Some Questions We Need to Answer...

- How can we be assured that we treating the symptoms rather than the root cause?

- Does your process for evaluating issues (non-existent controls, breakdown of controls, override of controls) contain a formal root cause analysis?

- Do you understand ethics and “Loopholes”?
Root Cause Analysis
Finding The First Domino

Why is this important?

Answer: You don’t want your remediation activities focused on the symptoms, rather than the cause!

Ethics

Chief Justice of the U.S. Supreme Court Potter Stewart once stated: “Ethics is knowing the difference between what you have the right to do and what is right to do.” ... And therein lays the problem: people often have different and opposing ethical standards
Loopholes

A loophole is an ambiguity or inadequacy in a system, such as a law or security, which can be used to circumvent or otherwise avoid the purpose, implied or explicitly stated, of the system. ... In a loophole, a law addressing a certain issue exists, but can be legally circumvented due to a technical defect in the law.

Theory

- An individual’s integrity does not generalize across situations and is not internalized as a personal value.
- An individual’s behavior is influenced more by the situation:
  - Opportunity to be dishonest
  - Probable gain from cheating
  - Likelihood of getting caught
  - Severity of the punishment
  - Perceived need for more money
- Usually, most individuals-
  - Believe in honesty
  - Can be tempted by convenient opportunities and intense situational pressures
A Brief History Behind Root Cause Analysis (RCA)

- Developed by Sakichi Toyoda who later founded Toyota Motor organization.
- RCA was first used during the development of Toyota's manufacturing processes in 1958.

From the 2019 DOJ Guidance:

**Root Cause Analysis** – What is the organization’s root cause analysis of the misconduct at issue? Were any systemic issues identified? Who in the organization was involved in making the analysis?

**Remediation** – What specific changes has the organization made to reduce the risk that the same or similar issues will not occur in the future? What specific remediation has addressed the issues identified in the root cause and missed opportunity analysis?
Investigations and Prosecutions 9-47.120 – FCPA Corporate Enforcement Policy

The following items will be required for an organization to receive full credit for timely and appropriate remediation for purposes of USAM 9-47-120(1) (beyond the credit available under the U.S.S.G.):

- Demonstration of thorough analysis of causes of underlying conduct (i.e., a root cause analysis) and, where appropriate, remediation to address the root causes...

https://www.justice.gov/jm/jm-9-47000-foreign-corrupt-practices-act-1977#9-47.120

Importance of Timely Fixes

The Justice Department and the SEC have consistently preached the importance of remediation — that is, efforts by organizations to address compliance deficiencies during the pendency of an investigation.

Some suggestions...

- Don’t wait until the resolution of a case to remediate a compliance breakdown;
- Initiate remediation steps as soon as possible during an investigation.

*In other words, once the problem is discovered, do not delay and fix the problem.*
Why Are We Here Today?

Some Techniques Are Available To Identify Root Causes:

- **Five Whys**
- Flowcharting of the process flow, system flow, and data flow
- **Why-because diagram**
- Fishbone or “Ishikawa” or 5M diagrams
- Failure mode and effects analysis
- **Pareto chart**
- Statistical correlation
- **COSO Internal Control Components**
Simple Example To Set the Tone

Player presents to team trainer with a problem after practice. He has a headache.

**Why 1** do I have such a bad headache?
First answer: Because I can't see straight.

**Why 2**: Why can't you see straight?
Second answer: Because I hit my head on the ground.

**Why 3**: Why did your head hit the ground?
Third answer: I was tackled and fell backwards and my head hit the ground hard.

**Why 4**: Why did hitting the ground hurt so much?
Fourth answer: Because I wasn't wearing a helmet.

**Why 5**: Why weren't you wearing a helmet?
Fifth answer: Because we didn't have enough helmets in our locker room that fit my head.

**Aha Moment!** After these five questions, we discover that the root cause of the concussion was most likely from a lack of available helmets that fit his head. In the future, we could reduce the risk of this type of concussion by making sure every football player has a helmet. (Of course, helmets don’t make us immune to concussions. Be safe!)

Restaurant Complaints...Was Anything Ok?

Before and after!
So What is Root Cause Analysis?

- Root cause analysis (RCA) is defined as the identification of **why an issue occurred** vs. only identifying or reporting the issue itself.

- In this context, an issue is defined as a **problem**, **error**, **instance of noncompliance**, or **missed opportunity**.

