Audit completed its Self-Assessment with External Independent Validation during July 2017. The Independent Validator issued her statement on July 19, 2017. She concurred fully with our self-assessment that the Internal Audit activity generally conforms to the Standards and Code of Ethics.

The Quality Assurance Review was part of the 2016-2017 internal audit work plan approved by the FGCU Board of Trustees at its June 7, 2016 meeting.

Supporting Documentation Included: Self-Assessment with Independent Validation of Florida Gulf Coast University’s Internal Audit Activity

Prepared by: Director of Internal Audit William Foster

Legal Review by: N/A

Submitted by: Director of Internal Audit William Foster
FLORIDA GULF COAST UNIVERSITY

SELF-ASSESSMENT WITH INDEPENDENT VALIDATION OF FLORIDA GULF COAST UNIVERSITY’S INTERNAL AUDIT ACTIVITY

MARCH 2017
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2. Risk Assessment Process Documentation

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ATTACHMENT B: INDEPENDENT VALIDATION STATEMENT
EXECUTIVE SUMMARY

The self-assessment team conducted a quality assessment of the Office of Internal Audit (OIA) activity of Florida Gulf Coast University (FGCU) in preparation for validation by an independent assessor. The principal objectives of the quality assessment were to assess the internal audit activity’s conformance to The Institute of Internal Auditors’ (IIA’s) International Standards for the Professional Practice of Internal Auditing (Standards), evaluate the internal audit activity’s effectiveness in carrying out its mission (as set forth in its charter and expressed in the expectations of Florida Gulf Coast University’s management), and identify opportunities to enhance its management and work processes, as well as its value to Florida Gulf Coast University.

OPINION AS TO CONFORMANCE WITH THE STANDARDS

It is our overall opinion that the internal audit activity generally conforms with the Standards and Code of Ethics. For a detailed list of conformance with individual Standards, please see Attachment A. The quality assessment team identified opportunities for further improvement, details of which are provided in this report.

The IIA’s Quality Assessment Manual suggests a scale of three ratings, “Generally Conforms,” “Partially Conforms,” and “Does Not Conform.” “Generally Conforms” means that an internal audit activity has a charter, policies, and processes that are judged to be in conformance with the Standards. “Partially Conforms” means deficiencies in practice are noted that are judged to deviate from the Standards, but these deficiencies did not preclude the internal audit activity from performing its responsibilities in an acceptable manner. “Does Not Conform” means deficiencies in practice are judged to be so significant as to seriously impair or preclude the internal audit activity from performing adequately in all or in significant areas of its responsibilities.

SCOPE AND METHODOLOGY

As part of the preparation for the quality assessment, the internal audit activity prepared an advanced preparation document with detailed information. The internal audit
activity’s risk assessment and audit planning processes, audit tools and methodologies, engagement and staff management processes, and a representative sample of the internal audit activity’s working papers and reports were also reviewed. The independent external assessor validated the work of the OIA’s self-assessment through review of assessment planning documents, re-performing a sample of assessment work program steps, conducting interviews with key stakeholders, and assessing the conformance conclusions reported by the OIA. See Attachment B for the Independent Validation Statement.

OBSERVATIONS

Part I: Recommendations

There were no recommendations made to Senior Management and the Internal Audit Activity to address nonconformance with a standard; however, process improvement opportunities are noted under Part III of this report.

Part II: Observations of Best Practices

1. Proficiency

All OIA staff are members of professional organizations including the Institute of Internal Auditors (IIA) and the Association of College and University Auditors (ACUA). More specifically, we are actively involved in the Institute of Internal Auditors’ Southwest Florida Chapter. The Interim Director served as Secretary during Fiscal Year 2015-16 and is currently the Vice President for Fiscal Year 2016-17. He is scheduled to become President of the Southwest Florida Chapter on June 1, 2017. All auditors attend the Chapter's meetings and seminars on a regular basis. These affiliations have allowed the personnel to remain current with emerging trends and issues.

The Interim Director earned three certifications and passed the CISA exam during FY2015-16. This contribution has increased the knowledge and skills inventory of the OIA. The Staff Auditor is currently studying for her Internal Audit Practitioner and Certified Internal Auditor certifications.
2. Computer-Assisted Audit Techniques

The OIA transitioned to a paperless system by acquiring the audit software *AutoAudit* in 2014. This software has allowed the department to document all audit work in a single, shared, secured system. The software has allowed OIA to improve both the quality and consistency of the audit work papers. Internal auditors can cross reference audit work with supporting files, automate report creation, track recommendations and actions plans, etc. The system keeps a log with the time and date of approval and review of work papers.

Additionally, the OIA acquired the license to use IDEA data analysis software and efforts are made to incorporate data analysis in audits when appropriate. Audit staff are encouraged to learn and take advantage of this powerful tool.

3. Audit Processes

OIA has incorporated into its routine practices the use of risk assessment memos, activity checklists, audit working paper reviews, post audit feedback surveys, and consulting with General Counsel for all audits. These tools have allowed for the enhanced efficiency, effectiveness and quality of the internal audit process, as well as improved compliance with the Standards.

4. Risk Management

Our staff regularly attends meetings held throughout the University to be cognizant of, and to better understand, changes to the regulatory, academic, and physical environment as well as Management initiatives that take place across campus. Such meetings include the Planning & Budget Council, Data Standards Meetings, and Auditor General entrance and exit meetings. Attendance at these meetings improves OIA awareness of potential risks that may exist or may emerge within the University. In addition, the OIA works with other departments to increase its staff members’ knowledge and understanding of other assurance activities throughout the University to minimize the duplication of audit efforts.
Part III: Observations of Process Improvement Opportunities

1. Update to Internal Audit Policies and Procedures

The Office of Internal Audit policies and procedures should be updated to include the following practices:

- On an annual basis, every member of the OIA Staff should read the Operations Manual and sign a written acknowledgment that they have reviewed and understood the information within the manual.

- The OIA should update its Operations Manual to document the policy emphasizing management’s support for obtaining professional certifications and participating in professional associations. Currently, these activities are performed to varying degrees by all members.

- The OIA should document in its Operations Manual the process of communicating to Senior Management the Office’s disagreement with operating management’s acceptance of risk from poor or nonexistent control processes disclosed by an audit, including possible escalation of these risks to the Audit Committee or the Board of Trustees.

- Internal Audit’s Quality Assurance and Improvement Program (QAIP) policy should receive an in-depth review and update to include a standardized internal self-assessment process, including the information that should be reported to the Board of Trustees in its Annual Report. The policy should include a detailed outline of the performance metrics currently used by the office, and other performance metrics to provide additional information.

2. Risk Assessment Process Documentation

The OIA Audit Plan is developed through the annual risk assessment process that includes consultation with the President, Senior Management and the Board; in particular, the Chair of the Audit Committee. The risk assessment process would benefit from a more formalized process and enhanced documentation from year to year. Moreover, the Audit Universe should be updated annually as a part of the risk assessment process to ensure completeness, i.e., the scope of auditable topics is applicable to the current University structure as disclosed in its organizational charts. The OIA has an existing audit universe that was last updated February 2015.
Jena Valeriotti, MBA
Internal Auditor
Team Leader

Viviana Lauke
Staff Auditor
Team Member

William D. Foster, MBA, CPA, CIA, CGAP, CFE, CRMA, CCSA
Interim Director, Internal Audit, Florida Gulf Coast University
Team Member
## ATTACHMENT A

### FLORIDA GULF COAST UNIVERSITY

Quality Assessment Evaluation Summary

(GC = Generally Conforms, PC = Partially Conforms, DNC = Does Not Conform)

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ATTACHMENT B
FLORIDA GULF COAST UNIVERSITY
Independent Validation Statement
Office of Internal Audit

Independent External Validation

Quality Assurance Review (QAR)

July 10-12, 2017

Reviewer:
Monica Moyer, MBA, CIA, CFE, CRMA, CCEP, CICA
Florida Gulf Coast University - Quality Assurance Review, Independent External Validation

July 19, 2017

To:  Mr. Joseph Fogg III, Audit and Compliance Committee Chair, FGCU Board of Trustees
     Dr. Michael Martin, President, Florida Gulf Coast University
     Mr. William Foster, Director of Internal Audit, Florida Gulf Coast University

Greetings:

I was engaged as the validator to conduct an Independent Validation of the Quality Self-Assessment (QA) of the Florida Gulf Coast University (FGCU) Office of Internal Audit Program as required every five years by the Institute of Internal Auditors International Standards for the Professional Practice of Internal Auditing (IIA Standards). The objectives of the QA were to:

1. Assess conformance with the IIA Standards;
2. Assess the effectiveness and efficiency of the Internal Audit activity in providing services to the Board of Trustees and management of Florida Gulf Coast University; and
3. To identify opportunities for improving the Internal Audit Program at Florida Gulf Coast University.

In acting as independent validator, I am fully independent of Florida Gulf Coast University and have the necessary knowledge and skills to undertake this engagement. The validation, conducted July 10, 2017 through July 17, 2017 consisted primarily of reviewing and testing the self-assessment documentation related to the FGCU self-assessment report issued March 2017. Additionally, I interviewed FGCU key administrators, current Chair of the FGCU Board of Trustees (BOT), and the current Chair of the Audit and Compliance Committee of the FGCU BOT. These interviews helped me gain a better understanding of the internal control environment within which FGCU’s internal auditing department operates. Overall, it is my opinion that FGCU’s Office of Internal Audit (IA) generally conforms to the IIA Standards, the highest rating available. I noted two (2) opportunities for improvement that may improve the efficiency and effectiveness of the Internal Audit Program that are described in this report.

Monica Moyer, MBA, CIA, CFE, CRMA, CCEP, CICA
Director of Internal Audit Services, Saint Leo University, Saint Leo, FL
# Florida Gulf Coast University - Quality Assurance Review, Independent External Validation

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Florida Gulf Coast University - Quality Assurance Review, Independent External Validation

Executive Summary

Organizationally, the Office of Internal Audit has a dual reporting structure, as per Florida Gulf Coast University (FGCU) Office of Internal Audit Charter which states in part, "To ensure organizational independence, the Director of Internal Audit shall report functionally to the Chair of the Audit and Compliance Committee of the FGCU Board of Trustees and administratively to the President."

The mission of FGCU’s internal audit office is: “Internal Audit is an independent assurance and consulting function designed to add value and improve the University’s operations. It assists Florida Gulf Coast University to accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.”

The consensus of senior leaders within Florida Gulf Coast University regarding the university’s Office of Internal Audit is that it is an effective, collaborative, professional, and well-managed function. The FGCU Office of Internal Audit is a respected internal audit operation among its audit and higher education peers as FGCU IA staff are engaged with many audit organizations including the IIA (Institute of Internal Auditors), ACFE (Association of Certified Fraud Examiners), ISACA (Information Systems Accountability and Control Association), ACUA (Association of College and University Auditors), and SUAC (State University Audit Council).

