NOVA SCOTIA

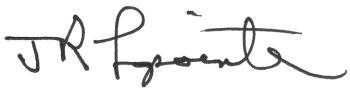
May 1, 2013

Honourable Gordie Gosse
Speaker
House of Assembly
Province of Nova Scotia

Dear Sir:

I have the honour to submit herewith my Report to the House of Assembly under Section 18(2) of the Auditor General Act, to be laid before the House in accordance with Section 18(4) of the Auditor General Act.

Respectfully submitted



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Office of the Auditor General

Our Vision

A relevant, valued and independent audit office serving the public interest as the House of Assembly's primary source of assurance on government performance.

Our Mission

To make a significant contribution to enhanced accountability and performance in the provincial public sector.

Our Priorities

Conduct and report audits that provide information to the House of Assembly to assist it in holding government accountable.

Focus our audit efforts on areas of higher risk that impact on the lives of Nova Scotians.

Contribute to a better performing public service with practical recommendations for significant improvements.

Encourage continual improvement in financial reporting by government.

Promote excellence and a professional and supportive workplace at the Office of the Auditor General.

Who We Are and What We Do

The Auditor General is an independent nonpartisan officer of the Legislature, appointed by the House of Assembly for a ten-year term. He or she is responsible to the House for providing independent and objective assessments of the operations of government, the use of public funds, and the integrity of financial reports. The Auditor General helps the House to hold the government to account for its use and stewardship of public funds.

The Auditor General Act establishes the Auditor General's mandate, responsibilities and powers. The Act provides his or her Office with a modern performance audit mandate to examine entities, processes and programs for economy, efficiency and effectiveness and for appropriate use of public funds. It also clarifies which entities are subject to audit by the Office.

The Act stipulates that the Auditor General shall provide an opinion on government's annual consolidated financial statements; provide an opinion on the revenue estimates in the government's annual budget address; and report to the House at least annually on the results of the Office's work under the Act.

The Act provides the Office a mandate to audit all parts of the provincial public sector, including government departments and all agencies, boards, commissions or other bodies responsible to the crown, such as regional school boards and district health authorities, as well as funding recipients external to the provincial public sector. It provides the Auditor General with the authority to require the provision of any documents needed in the performance of his or her duties.

In its work, the Office of the Auditor General is guided by, and complies with, the professional standards established by the Canadian Institute of Chartered Accountants, otherwise known as generally accepted auditing standards. We also seek guidance from other professional bodies and audit-related best practices in other jurisdictions.

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Introduction

1 Message from the Auditor General

Introduction

1.1 I am pleased to present my May 2013 Report to the House of Assembly on work completed by my Office in early 2013.

1.2 In the last year I have submitted the following reports.

- My Business Plan for 2012-13, and my Report on Performance for 2011-12 were provided to the Public Accounts Committee on May 25, 2012 and July 3, 2012 respectively.
- My Report to the House of Assembly on work completed by my Office in the late and early 2012, dated May 11, 2012, was tabled on May 30, 2012.
- My Report on the Province's March 31, 2012 consolidated financial statements, dated July 30, 2012, was tabled with the Public Accounts by the Minister of Finance on August 2, 2012.
- My Report to the House of Assembly on work completed in the summer and fall of 2012, dated November 1, 2012, was tabled on November 21, 2012.
- My February 2013 Report to the House of Assembly on financial reporting issues, dated January 11, 2013, was tabled on February 6, 2013.
- My Report on the Estimates of Revenue for the fiscal year ended March 31, 2014, dated April 2, 2013, was included with the budget address delivered by the Minister of Finance on April 4, 2013.

1.3 I wish to acknowledge the valuable efforts of my staff who deserve the credit for the work reported here. As well, I wish to acknowledge the cooperation and courtesy we received from staff in departments and agencies during the course of our work.

Chapter Highlights

1.4 This report presents the results of audits completed in early 2013 at a number of departments and agencies. Where appropriate, we make recommendations for improvements to government operations, processes and controls. Department or agency responses have been included in the appropriate chapter. We will follow up on the implementation of our recommendations in two years, with the expectation that significant progress will have been made.

Follow-up

Chapter 2 – Follow-up of 2007 to 2010 Performance Audit Recommendations

1.5 Only 41% of our performance audit recommendations from 2010 have been implemented. Government's lack of action has consequences for significant programs and services. Our 2010 audits included contaminated sites; business, land and vital statistics registries; mental health services; and P3 school contract management. Uncorrected deficiencies can impact government finances, service delivery to the public, and health and safety. Government senior management are failing to take action to correct known deficiencies in their programs.

Performance Audits

Chapter 3 – Community Services: Child Welfare – Investigations, Monitoring, and Foster Care

1.6 Although the Department of Community Services has adequate processes to investigate allegations of abuse or neglect, investigations are not always started on time and we identified many situations in which there were significant gaps in activity. We also found Department staff are not meeting with foster families and children in care as frequently as required by standards. Screening and approval of regular foster families was generally adequate but we found many issues with the approval of kinship foster families. New policies are needed to address this area. Finally, we noted the Children and Family Services Act has significant gaps which mean certain children are not covered after age 16; the Act also has an outdated definition of neglect which restricts it to physical abuse. We recommended these areas of the legislation be updated but the Department does not intend to take action to address these concerns.

Chapter 4 – Transportation and Infrastructure Renewal: Mechanical Branch Management

1.7 Operational oversight of mechanical branches is inadequate. Transportation and Infrastructure Renewal management lack basic information needed to manage branch operations. The deficiencies we identified could expose costly parts and tools to theft or loss. Management do not have detailed information on specific repair jobs to allow them to assess staff efficiency and reasonability of repair parts and labour. We also found instances in which required preventative maintenance was not completed and agreements with suppliers to limit the Department's exposure to repair and maintenance costs are not adequately managed.

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Chapter 5 – Agencies, Boards and Commissions: Travel and Other Expenses

1.8 We found weaknesses in controls over expense claims at all the entities we visited. In many instances, claims lacked support for expenses incurred but the claims were still paid. Certain entities either did not approve all claims before payment or the approval processes were not appropriate. We recommended Treasury Board Office communicate with all agencies, boards and commissions and ask them to evaluate their systems in light of the findings in our audit.

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Follow-up

2 Follow-up of 2007 to 2010 Performance Audit Recommendations

Summary

Government's overall implementation rate of our performance audit recommendations is poor. Government departments are not taking adequate measures to correct operational deficiencies identified in our audit findings. We continue to find a low level of commitment to implementing the recommendations we make to correct these deficiencies. At this point, only 41% of our 2010 recommendations have been implemented. Overall, only 62% of recommendations from our 2007 to 2010 reports have been implemented.

The low implementation rate for 2010 is in large part due to the very low rates at the Departments of Environment (24%), Service Nova Scotia and Municipal Relations (24%), Health and Wellness (41%), Community Services (45%), and Education and Early Childhood Development (47%). This lack of action has practical consequences in the management of programs. It means, for instance, that higher risk contaminated sites may not be given priority for monitoring; critical security weaknesses in registry systems and electronic health records remain a risk; mental health standards and service standards for the residential care sector are not implemented; and deficiencies in P3 school contract management processes which may impact student health and safety continue.

The Department of Health and Wellness has failed to implement 12 recommendations and certain district health authorities have failed to implement four recommendations from our 2007 audits. Due to this lack of appropriate action to address weaknesses, limited funds for medical equipment may not be allocated to the highest priority needs; patient safety risks associated with the use of MRIs and CT scanners may not be adequately addressed; ambulance fees and overpayments to service providers may not all be collected; and some nursing homes may not provide an appropriate level of care to residents. Uncorrected deficiencies such as these can impact government finances, service delivery to the public, and health and safety.

We reviewed the information supporting government's Provincial Update on the Auditor General Recommendations and found numerous errors in management's assessment of the status of recommendations. Reporting to the public and developing an internal tracking system are positive steps toward ensuring program weaknesses are addressed. We support these steps; however, we are concerned that their effectiveness is compromised due to inaccurate information.

Continued poor results are indicative of a systemic problem in which many senior management in government are ineffective in addressing operational weaknesses they know to exist in their programs.

Details on the status of all performance audit recommendations from 2007 to 2010 can be found on our website at oag-ns.ca.

2 Follow-up of 2007 to 2010 Performance Audit Recommendations

Background

2.1 Our Office's strategic priorities include serving the House of Assembly, considering the public interest, and improving government performance. We work toward these priorities by providing legislators with the information they need to hold government accountable. We obtain this information primarily by conducting audits which, over time, will cover major activities of government. The results of our audits are detailed in our Reports to the House of Assembly. Each report contains recommendations which provide practical, constructive advice to address issues raised by these audits.

2.2 We initially follow up the implementation status of recommendations two years after they are made. We believe two years is sufficient time for auditees to substantially address all our recommendations.

2.3 This year we reported three follow-up chapters. Chapter 6 of our February 2013 Report provided information on the status of recommendations concerning financial reporting and other financial management issues, as well as how responsive departments and agencies were in implementing related recommendations from our 2007 to 2010 audits. The February 2013 report also included a chapter on the status of recommendations to the Office of the Speaker resulting from our 2010 audit of Members' constituency and other expenses. Finally, this chapter reports the results of follow-up on the implementation status of the remaining recommendations from our 2007 to 2010 performance audits.