What is Root Cause Analysis? Continued

- Auditors/Compliance/Investigators whose reporting only recommends that management fix the issue and not the underlying reason that caused the issue are failing to add insights that improve the longer-term effectiveness and efficiency of business processes and thus, the overall governance, risk, and control environment.

- A core competency necessary for delivering insights is the ability to identify the need for root cause analysis and as appropriate, actually facilitate, review, and/or conduct a root cause(s) analysis.
What is Root Cause Analysis? Continued

- Internal Audit is generally the ideal group to analyze issues and identify root causes given their independence and objectivity. This perspective helps ensure biases are minimized, assumptions are challenged, and evidence is fully evaluated. **Sometimes you might have to go outside the organization!**
- There are instances where compliance, the investigative team, and legal can and should be involved.
- Internal Auditors by working across various reporting chains and departments of an organization may have developed a broad and deep understanding of the underlying issues that may exceed that of any single member of management which makes them best positioned to analyze an issue.
- **Caution:** In circumstances where the root cause of an issue is a result of actions or inaction by management, it is critical to use an objective party such as Internal Audit or an outside consultant to investigate and report back to Senior Management.

Key Benefits

Root cause analysis benefits the organization by **identifying the underlying cause(s) of an issue.** This approach provides a long-term perspective for the improvement of business processes.

Without the performance of an effective root cause analysis and the appropriate remediation activities, an issue may have a **higher probability to reoccur** (recidivism).

Root cause analysis **helps prevent additional rework** and **proactively addresses future recurrences** of the issues.
Some Things to Note

- Root-cause identification can be time-consuming in case of complex findings, it is important to:
  - Anticipate the time needed for the proper investigation of causes
  - Directly recommend a “root-cause analysis” in the audit report, if it is not possible to perform this analysis during assignment, due to time / skills constraints

Before starting root cause analysis consider:
- The level of complexity
- Potential barriers (e.g. management reluctance)

Organizational Impact

Root cause
Remediation
Better Understanding of Risks
Better Designed Internal Controls
Enhance Compliance & Ethics Program
Internal Controls – Designed to Detect and Deter Fraud

![Diagram showing the relationship between Perpetrator(s), Anti-Fraud Measures, and Detection Measures.]

**Internal Control**

An action or a process of interlocking activities designed to support the policies and procedures detailing the specific preventive, detective, corrective, directive, and corroborative actions required to achieve the desired process outcomes. This along with on-going/continuous monitoring, and training that reasonably assures:

- The achievement of the process objectives linked to the organization’s objectives;
- Operational effectiveness and efficiency;
- Reliable (complete and accurate) books and records (financial reporting);
- Compliance with laws, regulations, and policies;
- Reducing risk – fraud, waste, and abuse, which
- Aids in the reduction of process and policy variations leading to more predictive outcomes.

- Jonathan T. Marks, CPA, CFE

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Phases and Tools

The COSO framework consists of 5 components derived from the way management runs a business. These components provide an effective framework for describing and analyzing the internal control systems implemented in an organization:

- **Control environment**: factors including the integrity, ethical values, management style, delegation of authority systems, or processes for managing and developing people in the organization.
- **Risk assessment**: identification and analysis of relevant risks to the achievement of assigned objectives. Risk assessment is a prerequisite for determining how the risks should be managed.
- **Control activities**: procedures that help ensure management directives are carried out, such as approvals, authorizations, reconciliations, reviews of performance, security of assets and segregation of duties principles.
- **Information and communication**: reports, including operational, financial and compliance-related information, that make it possible to run and control the business. Effective communication must ensure information flows down, across and up the organization and with external parties, such as customers, suppliers, regulators and shareholders about related policy positions.
- **Monitoring**: Internal control systems need to be monitored to assess the quality of the system’s performance over time. Deficiencies detected through these monitoring activities should be reported and corrective actions should be taken to ensure continuous improvement of the system.
Good Root Cause Analysis

A root cause analysis that seeks to understand why people make/take bad or inadequate decisions/actions

A root cause analysis that stops at the identification of physical and process components (e.g. systems, policies, KPI, training...)

Examples of potentially key questions:

1. Why did you do this (why did it happen)?
2. Why risk your job?
3. What was the benefit?
4. Is the subject competent at their job?
5. How could the Organization have prevented this?
6. Is there an organization policy that covers this?
7. Is the policy clear?
8. Did you circumvent existing controls to do this?
9. Have you received training regarding this issue?
10. Was training effective?
11. Did you know this is not allowed by policy? OR
12. Did you consider that this may be against organization policy?
13. Did you know it was wrong?
14. Were you given permission?
15. Did anyone know about this? Did the "look the other way"?
16. Where is your manager located?
17. Do you work the same shift as your manager?
18. How often do you telecommute or work virtual?