Chief Audit Executive (CAE), William Foster, Director of Internal Audit, was hired at FGCU in June 2014. In August 2014 he assumed the role of Senior Auditor. In November 2016, he became the Interim Director of Internal Audit and in May 2017 was named the Director of Internal Audit. William Foster has also been a champion for professional development by obtaining multiple audit-related certifications in the recent years as well as encouraging his staff to work towards certification designations. Mr. Foster is currently working towards the QIAL (Qualification in Internal Audit Leadership) designation. Mr. Foster is involved with The IIA Southwest Florida chapter as its President effective June 1, 2017. He is a member of the IIA, ACUA, ISACA, ACFE, and SUAC. He has an MBA from Xavier University. He holds the following certifications and credentials: CPA, CIA, CGAP, CFE, CRMA, and CCSA.

Appendix III is a capability model developed by the IIA that is designed for commercial enterprises. It is presented for informational purposes only. There are other models perhaps more suited to the University’s circumstances that could be used as a basis for discussion with senior management and the Audit Committee about the Internal Audit Program’s current and desired future state.
Conformance with IIA Standards

Generally Conforms means that internal audit has a charter, policies and processes that are judged to meet the spirit and intent of the IIA Standards with some potential opportunities for improvement.

Partially Conforms means deficiencies in practice are noted that are judged to deviate from the spirit and intent of IIA Standards, but these deficiencies did not preclude internal audit from performing its responsibilities in an acceptable manner.

Does Not Conform means deficiencies in practice are judged to be so significant as to seriously impair or preclude internal audit from performing adequately in all or in significant areas of its responsibilities.

Overall, the Florida Gulf Coast University Office of Internal Audit Program was judged to Generally Conform to IIA Standards, the highest rating available. While improvement opportunities remain in various areas, they did not preclude this assessment.

I concluded the following standards Generally Conform to the IIA Standards:

1000 — Purpose, Authority and Responsibility
1100 — Independence and Objectivity
1200 — Proficiency and Due Professional Care
1300 — Quality Assurance and Improvement Program
2000 — Managing the Internal Audit Activity
2100 — Nature of Work
2200 — Engagement Planning
2300 — Performing the Engagement
2400 — Communicating Results
2450 — Overall Opinions
2500 — Monitoring Progress
2600 — Communicating the Acceptance of Risk
IIA Code of Ethics

I did identify two (2) Opportunities for Continuous Improvement, although the improvements do not preclude my opinion that the FGCU OIA generally conforms to the IIA Standards:

2110 — Governance
2230 — Engagement Resource Allocation
Florida Gulf Coast University - Quality Assurance Review, Independent External Validation

Positive Attributes of the Internal Audit Program

- **Governance** - Florida Gulf Coast University CAE has dual reporting; functionally to the Board of Trustees Audit and Compliance Committee Chair, and administratively to the President. Briefing meetings are held between the FGCU CAE and BOT Audit and Compliance Committee prior to Audit and Compliance Meetings which evidences independence. Additionally, the CAE meets routinely with the President to discuss internal audit operations.

- **Reputation** - The FGCU Office of Internal Audit is well-regarded by senior leaders. The IA function is seen as collaborative; management feels comfortable seeking their opinion on problematic situations.

- **Professional Development** - All of the FGCU IA staff and are involved with various audit, fraud, and IT associations in varying capacities. The internal and staff auditors are working towards their CIA designations. Continuing professional education (CPE), although required to maintain most certifications, is a paramount value and goal with FGCU’s Office of Internal Audit. CPE offers the IA staff the opportunity to keep up-to-date with audit and industry trends, risks, regulations, best practices, and knowledge-sharing; all necessary items to keep the IA activity relevant.
Opportunities for Continuous Improvement

GENERALLY CONFORMS TO STANDARDS – ENHANCEMENTS

[Florida Gulf Coast University conforms to the IIA Standards noted below; the items presented are suggested enhancements to the internal auditing operations.]

**Observation (1)** Value Added: IIA formal definition of Internal Auditing and standard 2110 discuss the expectation of value added by the internal audit function. Specifically, the definition of internal auditing, as defined by the IIA states, “Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organization’s operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.” Standard 2110 states, in part, “coordinating the activities of and communicating information among the board, external and internal auditors, and management.”

I believe Florida Gulf Coast University’s Internal Auditing Services are adding value to the institution in their work; however, I believe more value can be added with an expanded interaction with senior leadership. Standard 2110 states, in part, that Internal Auditors need to be effective in “coordinating the activities of and communicating information among the board … and management.”

Currently, the CAE does not regularly meet with some senior leaders unless an audit engagement impacts their areas or to obtain input for the annual risk assessment process. The CAE has not had the opportunity to be a part of the President’s Cabinet Meetings.

**Recommendation** The QAR validator recommends that the FGCU CAE enhance the communication with FGCU senior management through increased interaction between the CAE and the FGCU senior leadership team in order that all parties be apprised of critical activities/events on the horizon for FGCU. Specifically, as a best practice, the CAE should make periodic presentations to the President’s Cabinet to include, but not limited to: annual enterprise risk assessment, the annual audit plan, updates on the annual audit plan, high and moderately high risks identified within audits particularly if a theme occurs, repeat audit findings, and follow up progress.

**Response by CAE** I concur with the recommendation of the external reviewer and appreciate the opportunity for improvement.
Observation (2) Engagement Resource Allocation: Standard 2230 addresses the appropriate resources. Specifically, standard 2230 states, “Internal auditors must determine appropriate and sufficient resources to achieve engagement objectives based on an evaluation of the nature and complexity of each engagement, time constraints, and available resources.” Furthermore, standard 1210.A3 states, “Internal auditors must have sufficient knowledge of key information technology risks and controls and available technology-based audit techniques to perform their assigned work. However, not all internal auditors are expected to have the expertise of an internal auditor whose primary responsibility is information technology auditing.” Additionally, standard 2030 states “The chief audit executive must ensure that internal audit resources are appropriate, sufficient, and effectively deployed to achieve the approved plan.”

Concern was expressed to the QAR validator regarding the lack of IT audit resources. Currently, the IT Auditor position is vacant with no definitive plan to fill it. The CAE recently passed the CISA (Certified Information System Auditor) exam, yet lacks IT audit experience to fill the IT audit gap.

Please note: The OIA has engaged Mauldin & Jenkins to perform the testing related to the Performance Metrics Data Audit. The QAR validator feels that the Performance Based Funding Data Integrity Audit is appropriately resourced and managed.

Recommendation: The QAR validator recommends that the FGCU CAE fills the IT audit position. The addition of an IT Auditor to the OIA will provide an additional skill to appropriately ensure IT risks are assessed and addressed. The IT auditor can be incorporated into all non-IT audits for IT-related matters.

Response by CAE: I concur with the recommendation of the external reviewer and appreciate the opportunity for improvement, although current budgetary constraints may not permit the addition of an IT Auditor at this time.

***
Florida Gulf Coast University - Quality Assurance Review, Independent External Validation

Appendices

Appendix I - Engagement Methodology
Review procedures included:

- Review of background/organizational materials regarding Florida Gulf Coast University and the Office of Internal Audit
- Review of the Office of Internal Audit Charter
- Review of QA advance preparation materials providing background on the internal auditing program and practices
- Review of the annual audit plan and its development process
- Review of selected internal audit project work papers and reports
- Review of training histories for staff
- Interview with FGCU BOT current Audit and Compliance Committee Chair
- Interview with FGCU BOT Chair (former Audit Committee Chair)
- Interview with FGCU senior management
- Interviews with FGCU IA CAE and staff
- Review of audit follow-up practices and reporting of follow-up activities
- Review of prior quality assessment reports
Appendix II - List of Stakeholders Interviewed

Board of Trustees
Mr. J. Dudley Goodlette, Board of Trustees Chair, Florida Gulf Coast University
Mr. Joseph Fogg III, Board of Trustees Audit and Compliance Committee Chair, Florida Gulf Coast University

Senior FGCU Management
Dr. Michael Martin, President
Dr. Wilson Bradshaw, former President
Dr. Ronald Toi, Provost and Vice President for Academic Affairs
Mr. Steve Magiera, Vice President for Administrative Services and Finance and Executive Director of FGCU Financing Corp.
Ms. Susan Evans, Vice President and Chief of Staff and University Spokesperson
Ms. Vee Leonard, Vice President and General Counsel
Dr. J. Michael Rollo, Vice President for Student Affairs
Mr. Christopher Simoneau, Vice President for University Advancement and Executive Director of FGCU Foundation

FGCU Internal Audit Team
Mr. William Foster, Director of Internal Audit and Chief Audit Executive
Ms. Jena Valerioti, Internal Auditor
Ms. Viviana Lauke, Staff Auditor
Ms. Carol Slade, Internal Auditor
# Florida Gulf Coast University - Quality Assurance Review, Independent External Validation

## Appendix III – The IIA Research Foundation – Internal Audit Capability Model Matrix

<table>
<thead>
<tr>
<th>Level 5 – Optimizing</th>
<th>Level 4 – Managed</th>
<th>Level 3 – Integrated</th>
<th>Level 2 – Infrastructure</th>
<th>Level 1 – Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services and Role of IA</td>
<td>People Management</td>
<td>Professional Practices</td>
<td>Performance Management and Accountability</td>
<td>Organizational Relationships and Culture</td>
</tr>
<tr>
<td>IA Recognized as Key Agent of Change</td>
<td>Leadership Involvement with Professional Bodies</td>
<td>Continuous Improvement in Professional Practices</td>
<td>Public Reporting of IA Effectiveness</td>
<td>Effective and Ongoing Relationships</td>
</tr>
<tr>
<td>Overall Assurance on Governance, Risk Management, and Control</td>
<td>IA Contributes to Management Development</td>
<td>Audit Strategy Leverages Organization’s Management of Risk</td>
<td>Integration of Qualitative and Quantitative Performance Measures</td>
<td>CAE Advises and Influences Top-level Management</td>
</tr>
<tr>
<td>Competency Development</td>
<td>IA Activity Supports Professional Bodies</td>
<td>Audit Planning and Risk Management</td>
<td>Quality Management Framework</td>
<td>Performance Measures</td>
</tr>
<tr>
<td>Workforce Planning</td>
<td>Workforce Planning</td>
<td>Risk-based Audit Plans</td>
<td>Cost Information</td>
<td>IA Management Reports</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level 3 – Integrated</th>
<th>Level 2 – Infrastructure</th>
<th>Level 1 – Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advisory Services</td>
<td>Compliance Auditing</td>
<td>Ad hoc and unstructured; isolated single audits or reviews of documents and transactions for accuracy and compliance; outputs dependent upon the skills of specific individuals holding the position; no specific professional practices established other than those provided by professional associations; funding approved by management, as needed; absence of infrastructure; auditors likely part of a larger organizational unit; no established capabilities; therefore, no specific key process areas</td>
</tr>
<tr>
<td>Performance/Value-for-Money Audits</td>
<td>Individual Professional Development</td>
<td>Skilled People Identified and Recruited</td>
</tr>
<tr>
<td>Team Building and Competency</td>
<td>Professional Practices and Processes Framework</td>
<td>Audit Plan Based on Management/ Stakeholder Priorities</td>
</tr>
<tr>
<td>Professionally Qualified Staff</td>
<td>Audits and Processes Framework</td>
<td>IA Operating Budget</td>
</tr>
<tr>
<td>Workforce Coordination</td>
<td>IA Business Plan</td>
<td>Managing within the IA Activity</td>
</tr>
<tr>
<td>Coordination with Other Review Groups</td>
<td>Full Access to the Organization’s Information, Assets, and People</td>
<td></td>
</tr>
<tr>
<td>Management Oversight of the IA Activity</td>
<td>Reporting Relationship Established</td>
<td>11</td>
</tr>
</tbody>
</table>
Appendix IV - Biography of Reviewer