2.4 During this assignment we reviewed government managements' self-assessment of their progress in implementing the outstanding 2007 to 2010 recommendations. We also asked management to provide supporting information for recommendations they assessed as complete. Our review process focused on whether self-assessments and information provided by management were accurate, reliable and complete. This chapter includes summary level information on implementation status. More detailed information, including specific recommendations, can be found on our website at oag-ns.ca.

2.5 Our role is to make recommendations to improve government operations, and to report to the House on the status of those recommendations to assist Members in holding government accountable for their implementation. Once recommendations have been accepted, it is government's responsibility to regularly monitor to ensure that appropriate action has been taken to implement the recommendations.

Review Objective and Scope

2.6 In January 2013, we completed a review of the status of performance audit recommendations included in reports of the Auditor General from 2007 to 2010. Our objective was to provide moderate assurance on the implementation status of those recommendations.

2.7 We obtained government's assessment of the recommendations and performed additional procedures on those which government assessed as do not intend to implement or action no longer applicable. We focused on the reasons why government has chosen not to implement these recommendations. If the rationale appeared reasonable, we removed the recommendation from our statistics and will not conduct further follow-up work on it.

2.8 Our review of the implementation status was based on representations by department and agency management which we substantiated through interviews and examination of documentation for those recommendations assessed as complete. We performed sufficient work to satisfy us that the implementation status of complete, as described by management, is plausible in the circumstances. This provides moderate, not high level, assurance. Further information on the difference between high and moderate assurance is available in the Canadian Institute of Chartered Accountants (CICA) Handbook, Section 5025 – Standards for Assurance Engagements other than Audits of Financial Statements.

2.9 Our criteria were based on qualitative characteristics of information as described in the CICA Handbook. We did not perform any procedures, and provide no assurance on recommendations noted in this report other than those we have reported as complete.

Significant Observations

Accuracy of Information

Conclusions and summary of observations

We found a number of instances in which management's reported recommendation status was not accurate. 25% of the recommendations assessed as complete were not. This is a significant error rate. Although we did not review the Provincial Update on the Auditor General Recommendations issued in November 2012 in detail, it is clear from a summary review that the number of recommendations reported as complete was misrepresented. Although we support and encourage government to be more accountable for implementing our recommendations, the usefulness of the Provincial Update as an accountability tool is questionable when it does not accurately represent progress made. The current year results

further support the need for a quality assurance process as recommended in our May 2012 Report. Treasury Board Office did not agree with this recommendation.

2.10 For the past four years, we have reported that information we received from government entities on the status of recommendations was both incomplete and inaccurate. We found similar problems this year. The status of 39 of the 153 (25%) completed recommendations we reviewed changed following our review and consultation with staff of departments and agencies. This error rate is too high and misrepresents what was accomplished. Based on the status errors related to completed recommendations, we are concerned there are further errors for recommendations which were in process. Twelve (31%) of the 39 recommendations relate to the Department of Health and Wellness (including certain district health authorities), and ten (26%) recommendations relate to the Department of Education and Early Childhood Development. These two departments were also identified last year with high inaccuracy rates.

2.11 The reliability of information is particularly important since government has committed to providing regular updates to the public on the implementation status of our recommendations. The most recent Provincial Update on the Auditor General Recommendations was released in November 2012. It covers recommendations from April 2009 to May 2012, with an appendix covering 2005 to 2008. Although we did not conduct a detailed assessment of the accuracy and completeness of the information in the Provincial Update, it is clear from a summary review that there were many recommendations reported as complete which were not. The usefulness of the Provincial Update as an accountability tool is questionable when it misrepresents actual progress being made.

2.12 We expressed similar concerns last year with the integrity of the information provided to us and supporting the Update; we recommended that Treasury Board Office implement a quality assurance process to ensure information reported on the implementation status of recommendations in our reports is accurate and complete. Although Treasury Board Office did not accept our recommendation, the issues we identified demonstrated a process is still needed. As an alternative, each department or agency could implement a quality control process, including sign-off by the applicable Deputy Minister, that recommendation statuses are complete and accurate.

2.13 We see government's Provincial Update and management's tracking system as positive steps in ultimately addressing the program weaknesses noted in our reports. However, the effectiveness of such systems and public reports is compromised without accurate and complete information.

Failed to Implement

Conclusions and summary of observations

We expect to see substantial implementation of our recommendations within two years and complete implementation after five years. We issued one report in 2007 with a total of 77 recommendations. We determined 61 (79%) of the recommendations have been implemented. The Department of Health and Wellness failed to implement 12 (16%) recommendations; certain district health authorities did not implement four (5%) of the remaining recommendations. This failure means limited funds for medical equipment may not be allocated to the highest priority needs; patient safety risks associated with the use of MRIs and CT scanners may not be adequately addressed; ambulance fees and overpayments to service providers may not be fully collected; and some nursing homes may not be providing an appropriate level of care to residents.

2.14 *Failed to implement* – We expect to see substantial implementation of our recommendations within two years and complete implementation after five years. Government has generally indicated their intention to implement the recommendations in our audits at the time we report them. If recommendations are not implemented within five years, we consider the departments have failed to implement.

2.15 In 2007, we issued one report with 77 recommendations. During this year's review, we determined that 61 (79%) of these recommendations have been implemented. Of the remaining 16 recommendations, the Department of Health and Wellness failed to implement 12 (16%) recommendations. Certain district health authorities failed to implement four (5%) recommendations.

2.16 Appendix 1 at the end of this chapter provides a complete listing of recommendations from 2007 which have not been implemented. The following are examples of the risks and concerns we identified in our 2007 audits which were not addressed.

- A long-term provincial medical equipment capital plan is needed to ensure the right equipment is acquired and placed in the right areas. This would help address the highest priority needs with the limited funds available.
- The province needs a quality assurance program for all MRIs and CT scanners to mitigate patient safety risks associated with use of these machines.
- The completeness and accuracy of ambulance user fee revenues should be verified to ensure all monies due are submitted.
- Payments to service providers must be reconciled quarterly and overpayments collected to ensure service providers are only paid for the services they provide. Funds collected can be used to provide other needed services.
- Nursing home licensing and inspection needs to be improved to ensure residents receive an appropriate level of care and patient safety requirements are met.

2.17 Since our 2012 follow-up report, the Department of Health and Wellness implemented three more of the original 23 recommendations we made to the Department in 2007. Given the department's commitment to improve its implementation rate, we expected more progress for 2007.

2.18 As time elapses and recommendations are not addressed, management is likely to lose track of important program and service issues raised in our audits; changes encouraged by our recommendations may not occur. Along with missed improvements in existing programs and services as a result of this inaction, government may miss the opportunity to incorporate best practices in new or revised programs. Government's failure to correct the deficiencies pointed out in our reports indicates a systemic problem with managing and carrying out its responsibilities.

Implementation Results – 2007 to 2010

Conclusions and summary of observations

Only 41% of the recommendations in our 2010 report were implemented; the overall implementation rate from our 2007 to 2010 reports was 62%. Government's response in implementing recommendations is poor. Significant improvement is required by the Departments of Environment, Service Nova Scotia and Municipal Relations, Health and Wellness, Community Services, and Education and Early Childhood Development. The poor responses mean higher risk contaminated sites may not be given priority for monitoring; critical security issues with the registry systems and electronic health records have not been addressed; mental health standards and service standards for the residential care sector have not been implemented; and deficiencies in P3 school contract management processes which may impact student health and safety have not been addressed. Government indicated it does not intend to implement seven of our recommendations. We disagree with government's rationale for not implementing these recommendations because the risks they addressed still exist.

2.19 *Do not intend to implement or action no longer appropriate* – We made 417 recommendations in our reports from 2007 to 2010. For twelve recommendations, government told us they do not intend to implement or the action is no longer appropriate. We reviewed the information government provided to explain why these recommendations are no longer appropriate or should not be implemented and determined the rationale for five recommendations was reasonable. These recommendations have been removed from further analysis and statistics. We disagree with government's rationale for not implementing the remaining seven recommendations as the risks which the recommendations addressed still exist. Examples of continuing risks include the following.

- The Pension Regulation Division at the Department of Labour and Advanced Education does not intend to implement a process to verify that pension plan assets are prudently invested in accordance with legislation and the plan's

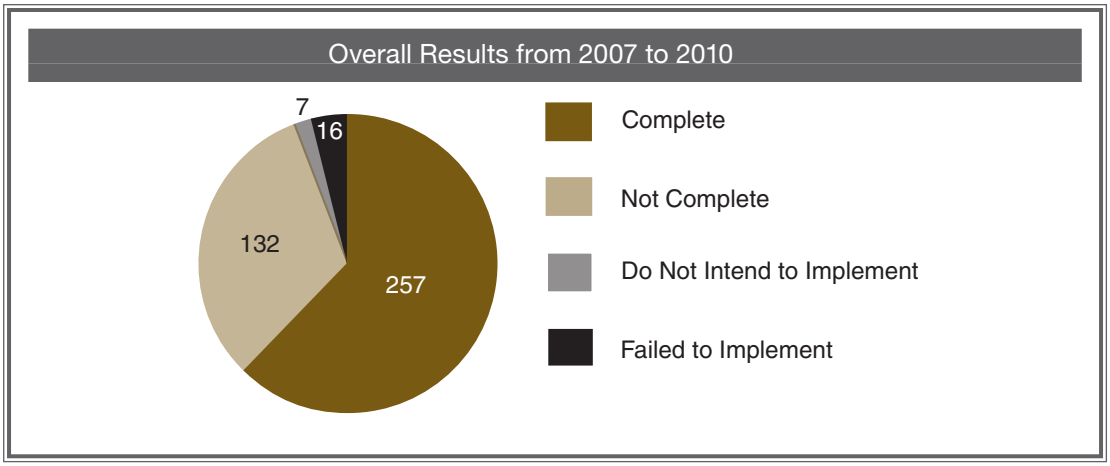
provisions. An investment strategy which is not reasonable based on the current economic climate or which has not been implemented as designed poses a significant risk to plan assets, and ultimately to the benefits pensioners may receive in the future.