Collection of the Right Information Is Critical

<table>
<thead>
<tr>
<th>Root Cause Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Factors</strong></td>
</tr>
<tr>
<td>Intentional/Unintentional</td>
</tr>
<tr>
<td><strong>Systemic Factors</strong></td>
</tr>
<tr>
<td>Internal Controls/Inadequate Policy/Training</td>
</tr>
<tr>
<td><strong>Social</strong></td>
</tr>
<tr>
<td>Mgt/Lack of Enforcement</td>
</tr>
</tbody>
</table>

Social

Culture
Socratic Questioning

Disciplined questioning that can be used to pursue thought in many directions and for many purposes, including: to explore complex ideas, to get to the truth, to open up issues and problems, to uncover assumptions, to analyze concepts, to distinguish what we know from what we don’t know, to follow out logical implications of thought, or to control the discussion.

The key to distinguishing Socratic questioning from questioning per se is that Socratic questioning is systematic, disciplined, deep and usually focuses on fundamental concepts, principles, theories, issues or problems.

Socratic Questioning – Continued

**Questions for clarification** – Prove the concepts behind their argument. Use basic *tell me more* questions that get them to go deeper.

- Why do you say that?
- How does this relate to our discussion?
- Can you give me an example?
- Can you rephrase that?

**Questions that probe assumptions** – Probing their assumptions makes them think about the presuppositions and unquestioned beliefs on which they are founding their argument.

- What could we assume instead?
- How can you verify or disapprove that assumption?
- What would happen if...
Socratic Questioning – Continued

Questions that probe reasons and evidence – When they give a rationale for their arguments, dig into that reasoning rather than assuming it is a given. People often use un-thought-through or weakly understood supports for their arguments.

- What would be an example
- What is analogously to?
- What do you think causes this to happen...? Why?:
- What evidence is there to support what you are saying
- On what authority are you basing your argument?

Questions about Viewpoints and Perspectives – Most arguments are given from a particular position. So attack the position. Show that there are other, equally valid, viewpoints.

- What would be an alternative?
- What is another way to look at it?
- Would you explain why it is necessary or beneficial, and who benefits?
- Why is the best?
- What are the strengths and weaknesses of...?
- How are...and ...similar?
- What is a counter argument for...?

Socratic Questioning – Continued

Questions that probe implications and consequences – The argument that they give may have logical implications that can be forecast.

- Do these make sense? Are they desirable?
- What generalizations can you make?
- What are the consequences of that assumption?
- What are you implying?
- How does...affect...?
- How does...tie in with what we learned before?
- What is the best ...? Why?

Questions about the question – And you can also get reflexive about the whole thing, turning the question in on itself. Use their position against themselves. Bounce the ball back into their court, etc.

- What was the point of this question?
- Why do you think I asked this question?
- What does...mean?
Cause and Effect

Perhaps the most useful tool for identifying root causes is the cause and effect diagram (it goes by several names: Ishikawa, fishbone, etc.) and is primarily a tool for organizing information to establish and clarify the relationships between an effect and its main causes.

Cause and Effect - Root Cause Analysis

People - Anyone involved with the process

Methods - How the process is performed and the specific requirements for doing it, such as policies, procedures, rules, regulations and laws

Machines - Any equipment, computers, tools, etc. required to accomplish the job

Materials - Raw materials, parts, pens, paper, etc. used to produce the final product

Measurements - Data generated from the process that are used to evaluate its quality

Environment - The conditions, such as location, time, temperature, and culture in which the process operates
3 Lines of Defense – The Who!

1. Identification of a finding / anomaly,
2. « 5 Why » exercise to underline the potential reasons for the anomaly
3. Positioning of the reasons on a why-because diagram (or fishbone) to precise and validate the cause of the anomaly
4. Final assessment of the anomaly based on the main causes identified and the COSO components, to understand the reason why this cause happened without being detected through the internal controls in place.
5. Review the 3 lines and depict the areas with issues

Sample Flow
5 Why Exercise

- **Root Cause** is the most basic reason a problem has or could occur
  - Ask "Why" 3 - 5 times
  - Why does this occur? Why does the condition exist?

- Do not mix root-cause with potential solutions or action plans!
  - "No procedure", "no KPI" and "no training" are potential solutions, but NOT a recommendation.