Monica Moyer, MBA, CIA, CFE, CRMA, CCEP, CICA, is the Director of Internal Audit and Advisory Services for Saint Leo University in west central Florida. She holds a bachelor of fine arts in Public Relations from Wayne State University, a bachelor of science in Accounting from Cleary University, and a master in Business Administration from Saint Leo University. Monica has over 20 years of both internal audit and accounting/finance experience in the industries of higher education, health care, insurance, and logistics. Monica successfully completed The Institute of Internal Auditors "Performing an Effective Quality Assurance" training. Recently, Monica has performed and/or led external QAR validations for Georgia State College and University, Indiana Wesleyan University, the University of Calgary, and Wayne State University. Monica has performed QAR self-assessments and has received a "generally conforms" opinion regarding her audit function from her 2014 external QAR. Monica’s professional activities include serving as the ACUA annual conference director (2014-2017), track coordinator, proctor, IA Awareness committee member, Membership committee member, speaker/presenter, and mentor. Monica has been involved with the IIA as an international ambassador and is a member of the ACFE, SCCE (Society of Corporate Compliance and Ethics), ISACA, and IIC (The Institute for Internal Controls). Monica is a national competition judge for the FBLA (Future Business Leaders of America).

*******

I appreciate the opportunity to be of service to Florida Gulf Coast University and the courtesies and cooperation extended to me during this review.
ITEM: __4__

Florida Gulf Coast University Board of Trustees
Audit and Compliance Committee
August 17, 2017

SUBJECT:  2017-2018 Internal Audit Work Plan

PROPOSED COMMITTEE ACTION

Approve the 2017-2018 Internal Audit Work Plan, and forward it to the FGCU Board of Trustees for final approval.

BACKGROUND INFORMATION

To comply with Board of Governors Regulation 4.002 (State University System Chief Audit Executives), “each university shall have an office of chief audit executive as a point for coordination of and responsibility for activities that promote accountability, integrity, and efficiency in the operations of the university.” FGCU’s chief audit executive is the Director of Internal Audit who must develop, at least annually, audit plans that are communicated to the President and submitted to the FGCU Board of Trustees for approval.

The same regulation requires that, upon approval of the Work Plan by the FGCU Board of Trustees, a copy of the plan will be provided to the Board of Governors.

Supporting Documentation Included: 2017-2018 Internal Audit Work Plan

Prepared by: Director of Internal Audit William Foster

Legal Review by: N/A

Submitted by: Director of Internal Audit William Foster
Florida Gulf Coast University
Office of Internal Audit
DRAFT 2017-2018 Audit Work Plan

AUDITS
Objectives may be adjusted as we obtain additional information and/or conditions change relative to risk.
Project objectives appear under audit name.

Academic Camps
Determine whether FGCU Academic Camps, Conferences, or similar programs were conducted in compliance with applicable state statutes, university policies and procedures, and other applicable guidelines.
Determine whether additional guidelines, policies or procedures are needed to provide the necessary control policies to govern these activities.
Determine whether appropriate fees and revenues are collected in accordance with university procedures and guidelines, and sound business practices.

Performance Measures Data Integrity Audit
Determine whether there are effective internal controls, processes, and procedures to ensure the completeness, accuracy, and timeliness of data submissions to the BOG, which support performance measures funding.
Audit testing will be outsourced. Review and assistance will be provided by Internal Audit staff.

International Services - Outgoing Students and Faculty
Determine whether there are documented policies and procedures to maintain the security of students and faculty abroad.
Determine whether the impact of Import/Export controls has been addressed with policies and procedures, monitoring compliance, and the existence of a training and awareness program.
Determine whether there are policies and procedures that require documentation of exchange rates and that travelers are trained regarding such requirements.
Determine whether study abroad programs are monitored for federal regulation that restrict study abroad.

Information Technology Security - Board of Governors Regulation 3.0075
Determine whether FGCU has appointed an Information Security Manager (ISM) and whether that is reflected in the employee's position description.
Determine whether the University has developed and annually reviews and update an information security plan.
Determine whether the information security risk management program include risk/self assessment components.
Determine whether documented procedures for reporting and handling security violations and the consequences for violating security policies and procedures exist.
Determine whether processes for verifying adherence to the information security plan policies and procedures are in operation.

OTHER ON-GOING ACTIVITIES
Management Assistance, investigations, and special projects as requested.

Follow-up of management’s actions in response to audit recommendations.
Responses to requests for information from external auditors.

DRAFT

Prepared by William Foster, Director of Internal Audit 07/26/17
Recommended for Approval by President Mike Martin, 07/28/17
and Audit and Compliance Committee Chair Joseph Fogg III, xx/xx/17
SUBJECT: 2016-2017 Compliance and Ethics Office Annual Report

PROPOSED COMMITTEE ACTION

Accept the 2016-2017 Compliance and Ethics Office Annual Report, and recommend its acceptance by the FGCU Board of Trustees.

BACKGROUND INFORMATION

To comply with Board of Governors Regulation 4.003 (State University System Compliance and Ethics Programs), FGCU's BOT must implement a university-wide compliance and ethics program that promotes ethical conduct and maximizes compliance with applicable laws, regulations, rules, policies, and procedures. The BOT designates a senior level administrator as the Chief Compliance Officer. The Chief Compliance Officer submits a report, on at least an annual basis, to the FGCU BOT on the effectiveness of the compliance and ethics program. Upon approval of the annual report by the FGCU BOT, a copy is provided to the Board of Governors.


Prepared by: Chief Compliance and Ethics Officer Stacey Chados

Legal Review by: N/A

Submitted by: Chief Compliance and Ethics Officer Stacey Chados
FLORIDA GULF COAST UNIVERSITY

FY 2016-2017 REPORT
Compliance and Ethics Office
MEMORANDUM

August 17, 2017

To: Joseph G. Fogg III, Trustee and Chair Audit and Compliance Committee, FGCU BOT

From: Stacey P. Chados, Chief Compliance and Ethics Officer

RE: 2016-2017 Annual Status of Activities

Attached, please find the annual activity report for the Compliance and Ethics Office for fiscal year 2016-2017. The Office was established in late October 2016; accordingly, this report covers the eight-month period November 2016 through June 2017.

Florida Gulf Coast University’s (FGCU’s) compliance and ethics program is modeled on the seven elements of an effective compliance and ethics program as contained in Chapter 8 of the Federal Sentencing Guidelines. An effective program demonstrates due diligence in preventing and detecting criminal conduct, unethical behavior, and noncompliance with rules, as well promoting an organizational culture that encourages ethical conduct and a commitment to compliance. Following is a summary of the seven elements.

1. Code of Conduct
   Promote responsibility and accountability for ethical conduct and compliance with applicable federal, state, and local laws and regulations.

2. Governance Framework
   Appoint knowledgeable individuals responsible for developing and implementing a comprehensive compliance and ethics program.

3. Training and Education
   Educate the FGCU community on its compliance responsibilities, regulatory obligations, and the university compliance and ethics program.

4. Communication
   Create communication pathways that allow for the dissemination of education and regulatory information and provide a mechanism for reporting concerns, without fear of retaliation.
5. **Monitoring and Auditing**
   Assess, evaluate, monitor, and audit compliance with regulatory requirements and university regulations and policies.

6. **Incentives and Discipline**
   Promote the compliance and ethics program as well as the consequences for noncompliance.

7. **Respond to Detected Offenses**
   Timely review allegations of wrongdoing, take corrective actions, and implement effective internal controls to prevent further similar misconduct from occurring.

The attachment outlines the Compliance and Ethics Office accomplishments based on the seven elements.

I am committed to working with the President and Cabinet to ensure that FGCU recruits and retains top quality faculty and staff, fosters a satisfying and productive work environment, builds and sustains its reputation within southwest Florida, encourages open discussion of ethical issues, and aligns the work efforts of its employees with the mission, vision, and guiding principles of the university.

In addition, I look forward to training faculty and staff on the benefits of a compliance and ethics program and to encourage employees to bring forward matters of ethical import in order to sustain a culture of compliance and a commitment to integrity.

If you have any questions regarding this Memorandum, please contact me at (239) 590-1039 or schados@fgcu.edu.

Attachment:
Background

Introduction
In accordance with Board of Governors (BOG) Regulation 4.003, State University System Compliance and Ethics Programs, the Chief Compliance and Ethics Officer has prepared this annual report to summarize the office’s activities for the 2016-2017 fiscal year. This report is submitted to the FGCU Board of Trustees (BOT) through the Chair of the Audit and Compliance Committee. Upon approval of the report by the FGCU BOT, a copy of the report is provided to the BOG.

Authority
BOG Regulation 4.003 requires the FGCU BOT to implement a university-wide compliance and ethics program that promotes ethical conduct and maximizes compliance with applicable laws, rules, regulations, and policies.

Mission
The mission of FGCU’s Compliance and Ethics Office is to assist FGCU with promoting an organizational culture that encourages ethical conduct and a commitment to compliance.