- The Department of Education and Early Childhood Development does not intend to make the necessary changes to the Education Act regulations to reflect school board audit committee best practices. The committees' roles and responsibilities should be expanded to include oversight and monitoring the ethical tone at the top, as well as reviewing financial information provided to the government and other stakeholders.

- Government does not intend to assess the extent of internal audit activity within the government reporting entity in order to identify gaps and develop a plan to address internal audit needs. An internal audit function contributes to improved risk management and control systems. This helps ensure the reliability and integrity of financial and operational information, compliance with regulations, and safeguarding of assets.

2.20 *Overall analysis* – The following exhibits summarize the implementation status of the 412 recommendations made from 2007 to 2010.

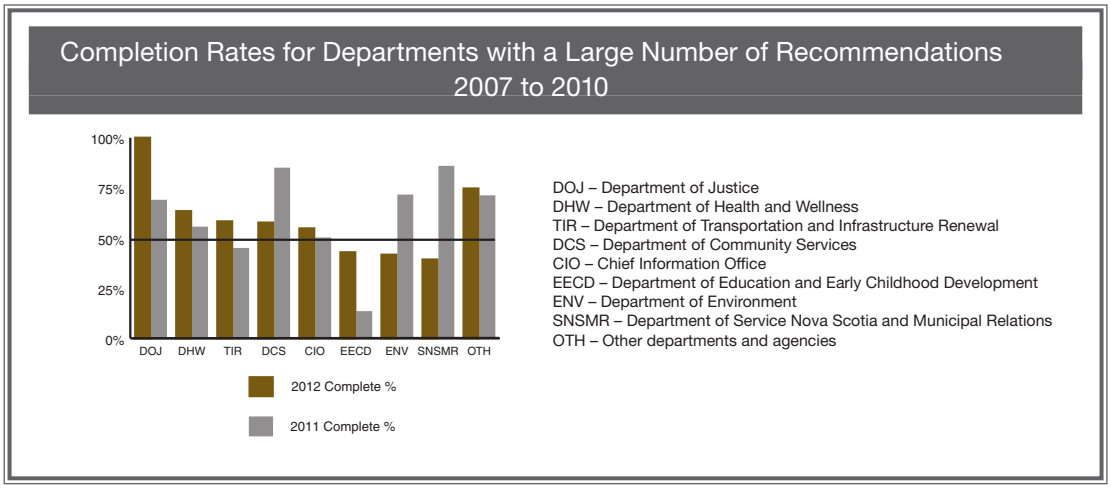
Implementation Status	2007	2008	2009	2010	Overall
Complete	79%	71%	75%	41%	62%
Not Complete	0%	26%	20%	59%	32%
Do Not Intend to Implement	0%	3%	5%	0%	2%
Failed to Implement	21%	0%	0%	0%	4%
	100%	100%	100%	100%	100%



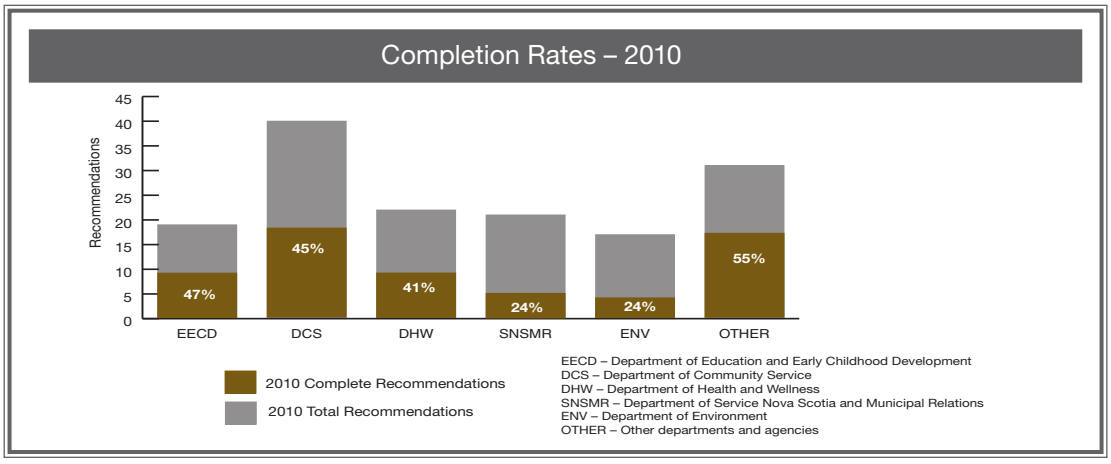
2.21 The overall implementation rate this year is 62%, a slight decrease from the 63% implementation rate reported in May 2012. Similar to last year, the overall response from government in implementing recommendations is poor. While 79% of our 2007 recommendations have been implemented, only 41% from 2010 are complete.

Government and certain district health authorities have failed to implement the remaining 16 recommendations from 2007. These statistics show a lack of commitment by government to implement our recommendations.

2.22 *Department and agency analysis 2007 to 2010* – The results by department and agency provide an indication of which organizations have made it a priority to address our recommendations. The following graph shows the implementation rate for those organizations to which we have made a significant number of recommendations. The Department of Justice achieved a 100% implementation rate for all the recommendations from the one audit (2007) we conducted during our review period. The Department of Service Nova Scotia and Municipal Relations has the lowest rate at 39%.



2.23 *Department and agency analysis: 2010* – When we make recommendations as a result of our audits, we seek acknowledgement from departments and agencies that they agree with and intend to implement the recommendations. Almost all published responses included in our reports indicate both agreement and intention to implement our recommendations. We therefore expect to see better implementation rates than what we have found to date; we also expect to see substantially full implementation within two years. The following graph shows the implementation rate for those organizations in which we conducted audits during 2010.



2.24 In 2010, we audited program areas covering electronic health records, contract management of P3 schools, financial assistance to businesses, management of contaminated sites, mental health services, rent supplement housing, services for persons with disabilities, and registry systems (land, business, and vital statistics). These audits examined matters of importance to public health, safety, and economic well-being. We identified significant deficiencies that needed to be addressed. We are disappointed with the overall implementation rate of 41% for our 2010 recommendations. The following paragraphs outline our concerns with the slow response at the five departments to which the majority of the recommendations were made.

2.25 *Environment* – The Department of Environment implemented 24% of our 2010 recommendations. Although it completed six of the seven (86%) recommendations from our 2008 audit of environmental monitoring and compliance, it implemented only four of the 17 recommendations from our 2010 audit of contaminated sites. Among the issues we identified, the Department still does not have a process to ensure contaminated sites with higher risk are given priority for monitoring and has not implemented timeframes for follow-up to ensure cleanup is done in a timely manner and risks are adequately addressed. The Department needs to complete implementation of recommendations related to this critical program.

2.26 *Service Nova Scotia and Municipal Relations* – The Department of Service Nova Scotia and Municipal Relations implemented 24% (5 of 21) of the recommendations from our 2010 audit of registry systems. This is in sharp contrast to the Department's 83% implementation rate of recommendations from our 2009 audit of truck safety. The 16 outstanding recommendations from 2010 cover critical security issues around the registry systems, such as identification and deletion of duplicate and dormant accounts, changing temporary passwords, and setting expiry dates for external contractor accounts. The Department's response to our recommendations is inadequate.

2.27 *Health and Wellness* – The Department of Health and Wellness implemented 41% (9 of 22) of the recommendations we made in 2010. The Department has shown some improvement in its overall implementation rate over the last three years. However, progress on 2010 recommendations has been lacking. The Department is responsible for oversight of the mental health system; it developed program standards over seven years ago but has yet to fully implement those standards. We also identified privacy and security issues related to the electronic health records project that still have not been addressed. The Department appears to have focused efforts on 2008 and 2009 recommendations. Greater attention is required to more current recommendations.

2.28 *Community Services* – The Department of Community Services implemented 45% (18 of 40) of our 2010 recommendations. While the Department implemented all 12 recommendations from our 2007 audit on regional housing authorities, this was done over a five-year period which is not a timely response. The Department has only implemented nine of 29 (31%) recommendations from our 2010 audit of services for

persons with disabilities. There are a number of areas of concern which have not been addressed. The Department has not assessed the future demand for services and determined the resources required to meet those needs; service standards for the residential care sector have not been implemented; and a process to ensure client support plans are reviewed and reassessed on a timely basis has not been implemented. The Department's progress in addressing our concerns is not sufficient.

2.29 *Education and Early Childhood Development* – The Department of Education and Early Childhood Development implemented 47% of our 2010 recommendations. Of the Department's 19 recommendations from our audit of contract management of P3 schools, only nine have been implemented. We identified significant deficiencies in the Department's contract management processes which could impact student health and safety, such as ensuring fire safety inspections are completed, preventative maintenance is completed, and required cleaning services and maintenance work are provided. The Department has not addressed our concerns in these areas. As well, the Department has not established an adequate contract management process to ensure payments made under P3 contracts comply with contract terms. Without an adequate process, the Department cannot be sure operating payments are correct and developers are not underpaid or overpaid. The Department's overall progress in implementing our recommendations needs improvement.

