Attachment 11.6.1

PAXON

SHIRE OF NANNUP

Regulation 17 Review

Final | March 2023

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1. INTRODUCTION AND SCOPE

1.1 Background

The requirement for this internal audit review is set out within regulation 17 of the *Local Government (Audit) Regulations 1996,* stating:

"(1) The CEO is to review the appropriateness and effectiveness of a local government's systems and procedures in relation to —

(a) risk management; and

(b) internal control; and

(c) legislative compliance.

(2) The review may relate to any or all of the matters referred to in subregulation (1)(a), (b) and (c), but each of those matters is to be the subject of a review not less than once in every 3 financial years.

(3) The CEO is to report to the audit committee the results of that review."

1.2 Internal Audit Objective

The objective of our review was to provide a report, based on our understanding of the Shire Nannup's ('Shire') processes and associated risks, to assist the CEO to report to the Audit & Risk Committee on the appropriateness and effectiveness of the Shire's systems and procedures in relation to:

- Risk management;
- Internal control; and
- Legislative compliance

as required by the *Local Government (Audit) Regulations 1996* (Regulation 17 Review).

2. EXECUTIVE SUMMARY

Paxon reviewed the appropriateness of the design and operational effectiveness of the Shire's systems and procedures in relation to:

- Risk management;
- Internal control; and
- Legislative compliance.

Overall we have noted nine findings which are broad in nature and cover the majority of the areas reviewed within our scope. We also noted that these are for the most part the same as those raised during the previous Regulation 17 review performed in 2019. Finding 5.3 in relation to monitoring the effective implementation of actions to address findings should help to alleviate these issues.

Paxon noted that risk management is not operational within the Shire and has not been for an extended period of time. The Shire should develop a plan and timeframe for the short to medium term to make risk management operational and establish reporting to the Audit Committee.

There are improvements that related to internal control including establishing an integrity framework to meet Public Sector Commission requirements, documentation within a register of delegation from CEO to employees and annual review of all delegated authority and documentation of a business continuity plan.

There is also no documented compliance framework in place within the Shire.

Whilst there are gaps identified within the areas under review, it is important to note the limited resource available within the Shire to support what are largely second line of defence functions. Given this the commitments made by Management within the comments section of each detailed finding should establish a balance between putting effective processes and controls in place and setting an expectation of delivery that cannot be achieved.

Paxon's audit findings are summarised within the table below and are documented in more detail within sections 5-7 of this report. It should be noted that where management comment states that actions have already been taken these have not been evidenced to Paxon.

Process	Finding	Risk Rating
Risk Management	5.1 Risk Governance	**High risk**
	5.2 Risk Management	**High risk**
	5.3 Implementation of recommendations	**High risk**
Internal Control	6.1 Fraud Framework	**High risk**
	6.2 Delegated Authority to Employees	**Medium risk**
	6.3 Business Continuity Plan	**Medium risk**
	6.4 Document update	**Low risk**
	6.5 Record Keeping Plan	**Low risk**
Legislative Compliance	7.1 Lack of compliance framework	**Medium risk**

Paxon is also performing an internal audit review of Financial Management in accordance with Regulation 5 of the Local Government (Financial Management) Regulations 1996. This review will include a more detailed assessment of internal control processes for financial management.

We would like to thank all officers that have facilitated the performance of this review.

3. METHODOLOGY

Paxon's methodology for the Regulation 17 Review comprised:

- Conducting an initial meeting with management to obtain an understanding of processes and potential issues;
- Developing overview documentation of the processes including key controls by discussion with staff and review of the processes;
- Evaluating the adequacy of the controls to cover the identified risks and testing the compliance with the key controls;
- Researching the issues, weaknesses and potential improvements noted from our discussions and review of the existing processes including compliance with key controls;
- Developing appropriate recommendations for improvement for discussion with management;
- Drafting a report of findings and recommendations and obtaining formal responses from management; and
- Finalising the report and issuing it to the CEO for distribution to the Audit Advisory Committee (Committee).