Scope of Work
The scope of work for the Compliance and Ethics Office is to:
- Encourage and support ethical behavior, a culture of integrity, and a commitment to compliance into all facets of the University;
- Provide University stakeholders with a reporting mechanism to bring forward good-faith concerns of wrongdoing, without fear of retaliation;
- Respond to employee inquiries about compliance and ethics-related matters and assist employees with understanding University policies and regulations, as well as state and federal laws and rules pertaining to compliance and ethics;
- Disseminate and communicate information about compliance and ethics-related laws, rules, regulations, and policies;
- Conduct ongoing oversight of compliance with the laws, rules, regulations, and policies;
- Identify and evaluate risks critical to the University and ensure that the risks are properly managed by the appropriate University component;
- Administer and coordinate a compliance and ethics training program;
- Chair a compliance committee to collaborate with and provide proactive guidance for University employees responsible for compliance functions;
FLORIDA GULF COAST UNIVERSITY
2016-2017 COMPLIANCE AND ETHICS OFFICE ACTIVITY

Attachment
Page 2 of 4

- Chair an investigations working group to triage concerns received through the University's hotline to ensure consistent and appropriate responses to good-faith concerns; and
- Review and advise management on conflict of interest issues and critical institutional risks.
**FLORIDA GULF COAST UNIVERSITY**

**2016-2017 COMPLIANCE AND ETHICS OFFICE ACTIVITY**

<table>
<thead>
<tr>
<th>1. Code of Conduct</th>
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<tbody>
<tr>
<td>✓ Drafted a Regulation on the Code of Ethics</td>
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<tr>
<td>✓ Drafted a Compliance and Ethics Program Plan</td>
</tr>
<tr>
<td>✓ Drafted a Code of Conduct for university employees</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Governance Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Prepared a Charter for the Compliance and Ethics Office</td>
</tr>
<tr>
<td>✓ In collaboration with Internal Audit, prepared an Audit and Compliance Committee Charter for the Board of Trustees</td>
</tr>
<tr>
<td>✓ Established a Compliance Liaison Group to discuss new and supplemental changes to federal and state rules and regulations, as well as university regulations and policies; and to stay abreast of best practices in the higher education compliance sector</td>
</tr>
<tr>
<td>✓ Established an Investigations Working Group to triage concerns, ensure timely reviews of concerns, and provide a consistent institutional response to concerns</td>
</tr>
<tr>
<td>✓ Met with each member of the Board of Trustees to introduce the compliance and ethics program</td>
</tr>
<tr>
<td>✓ Met with each member of the President’s Cabinet to introduce the compliance and ethics program and understand compliance concerns at the vice president level</td>
</tr>
<tr>
<td>✓ Met with each university Director responsible for carrying out compliance-related responsibilities for a specific program or function within the university to introduce the compliance and ethics program and understand specific responsibilities and concerns</td>
</tr>
</tbody>
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<tr>
<th>3. Training and Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Provided overview of ethics and compliance program to President’s Cabinet</td>
</tr>
<tr>
<td>✓ Provided overview of ethics and compliance program to FGCU Senate and SAC</td>
</tr>
<tr>
<td>✓ Incorporated ethics and compliance material, including information about the FGCU Hotline, into the new hire orientation</td>
</tr>
<tr>
<td>✓ Office of Institutional Equity and Compliance provided training to all supervisors on workplace conduct</td>
</tr>
<tr>
<td>✓ Environmental Health and Safety conducted Basic Safety training for new hires and Laboratory Safety for certain students, faculty, and staff</td>
</tr>
<tr>
<td>✓ Human Resources conducted orientation training for all new hires</td>
</tr>
<tr>
<td>✓ Attended and participated in all training sessions of the SUS Compliance and Ethics Consortium sponsored by the BOG Inspector General</td>
</tr>
<tr>
<td>✓ Attended the Higher Education Compliance Conference sponsored by the Society of Corporate Compliance and Ethics as well as participated in live webinars to maintain professional certifications</td>
</tr>
</tbody>
</table>
# FLORIDA GULF COAST UNIVERSITY
## 2016-2017 COMPLIANCE AND ETHICS OFFICE ACTIVITY

### 4. Communication
- Disseminated correspondence about the EthicsPoint Hotline to all university employees
- Displayed posters about the Hotline in all campus buildings
- Developed an index card with information about Hotline and investigations contacts for distribution to all employees
- Developed website page for the Compliance and Ethics Office

### 5. Monitoring and Auditing
- Developed a compliance matrix to identify all federal higher education compliance requirements
- Developed a risk assessment matrix to assess high risk areas
- Researched Conflict of Interest Disclosure Forms
- Assisted Office of Research/Sponsored Programs with amending guidelines for Responsible Conduct of Research
- Received and responded to 13 inquiries regarding conflicts of interest and other matters.
- Developed a database to track and trend inquiries.

### 6. Incentives and Discipline
- Worked with HR to incorporate conformance with Regulation on Ethics and Code of Conduct into job descriptions to allow supervisors to reward ethics and integrity. This action will occur upon approval of the Regulation and Code by the FGCU BOT.
- Recommended to the appropriate authorities consistent discipline for substantiated employee misconduct.
- Discussed sensitive case information with President and Chair of Audit and Compliance Committee

### 7. Respond to Detected Offenses
- Received 9 concerns through the EthicsPoint Hotline, of which 5 were reviewable and 4 did not contain specific enough information to warrant a review. Of the 5 cases that were reviewable, 3 cases were not substantiated, 1 case was partially substantiated, and 1 case was ongoing at June 30, 2017.
- Office of Institutional Equity and Compliance processed 112 matters, of which 72 were classified as inquiries; 23 were classified as an investigation resolved through an informal resolution; 9 were classified as an investigation with a finding of insufficient evidence; 6 were classified as an investigation with a finding of sufficient evidence; and 2 were classified as ongoing investigations at June 30, 2017.
- Served as the administrator for the FGCU Hotline, including review and triage of all concerns; monitor concerns, and compile and trend data for reporting to FGCU BOT.
- Provided recommendations for corrective actions and improvements of ethical conduct to appropriate authorities.
SUBJECT: Discussion of Whistleblower Procedures

PROPOSED COMMITTEE ACTION

Information Only

BACKGROUND INFORMATION

Committee Chair Fogg requested discussion of Whistleblower procedures. To facilitate the discussion, the following documents are being provided to the Committee:

- FGCU Regulation on Whistleblower Protection
- FGCU Policy Against Fraudulent or Other Dishonest Acts
- BOG Regulation on Processes for Complaints of Waste, Fraud, or Financial Mismanagement
- BOG Regulation on Chief Audit Executives
- BOG Regulation on Compliance and Ethics Programs
- Florida Statutes 112.3187-112.31895 collectively cited as the “Whistleblower’s Act”

Supporting Documentation Included: As detailed in the Background Information section, above.

Prepared by: Chief Compliance and Ethics Officer Stacey Chados

Legal Review by: N/A

Submitted by: Chief Compliance and Ethics Officer Stacey Chados and Director of Internal Audit William Foster
FLORIDA GULF COAST UNIVERSITY REGULATION

Regulation Number: 1.006
Regulation Title: Whistle-blower Protection
Effective Date: 09/13/16

A. GENERAL STATEMENT

Florida Gulf Coast University (“University”) employees have a responsibility to be good stewards of the public resources that have been entrusted to the University’s care. The University and its employees are to behave ethically and to abide by all applicable laws, regulations, rules, and policies. The University takes seriously any allegation of fraud, criminal conduct, mismanagement, misrepresentation, or other dishonest acts. To that end, the University shall provide “Whistle-blower” protection from retaliatory action for its employees, former employees, or applicants for employment who report violations affecting the University’s resources and assets and that create a substantial and specific danger to the public’s health, safety, or welfare. The University shall also protect from retaliatory action any person who discloses information alleging improper use of one’s position, gross waste of funds, or any other gross neglect of duty on the part of a University employee.

B. DEFINITIONS

1. Whistle-blower: An employee, former employee, or an applicant for employment who discloses information of any activity that is a violation or suspected violation of law by an employee or agent of the University which creates and presents a substantial and specific danger to the public’s health, safety, or welfare. The information disclosed must also include an act or suspected act of gross mismanagement, malfeasance, misfeasance, gross waste of public funds, or gross neglect of duty committed by an employee or agent of the University.

2. Gross mismanagement: Substantial risk of significant adverse impact on the University’s mission.

3. Malfeasance: An act by an University employee or agent that is legally unjustified, harmful, or contrary to law.

4. Misfeasance: An act that is not illegal but is improperly performed. It is a failure to discharge University legal obligations.

5. Gross waste of public funds: The use of funds is significantly out of proportion to the benefit received.

6. Gross neglect of duty: A dereliction of duty that endangers the welfare of the
University or an arbitrary decision for personal gain and/or to injure others.

7. **Complainant**: A Complainant is a person alleging a violation under this Regulation.

C. **UNIVERSITY OFFICIAL CONTACT**

   Allegations of activities such as, but not limited to, bribery, asset misappropriations, and fraudulent financial and/or non-financial statements should be reported to the University’s Director of Internal Auditor or through the University’s reporting hotline.

D. **WHISTLE-BLOWER DETERMINATION PROTOCOL**

   When a complaint is filed, it will be filed with the Director of Internal Audit (Director). The Director will coordinate all activities of the University covered under the Whistle-blower’s Act. A determination of the status of a Complainant as a Whistle-blower will be completed within the time limits required by law.

E. **DISCIPLINARY PROCEDURES**

   Retaliation against a Whistle-blower, once established, shall result in employee disciplinary action against the retaliator pursuant to University Regulations and any applicable collective bargaining agreement. University agents found to have violated this Regulation will receive sanctions or other disciplinary actions consistent with law and/or contract.

---

*Action by Florida Gulf Coast University Board of Trustees*

   Approved 09/13/16

*Specific Authority*

   §112.3187-112.31895, F.S.

*History of Regulation*

   New 09/13/16
I. POLICY STATEMENT

Florida Gulf Coast University employees and entities doing business with the University have a responsibility to be good stewards of the public resources that have been entrusted to the University’s care. As good stewards, employees both of the University and of entities doing business with the University are to behave ethically and to abide by all applicable laws, regulations, rules and policies.

University employees and agents are required to report any suspected act of fraud, criminal conduct, mismanagement or misrepresentation to the appropriate supervisor, administrator, vice-president, or to the Office of Internal Audit.

Any employee who is found to have participated in or failed to report fraudulent or other dishonest acts may be subject to disciplinary action.

II. REASON FOR POLICY

The University must be a good steward of the public resources that have been entrusted to its care. Adherence to a Code of Ethics, safeguarding of resources, and compliance with laws, rules, regulations, and policies by University employees and entities doing business with the University provide stewardship and accountability for the University’s public resources.

Generally, University employees and contractors abide by laws and regulations; however, incidents of fraudulent or other dishonest acts may occur. The University does not tolerate fraud, criminal conduct, mismanagement, or misrepresentations. This policy provides a process for reporting suspected fraudulent or other dishonest activities and defines relevant terms.

III. PROCEDURES

All University employees are expected to observe the provisions of the Code of Ethics for Public Officers and Employees, Part III of Chapter 112, Florida Statutes.
Administrators at all levels of management should set the appropriate tone by displaying the proper attitude towards the resources entrusted to the University. The appropriate tone includes but is not limited to ethical behavior and compliance with laws, regulations, rules and policies. Administrators and management also are responsible for establishing and maintaining proper internal controls to provide for the security and accountability of resources entrusted to them. In addition, administrators should be cognizant of inherent risks and exposures in their areas of responsibility, and be aware of possible symptoms of fraudulent and other dishonest acts.

Employees and other individuals who have a reasonable basis for believing that fraud, mismanagement or misrepresentation has occurred must report it to his or her supervisor, to the appropriate administrator or vice-president, or to the Director of Internal Audit. However, individuals who observe a criminal act in progress, such as theft or destruction of property, or who have reasonable suspicion that a criminal act has been committed, should immediately report the suspected criminal activity to the University Police or, if the activity occurs off-campus, other law enforcement agency. They should not confront the individual in question (being observed) but allow the law enforcement agency to handle the matter.