Appendix 1

2007 Failed to Implement Recommendations

June 2007 Recommendations

Chapter 2 – Management of Diagnostic Imaging Equipment – Health (now Health and Wellness)

2.1 We recommend that DOH, in conjunction with the DHAs, develop a long-term Provincial medical equipment capital plan including criteria for assessing competing DHA needs on a Province-wide basis.
Department of Health and Wellness

2.6 We recommend that the Department of Health, in conjunction with radiologists, establish and implement clinical practice guidelines for use of MRIs and CT scans in the Province.
Department of Health and Wellness

2.8 We recommend that CDHA and CBDHA establish utilization standards for each MRI and CT scanner and monitor performance in achieving the standard.
Cape Breton District Health Authority
Capital District Health Authority

2.11 We recommend that CDHA and CBDHA document policies and procedures relating to the quality assurance processes, including patient safety, for diagnostic imaging equipment and related testing of MRIs and CT scanners.
Cape Breton District Health Authority

2.13 We recommend that the Department of Health and the DHAs establish and implement a quality assurance program for all MRIs and CT scanners in the Province.
Department of Health and Wellness

2.14 We recommend that CDHA and DOH establish conflict of interest guidelines for medical staff including policies on relationships with private facilities.
Department of Health and Wellness
Capital District Health Authority

Chapter 3 – Emergency Health Services – Health (now Health and Wellness)

3.2 We recommend that DOH exercise its right to audit financial records under the ground ambulance contract to monitor EMC's performance and gain assurance that EMC's expenditures were incurred with due regard for economy and efficiency.
Department of Health and Wellness

3.5 We recommend that EHS verify the completeness and accuracy of user fee revenues submitted by EMC.
Department of Health and Wellness

3.9 We encourage EHS, EMC and Capital Health to continue to work together to resolve ambulance turnaround delays on a timely basis.
Department of Health and Wellness

2007 Failed to Implement Recommendations

Chapter 4 – Long-term Care – Nursing Homes and Homes for the Aged – Health (now Health and Wellness)

4.2 We recommend DOH ensure reporting requirements for all nursing homes are practical, and establish a process to ensure requirements are met and appropriate action taken if inconsistencies are identified. DOH should also require nursing homes to submit auditors' management letters for review.

4.4 We recommend that DOH perform quarterly reconciliations and collect funding overpayments in a timely manner.

4.5 We recommend that DOH work towards having the House of Assembly update the Homes for Special Care Act and Regulations to ensure the legislative framework reflects current long-term care operations and standards.

4.6 We recommend that DOH review and improve the licensing and inspection process to address deficiencies noted in paragraph 4.40.

4.7 We recommend DOH develop and implement a quality assurance process to help ensure compliance with policies and accuracy of SEAscape information.

Appendix 2

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Department of Community Services						
June 2007 Chapter 6: Regional Housing Authorities	DCS MRHA CBIHA	6 3 3				6 3 3
November 2010 Chapter 2: Rent Supplement Program Chapter 3: Services for Persons with Disabilities	DCS MRHA WRHA DCS	5 1 3 9	2 20			7 1 3 29
Recommendations		**30** **58%**	**22** **42%**	**0** **0%**	**0** **0%**	**52** **100%**
Department of Education and Early Childhood Development						
April 2009 Chapter 2: Audit Committees	EECD			2		2
February 2010 Chapter 3: Contract Management of P3 Schools	EECD	9	10			19
Recommendations		**9** **43%**	**10** **48%**	**2** **9%**	**0** **0%**	**21** **100%**
Regional School Boards						
February 2008 Chapter 2: South Shore Regional School Board	SSRSB	16	2			18
February 2010 Chapter 3: Contract Management of P3 Schools	CBVRSB SRSB	1 1				1 1
Recommendations		**18** **90%**	**2** **10%**	**0** **0%**	**0** **0%**	**20** **100%**
Department of Environment						
February 2008 Chapter 3: Environmental Monitoring and Compliance	ENV	6	1			7

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Department of Environment (continued)						
June 2010 Chapter 3: Management of Contaminated Sites	ENV	4	13			17
Recommendations		**10 42%**	**14 58%**	**0 0%**	**0 0%**	**24 100%**
Department of Health and Wellness						
June 2007 Chapter 2: Management of Diagnostic Imaging Equipment	DHW	1			4	5
Chapter 3: Emergency Health Services	DHW	7			3	10
Chapter 4: Long-term Care – Nursing Homes and Homes for the Aged	DHW	3			5	8
February 2008 Chapter 4: Communicable Disease Prevention and Control (former Department of Health Promotion and Protection)	DHW	15	4			19
November 2008 Chapter 4: Home Care	DHW	17	11	1		29
April 2009 Chapter 2: Audit Committees	DHW	1	1			2
July 2009 Pandemic Preparedness	DHW	25	3			28
February 2010 Chapter 2: Electronic Health Records	DHW	2	6			8
June 2010 Chapter 4: Mental Health Services	DHW	7	7			14
Recommendations		**78 63%**	**32 26%**	**1 1%**	**12 10%**	**123 100%**

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
District Health Authorities						
June 2007 Chapter 2: Management of Diagnostic Imaging Equipment	CBDHA CDHA	9 10			2 2	11 12
July 2009 Pandemic Preparedness	PCHA	1				1
June 2010 Chapter 4: Mental Health Services	AVDHA CDHA CEHHA CHA IWK PCHA	3 3 2 2	1 1 2 1 1 1			4 4 4 1 3 1
Recommendations		**30** **73%**	**7** **17%**	**0** **0%**	**4** **10%**	**41** **100%**
Department of Justice						
June 2007 Chapter 5: Maintenance Enforcement Program	DOJ	18				18
Recommendations		**18** **100%**	**0** **0%**	**0** **0%**	**0** **0%**	**18** **100%**
Department of Service Nova Scotia and Municipal Relations						
June 2007 Chapter 5: Maintenance Enforcement Program	SNSMR	1				1
April 2009 Chapter 4: Truck Safety	SNSMR	5	1			6
November 2010 Chapter 4: Registry Systems	SNSMR	5	16			21
Recommendations		**11** **39%**	**17** **61%**	**0** **0%**	**0** **0%**	**28** **100%**
Department of Transportation and Infrastructure Renewal						
November 2008 Chapter 6: Public Passenger Vehicle Safety (formerly assigned to Nova Scotia Utility and Review Board)	DTIR	5	2			7

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Department of Transportation and Infrastructure Renewal (Continued)						
April 2009 Chapter 4: Truck Safety	DTIR	2	3			5
Recommendations		**7 58%**	**5 42%**	**0 0%**	**0 0%**	**12 100%**
Office of the Chief Information Officer						
February 2008 Chapter 5: Governance of Information Technology Operations	CIO	1	5			6
April 2009 Chapter 3: Information Technology Security	CIO	15	6			21
November 2010 Chapter 4: Registry Systems	CIO	1	3			4
Recommendations		**17 55%**	**14 45%**	**0 0%**	**0 0%**	**31 100%**
Department of Economic and Rural Development and Tourism						
February 2010 Chapter 2: Financial Assistance to Businesses through NSBI and IEF (former Office of Economic Development)		2	2			4
Department of Finance						
June 2010 Chapter 5: Follow-up of 2007 Audit Recommendations			1			1
Department of Labour and Advanced Education						
November 2008 Chapter 5: Pension Regulation		2	2	1		5

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Emergency Management Office						
July 2009 Pandemic Preparedness			1	1		2
Executive Council Office						
July 2009 Pandemic Preparedness		2				2
June 2010 Chapter 2: Financial Assistance to Businesses through NSBI and IEF		1				1
Sub-total		**3**				**3**
Internal Audit Centre						
November 2008 Chapter 3: Internal Audit		4				4
Nova Scotia Business Inc.						
June 2010 Chapter 2: Financial Assistance to Businesses through NSBI and IEF		1	1			2
Nova Scotia Community College						
November 2008 Chapter 3: Internal Audit		3	1			4
Nova Scotia Liquor Corporation						
November 2008 Chapter 3: Internal Audit		3				3
Office of Immigration						
June 2008 Phase One: Economic Steam of the Nova Scotia Nominee Program		1				1

Status of Recommendations by Entity, by Chapter

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	Failed to Implement	Total
Office of Immigration (Continued)						
October 2008 Phase Two: Economic Stream of the Nova Scotia Nominee Program		1				1
Sub-total		**2**				**2**
Treasury Board Office						
February 2008 Chapter 5: Governance of Information Technology Operations		1				1
November 2008 Chapter 3: Internal Audit				1		1
April 2009 Chapter 2: Audit Committees		8	1	1		10
Sub-total		**9**	**1**	**2**	**0**	**12**
Total Recommendations		**257 62%**	**132 32%**	**7 2%**	**16 4%**	**412 100%**

NOVA SCOTIA

Performance Audits

3 Community Services: Child Welfare – Investigations, Monitoring, and Foster Care

Summary

The Department of Community Services responds to allegations of child abuse or neglect, assesses the level of risk to the child and determines how quickly the allegations should be investigated based on the risk assessment. While this aspect of the child welfare program is working well, investigations are not always started on time or completed in a timely manner. Further, deficiencies in the program, particularly in ongoing monitoring of foster children, families under court supervision and foster families, significantly impair the Department's ability to protect children's interests or support foster families on an ongoing basis.