Each finding detailed in sections 5 to 7 is rated based on the following scale:

Rating	Definition
High	Major contravention of policies, procedures or laws, unacceptable internal controls, high risk for fraud, waste or abuse, major opportunity to improve effectiveness and efficiency, major risk identified. Immediate corrective action is required. A short-term fix may be needed prior to it being resolved properly.
Medium	Moderate contravention of policies, procedures or laws, poor internal controls, significant opportunity to improve effectiveness and efficiency, moderate risk identified. Corrective action is required. Need to be resolved as soon as resources can be made available, but within six months.
Low	Minor contravention of policies and procedures, weak internal controls, opportunity to improve effectiveness and efficiency, low risk identified. Corrective action is required. Need to be resolved within twelve months.

4. INHERENT LIMITATIONS

Due to the inherent limitations in any internal control structure, it is possible errors or irregularities may occur and not be detected. Further, the internal control structure, within which the control procedures that have been reviewed operate, has not been reviewed in its entirety and therefore no opinion is expressed as to the effectiveness of the greater internal control structure.

It should also be noted our review was not designed to detect all weaknesses in control procedures as it was not performed continuously throughout the period subject to review.

The review conclusion and any opinion expressed in this report have been formed on the above basis.

5. RISK MANAGEMENT

5.1 Audit Finding – Risk Management Governance

There is an Audit Advisory Committee ('Committee') in place within the Shire, but it does not have risk management within its remit apart from receiving the CEO's report on Regulation 17. Hence the remit of the Committee is narrower than many equivalent organisations and does not cover areas included within good practice guidance such as the Department's 'Operational Guideline Number 9 The Appointment, Function and Responsibilities of Audit Committees' and the Office of the Auditor General's 'Public Sector Audit Committees Better Practice Guide'. It was also noted that the Committee has only met once a year in March for the last two years to consider the financial statements and the Compliance Audit Return.

There is a Risk Management Advisory Group ('Group') in place which meets regularly, though based upon review of the Terms of Reference and recent agenda the focus is solely on Occupational Safety and Health.

Given the above there is no formal operational oversight body for risk and no reporting of the risk management framework or related activity.

Paxon also noted that risks are not overtly considered within Council or Committee reports included within meeting agenda, as there is no risk implication section within the reports template.

Risk Rating

Paxon has determined this finding to be of **High Risk.**

Implication

There is a lack of formal functioning risk management within the Shire, which could lead to failure to identify and manage risks resulting in strategic or operational impacts or failure to achieve desired objectives and outcomes.

Recommendation

5.1.1 The Committee's remit should be extended to include risk management both within the name of the Committee and at an increased level of oversight of risk management processes. Consideration should be given to the 'Operational Guideline Number 9 The Appointment, Function and Responsibilities of Audit Committees' and the Office of the Auditor General's 'Public Sector Audit Committees Better Practice Guide' in developing the degree of oversight.

5.1.2 The Groups Terms of Reference should be amended or a new risk management oversight body established to ensure an appropriate risk management framework is in place and operational. See finding 5.2 for further details on what this could include.

Management Comment:

- The current format of the Audit Advisory Committee is compliant, the suggested non-compliance that references the DLGSC Operational Guideline and OAG Best Practice Guide are simply a guideline and best practice not a non-compliance. Risk is being considered on all operations of the Shire not just Occupational Health and Safety related. The issue is the limited supporting documentation of the framework. To address documentation finding the Shire has focused on the highest impact areas to focus on first. For example the recently completed Annual Compliance Calendar for the whole organisation.
- It is noted that a revision of the Audit Advisory Committee's Term of Reference could be expanded to include overall risk management, but again this is a guideline not a requirement and is the decision of the local government to implement or not at Council Committee level or remain at operational level.
- The Risk Management Advisory Group meeting has historically had an Occupational Health and Safety focus, however, this has been expanded to include overall risk management of all organisational operations which will of course include OHS as one of those components. This change is currently in place.