Supervisors and administrators at all levels of management who become aware of suspected fraudulent and dishonest activity should report the suspected activity to the appropriate Vice President, Senior Administrator, Director of Internal Audit, or Campus Police. The President has designated the Office of Internal Audit as the official contact for reporting suspected fraudulent or other dishonest acts. It is the responsibility of the Office of Internal Audit to investigate or direct to the proper agency for handling, allegations of fraudulent, other dishonest acts, or any other acts covered under this policy. Employees shall not confront the individual being investigated, or initiate investigations on their own, as such actions can compromise any ensuing investigation.

The constitutional rights of all persons are to observed during all aspects of an investigation. Employees are required to cooperate with any police or audit investigation, and the employee may be requested to keep their knowledge of an investigation confidential as permitted by Florida Statutes.

The Whistle-blower’s Act, Section 112.3187, F.S., provides protection from retaliatory action for employees of the University who report suspected fraudulent or other dishonest acts, and for employees who cooperate with an ensuing investigation. The University’s Director of Internal Audit is the University’s official contact for reporting suspicious activities under the Whistle-blower’s Act. Information about the Whistle-blower’s Act is available from the Office of Internal Audit, from the Internal Audit website or Sections 112.3187 and 112.3188 of the Florida Statutes.
Employees found to have participated in or failed to report a fraudulent or other dishonest act, may be subject to disciplinary action pursuant to a collective bargaining agreement or University regulation. Criminal or civil actions may also be taken against employees or other individuals who participate in criminal or other dishonest acts.

IV. HISTORY

This is the first policy to address the subject matter.

V. APPENDICES

Florida Statutes:

- Part III, Chapter 112, F.S., Code of Ethics for Public Officers and Employees
- Section 1001.74, Powers and Duties of University Boards of Trustees
- Appendix A

APPROVED

*s/Wilson G. Bradshaw

President

July 24, 2008

Date

*Note: This policy reflects changes to the formatting only. No changes have been made to the text.
EXHIBIT “A”

EXAMPLES OF OCCUPATIONAL FRAUD AND ABUSE

I. Corruption
   a. Conflicts of Interest: Purchasing Schemes, Sales Schemes, Other
   b. Bribery: Invoice Kickbacks, Bid Rigging, Other
   c. Illegal Gratuities
   d. Economic Extortion

II. Asset Misappropriation
   a. Cash
      i. Larceny of Cash on Hand, from the Deposit, Other
      ii. Fraudulent Disbursements
      iii. Billing Schemes, Ghost Employees, Commission Schemes,
           Workers Compensation, Falsified Wages
      iv. Payroll Schemes: Ghost Employees, Commission Schemes,
          Workers Compensation, Falsified Wages
      v. Expense Reimbursement: Mischaracterized Expenses, Overstated
         Expenses, Fictitious Expenses, Multiple Reimbursements
      vi. Check Tampering: Forged Marker, Forged Endorsement, Altered
          Payee, Concealed Checks, Authorized Marker
      vii. Register Disbursements: False Voids, False Refunds
      viii. Skimming
          1. Sales: Unrecorded, Understated
          2. Receivables: Write-Off Schemes, Lapping Schemes,
             Unconcealed
          3. Refunds and Other
   b. Inventory and All Other Assets
      i. Misuse
      ii. Larceny: Asset Requisition and Transfer, False Sales and
         Shipping, Purchasing and Receiving, Unconcealed Larceny

III. Fraudulent Statements
   a. Financial
      i. Asset/Revenue Overstatement: Timing Differences, Fictitious
         Revenues, Concealed Liabilities and Expenses, Improper
         Disclosure, Improper Asset Valuations
      ii. Asset/Revenue Understatements
   b. Non-Financial
      i. Employment Credentials
      ii. Internal Documents
      iii. External Documents

Source: Association of Certified Fraud Examiners, Report to the Nation on Occupational Fraud and Abuse, 1999
4.001 University System Processes for Complaints of Waste, Fraud, or Financial Mismanagement

(1) The Office of Inspector General and Director of Compliance (OIGC) for the State University System of Florida Board of Governors shall be organized to promote accountability, efficiency, and effectiveness, and to detect fraud and abuse within state universities. The OIGC charter is incorporated herein by this reference.

(2) Each board of trustees shall have a process for university staff, faculty, students, and board of trustees members to report allegations of waste, fraud, or financial mismanagement to the university chief audit executive.

(3) Significant and credible allegations are those that, in the judgment of the chief audit executive, require the attention of those charged with governance and have indicia of reliability. For significant and credible allegations of waste, fraud, or financial mismanagement within the university and its board of trustees’ operational authority, the chief audit executive shall timely provide the OIGC sufficient information to demonstrate that the board of trustees is both willing and able to address the allegation(s). If the information provided by the chief audit executive does not clearly demonstrate that the board of trustees is both willing and able to address the allegation(s), then the OIGC will conduct a preliminary inquiry in accordance with section 10.2.a of the OIGC charter.

(4) Upon the OIGC’s receipt of a complaint, the OIGC will evaluate the nature of the allegation(s) to determine operational authority, proper handling, and disposition. University-related allegations will be handled as described below:

(a) Such allegations will be referred to the university chief audit executive for appropriate action without regard to the final responsible entity at the university. As appropriate, a copy of the referral will be provided to the chief compliance officer and general counsel. For significant and credible allegations of waste, fraud, or financial mismanagement, the chief audit executive shall provide the OIGC with university action and final case disposition information sufficient to demonstrate that the board of trustees was both willing and able to address such allegations.

(b) When case disposition information does not clearly demonstrate that the board of trustees was both willing and able to address significant and credible allegation(s), then the OIGC will conduct a preliminary inquiry in accordance with section 10.2.a of the OIGC charter.

(5) Each board of trustees shall adopt a regulation which requires timely notification to the Board of Governors, through the OIGC, of any significant and credible allegation(s) of fraud, waste, mismanagement, misconduct, and other abuses made
against the university president or a board of trustees member. Such allegations will be handled as follows:

(a) The chair of the board of trustees (or chair of the board of trustees’ committee responsible for handling audit matters if the allegations involve the board chair), in consultation with the chair of the Board of Governors, shall review the matter and may ask the OIGC to conduct a preliminary inquiry, in accordance with section 10.2.a of the OIGC charter. If it is determined that an investigation is warranted, it shall take one of the following forms:

1. The board of trustees will hire an independent outside firm to conduct the investigation with OIGC guidance and monitoring; or

2. The OIGC will perform the investigation.

(b) At the conclusion of such investigation, the report shall be submitted to the subject, who shall have twenty (20) working days from the date of the report to submit a written response. The subject’s response and the investigator’s rebuttal to the response, if any, shall be included in the final report presented to the chair of the board of trustees and the Board of Governor’s Audit and Compliance Committee.

(6) The board of trustees’ regulation shall articulate how the university will address any significant and credible allegation(s) of fraud, waste, mismanagement, misconduct, and other abuses made against the chief audit executive or chief compliance officer.

Authority: Section 7(d), Art. IX, Fla. Const.; History: New 11-3-16.
4.002 State University System Chief Audit Executives

(1) Each university shall have an office of chief audit executive as a point for coordination of and responsibility for activities that promote accountability, integrity, and efficiency in the operations of the university.

(2) Each board of trustees shall establish a committee responsible for addressing audit, financial- and fraud-related compliance, controls, and investigative matters. For purposes of this regulation, this committee will be referred to as the audit and compliance committee. This committee shall have a charter approved by the board of trustees and reviewed at least every three (3) years for consistency with applicable Board of Governors and university regulations, professional standards, and best practices. A copy of the approved charter and any subsequent changes shall be provided to the Board of Governors.

(3) Each board of trustees shall adopt a charter which defines the duties and responsibilities of the office of chief audit executive. The charter shall be reviewed at least every three (3) years for consistency with applicable Board of Governors and university regulations, professional standards, and best practices. A copy of the approved charter and any subsequent changes shall be provided to the Board of Governors. At a minimum, the charter shall specify that the chief audit executive:

(a) Provide direction for, supervise, and coordinate audits and investigations which promote economy, efficiency, and effectiveness in the administration of university programs and operations including, but not limited to, auxiliary facilities and services, direct support organizations, and other component units.

(b) Conduct, supervise, or coordinate activities for the purpose of preventing and detecting fraud and abuse within university programs and operations including, but not limited to, auxiliary facilities and services, direct support organizations, and other component units.

(c) Address significant and credible allegations relating to waste, fraud, or financial mismanagement as provided in Board of Governors Regulation 4.001.

(d) Keep the president and board of trustees informed concerning significant and credible allegations and known occurrences of waste, fraud, mismanagement, abuses, and deficiencies relating to university programs and operations; recommend corrective actions; and report on the progress made in implementing corrective actions.

(e) Promote, in collaboration with other appropriate university officials, effective coordination between the university and the Florida Auditor General, federal auditors, accrediting bodies, and other governmental or oversight bodies.

(f) Review and make recommendations, as appropriate, concerning policies and regulations related to the university’s programs and operations including, but not limited to, auxiliary facilities and services, direct support organizations, and other component units.
Communicate to the president and the board of trustees, at least annually, the office’s plans and resource requirements, including significant changes, and the impact of resource limitations.

Provide training and outreach, to the extent practicable, designed to promote accountability and address topics such as fraud awareness, risk management, controls, and other related subject matter.

Coordinate or request audit, financial- and fraud-related compliance, controls, and investigative information or assistance as may be necessary from any university, federal, state, or local government entity.

Develop and maintain a quality assurance and improvement program for the office of chief audit executive.

Establish policies which articulate the steps for reporting and escalating matters of alleged misconduct, including criminal conduct, when there are reasonable grounds to believe such conduct has occurred.

Inform the board of trustees when contracting for specific instances of audit or investigative assistance.

The board of trustees must obtain Board of Governors’ approval before outsourcing the chief audit executive’s entire audit or investigative function.

Each board of trustees shall ensure that the university chief audit executive is organizationally independent and objective to perform the responsibilities of the position. The chief audit executive shall:

(a) Report functionally to the board of trustees and administratively to the president.
(b) Report routinely to the board of trustees on matters including significant risk exposures, control issues, fraud risks, governance issues, and other matters requested by the president and the board of trustees.
(c) Conduct and report on audits, investigations, and other inquiries free of actual or perceived impairment to the independence of the chief audit executive’s office.
(d) Have timely access to any records, data, and other information in possession or control of the university including information reported to the university’s hotline/helpline.
(e) Notify the chair of the board of trustees’ audit committee or the president, as appropriate, of any unresolved restriction or barrier imposed by any individual on the scope of an inquiry, or the failure to provide access to necessary information or people for the purposes of such inquiry. The chief audit executive shall work with the board of trustees and university management to remedy scope or access limitations. If the university is not able to remedy such limitations, the chief audit executive shall timely notify the Board of Governors, through the OIGC, of any such restriction, barrier, or limitation.
(6) In carrying out the auditing duties and responsibilities set forth in this regulation, each chief audit executive shall review and evaluate controls necessary to enhance and promote the accountability of the university. The chief audit executive shall perform or supervise audits and prepare reports of their findings, recommendations, and opinions. The scope and assignment of the audits shall be determined by the chief audit executive; however, the president and board of trustees may request the chief audit executive direct, perform, or supervise audit engagements.