We found many lapses in policy-mandated contacts to monitor children and foster families. We identified 13 situations in which the required three-month contact with the foster family did not happen for more than a year and 18 situations in which the required 30-day contact with children in care was more than 60 days late. When monitoring did occur, we found issues were appropriately addressed by the Department. One quarter of the children in care files we tested had no care plans; most plans we found were completed late and regular plan reviews were late in more than 70% of the files tested. These plans are significant because they document the services the child or family needs.

We tested 140 investigations. In each case, the Department determined how quickly an investigation was required based on its assessment of risk to the child. However, following this assessment, we found investigations were not always started or completed in a timely manner. Investigations began late for 12% of the files we tested and one quarter of investigations had gaps of more than three weeks with no investigative activity. Once allegations were examined, we found the Department's processes were adequate to ensure reports of abuse and neglect are appropriately investigated.

Screening and approval of regular foster families was generally adequate. However, little guidance exists for screening and approval of kinship foster homes. We identified many inconsistencies in approving these homes and recommended new policies be implemented to address this area.

The Department does not know how long it takes to approve foster families. Having an adequate number of foster families to care for children in need is a major challenge in the foster care system and this information would assist management in evaluating the effectiveness of its current process.

We found the Children and Family Services Act has gaps related to age limits for foster care and an outdated definition of neglect. We recommended those areas of the Act be updated.

3 Community Services: Child Welfare – Investigations, Monitoring, and Foster Care

Background

3.1 Child Welfare Services includes child protection and children in care. It covers investigations into allegations of abuse or neglect, monitoring children and families, and foster care. The Department of Community Services administers child welfare programs in Nova Scotia. The Department's Program Division is located in Halifax, and is responsible for the policies, procedures and oversight for 19 district offices throughout the Province.

3.2 All child welfare services fall under the Children and Family Services Act. The purpose of this Act is *"to protect children from harm, promote the integrity of the family, and assure the best interests of the child."*

3.3 From April 1, 2010 to September 30, 2012, there were 25,833 reports of possible abuse or neglect, of which 14,919 were investigated. Many complaints do not warrant an investigation due to the nature of the complaint. 1,883 cases were opened for ongoing services and 519 of those resulted in 819 children being brought into care.

3.4 When complaints are investigated, Community Services may find nothing further is required, may monitor the family, or may remove the child from his or her home and bring the child into care. Once a child is removed from the home, that child becomes the responsibility of the Minister of Community Services and may be placed with a foster family or in a residential child care facility (for those requiring greater supervision than that provided by foster families). The Department can also offer services to the child's family if staff feel this would be helpful in situations in which ongoing monitoring or removal from the home are not warranted.

3.5 As required by the Act, child welfare services becomes involved with children and families when reports of child abuse or neglect are investigated. If an investigation determines allegations are substantiated, a risk assessment is completed and Department staff decide whether ongoing services are required.

3.6 A child protection team is responsible for ongoing services. Staff may determine it is appropriate to leave the child in the home and develop a case plan for the parents and child. The case plan outlines the goals, objectives and tasks to mitigate the risk to the child. If the child protection team determines this voluntary approach will not work, the team may pursue a supervision order in court which provides the child protection team with the power to enforce the case plan. Alternatively, if the team believes the risk cannot be mitigated with a supervision order, it may petition the court to remove the child from the home and place the child in care.

3.7 If child welfare services determine there is imminent risk of harm to the child, they can remove the child from the home immediately. In these situations, Department staff must justify these actions to a judge within five days.

3.8 When a child is taken into care, the children in care team develops a care plan which includes details on the child's placement, physical and emotional needs, family and social relationships, and educational or developmental progress. This plan is a key monitoring tool for ongoing review of children in foster family homes.

3.9 In addition to monitoring children in care, child welfare services also recruits, assesses, approves, trains and monitors foster families. Each foster family has its own social worker to monitor and support the family; families would also have contact with the child's social worker.

3.10 As of March 2013, there were 1,365 children in care, with 935 residing in foster homes. There were approximately 725 foster homes across the province. One-third (around 238) of these were kinship homes, situations in which family friends or relatives become the child's foster family.

Audit Objectives and Scope

3.11 In winter 2013, we completed a performance audit of certain child welfare services at the Department of Community Services. Our audit covered investigations; monitoring of children in their family homes or in foster homes; and approval and monitoring of foster families. This involved a number of program areas at the Department including foster care, children in care and child protection.

3.12 We wanted to determine whether the Department of Community Services:

- has processes to ensure allegations of child abuse or neglect are adequately investigated;
- has processes to ensure foster families are adequately screened prior to approval and appropriately monitored thereafter; and
- performs appropriate monitoring to protect the best interests of children placed in foster care.

3.13 The audit was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

3.14 The objectives of the audit were to assess whether:

- the Department of Community Services' processes to investigate reports of alleged child abuse or neglect are adequate;

- the process to screen and approve foster families is adequate;
- the Department's monitoring of children in foster care; families with voluntary care arrangements; or supervision orders is adequate;
- the Department's monitoring of foster families is adequate;
- timely and appropriate action is taken to address issues identified; and
- the Department is fulfilling its requirements under the tri-partite agreement between the governments of Nova Scotia and Canada, and Mi'kmaw Family and Children Services.

3.15 We excluded matters relating to adoption and monitoring of children living in residential child caring facilities from our audit. We did not review financial remuneration or the provision of services, such as counselling, to children in care or foster families. Our work on Mi'kmaw Family and Children Services was limited to assessing whether the Department of Community Services met its requirements under the tri-partite agreement.

3.16 Criteria were developed specifically for this engagement. The objectives and criteria were discussed with, and accepted as appropriate by, senior management of the Department.

3.17 Our audit approach included interviews with management and staff at the Department; review of documentation; and testing of investigation, children in care, child protection, and foster family files for compliance with Department policies. We selected the policies that we determined were the most relevant and important to assessing our audit objectives. We conducted our audit in the fall of 2012 and winter 2013 using data for the period from April 1, 2010 to the start of field work on September 27, 2012. We visited seven district offices across the four Provincial regions.

Significant Audit Observations

Department-wide Issues

Conclusions and summary of observations

Policy manuals for child protection, foster care and children in care lack clarity in certain areas and need updating. The Children and Family Services Act should be amended to address gaps related to age limits when children can be protected and the definition of harm; the existing Act does not reflect modern views regarding risks to children. The Department has a central file audit process for child protection investigations and children in care case files. We recommended this process be extended to include foster family

approval and screening. Although the Department has a public complaint process, some complaints through regional offices are not tracked.

Policy and Procedure Manuals

3.18 During the audit, we reviewed the Department's three child welfare policy manuals. Our testing was based on selected standards and recommended practices from these manuals.

- Child Protection Services Policy Manual
- Foster Care Manual
- Children in Care and Custody Manual

3.19 *Child protection manual* – The child protection manual is over fifteen years old and has not undergone any substantial review or revision. Regular reviews are needed to ensure content remains relevant. Additionally, the manual is not available electronically, only as a binder of many hundreds of pages which is very difficult to navigate. Without a common electronic version, staff must insert updates when the manual changes.

3.20 While the investigative framework outlined in the manual is reasonable, we found the manual lacked clarity in some areas. For example, the maximum time period to initiate an investigation into lower risk allegations is not clear. Different sections refer to 21 days versus 21 working days. During our testing, it was clear that some staff interpreted this as 21 calendar days while others interpreted working days as Monday to Friday, which would allow 29 calendar days to start an investigation. We also found staff had different interpretations regarding which elements of an investigation would always be required versus those which would be optional depending on the circumstances. These differences may lead to inconsistent approaches in investigations.

Recommendation 3.1
The Department of Community Services should update the Child Protection Services Policy Manual to ensure it clearly describes current processes and required documentation. The manual should also be provided in a user-friendly, electronic format.

Department of Community Services Response:
The Department agrees with the recommendation, and will make the manual available in an electronic format. The Department has recently initiated a standards renewal project to review and update child protection standards.

3.21 *Foster care manual* – The foster care manual is also outdated and not reflective of current processes for foster family screening and approval. The manual is available only in paper format and there is a reliance on individual workers to update manuals

as changes are communicated. This could result in different manuals across the province.

3.22 The manual includes references to forms which are no longer in use, and the version we were provided had several sections noted as either under revision or targeted for revision. Most notably the section dealing with kinship homes is outdated, includes no specific standards, lacks appropriate process descriptions, and does not reflect current practice. Kinship homes are discussed in greater detail later in this chapter.

Recommendation 3.2
The Department of Community Services should update the Foster Care Manual to ensure it clearly describes current processes and required documentation. The manual should also be provided in a user-friendly electronic format.

Department of Community Services Response:
The Department agrees with the recommendation, and will make the manual available in an electronic format. As noted in the audit, the Foster Care Manual is revised, on a section by section basis. A new chapter on kinship care is at the drafting stage, and will be submitted for approval shortly.

3.23 *Children in care and custody manual* – Although the children in care and custody manual is available in a searchable electronic format, it is nearly ten years old and has not had a complete review.

3.24 *Regular review* – Community Services does not have a process to regularly review and update its child protection, children in care, and foster care manuals. Although management told us they review and update manuals on a section by section basis, there is no schedule to ensure all sections are reviewed regularly and no required timeframe for reviews. Regularly scheduled reviews would help ensure manuals are appropriate and reflect current practices. Up-to-date manuals are important to promote consistency and are also useful in training new employees.