- Review of the current Terms of Reference to consider the Audit Advisory Committee to include Risk Management, giving full consideration to the DLGSC Operational Guideline Number 9 the Appointment, Function and Responsibilities of Audit Committees and the Officer of the Auditor General's Public Sector Audit Committees Better Practice Guide.
- Agree that Council reports should include a Risk Implication section for consideration within the report.

Action Owner: Corporate Services and Governance

Target Completion Date: Within 12 months of this reports adoption

5.2 Audit Finding – Operational Risk Management

There is a risk management policy in place, which was last reviewed in 2018. Although much of the content is appropriate it includes references to ISO 31000:2009, which was updated in 2018.

Within the Risk Management Policy it is stated that it should be updated annually, along with the Risk Management Plan though there is no Plan in place.

The last known formal risk management activity was a Strategic Risk Workshop facilitated by LGIS in 2014 which developed a draft strategic risk register, ratings, mitigating controls and further actions. The report also documented future action plan to embed risk and within an Appendix the draft risk register. However this exercise was not completed for all areas of the Shire due to a lack of time during the workshop and subsequently was never progressed and implemented operationally.

As such there are no operational processes in place for risk management including identifying risks, assessing the risk level and identifying risks which require risk management plans.

Risk Rating

Paxon has determined this finding to be of **High Risk.**

Implication

There is a lack of formal risk management within the Shire, which could lead to failure to identify and manage risks resulting in strategic or operational impacts or failure to achieve desired objectives and outcomes.

Recommendation

5.2.1 The Risk Management Policy should be reviewed and updated.

5.2.2 A Risk Management Plan of risk related activity and its timing should be developed to determine how the Shire will implement the Policy and the level of maturity that the Shire wishes to achieve with regards to risk management. This should include consideration of the development of strategic and operational risk registers including: ratings; controls and risk management plans. Reporting of risk to the oversight bodies of the Group and Committee should also be included.

5.2.3 Given the length of time since risk management was last operational, training of staff may be required in order to update risk management and embed it within the Shire.

Management Comment:

- This was raised as an item requiring action at the Shire's 2019 Regulation 17 Audit. Inconsistency in the person appointed in the Manager Corporate Services role has been the reason this has not been actioned. The Risk Management Policy needs updating/reviewing as a whole; not just the reference to ISO 31000:2009.
- Risk Management Plan should be a priority for Shire of Nannup staff along with associated refresher training. Agree completely with recommendations of audit.

Action Owner:	Corporate Services and Governance
Target Completion Date:	Within 12 months of this reports adoption

5.3 Audit Finding – Monitoring Implementation of Findings

As noted within Finding 5.2 a Strategic Risk Workshop was facilitated by LGIS in 2014. The arising report documented future risk related actions but these were not implemented.

Paxon also noted that a review of Regulation 17 and Regulation 5 was performed by Moore Stephens in June 2019 and a spreadsheet to track the implementation of actions was set up. However, it does not appear based upon the comments within the document and through performance of our review that actions were undertaken, or if they were then the spreadsheet was not updated and the actions were not embedded, as they no longer appear to be operational.

Given the points noted above this would indicate that there is no appropriate process in place to implement actions and to monitor their implementation.

Risk Rating

Paxon has determined this finding to be of **High Risk.**

Implication

The Shire is exposed to increased risk as a result of not remediating findings raised by assurance providers.

Recommendation

5.3.1 All reports from assurance providers should be provided to the Group and Committee so that findings can be accepted.

5.3.2 An audit log of all findings raised by independent assurance providers should be developed and reported to Group and Committee on a regular basis so that implementation can be monitored.

5.3.3 In order to ensure the accuracy of this reporting regular independent review of the status of actions and appropriate remedial measures noted as completed by management should be put in place to ensure that the activity has occurred.

Management Comment:

- Agreed that frameworks and processes to implement and monitor findings needs review and implementation. Some actions from the 2019 Moore Stephens review have been implemented but the officers of the time appear to not have documented these changes.
- Management comments per 5.1 and 5.2 directly relate to this section's effectiveness.
- Inconsistency in the person appointed in the Manager Corporate Services role has been a major weakness in the process.