(a) Audit engagements shall be performed in accordance with the International Professional Practices Framework, published by the Institute of Internal Auditors, Inc.; the Government Auditing Standards, published by the United States Government Accountability Office; and/or the Information Systems Auditing Standards published by ISACA. All audit reports shall describe the extent to which standards were followed.

(b) At the conclusion of each audit engagement, the chief audit executive shall prepare a report to communicate the audit results and action plans to the board of trustees and university management. A copy of the final audit report will be provided to the Board of Governors consistent with Board of Governors Regulation 1.001(6)(g).

(c) The chief audit executive shall monitor the disposition of results communicated to university management and determine whether corrective actions have been effectively implemented or that senior management or the board of trustees, as appropriate, has accepted the risk of not taking corrective action. If, in the chief audit executive’s judgment, senior management or the board of trustees has chosen not to take corrective actions to address substantiated instances of waste, fraud, or financial mismanagement, then the chief audit executive shall timely notify the Board of Governors, through the OIGC.

(d) The chief audit executive shall develop audit plans based on the results of periodic risk assessments. The plans shall be submitted to the board of trustees for approval. A copy of approved audit plans will be provided to appropriate university management and the Board of Governors.

(e) The chief audit executive must develop and maintain a quality assurance and improvement program in accordance with professional audit standards. This program must include an external assessment conducted at least once every five (5) years. The external assessment report and any related improvement plans shall be presented to the board of trustees, with a copy provided to the Board of Governors.

(7) Each chief audit executive shall initiate, conduct, supervise, or coordinate investigations that fall within the purview of the chief audit executive’s office and be designated by their board of trustees as the employee to review statutory whistle-blower information and coordinate all activities of the university as required by the Florida Whistle-blower’s Act. Investigative assignments shall be performed in
accordance with professional standards issued for the State University System. All final investigative reports shall be submitted to the appropriate action officials, board of trustees, and the Board of Governors if, in the chief audit executive’s judgment, the allegations are determined to be significant and credible. Such reports shall be redacted to protect confidential information and the identity of individuals, when provided for by law.

(8) By September 30th of each year, the chief audit executive shall prepare a report summarizing the activities of the office for the preceding fiscal year. The report shall be provided to the president, board of trustees, and the Board of Governors.

Authority: Section 7(d), Art. IX, Fla. Const.; History: New 11-3-16.
4.003  State University System Compliance and Ethics Programs

(1) Each board of trustees shall implement a university-wide compliance and ethics program (Program) as a point for coordination of and responsibility for activities that promote ethical conduct and maximize compliance with applicable laws, regulations, rules, policies, and procedures.

(2) The Program shall be:
   (a) Reasonably designed to optimize its effectiveness in preventing or detecting non-compliance, unethical behavior, and criminal conduct, as appropriate to the institution’s mission, size, activities, and unique risk profile;
   (b) Developed consistent with the Code of Ethics for Public Officers and Employees contained in Part III, Chapter 112, Florida Statutes; other applicable codes of ethics; and the Federal Sentencing Guidelines Manual, Chapter 8, Part B, Section 2.1(b); and
   (c) Implemented within two (2) years of the effective date of this regulation.

(3) Each board of trustees shall assign responsibility for providing governance oversight of the Program to the committee of the board responsible for audit and compliance. The charter required by Board of Governors Regulation 4.002(2) shall address governance oversight for the Program.

(4) Each university, in coordination with its board of trustees, shall designate a senior-level administrator as the chief compliance officer. The chief compliance officer is the individual responsible for managing or coordinating the Program. Universities may have multiple compliance officers; however, the highest ranking compliance officer shall be designated the chief compliance officer. Nothing in this regulation shall be construed to conflict with the General Counsel’s responsibility to provide legal advice on ethics laws. The chief compliance officer shall not be the same individual as the chief audit executive with the exception of New College of Florida and Florida Polytechnic University who may, due to fiscal and workload considerations, name the same individual as both chief audit executive and chief compliance officer.

(5) The chief compliance officer shall report functionally to the board of trustees and administratively to the president. If the university has an established compliance program in which the chief compliance officer reports either administratively or functionally to the chief audit executive, then the university shall have five (5) years from the effective date of this regulation to transition the reporting relationship of the chief compliance officer to report functionally to the board of trustees and administratively to the president.
(6) The office of the chief compliance officer shall be governed by a charter approved by the board of trustees and reviewed at least every three (3) years for consistency with applicable Board of Governors and university regulations, professional standards, and best practices. A copy of the approved charter and any subsequent changes shall be provided to the Board of Governors.

(7) The Program shall address the following components:

(a) The president and board of trustees shall be knowledgeable about the Program and shall exercise oversight with respect to its implementation and effectiveness. The board of trustees shall approve a Program plan and any subsequent changes. A copy of the approved plan shall be provided to the Board of Governors.

(b) University employees and board of trustees' members shall receive training regarding their responsibility and accountability for ethical conduct and compliance with applicable laws, regulations, rules, policies, and procedures. The Program plan shall specify when and how often this training shall occur.

(c) At least once every five (5) years, the president and board of trustees shall be provided with an external review of the Program's design and effectiveness and any recommendations for improvement, as appropriate. The first external review shall be initiated within five (5) years from the effective date of this regulation. The assessment shall be approved by the board of trustees and a copy provided to the Board of Governors.

(d) The Program may designate compliance officers for various program areas throughout the university based on an assessment of risk in any particular program or area. If so designated, the individual shall coordinate and communicate with the chief compliance officer on matters relating to the Program.

(e) The Program shall require the university, in a manner which promotes visibility, to publicize a mechanism for individuals to report potential or actual misconduct and violations of university policy, regulations, or law, and to ensure that no individual faces retaliation for reporting a potential or actual violation when such report is made in good faith. If the chief compliance officer determines the reporting process is being abused by an individual, he or she may recommend actions to prevent such abuse.

(f) The Program shall articulate the steps for reporting and escalating matters of alleged misconduct, including criminal conduct, when there are reasonable grounds to believe such conduct has occurred.

(g) The chief compliance officer shall:

1. Have the independence and objectivity to perform the responsibilities of the chief compliance officer function;
2. Have adequate resources and appropriate authority;
3. Communicate routinely to the president and board of trustees regarding Program activities;
4. Conduct and report on compliance and ethics activities and inquiries free of actual or perceived impairment to the independence of the chief compliance officer;

5. Have timely access to any records, data, and other information in possession or control of the university, including information reported to the university's hotline/helpline;

6. Coordinate or request compliance activity information or assistance as may be necessary from any university, federal, state, or local government entity;

7. Notify the president, or the administrative supervisor of the chief compliance officer, of any unresolved restriction or barrier imposed by any individual on the scope of any inquiry, or the failure to provide access to necessary information or people for the purposes of such inquiry. In such circumstances, the chief compliance officer shall request the president remedy the restrictions. If unresolved by the president or if the president is imposing the inappropriate restrictions, the chief compliance officer shall notify the chair of the board of trustees committee charged with governance oversight of the Program. If the matter is not resolved by the board of trustees, the chief compliance officer shall notify the Board of Governors through the Office of Inspector General and Director of Compliance (OIGC);

8. Report at least annually on the effectiveness of the Program. Any Program plan revisions, based on the chief compliance officer’s report shall be approved by the board of trustees. A copy of the report and revised plan shall be provided to the Board of Governors;

9. Promote and enforce the Program, in consultation with the president and board of trustees, consistently through appropriate incentives and disciplinary measures to encourage a culture of compliance and ethics. Failures in compliance or ethics shall be addressed through appropriate measures, including education or disciplinary action;

10. Initiate, conduct, supervise, coordinate, or refer to other appropriate offices (such as human resources, audit, Title IX, or general counsel) such inquiries, investigations, or reviews as deemed appropriate and in accordance with university regulations and policies; and

11. Submit final reports to appropriate action officials.

(h) When non-compliance, unethical behavior, or criminal conduct has been detected, the university shall take reasonable steps to prevent further similar behavior, including making any necessary modifications to the Program.

(8) The university shall use reasonable efforts not to include within the university and its affiliated organizations individuals whom it knew, or should have known (through the exercise of due diligence), to have engaged in conduct not consistent with an effective Program.

Authority: Section 7(d), Art. IX, Fla. Const.; History: New 11-3-16.
The 2017 Florida Statutes

Title X
PUBLIC OFFICERS, EMPLOYEES, AND RECORDS

Chapter 112
PUBLIC OFFICERS AND EMPLOYEES: GENERAL PROVISIONS

112.3187  Adverse action against employee for disclosing information of specified nature prohibited; employee remedy and relief.—

1  SHORT TITLE. — Sections 112.3187-112.31895 may be cited as the “Whistle-blower’s Act.”

2  LEGISLATIVE INTENT. — It is the intent of the Legislature to prevent agencies or independent contractors from taking retaliatory action against an employee who reports to an appropriate agency violations of law on the part of a public employer or independent contractor that create a substantial and specific danger to the public’s health, safety, or welfare. It is further the intent of the Legislature to prevent agencies or independent contractors from taking retaliatory action against any person who discloses information to an appropriate agency alleging improper use of governmental office, gross waste of funds, or any other abuse or gross neglect of duty on the part of an agency, public officer, or employee.

3  DEFINITIONS. — As used in this act, unless otherwise specified, the following words or terms shall have the meanings indicated:

(a) “Agency” means any state, regional, county, local, or municipal government entity, whether executive, judicial, or legislative; any official, officer, department, division, bureau, commission, authority, or political subdivision therein; or any public school, community college, or state university.

(b) “Employee” means a person who performs services for, and under the control and direction of, or contracts with, an agency or independent contractor for wages or other remuneration.

(c) “Adverse personnel action” means the discharge, suspension, transfer, or demotion of any employee or the withholding of bonuses, the reduction in salary or benefits, or any other adverse action taken against an employee within the terms and conditions of employment by an agency or independent contractor.

(d) “Independent contractor” means a person, other than an agency, engaged in any business and who enters into a contract, including a provider agreement, with an agency.

(e) “Gross mismanagement” means a continuous pattern of managerial abuses, wrongful or arbitrary and capricious actions, or fraudulent or criminal conduct which may have a substantial adverse economic impact.

4  ACTIONS PROHIBITED.—

(a) An agency or independent contractor shall not dismiss, discipline, or take any other adverse personnel action against an employee for disclosing information pursuant to the provisions of this section.