Recommendation 3.3
The Department of Community Services should establish a regular review schedule for its child protection, children in care and foster care manuals. As sections are reviewed, any changes identified should be implemented promptly.

Department of Community Services Response:
The Department agrees with the recommendation and will immediately develop a roster which sets out a formal review schedule.

Legislation

3.25 *Legislative gaps* – The Children and Family Services Act came into effect in 1990; it is more than 20 years old. Department management identified two areas of concern with the Act which could expose some children to unnecessary risks.

3.26 *Age limits* – Under the current legislation, Community Services has no authority to investigate complaints of possible abuse or neglect if a child is between the ages of 16 and 18, unless the child is already in care. Allegations regarding a child already in care can be investigated. This provision means the Department has to treat children who are the same age differently depending on individual circumstances. In some provinces, children in need of protection are covered up to age 18.

3.27 *Definition of neglect* – The Children and Family Services Act deems a child to be in need of protective services due to neglect when there is physical harm, or risk of physical harm. This conflicts with modern views of neglect. Limiting the definition of neglect to only physical harm ignores the emotional and developmental impact that neglect can have on a child. The Act's wording limits the Department's authority to investigate complaints related to emotional and developmental neglect. Harm is defined more broadly in other jurisdictions.

Recommendation 3.4
The Department of Community Services, in partnership with Executive Council, should update the Children and Family Services Act to ensure it adequately addresses modern practices related to age groups covered by child welfare and includes a modern definition of harm due to neglect.

Department of Community Services Response:
The Department agrees to submit these recommendations for consideration by the Government, when the Children and Family Services Act is next amended.

OAG Comment: *This response describes a process which does not exist. It does not address our recommendation. It is clear that the Department does not intend to initiate a revision to the legislation.*

Other Matters

3.28 *Complaints process* – The Department has a documented complaints policy called *"When You Disagree."* It provides for escalation of complaints through Department hierarchy until resolution. It does not apply to cases before the courts. Some complaints are initially addressed at regional offices and may not proceed to the formal *"When You Disagree"* process. The Department only tracks complaints which are received by head office. There is no complete record of all complaints received and addressed within the province.

3.29 A system to record complaints and the work completed to resolve these would provide valuable information to staff and management. For example, complaints may highlight particular areas in which the Department needs to make improvements, or in which further public education is required. Furthermore, it would provide a means of ensuring each complaint is responded to appropriately.

Recommendation 3.5
The Department of Community Services should record and track all complaints, including any investigation carried out and the resolution.

Department of Community Services Response:
The Department agrees with the recommendation. It tracks provincial data from case reviews under the "When You Disagree" policy, including investigations and outcomes. It will work with the regional and district offices to establish a data collection process at those levels, by August 1, 2013.

3.30 *File audits* – Throughout its work on investigations, monitoring and foster care, the Department requires regular supervisory reviews to help ensure appropriate decisions are made. In addition, one staff member at the Department's program office is responsible to complete file audits and assess compliance with child protection standards.

3.31 Since 2008, 15 of the 19 district offices have been reviewed. Two reviews have also been completed of Mi'kmaw Children and Family Services (see discussion of the tri-partite agreement later in this chapter). The file audits do not cover foster family screening and approval. Foster families are key to a well-functioning child welfare system; the approval process could benefit from regular file audits.

Recommendation 3.6
The Department of Community Services should extend its file audits to cover all aspects of foster care, including screening and approval of foster families.

Department of Community Services Response:
The Department agrees with this recommendation. The Department will develop a work plan to review foster process, to begin September 1, 2013.

Child Protection Investigations

Conclusions and summary of observations

In all 140 investigations we tested, Community Services reviewed allegations of abuse or neglect and determined the timeframe in which the investigation should start based on the Department's assessed risk to the child. Once this initial examination occurred, we identified significant concerns with the timeliness of investigations. 12% of the investigations we examined were not started within the required time frame based on the assessed risk; in one instance, a response required the same day took three days. During investigations, 27% of the files we tested had gaps of more than three weeks with no investigative activity. Seven investigations took more than six months to complete and one of these was still ongoing when we completed our audit. Once investigations were completed, we generally found the

Department's framework for investigation and supervision was followed. However, we found two instances in which allegations were not investigated but should have been based on the case information. In both cases, the individuals involved were investigated later based on subsequent complaints. Our audit did not comment on whether investigation conclusions were reasonable; we assessed whether the Department's policies were followed.

3.32 *Investigated allegations* – We reviewed 140 child abuse or neglect case files in which the Department conducted investigations. We assessed the initial response to the allegation and compliance with the investigation process detailed in the child protection policy manual. We did not attempt to determine whether the conclusions reached in the investigations were correct, but instead tested to determine whether the Department's policies were followed.

3.33 The initial decision to investigate an allegation includes determining how quickly the investigation must be started based on an assessment of the risk to the child. There are four risk categories, with the highest priority allegations requiring a response within one hour. For the 140 allegations we tested, we found the Department responded to the allegation by assessing risk and determining how quickly an investigation should begin. There was appropriate evidence of supervisory involvement in this decision in 139 of the 140 files.

3.34 The child protection policy manual is not clear regarding the maximum time to begin an investigation for the lowest risk category. The manual states the investigative response should be *"beyond two working days and within 21 days."* Another section of the manual as well as the referral intake form both refer to this standard as 21 working days. In practice, we found regional staff used 21 working days based on a Monday to Friday work week which results in 29 calendar days. This is a significant difference in measurement, and it is unclear what the original intent was. For testing purposes, we accepted the Department's practice of 21 working days and assessed each sample accordingly.

3.35 Following the initial assessment of risk, investigations were not always started in a timely manner. For 17 (12%) of the 140 cases we tested, responses were not initiated within the required time. In one higher risk case, requiring same-day response, three days elapsed before the investigation was started.

3.36 15 (88%) of the 17 late responses were in the lowest risk category; this means a response should begin within 21 working days. However, in three of those instances, the responses were significantly delayed, taking 57, 58 and 130 days. Although these cases were assessed as lower risk, an investigation is still required and until it has been carried out, the Department cannot be certain the child is safe.

3.37 Investigations into allegations of abuse or neglect should always be started within the required response time based on the assessed level of risk; this ensures the risk to the child or children is the primary consideration.

Recommendation 3.7
The Department of Community Services should clarify the priority response times for commencing child abuse or neglect investigations.

Department of Community Services Response:
The Department agrees with the recommendation, and will immediately amend the Intake Form to ensure the response time for low risk category, 21 days, is defined consistently with Standard 3.15 in the Standards Manual.

Recommendation 3.8
The Department of Community Services should commence all investigations within the assigned priority response times.

Department of Community Services Response:
The Department agrees with this recommendation. The report indicates that of the 140 investigations sampled, there were 2 moderate to high risk situations, 1.4% of the sample, where the mandatory response time was not met. [OAG note: Sentence deleted – misinterpretation of audit conclusion.] The Department will work with staff to ensure that all investigations are begun within the assigned response time. The Department will follow up on the two high to moderate risk cases, to determine what transpired in those situations, and what, if any changes are necessary to prevent a reoccurrence.

3.38 134 of the 140 investigations we tested were complete at the time of our audit. We found applicable policies were followed for all 134 completed investigations. The remaining investigation were not complete at the end of our audit period.

3.39 In 73 (55%) of 134 files with completed investigations, as well as for five of the six ongoing investigations, we found the length of investigation exceeded the Department's six-week guideline. Management told us this guideline is a recommended practice and staff are not required to complete investigations within six weeks. However, we found extending an investigation beyond six weeks requires supervisory approval; this implies an expectation that the timeframe be met. Following an investigation, the child protection manual requires supervisors to verify *"the maximum six week time-limit has been met for completing an investigation, unless supervisory approval given for extension."* Staff in two of the regions we visited also expressed concerns with difficulties completing investigations within six weeks.

3.40 Six of the investigations we tested were not completed at the end of our audit period. One investigation had been ongoing for 47 weeks as of September 2012, due in large part to numerous periods with no investigation activity.

3.41 The following table provides more detail on the number and length of investigations, and measures the time spent to the end of our audit period on the incomplete investigations.

Duration of Investigations		
Length of Investigation	**Number of Sample Items**	**Percentage of Sample**
0 – 6 weeks	62	44%
Over 6 – 7 weeks	18	13%
Over 7 – 12 weeks	36	26%
Over 12 – 18 weeks	10	7%
Over 18 – 24 weeks	7	5%
Over 24 – 30 weeks	4	3%
Over 30 – 36 weeks	1	1%
Greater than 36 weeks	2	1%
Total	**140**	**100%**

3.42 There are many reasons why investigations may take longer than six weeks, including some valid challenges such as difficulty contacting people or the need to interview a large number of people. We excluded these instances from our reporting of investigation gaps. We found general inactivity was often a significant factor in extended investigations. Of the 78 investigations we tested which took longer than six weeks, 38 (49%) had gaps of more than three weeks without any activity. Within those 38 cases, we found a total of 52 gaps, with the longest extending 24 weeks. The tables below provide more details on these gaps, and show the extent to which many of these cases had no investigative activity for extended periods of time.