Action Owner: Corporate Services and Governance

Target Completion Date: Within 12 months of this report to substantially commence

6. INTERNAL CONTROL

6.1 Audit Finding – Fraud/Integrity Framework

The Public Sector Management Act requires a formal integrity framework to be developed by June 2023.

It was noted that the Shire has Finance Policy FNC10 – Fraud Management in place, but this was last reviewed in January 2018. This is a brief overview and there are no referenced procedures that would provide further detail as to processes for reporting or investigating allegations, including a means to report anonymously.

Paxon also noted that there is no information on the website for reporting fraud and misconduct or related items such as Public Interest Disclosure, which provides protection for any employee or community member making a report.

There are tools that would help to build the required integrity framework, such as the Public Sector Commission's 'Integrity Snapshot Tool', which is part of the Integrity Strategy for Public Authorities 2020-23 and the Office of the Auditor General's June 2022 report 'Fraud Risk Management Better Practice Guidance'.

Risk Rating

Paxon has determined this finding to be of **High Risk.**

Implication

- Non-compliance with Public Sector Management Act.
- Lack of information and reporting processes results in non-reporting of fraud or a failure to adequately address reports of fraud or misconduct.

Recommendation

6.1.1 A plan should be developed to implement an Integrity Framework, leveraging guidance from the OAG and PSC. This should include the review and update of existing documents and the development of any new required documents such as processes for reporting allegations and their investigation.

6.1.2 Fraud reporting and investigation processes should be developed and made available to Shire employees and to the community.

Management Comment:

- The compliance date for this framework to be developed is 30 June 2023 (future date), this finding is stating these new changes coming into effect in the future and that the Shire should be planning towards this completion date.

Action Owner: Corporate Services and Governance

Target Completion Date: Within 12 months of this report to substantially commence

6.2 Audit Finding – Delegated Authority to CEO and Officers

It was noted that a Delegated Authority document is in place for Council to CEO delegations. This was last reviewed on 28 May 2020 by Council, with no changes.

There is no register of delegation from CEO to Officers. We understand that these delegations are documented within position descriptions at the commencement of employment but are not reviewed or confirmed annually.

However, Section 5.46 of the Local Government Act 1995 requires the following:

"5.46. Register of, and records relevant to, delegation to CEO and employees.

(1) The CEO is to keep a register of the delegations made under this Division to the CEO and to employees.

(2) At least once every financial year, delegations made under this Division are to be reviewed by the delegator.

(3) A person to whom a power or duty is delegated under this Act is to keep records in accordance with regulations in relation to the exercise of the power or the discharge of duty."

Risk Rating

Paxon has determined this finding to be of **Medium Risk.**

Implication

- Non-compliance with legislation and regulation
- Inappropriate delegations due to infrequent reviews

Recommendation

6.2.1 A delegation register from CEO to officers should be established.

6.2.2 A process should be established to ensure all delegations are reviewed by the delegator every financial year.

Management Comment:

- The Register of Delegations has undergone a review in alignment with the WALGA template which addresses sub-delegations to officers. The majority of the delegations are not sub-delegated – health, building, animal control and purchasing are the relevant ones but these have been addressed as part of the review and hence the register of delegations is the records for sub-delegations where applicable as well.
- An annual compliance calendar has been implemented to capture these annual review requirements.

Action Owner: Corporate Services and Governance

Target Completion Date: Within 12 months of this report to substantially commence

6.3 Audit Finding – Business Continuity Planning

There is no business continuity plan or disaster recovery plan in place for the Shire. This is an expected practice for all organisations to coordinate activity and priorities in the occurrence of an event to minimise the impact or recommence operations on a timely basis.

Risk Rating

Paxon has determined this finding to be of **Medium Risk.**

Implication

The Shire may not be able to operate in the occurrence of an adverse event.

Recommendation

A business continuity plan, including a disaster recovery plan should be developed.

Management Comment:

Business Continuity and Disaster Recovery Planning is being practiced within the Shire's operations. The Shire currently has Disaster Recovery in place with offsite cloud backups and the recent commission of laptops so work can continue offsite in the event of a disaster to name a few. The Shire needs dedicate time to document these systems into a written document.