**WHY DID THIS HAPPEN?**

- Early questions are usually superficial, obvious; the later ones more substantive.

**Symptom 1**

**Symptom 2**

**Symptom 3**

**Symptom 4**

**Probable Root Cause**

Sample Problem

**FINDING ON SUPPLY CHAIN CYCLE**

<table>
<thead>
<tr>
<th>Finding</th>
<th>We have rotten apples in the warehouse!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Causal Analysis</td>
<td>???</td>
</tr>
<tr>
<td>Recommendation</td>
<td>???</td>
</tr>
</tbody>
</table>

Some advice before starting the Causal Analysis:

- **Root causes are not easy to find**
  - Challenge initial assumptions
  - Be patient
  - Seek input from as many sources as possible

- **Avoid pressure for quick solutions (auditees, team leaders, work program)**
  - Be patient. Do not jump to conclusions
  - Do not overlook easy opportunities
  - Communicate interim results to outsiders

- **Preconceived notions for causes are dangerous**
  - Let data reveal the true picture problems
  - Bring out and explore dissenting views, do not always rely on past audits
  - Use analytical tools

- **Resistance to collecting more data**
  - Look for data that is already available
  - Look for opportunities to collect cause data during initial data collection efforts
  - Distribute the workload evenly among all team members
  - Plan data collection; Use good checklist and collect the right data the first time
Rotten Apples – Know the Business

Why are so many apples rotting quickly in our warehouse?

Humidity – the amount of moisture vapor in the air – plays a direct role in the shelf life of fruits and vegetables.

Some of the produce that’s best stored in environments of 90% relative humidity (RH) or higher include asparagus, apples, broccoli, Brussels sprouts, cabbage, carrots, cauliflower, celery, collards, corn, grapes, kale, leeks, lettuce, parsley, pears, peas, radishes, rhubarb, rutabagas and spinach.

Apples stored in a commercial refrigerated storage will keep for 4 to 6 months, but for long term storage up to 12 months, growers use Controlled Atmosphere (“CA”) storage. Apples for CA are picked at their peak of internal quality and condition. They are rushed into a CA storage the day they are picked. The oxygen level is lowered to 1.5 to 3%, temperature is reduced to 30-32 degrees Fahrenheit, carbon dioxide levels are monitored and controlled. This puts the fruit to sleep (stops the ripening process) until ready for use.

---

Rotten Apples

**From probable root cause to problem/issue**

- If the probable root cause is eliminated or corrected, would it prevent the problem from existing or occurring?
- When the probable root cause occurs, does the problem surface?

Zone of suspicion (investigation required)
- Point without anomaly
- Point of deficiency
Rotten Apples

Synthesis of findings and recommendations

1. **No analysis:**
   ABC must implement KPI to monitor rotten apples.

2. **Level 1 Analysis (1st Why):**
   ABC must implement a procedure to manage the storage conditions of apples, notably to avoid rotten apples.

3. **Level 2 Analysis (2nd Why):**
   ABC must regularly control the humidity of the warehouse to ensure the proper conservation of apples stored.

4. **Level 3 Analysis (3rd Why):**
   ABC must comply with Group Policies and Quality guidelines, by:
   - reinforcing the air tightness and waterproofing of the warehouse,
   - implementing temperatures and hygrometers devices to monitor the humidity of the warehouse, to ensure the proper conservation of products stored.
Contributing Factors

Contributing Factor is a condition that influences the effect by increasing its likelihood, accelerating the effect in time, affecting severity of the consequences, etc.; eliminating a contributing factor(s) won't eliminate the effect, but it will give you better insight into risk!

The Contributing Factors List
Breakdown

- ETHICS?
- Intentional
  - Personal Benefit
  - Willful Disregard
  - Personal Pressures
  - Rationalization
- Individual
- Unintentional
  - Carelessness/Mistake
  - Inexcusable Ignorance
  - Competency
The Contributing Factors List Breakdown

### Social
- Culture
  - Business Target/Peer Pressures
    - Permissiveness
      - Ineffective Management
        - Lack of Policy Enforcement
          - Incentives Promoting Misconduct
            - Decision for organization Gain
  - Management
    - Incentives Promoting Misconduct
      - Decision for organization Gain