Gaps in Extended Investigations		
Number of Gaps per Case	**Number of Sample Cases**	**Percent**
1 gap of three weeks or longer	27	71%
2 gaps of three weeks or longer	9	24%
3 gaps of three weeks or longer	1	2.5%
4 gaps of three weeks or longer	1	2.5%
Total Cases	**38**	**100%**

Duration of Investigation Gaps		
Length of Gap	**Number of Gaps**	**Percent**
3 – 4 weeks	13	25%
Over 4 – 6 weeks	19	37%
Over 6 – 8 weeks	8	15%
Greater than 8 weeks	12	23%
Total Gaps	**52**	**100%**

3.43 The manual does allow investigations to extend beyond six weeks. We found 44 (56%) of the 78 extended investigations had no evidence the supervisor approved the extension; a further 10 cases (13%) had supervisory approval but no rationale for the extension.

Recommendation 3.9
The Department of Community Services should document supervisor approval and rationale for all investigations exceeding six weeks.

Department of Community Services Response:
The Department agrees with this recommendation. The Department's intention is to immediately review the requirement, and may modify it. However, if it is retained, it will require supervisory approval.

3.44 *Completing the investigation* – The child protection policy manual outlines the approach to reach and document the decision whether an allegation is substantiated and to determine what action is required going forward. Supervisory consultation is required throughout. These processes provide a framework to help ensure appropriate decisions are made based on the facts of the case.

3.45 We tested 140 investigation files and found the decision whether an allegation was substantiated was appropriately documented in 134 files. There was evidence of appropriate supervisory involvement in 133 of the 134 cases for which a decision had been made and was adequately documented. The remaining six investigations were not complete at the time of our audit.

3.46 In our sample of 134 completed investigations, 50 cases were substantiated. This means the allegation was founded; the Department then has to decide whether to open a file and provide services to the family. Alternatively, the investigation may show that although the allegation was substantiated, there is no ongoing risk to the child and thus no need for further action. This could occur if the allegation dealt with someone who is no longer associated with the child, or it was determined this was a one-time incident which the investigator does not anticipate reoccurring.

3.47 We found the decision whether to open a file was properly documented and had appropriate supervisory consultation for all 50 substantiated allegations.

3.48 *Risk assessments* – When allegations are substantiated following investigation by the Department, a risk assessment is conducted in consultation with the supervisor to help determine whether ongoing child protection services are needed. These assessments were completed in 44 (92%) of 48 files for which an assessment was required. Risk assessments were not completed in the remaining four instances.

3.49 *Case audits* – When an investigation is completed, supervisors are to complete a case audit to verify that key steps have been met and supporting documentation is included in the file. Case checklists, although not mandatory, are often used by supervisors to demonstrate they have completed the required case audit. We found the checklist was not completed for 36 (27%) of 133 files we tested. Without a checklist, there is no way to verify that the supervisor completed the required case audit. It is an important quality assurance tool to help demonstrate the completeness of the investigation.

Recommendation 3.10
The Department of Community Services should require case checklists be completed on every file closed at intake or opened for ongoing child protection services as evidence the supervisor completed the required case audit.

Department of Community Services Response:
The Department agrees with this recommendation. Standard 7.6, case audits, is comprehensive, and sets out twelve areas for supervisors to review, when auditing files. An audit checklist is already provided in the manual, under Guideline 7.7, as an aid to assist supervisors when completing file audits. The Department make the optional checklist mandatory.

3.50 *Allegations not investigated* – When the Department receives an allegation, an initial assessment is completed to determine whether an investigation is required. We tested 60 files in which the Department determined child protection investigations were not warranted; we found that decision reasonable in 58 (97%) of the 60 files. For the two remaining files, we determined an investigation should have been conducted based on the reported information. Department management agreed these situations should have been investigated. Subsequent to the allegations we reviewed, the individuals involved in both cases were investigated following new complaints. In all 60 files tested, we found that the decision not to investigate was documented with evidence of supervisory involvement.

Screening and Approval of Foster Families

Conclusions and summary of observations

Overall screening and approval of regular foster families was generally adequate, although we found minor issues in many files. We found significant inconsistencies in kinship foster family screening. The foster care manual has limited policy direction for kinship homes; policies for regular foster families are applied inconsistently to kinship homes. Staff noted confusion regarding which policies applied and many files we tested were missing required information. One-fifth of the kinship home files we tested were missing detailed assessments which are required within six months of a child being placed. We also found regular foster families are not always screened and approved in a timely manner; one approval we tested took two years to complete. The Department told us more foster families are needed in Nova Scotia; this emphasizes the need for a timely screening process.

3.51 *Screening and approval of foster families* – We tested 60 foster family files for compliance with the screening and approval processes defined in the foster care manual.

- 17 files met all the requirements (eight kinship, nine regular).
- Seven files had a single minor deficiency (seven kinship).
- 25 files had minor deficiencies (12 kinship, 13 regular).
- 11 files had significant deficiencies (11 kinship).

3.52 We defined significance based primarily on the volume of issues noted in each file; specific concerns included missing or late application documents. Minor deficiencies covered areas such as medicals, proof of insurance, general concerns with timeliness of the various steps in the process, or the failure to sign all documents.

3.53 *Lack of information on approval times* – Department management and regional staff told us the number of foster families is declining and cited this as a significant challenge. Given this situation, every effort should be made to approve new foster families as quickly as is reasonable while following related policies.

3.54 The Department does not know the average time to approve a new foster family. Management told us the only way to determine this would be to review each individual file.

3.55 For the 60 files we tested, we reviewed detailed case notes to determine the time to approve the foster family. Ten percent (6 of 60) took more than one year to complete the foster family screening and approval process. In one instance, this process took two years. These delays are not reasonable for potential foster families waiting to help care for and protect at risk children at a time when the Department is concerned it does not have enough foster families.

3.56 The availability of management information is key in making program decisions. This data is important to assess whether the current system is limiting the number of available foster families with unnecessary delays in approval. Department management should take the steps necessary to collect this information and use the information to take corrective action as needed. Given the small number of foster family applications the Department receives annually, this information could be tracked using a simple spreedsheet.

Recommendation 3.11
The Department of Community Services should track and monitor the length of time it takes to approve all foster families.

Department of Community Services Response:
The Department agrees with the recommendation, and if feasible from a cost perspective, will implement the proposed tracking and monitoring system into the Computerized Case Management System.

3.57 The foster care manual identifies specific screening requirements for foster families; the initial home consultation and home safety review are key steps in screening. We found the home safety review took place for all 60 files we tested. There was one instance in which the home consultation was not included in the file, but there were case notes indicating it had occurred. We identified concerns with the timeliness of both the home consultation and home safety review. These issues may contribute to the overall slowness in approving foster families.

3.58 *Kinship homes* – Kinship homes are foster homes in which the children already have a relationship with the foster family. The foster parents may be members of the child's extended family, neighbours, or close family friends. Kinship foster families are approved and children placed in the home much faster than for regular foster homes. Some of the required documentation is obtained after the child moves into the kinship home. For example, a detailed assessment is supposed to be completed within six months of approval of the kinship family arrangement; this includes greater details of the kinship parents' family history and environment.

3.59 Guidance for screening and approval of kinship homes is minimal. Management told us that, in practice, most foster family screening requirements apply to kinship files. However, we noted confusion among management and staff concerning screening requirements for kinship homes. There were a number of instances in which required information had not been collected for the kinship files we tested. Compliance with file documentation was generally better for regular foster family files than for kinship.

- 27 (71%) of 38 kinship files did not have required medical records. Only one (5%) of 22 regular foster family files was missing this information.
- Nine (24%) of 38 kinship files were missing required references. Only one (5%) of 22 regular foster family files did not have this information.
- Six (22%) of 27 kinship applications were missing long-form assessments. These must be completed within six months of a child being placed in a kinship home. For an additional seven files, the assessments were completed more than six months after placement. There is no comparative for regular foster care homes since the entire application process must be completed before children are placed in the home.

3.60 Management has draft policies and procedures for kinship arrangements and told us they hope to approve these soon.

Recommendation 3.12
The Department of Community Services should update the foster care manual to include clear, well-defined kinship foster family policies and procedures.

Department of Community Services Response:
The Department agrees with this recommendation. A new section on kinship care has been drafted and is currently being reviewed for approval, which has well defined

standards, policies and procedures for kinship foster care. Unless stated otherwise in the standards, policies and procedures that apply to general foster care, will also apply to kinship foster families.

Monitoring of Children in Care and Parents

Conclusions and summary of observations

Monitoring of children and foster families is inadequate to ensure the interests of the child are protected. We found significant concerns related to monitoring of children in 43% of the files we tested. A common problem was failure to meet social worker-child contact standards. In addition, 24% of the files we tested did not have care plans. Of the files we tested with care plans, the majority of plans were completed late and 74% of periodic plan reviews were not completed on time. One third of child protection files we tested did not have case plans. Monitoring of foster families was also inadequate to protect the interests of the child or to support the foster family. We found significant problems in 53% of these files; again, social worker-family contacts were a common issue. We found issues identified by social workers during monitoring were appropriately addressed.

3.61 *Monitoring children* – We tested a sample of 130 case files in which children were required to be monitored by the Department. They included the following:

- 68 children in care files;
- 32 court-ordered supervision files; and
- 30 child protection files (supervision in the home, not court-ordered).

Children in Care

3.62 We tested the 68 children in care files for compliance with Department policies and concluded:

- two files (3%) met all requirements;
- 33 files (48.5%) had minor deficiencies; and
- 33 files (48.5%) had significant deficiencies.