Action Owner: Corporate Services

Target Completion Date: Within 12 months of this reports adoption

6.4 Audit Finding – Internal Guidance Documents and Update

There is no policy or process in place to coordinate the review and update of policies or other internal guidance documents. We understand that this is performed when the need is identified.

Throughout this report we have identified documents that require update:

- The risk management policy and plan state that they should be updated annually
- The investments policy has not been updated since 2018
- The Code of Conduct for Staff was last updated in 2016. This still includes guidance in relation to Councillors and Candidates for whom a separate Code of Conduct was developed in 2021.
- There is a Complaints Handling Policy from 2017 and related forms for making complaints about employees and elected members.

We also noted that there are no management practice and limited procedures in place within the Shire which provide more detailed information on how policy should be operationally implemented. These help to provide guidance to employees and maintain a standard approach. They also act as a useful tool when there is a lack of handover if employees leave or during on-boarding processes.

Risk Rating

Paxon has determined this finding to be of **Low Risk.**

Implication

- Policy documents may be outdated and are at risk of providing inappropriate guidance to both employees and the wider community.
- There is a lack of operational guidance for employees if there is high turnover of employees or no handover and to standardise operations.

Recommendation

We understand that the Shire has limited resources to develop, review and update policy and other internal guidance documents hence. We recommend that a process be established to review documents based upon the resource available and the relative risk of documents and the function they relate to.

Management Comment:

- Shire staff have identified it is good practice to review policy and procedure and have commenced the implementation of procedure for the review/development of operational policies. The Annual Compliance Calendar initiates review of policies.
- The current review of the Register of Delegations found the removal from the register items that are a Council Policy not a delegation, the Council Policy Manual is filled with both Council and Operational Policies. Staff are in the process of separating these Council and Operational Policies into separate documents. The Council Policy document will have the revision of the items that were include in the Delegations but now removed because they were not Delegations.
- Management acknowledge that the Shire of Nannup Code of Conduct for Staff needs review. This will occur 2023.

Action Owner: Various – CEO and Corporate Service and Governance

Target Completion Date: Within 12 months of this report to substantially commence

6.5 Audit Finding – Record Keeping Plan Review

The Record Keeping Plan is dated December 2015. We were informed by management that this in the process of being updated.

We noted good practice in that there is a section on Freedom of Information on the Shire's website.

Risk Rating

Paxon has determined this finding to be of **Low Risk.**

Implication

Non-compliance with record keeping requirements.

Recommendation

The record keeping plan review should be completed and provided to the State Records Office for review.

Management Comment:

- Currently being amended. State Records Office is aware of Record Keeping Plan being delivered late and therefore non-compliant.
- Delay due to change in staff roles and responsibilities, lack of appropriate staff and resources.

Action Owner: Corporate Services

Target Completion Date: Within 12 months of this report to substantially commence

7. LEGISLATIVE COMPLIANCE

7.1 Audit Finding – Compliance Framework

There is no documented compliance framework in place within the Shire. Hence the approach to compliance within the Shire is unclear, including who the responsibility for compliance resides with or when compliance requirements need to be met.

Determining how compliance requirements are identified and when required updated should also be documented.

Risk Rating

Paxon has determined this finding to be of **Medium Risk.**

Implication

Legislative requirements may not be complied with due to a lack of awareness of their existence, identifying updates and the responsibility for these actions

Recommendation

A compliance framework document should be developed which identifies the approach to compliance and the responsibilities. This could also include a calendar of compliance requirements and processes for identifying changes to compliance requirements.

Management Comment:

- Compliance Calendar has been implemented based on WALGA template, DLGSC Operational Guidelines and best practice resources.
- Induction to Local Government and Governance being implemented as a part of new employee induction process, with the goal of increasing employee awareness and understanding of compliance requirements and responsibilities.
- A compliance framework is the Annual Compliance Return, it is not viable to develop a separate compliance framework with staff resource and budget.

Action Owner: Corporate Services and Governance

Target Completion Date: Within 12 months of this report to substantially commence

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