### Systematic
- Internal Controls
  - No Controls
    - Inadequate Controls
      - Lack of Monitoring
        - Ineffective Monitoring
          - No Policy/Process
            - Policy/Process Complexity/Volume
              - Ineffective Policy/Process
                - Lack of Training
                  - Ineffective Training
  - Policy
    - No Policy/Process
      - Policy/Process Complexity/Volume
        - Ineffective Policy/Process
          - Lack of Training
            - Ineffective Training
  - Training
    - Ineffective Training
      - Decision for organization Gain
## Contributing Factors Definitions

<table>
<thead>
<tr>
<th>Contributing Factor</th>
<th>Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Benefit</td>
<td>Willful violation of policy/ process to obtain a personal benefit</td>
<td>Working less hours than claimed, being paid for it.</td>
</tr>
<tr>
<td>Willful Disregard</td>
<td>Willful violation of policy / process without obtaining a personal benefit</td>
<td>Providing proprietary information to those who are not authorized</td>
</tr>
<tr>
<td>Personal Pressures</td>
<td>Personal pressures (substance abuse/divorce, gambling, etc.) contributed to process / policy violation</td>
<td>Self explanatory</td>
</tr>
<tr>
<td>Peer Pressure</td>
<td>Peer employees persuade others to engage in misconduct</td>
<td>A group of employees convince another to falsify records to conceal their own mistakes</td>
</tr>
<tr>
<td>Rationalization /Minimization</td>
<td>Behavior was rationalized because he/she was entitled or the organization owed them</td>
<td>Believed the organization owed them due to their service, so they have been taking supplies</td>
</tr>
<tr>
<td>Carelessness/Mistake</td>
<td>Negligent behavior contributed to process / policy violation (lack of willfulness)</td>
<td>Inattention during manufacturing process</td>
</tr>
<tr>
<td>Inexcusable Ignorance</td>
<td>Expected behavior is common sense or so basic, the process / policy violation should not have occurred</td>
<td>Throwing a match in a bucket of gasoline</td>
</tr>
<tr>
<td>Incentives Unintentionally Promoting Misconduct</td>
<td>Incentives (usually financial) provide strong motivation to the extent employees engage in misconduct to receive it</td>
<td>A sales incentive of $50,000 for being the top sales person in a given year</td>
</tr>
<tr>
<td>Competency</td>
<td>Poor skills contributed to policy violation (lack of willfulness)</td>
<td>Has not learned to use an online system and deleted files</td>
</tr>
<tr>
<td>Pressure to Meet Business Targets</td>
<td>Willful process / policy violation to get the job done</td>
<td>Rubber stamping by an inspector when they are behind schedule</td>
</tr>
<tr>
<td>Cultural Permissiveness</td>
<td>Workgroup norms contributed to process / policy violation</td>
<td>“This is the way we do this here”</td>
</tr>
<tr>
<td>Management Ineffectiveness</td>
<td>Management should have reasonably detected and/or prevented process / policy violation</td>
<td>Manager was warned by other employees about the behavior and took no action</td>
</tr>
<tr>
<td>Lack of Process and / or Policy Enforcement</td>
<td>Management was aware of policy / process violation, but did not enforce expected behavior</td>
<td>Self explanatory</td>
</tr>
<tr>
<td>Business Decision for organization Gain</td>
<td>Management decision to violate process / policy for organization benefit</td>
<td>Entering into a supplier contract without including SMP to save time</td>
</tr>
</tbody>
</table>
Contributing Factors Definitions

<table>
<thead>
<tr>
<th>Contributing Factor</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Controls in Place</td>
<td>A reasonable internal control should have identified and mitigated process / policy violation</td>
<td>No process to verify supplier account routing changes</td>
</tr>
<tr>
<td>Control Adequacy</td>
<td>A more robust control should have identified and mitigated process / policy violation</td>
<td></td>
</tr>
<tr>
<td>Lack of Monitoring</td>
<td>Monitoring could have detected process / policy violation, but no audits / monitoring in practice</td>
<td>No system/process to monitor QA Inspector performance</td>
</tr>
<tr>
<td>Monitoring Ineffectiveness</td>
<td>Monitoring performed, but did not detect process / policy violation</td>
<td>Audit did not detect a vendor w/o valid address or phone number</td>
</tr>
<tr>
<td>No policy / process</td>
<td>Lack of guidance surrounding policy or process</td>
<td></td>
</tr>
<tr>
<td>Policy and / or process</td>
<td>Process / policy not easily understood due to complexity / voluminous</td>
<td>Self-explanatory</td>
</tr>
<tr>
<td>complexity / volume</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy / Process Ineffectiveness</td>
<td>Current policy / process did not address behavior and/or actions which contributed to violation (Process loophole)</td>
<td>Policy allows for production to be done out of sequence</td>
</tr>
<tr>
<td>Lack of Training</td>
<td>Respondent was not trained nor had knowledge of policy / process</td>
<td>Self explanatory</td>
</tr>
<tr>
<td>Training Ineffectiveness</td>
<td>Respondent trained, but did not understand policy / process</td>
<td>Training does not require completion verification</td>
</tr>
</tbody>
</table>
Documentation – Consider Making It Stand Out!