(b) An agency or independent contractor shall not take any adverse action that affects the rights or interests of a person in retaliation for the person’s disclosure of information under this section.

(c) The provisions of this subsection shall not be applicable when an employee or person discloses information known by the employee or person to be false.

5  NATURE OF INFORMATION DISCLOSED.—The information disclosed under this section must include:

(a) Any violation or suspected violation of any federal, state, or local law, rule, or regulation committed by an employee or agent of an agency or independent contractor which creates and presents a substantial and specific danger to the public’s health, safety, or welfare.

(b) Any act or suspected act of gross mismanagement, malfeasance, misfeasance, gross waste of public funds, suspected or actual Medicaid fraud or abuse, or gross neglect of duty committed by an employee or agent of an...
agency or independent contractor.

6. TO WHOM INFORMATION DISCLOSED.—The information disclosed under this section must be disclosed to any agency or federal government entity having the authority to investigate, police, manage, or otherwise remedy the violation or act, including, but not limited to, the Office of the Chief Inspector General, an agency inspector general or the employee designated as agency inspector general under s. 112.3189(1) or inspectors general under s. 20.055, the Florida Commission on Human Relations, and the whistle-blower’s hotline created under s. 112.3189. However, for disclosures concerning a local governmental entity, including any regional, county, or municipal entity, special district, community college district, or school district or any political subdivision of any of the foregoing, the information must be disclosed to a chief executive officer as defined in s. 447.203(9) or other appropriate local official.

7. EMPLOYEES AND PERSONS PROTECTED.—This section protects employees and persons who disclose information on their own initiative in a written and signed complaint; who are requested to participate in an investigation, hearing, or other inquiry conducted by any agency or federal government entity; who refuse to participate in any adverse action prohibited by this section; or who initiate a complaint through the whistle-blower’s hotline or the hotline of the Medicaid Fraud Control Unit of the Department of Legal Affairs; or employees who file any written complaint to their supervisory officials or employees who submit a complaint to the Chief Inspector General in the Executive Office of the Governor, to the employee designated as agency inspector general under s. 112.3189(1), or to the Florida Commission on Human Relations. The provisions of this section may not be used by a person while he or she is under the care, custody, or control of the state correctional system or, after release from the care, custody, or control of the state correctional system, with respect to circumstances that occurred during any period of incarceration. No remedy or other protection under ss. 112.3187-112.31895 applies to any person who has committed or intentionally participated in committing the violation or suspected violation for which protection under ss. 112.3187-112.31895 is being sought.

8. REMEDIES.—

(a) Any employee of or applicant for employment with any state agency, as the term “state agency” is defined in s. 216.011, who is discharged, disciplined, or subjected to other adverse personnel action, or denied employment, because he or she engaged in an activity protected by this section may file a complaint, which complaint must be made in accordance with s. 112.31895. Upon receipt of notice from the Florida Commission on Human Relations of termination of the investigation, the complainant may elect to pursue the administrative remedy available under s. 112.31895 or bring a civil action within 180 days after receipt of the notice.

(b) Within 60 days after the action prohibited by this section, any local public employee protected by this section may file a complaint with the appropriate local governmental authority, if that authority has established by ordinance an administrative procedure for handling such complaints or has contracted with the Division of Administrative Hearings under s. 120.65 to conduct hearings under this section. The administrative procedure created by ordinance must provide for the complaint to be heard by a panel of impartial persons appointed by the appropriate local governmental authority. Upon hearing the complaint, the panel must make findings of fact and conclusions of law for a final decision by the local governmental authority. Within 180 days after entry of a final decision by the local governmental authority, the public employee who filed the complaint may bring a civil action in any court of competent jurisdiction. If the local governmental authority has not established an administrative procedure by ordinance or contract, a local public employee may, within 180 days after the action prohibited by this section, bring a civil action in a court of competent jurisdiction. For the purpose of this paragraph, the term “local governmental authority” includes any regional, county, or municipal entity, special district, community college district, or school district or any political subdivision of any of the foregoing.

(c) Any other person protected by this section may, after exhausting all available contractual or administrative remedies, bring a civil action in any court of competent jurisdiction within 180 days after the action prohibited by this section.

9. RELIEF.—In any action brought under this section, the relief must include the following:
(a) Reinstatement of the employee to the same position held before the adverse action was commenced, or to an equivalent position or reasonable front pay as alternative relief.

(b) Reinstatement of the employee's full fringe benefits and seniority rights, as appropriate.

(c) Compensation, if appropriate, for lost wages, benefits, or other lost remuneration caused by the adverse action.

(d) Payment of reasonable costs, including attorney's fees, to a substantially prevailing employee, or to the prevailing employer if the employee filed a frivolous action in bad faith.

(e) Issuance of an injunction, if appropriate, by a court of competent jurisdiction.

(f) Temporary reinstatement to the employee's former position or to an equivalent position, pending the final outcome on the complaint, if an employee complains of being discharged in retaliation for a protected disclosure and if a court of competent jurisdiction or the Florida Commission on Human Relations, as applicable under s. 112.31895, determines that the disclosure was not made in bad faith or for a wrongful purpose or occurred after an agency's initiation of a personnel action against the employee which includes documentation of the employee's violation of a disciplinary standard or performance deficiency. This paragraph does not apply to an employee of a municipality.

(10) DEFENSES.—It shall be an affirmative defense to any action brought pursuant to this section that the adverse action was predicated upon grounds other than, and would have been taken absent, the employee's or person's exercise of rights protected by this section.

(11) EXISTING RIGHTS.—Sections 112.3187-112.31895 do not diminish the rights, privileges, or remedies of an employee under any other law or rule or under any collective bargaining agreement or employment contract; however, the election of remedies in s. 447.401 also applies to whistle-blower actions.

History.—ss. 1, 2, 3, 4, 5, 6, 7, 8, ch. 86-233; s. 12, ch. 92-316; s. 1, ch. 93-57; s. 702, ch. 95-147; s. 1, ch. 95-153; s. 15, ch. 96-410; s. 20, ch. 99-333; s. 2, ch. 2002-400.
112.3188 Confidentiality of information given to the Chief Inspector General, internal auditors, inspectors general, local chief executive officers, or other appropriate local officials.—

(1) The name or identity of any individual who discloses in good faith to the Chief Inspector General or an agency inspector general, a local chief executive officer, or other appropriate local official information that alleges that an employee or agent of an agency or independent contractor:

(a) Has violated or is suspected of having violated any federal, state, or local law, rule, or regulation, thereby creating and presenting a substantial and specific danger to the public’s health, safety, or welfare; or

(b) Has committed an act of gross mismanagement, malfeasance, misfeasance, gross waste of public funds, or gross neglect of duty

may not be disclosed to anyone other than a member of the Chief Inspector General’s, agency inspector general’s, internal auditor’s, local chief executive officer’s, or other appropriate local official’s staff without the written consent of the individual, unless the Chief Inspector General, internal auditor, agency inspector general, local chief executive officer, or other appropriate local official determines that: the disclosure of the individual’s identity is necessary to prevent a substantial and specific danger to the public’s health, safety, or welfare or to prevent the imminent commission of a crime; or the disclosure is unavoidable and absolutely necessary during the course of the audit, evaluation, or investigation.

(2)(a) Except as specifically authorized by s. 112.3189, all information received by the Chief Inspector General or an agency inspector general or information produced or derived from fact-finding or other investigations conducted by the Florida Commission on Human Relations or the Department of Law Enforcement is confidential and exempt from s. 119.07(1) if the information is being received or derived from allegations as set forth in paragraph (1)(a) or paragraph (1)(b), and an investigation is active.

(b) All information received by a local chief executive officer or appropriate local official or information produced or derived from fact-finding or investigations conducted pursuant to the administrative procedure established by ordinance of a local government as authorized by s. 112.3187(8)(b) is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution, if the information is being received or derived from allegations as set forth in paragraph (1)(a) or paragraph (1)(b) and an investigation is active.

(c) Information deemed confidential under this section may be disclosed by the Chief Inspector General, agency inspector general, local chief executive officer, or other appropriate local official receiving the information if the recipient determines that the disclosure of the information is absolutely necessary to prevent a substantial and specific danger to the public’s health, safety, or welfare or to prevent the imminent commission of a crime. Information disclosed under this subsection may be disclosed only to persons who are in a position to prevent the danger to the public’s health, safety, or welfare or to prevent the imminent commission of a crime based on the disclosed information.

1. An investigation is active under this section if:

a. It is an ongoing investigation or inquiry or collection of information and evidence and is continuing with a reasonable, good faith anticipation of resolution in the foreseeable future; or
b. All or a portion of the matters under investigation or inquiry are active criminal intelligence information or active criminal investigative information as defined in s. 119.011.

2. Notwithstanding sub-subparagraph 1.a., an investigation ceases to be active when:
   a. The written report required under s. 112.3189(9) has been sent by the Chief Inspector General to the recipients named in s. 112.3189(9);
   b. It is determined that an investigation is not necessary under s. 112.3189(5); or
   c. A final decision has been rendered by the local government or by the Division of Administrative Hearings pursuant to s. 112.3187(8)(b).

3. Notwithstanding paragraphs (a), (b), and this paragraph, information or records received or produced under this section which are otherwise confidential under law or exempt from disclosure under chapter 119 retain their confidentiality or exemption.

4. Any person who willfully and knowingly discloses information or records made confidential under this subsection commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

History.—s. 6, ch. 90-247; s. 1, ch. 91-150; s. 3, ch. 91-285; s. 2, ch. 93-57; s. 1, ch. 95-136; s. 2, ch. 95-153; s. 1, ch. 95-166; ss. 36, 37, ch. 96-406; s. 21, ch. 99-333.

Note.—As amended by s. 1, ch. 95-166, s. 2, ch. 95-153, and s. 36, ch. 96-406; this version of paragraph (2)(a) was also amended by s. 21, ch. 99-333. A description of multiple acts in the same session affecting a statutory provision, see preface to the Florida Statutes, "Statutory Construction."

Section 112.3188 — Confidentiality of information given to the Chief Inspector General and agency inspectors general.

(1) The identity of any individual who discloses in good faith to the Chief Inspector General or an agency inspector general information that alleges that an employee or agent of an agency or independent contractor has violated or is suspected of having violated any federal, state, or local law, rule, or regulation, thereby creating and presenting a substantial and specific danger to the public’s health, safety, or welfare or has committed or is suspected of having committed an act of gross mismanagement, malfeasance, misfeasance, gross waste of public funds, or gross neglect of duty is exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution and shall not be disclosed to anyone other than a member of the Chief Inspector General’s or agency inspector general’s staff without the written consent of the individual, unless the Chief Inspector General or agency inspector general determines that:
   a. The disclosure of the individual’s identity is necessary to prevent a substantial and specific danger to the public’s health, safety, or welfare or to prevent the imminent commission of a crime, provided that such information is disclosed only to persons who are in a position to prevent the danger to the public’s health, safety, or welfare or to prevent the imminent commission of a crime;
   b. The disclosure of the individual’s identity is unavoidable and absolutely necessary during the course of the inquiry or investigation; or
   c. The disclosure of the individual’s identity is authorized as a result of the individual consenting in writing to attach general comments signed by such individual to the final report required pursuant to s. 112.3189(6)(b).