Rather than wading through a finding to determine its importance, layer the finding for your audience. Since your final audience is the executive and audit committee, layer an issue to emphasize items important to the end audience, similar to the following:

- Sentence 1: Root cause/topic sentence
- Sentence 2: Background or criteria
- Sentence 3: Evidence that points to the root cause
- Sentence 4: Conclusion based off of evidence
- Separate section: Risk
- Separate section: Recommendation

Senior Leadership and Audit committees are concerned with root causes, overall risks, and whether the issue is being handled. You can emphasize these sections by either introducing them first (like your root cause sentence) or placing information in its own section (like risk and recommendations that are frequently separated into individual sections in an audit finding).

Remediate Deficiencies Thoroughly

1. If accounting errors lead to a restatement, then the organization may have deficiencies in internal controls.

2. Failure to remediate gaps in internal controls provides the opportunity for the same problem or issue to resurface and additional errors or misconduct to occur, which could damage the organization’s credibility with regulators.

3. The SEC in particular will focus on what steps the organization took upon learning of the misconduct, whether the organization immediately stopped the misconduct, and what new and more effective internal controls or procedures the organization has adopted or plans to adopt to prevent a recurrence.

4. When documenting remedial actions, it’s often preferable to describe them as "control enhancements" to avoid potentially harmful collateral impacts in civil litigation.
Regulators

DOJ and the SEC regularly cite **remediation** as an important factor in determining whether a corporate monitor should be appointed as part of a settlement.

Organizations could get credit for their remediation efforts while the investigation is ongoing? Challenges?

Key Elements of an Effective Compliance/Remediation Plan

Build a plan tailored to address the size and services provided by your organization and the particular risks it faces.

- Compliance Officer and Program Oversight/Governance
- Policies and Procedures
- Education
- Audit
- **Corrective Actions to Identified Problems**
- Open Communications
- Enforce Violations
Lastly

Recommendations that only require local management to fix the issue (and not the underlying reasons that caused this issue) are failing to improve:

The long-term effectiveness and efficiency of business processes and consequently,

The overall efficiency of the governance, risk, and internal control environment.

We Can Do Better Is Not A Strategy!
Contact Info

Jonathan T. Marks, CPA, CFF, CITP, CGMA, CFE
and NACD Board Fellow
Partner
www.boardandfraud.com
@jtmarkscpa
(609) 402-9966 - Mobile

Appendix – Additional Materials

EXTRA
A Control Does Something...Here are some examples

- **Approve** - Authorization to execute a transaction by someone empowered to do so (e.g., approval of a write-off).
- **Calculate** - Computing or re-computing an amount from other data obtained in the process (e.g., using historical write-off data to compute a bad debt reserve, or checking a depreciation calculation to ensure the systematically computed amount is reasonable).
- **Document** - Preserving source information or documenting the rationale behind judgments made for future reference (e.g., scanning receiving documentation, invoices, and checks to support a payment or writing a memorandum to the files that outlines the judgments used in determining an accrual).
- **Verify** - Verification that an attribute exists (e.g., goods being paid for were in fact received).
- **Reconcile** – Timely reconciliations to be completed by an independent person who is properly segregated from that account/function.
- **Conflicts of Interest** – when a conflict arises require transparency and ensure there is competitive bidding.
- **Match** - Comparing two different attributes to verify they agree (e.g., a payment amount agrees the invoice amount).
- **Monitor** - Checking to ensure an action is occurring (e.g., ensuring that a trader does not exceed his or her limits).
- **Restrict** - Not allowing an unacceptable action (e.g., prohibiting speculation on interest rate fluctuations or not allowing unauthorized individuals to access certain data within key systems).
- **Segregate** - Separating incompatible duties that would create the potential for an undesirable action (e.g., separating check signing and invoice approval authority).
- **Supervise** - Providing direction and oversight to ensure actions and tasks are carried out as designed (e.g., supervisor approving a batch before computer processing).