(2)(a) Except as specifically authorized by s. 112.3189 and except as provided in subsection (1), all information received by the Chief Inspector General or an agency inspector general or information produced or derived from fact-finding or other investigations conducted by the Department of Legal Affairs, the Office of the Public Counsel, or the Department of Law Enforcement is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution for a period of not more than 30 days during which time a determination is made whether an investigation is required pursuant to s. 112.3189(5)(a) and, if an investigation is determined to be required, until the investigation is closed or ceases to be active. For the purposes of this subsection, an investigation is active while such investigation is being conducted with a reasonable good faith belief that it may lead to the filing of administrative, civil, or criminal charges. An investigation does not cease to be active so long as the Chief Inspector General or the agency inspector general is proceeding with reasonable dispatch and there is a good faith belief that action may be initiated by the Chief Inspector General or agency inspector general or other administrative or law enforcement agency. Except for active criminal intelligence or criminal investigative information as defined in s. 119.011, and except as otherwise provided in this section, all information obtained pursuant to this subsection shall become available to the public when the investigation is closed or ceases to be active. An investigation is closed or ceases to be active when the final report required pursuant to s. 112.3189(9) has been sent by the Chief Inspector General to the recipients specified in s. 112.3189(9). (c).

(b) Information deemed confidential under this subsection may be disclosed by the Chief Inspector General or agency inspector general receiving the information if the Chief Inspector General or agency inspector general determines that the disclosure of the information is absolutely necessary to prevent a substantial and specific danger to the public’s health, safety, or welfare or to prevent the imminent commission of a crime, and such information may be disclosed only to persons who are in a position to prevent the danger to the public’s health, safety, or welfare or to prevent the imminent commission of a crime based on the disclosed information.

(3) Information or records obtained under this section which are otherwise confidential under law or exempt from disclosure shall retain their confidentiality or exemption.

(4) Any person who willfully and knowingly discloses information or records made confidential under this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0100-0199/0112/Sections/0112.3188.html
The 2017 Florida Statutes

Title X
PUBLIC OFFICERS, EMPLOYEES, AND RECORDS

Chapter 112
PUBLIC OFFICERS AND EMPLOYEES: GENERAL PROVISIONS

112.3189 Investigative procedures upon receipt of whistle-blower information from certain state employees.—

(1) This section only applies to the disclosure of information as described in s. 112.3187(5) by an employee or former employee of, or an applicant for employment with, a state agency, as the term “state agency” is defined in s. 216.011, to the Office of the Chief Inspector General of the Executive Office of the Governor or to the agency inspector general. If an agency does not have an inspector general, the head of the state agency, as defined in s. 216.011, shall designate an employee to receive information described in s. 112.3187(5). For purposes of this section and s. 112.3188 only, the employee designated by the head of the state agency shall be deemed an agency inspector general.

(2) To facilitate the receipt of information described in subsection (1), the Chief Inspector General shall maintain an in-state toll-free whistle-blower’s hotline and shall circulate among the various state agencies an advisory for all employees which indicates the existence of the toll-free number and its purpose and provides an address to which written whistle-blower information may be forwarded.

(3) When a person alleges information described in s. 112.3187(5), the Chief Inspector General or agency inspector general actually receiving such information shall within 20 days of receiving such information determine:

(a) Whether the information disclosed is the type of information described in s. 112.3187(5).

(b) Whether the source of the information is a person who is an employee or former employee of, or an applicant for employment with, a state agency, as defined in s. 216.011.

(c) Whether the information actually disclosed demonstrates reasonable cause to suspect that an employee or agent of an agency or independent contractor has violated any federal, state, or local law, rule, or regulation, thereby creating and presenting a substantial and specific danger to the public’s health, safety, or welfare, or has committed an act of gross mismanagement, malfeasance, misfeasance, gross waste of public funds, or gross neglect of duty.

(4) If the Chief Inspector General or agency inspector general under subsection (3) determines that the information disclosed is not the type of information described in s. 112.3187(5), or that the source of the information is not a person who is an employee or former employee of, or an applicant for employment with, a state agency, as defined in s. 216.011, or that the information disclosed does not demonstrate reasonable cause to suspect that an employee or agent of an agency or independent contractor has violated any federal, state, or local law, rule, or regulation, thereby creating and presenting a substantial and specific danger to the public’s health, safety, or welfare, or has committed an act of gross mismanagement, malfeasance, misfeasance, gross waste of public funds, or gross neglect of duty, the Chief Inspector General or agency inspector general shall notify the complainant of such fact and copy and return, upon request of the complainant, any documents and other materials that were provided by the complainant.

(5)(a) If the Chief Inspector General or agency inspector general under subsection (3) determines that the information disclosed is the type of information described in s. 112.3187(5), that the source of the information is from a person who is an employee or former employee of, or an applicant for employment with, a state agency, as defined in s. 216.011, and that the information disclosed demonstrates reasonable cause to suspect that an
employee or agent of an agency or independent contractor has violated any federal, state, or local law, rule, or regulation, thereby creating a substantial and specific danger to the public’s health, safety, or welfare, or has committed an act of gross mismanagement, malfeasance, misfeasance, gross waste of public funds, or gross neglect of duty, the Chief Inspector General or agency inspector general making such determination shall then conduct an investigation, unless the Chief Inspector General or the agency inspector general determines, within 30 days after receiving the allegations from the complainant, that such investigation is unnecessary. For purposes of this subsection, the Chief Inspector General or the agency inspector general shall consider the following factors, but is not limited to only the following factors, when deciding whether the investigation is not necessary:

1. The gravity of the disclosed information compared to the time and expense of an investigation.
2. The potential for an investigation to yield recommendations that will make state government more efficient and effective.
3. The benefit to state government to have a final report on the disclosed information.
4. Whether the alleged whistle-blower information primarily concerns personnel practices that may be investigated under chapter 110.
5. Whether another agency may be conducting an investigation and whether any investigation under this section could be duplicative.
6. The time that has elapsed between the alleged event and the disclosure of the information.

(b) If the Chief Inspector General or agency inspector general determines under paragraph (a) that an investigation is not necessary, the Chief Inspector General or agency inspector general making such determination shall:

1. Copy and return, upon request of the complainant, any documents and other materials provided by the individual who made the disclosure.
2. Inform in writing the head of the state agency for the agency inspector general making the determination that the investigation is not necessary and the individual who made the disclosure of the specific reasons why an investigation is not necessary and why the disclosure will not be further acted on under this section.

(6) The agency inspector general may conduct an investigation pursuant to paragraph (5)(a) only if the person transmitting information to the agency inspector general is an employee or former employee of, or an applicant for employment with, the agency inspector general’s agency. The agency inspector general shall:

(a) Conduct an investigation with respect to the information and any related matters.
(b) Submit to the complainant and the Chief Inspector General, within 60 days after the date on which a determination to conduct an investigation is made under paragraph (5)(a), a final written report that sets forth the agency inspector general’s findings, conclusions, and recommendations, except as provided under subsection (11). The complaint shall be advised in writing by the agency head that the complainant may submit to the Chief Inspector General and agency inspector general comments on the final report within 20 days of the date of the report and that such comments will be attached to the final report.

(7) If the Chief Inspector General decides an investigation should be conducted pursuant to paragraph (5)(a), the Chief Inspector General shall either:

(a) Promptly transmit to the appropriate head of the state agency the information with respect to which the determination to conduct an investigation was made, and such agency head shall conduct an investigation and submit to the Chief Inspector General a final written report that sets forth the agency head’s findings, conclusions, and recommendations; or

(b) 1. Conduct an investigation with respect to the information and any related matters; and
2. Submit to the complainant within 60 days after the date on which a determination to conduct an investigation is made under paragraph (5)(a), a final written report that sets forth the Chief Inspector General’s findings, conclusions, and recommendations, except as provided under subsection (11). The complainant shall be advised in writing by the Chief Inspector General that the complainant may submit to the Chief Inspector General comments on the final report within 20 days of the date of the report and that such comments will be attached to the final report.
(c) The Chief Inspector General may require an agency head to conduct an investigation under paragraph (a) only if the information was transmitted to the Chief Inspector General by:

1. An employee or former employee of, or an applicant for employment with, the agency that the information concerns; or
2. An employee who obtained the information in connection with the performance of the employee’s duties and responsibilities.

(8) Final reports required under this section must be reviewed and signed by the person responsible for conducting the investigation (agency inspector general, agency head, or Chief Inspector General) and must include:

(a) A summary of the information with respect to which the investigation was initiated.
(b) A description of the conduct of the investigation.
(c) A summary of any evidence obtained from the investigation.
(d) A listing of any violation or apparent violation of any law, rule, or regulation.
(e) A description of any action taken or planned as a result of the investigation, such as:
   1. A change in an agency rule, regulation, or practice.
   2. The restoration of an aggrieved employee.
   3. A disciplinary action against an employee.
   4. The referral to the Department of Law Enforcement of any evidence of a criminal violation.

(9)(a) A report required of the agency head under paragraph (7)(a) shall be submitted to the Chief Inspector General and the complainant within 60 days after the agency head receives the complaint from the Chief Inspector General, except as provided under subsection (11). The complainant shall be advised in writing by the agency head that the complainant may submit to the Chief Inspector General comments on the report within 20 days of the date of the report and that such comments will be attached to the final report.

(b) Upon receiving a final report required under this section, the Chief Inspector General shall review the report and determine whether the report contains the information required by subsection (8). If the report does not contain the information required by subsection (8), the Chief Inspector General shall determine why and note the reasons on an addendum to the final report.

(c) The Chief Inspector General shall transmit any final report under this section, any comments provided by the complainant, and any appropriate comments or recommendations by the Chief Inspector General to the Governor, the Legislative Auditing Committee, the investigating agency, and the Chief Financial Officer.

(d) If the Chief Inspector General does not receive the report of the agency head within the time prescribed in paragraph (a), the Chief Inspector General may conduct the investigation in accordance with paragraph (7)(b) or request that another agency inspector general conduct the investigation in accordance with subsection (6) and shall report the complaint to the Governor, to the Joint Legislative Auditing Committee, and to the investigating agency, together with a statement noting the failure of the agency head to file the required report.

(10) For any time period set forth in subsections (3), (6), (7), and (9), such time period may be extended in writing by the Chief Inspector General for good cause shown.

(11) If an investigation under this section produces evidence of a criminal violation, the report shall not be transmitted to the complainant, and the agency head or agency inspector general shall notify the Chief Inspector General and the Department of Law Enforcement.

History.—s. 13, ch. 92-316; s. 3, ch. 93-57; s. 129, ch. 2003-261; s. 17, ch. 2011-34.