3.63 We defined significant deficiencies in children in care files as lacking a care plan, failing to meet with the child as required, or failure to follow up as required by standards. We also included files with many minor issues such as lack of required medical checks, supervisory reviews, or short delays in required contacts.

3.64 *Care plans* – We found care plans were missing in 15 (24%) of the 62 children in care files for which a plan was required. Care plans document the child's status (for example, physical and emotional state, relationships, developmental progress) upon

entering care and the interventions or services required to meet the child's needs. Without care plans, there is a risk the child does not receive the necessary structure and support.

3.65 In most instances, care plans were not completed in a timely manner. 37 (79%) of the 47 care plans we examined were not completed within 99 days of the child entering care. The Department's standards require plan completion within 90 days; we allowed for a reasonable overage of 10% in evaluating the results.

3.66 We also found significant lapses in the ongoing review of care plans. Department standards require plans be reviewed every 90 days. We allowed for 10% overage. 31 (74%) of 42 files were missing regular care plan reviews during our testing period.

- Five files had no reviews completed.
- 18 files had one lapse ranging from 100 days to 240 days.
- Seven files had two lapses ranging from 111 days to 469 days.
- One file had three lapses ranging from 106 days to 172 days.

3.67 Failure to monitor care plan implementation may result in the child not receiving the necessary services.

Recommendation 3.13
The Department of Community Services should prepare, and monitor compliance with, Comprehensive Plans of Care for all children in care according to policy requirements.

Department of Community Services Response:
The Department agrees with this recommendation. A new Case Planning Tool has been submitted for approval, which will streamline and simplify the planning process, and thereby enable the Department to implement the recommendation. The Department's goal is to provide training on the new planning tool beginning in September 2013.

3.68 *Initial contact* – Initial contact with the child (and parent) is required within seven days of placement. We found this standard was not met in 26 (38%) of the 68 files we tested. In two cases, the initial meeting did not take place for approximately three months following placement. In four cases, the initial meeting did not occur. This meeting is important to ensure the child is properly settling in, the foster family is comfortable with the child's needs, and appropriate services are in place.

Recommendation 3.14
The Department of Community Services should conduct all initial contact meetings within seven days following a child's placement in care as required by policy. Meetings should be documented in case files.

Department of Community Services Response:
The Department agrees with this recommendation, and is already following up on this issue. It has been working jointly with the Federation of Foster Families on the "Dialogue with Foster Parents" project. The committee is developing a number of new planning aids, to improve social work/foster parent contact, including a new scheduling tool, which will support the implementation of the recommendation.

3.69 *30-day contacts* – Social workers are required to make contact with a child at least every 30 days. We found this did not occur consistently in 50 (74%) of 68 files tested. 25 files had three or more lapses of the 30-day contact standard. The table below provides additional details on the instances of 30-day contact lapses we found during our testing.

Frequency of 30-day* contact lapses – Children in Care		
Number of Files	**Number of Lapses per File**	**Percent**
13	1	26%
12	2	24%
8	3	16%
7	4	14%
3	5	6%
2	6	4%
1	8	2%
1	9	2%
1	13	2%
2	No contacts	4%
50		**100%**

** We used 33 days to allow a reasonable overage of 10% in evaluating the results.*

3.70 During our testing, we identified 146 lapses in the 30-day contact standard. In those situations, the average contact period was 60 days which is double the timeframe required by policy. 88% of missed contacts were made within 90 days. The table below provides a breakdown of the duration of lapsed 30-day contacts.

Duration of 30-day* contact lapses – Children in Care		
Duration of Lapses	**Number of Lapses**	**Percent**
34 – 59 days	90	62%
60 – 89 days	38	26%
90 – 179 days	16	11%
180 – 270 days	2	1%
Total	**146**	**100%**

** We used 33 days to allow a reasonable overage of 10% in evaluating the results.*

Recommendation 3.15
The Department of Community Services should comply with the 30-day contact requirement for all children in care.

Department of Community Services Response:
The Department agrees with this recommendation. To implement the recommendation, it is developing a new Core Training Program for children-in-care workers, to begin in September 2013.

3.71 *Medical and dental requirements* – Medical standards for children in care were not consistently followed and dental standards do not specify the age at which a child should begin regular dental visits.

3.72 A medical is required within the first 30 days of placement and annually thereafter. Medicals were not completed in 21 (31%) of 67 files.

3.73 The Department's policy is not clear regarding the age at which children should start regular dental visits. A child is to visit a dentist within 90 days of placement and annually thereafter. Regional offices generally used between two years of age and four years of age which results in inconsistent application of the policy across the province.

Recommendation 3.16
The Department of Community Services should clarify dental standards for children to address the age at which visits are first required.

Department of Community Services Response:
The Department agrees with this recommendation, and will seek expert advice upon which to develop the standard.

Recommendation 3.17
The Department of Community Services should comply with health and dental standards for all children in care.

Department of Community Services Response:
The Department agrees with this recommendation and will follow up with the concern noted in the audit.

Court-ordered Supervision

3.74 *Supervision orders* – We tested 32 case files with court-ordered supervision.

- 22 (69%) files met all requirements.
- Seven (22%) files had minor deficiencies.
- Three (9%) files had significant deficiencies.

3.75 When monitoring did not occur within reasonable timeframes, we considered this a significant deficiency. We classified short lapses in meeting required timeframes as minor deficiencies.

3.76 The Department does not have monitoring standards for supervision orders and management told us that the court rarely establishes ongoing monitoring requirements. None of the 32 supervision orders we tested had court-ordered contact requirements. We discussed this issue with Department management around the province; they told us that monthly contact was considered the minimum acceptable practice. Accordingly, we evaluated the Department's monitoring of supervision orders against a 30-day standard.

3.77 We found monitoring occurred within 30 days in 20 (65%) of 31 applicable cases. In the remaining 11 files, the 30-day timeframe was exceeded a total of 22 times, with three of these lapses greater than 100 days.

Recommendation 3.18
The Department of Community Services should establish monitoring standards for families under court-ordered supervision.

Department of Community Services Response:
The Department agrees with this recommendation. It will develop a standard following consultation with key stakeholders.

Child Protection

3.78 *Child protection* – In certain situations, Community Services may determine it is appropriate for the child to remain in his or her home with ongoing Department involvement. Department staff are required to have a risk management conference in which staff document risks and prepare a case plan outlining the steps to address these risks. The case plan assists the social worker by providing a framework for goal setting and healthy development for the family; it forms the basis of monitoring by the Department.

3.79 We tested compliance with policies when the child remained in the home with ongoing Department involvement. We defined significant deficiencies in child protection monitoring as the absence of a case plan, a case plan missing more than two components, or failing to conduct a risk management conference. Minor deficiencies typically included preparing the case plan slightly later than required, not defining the objectives in measurable terms, or parents not signing the plan. We considered situations with multiple minor issues to be an overall significant deficiency.

3.80 We tested 30 child protection files and found:

- two (7%) files met all requirements;

- eight (26%) files had minor deficiencies; and
- 20 (67%) files had significant deficiencies, including one file for which a risk management conference was not conducted.

3.81 We found 20 (67%) of 30 files tested had case plans. However, nine case plans were not completed within the 30 days required by policy; four plans took more than 100 days to complete, including two which took more than 200 days.

3.82 We also noted deficiencies in the case plans, including nine (45%) of 20 files in which case plans did not include objectives. This reduces the plan's usefulness in guiding monitoring. Without timely and complete case plans, there may be risks to the child which are not properly addressed.

Recommendation 3.19
The Department of Community Services should prepare complete case plans within 30 days as prescribed by standards.

Department of Community Services Response:
The Department agrees with this recommendation. It will implement the recommendation by introducing a new planning tool, which has already been developed and submitted for approval. It will streamline and simplify the planning process, to reduce delays. The Department will begin training on the new tool, in September 2013, as part of the new Core Training Program for child-in-care social workers and casework supervisors.

3.83 We found evidence of supervisory file review every 90 days as required by standards for 23 (77%) of 30 files tested. However, only six (30%) of the 20 files with case plans evaluated the plan for achievement of objectives. Families with ongoing monitoring by the Department should be accountable for achieving objectives and reviews by supervisory staff would help provide assurance of this.

Recommendation 3.20
The Department of Community Services should conduct supervisory reviews to assess progress implementing case plans every 90 days, or sooner if defined in the plan. These reviews should be documented in the case file.

Department of Community Services Response:
The Department agrees with this recommendation. The Department will work with staff to ensure the case plans are reviewed, and the review is documented in the case file.

Foster Family Monitoring

3.84 *Testing* – We examined a sample of 100 foster family files for compliance with the Department's monitoring standards.

- 10 (10%) files met all requirements.

- 37 (37%) files had minor deficiencies.
- 53 (53%) files had significant deficiencies.

3.85 Minor deficiencies involved shorter lapses in required contacts or failure to properly update the safeguarding plan. Significant deficiencies included situations in which required contacts or reviews were either not completed or there were longer lapses between contacts.

3.86 Monitoring requirements are the same for regular and kinship foster homes. We did not identify significant differences in the monitoring results between regular versus kinship homes; accordingly, they are reported together for this section.

3.87 *Contacts* – Policy requires the social worker make contact with foster families in the home at least once every three months. This contact is to *"ensure that the foster family is able to maintain the expected standard of care and to meet the terms of the Foster Home Agreement."*

3.88 75 (78%) of 96 files were missing at least one three-month contact. We found numerous instances in which there were significant lapses in foster family contacts. 60% of the files we tested had three or more contact lapses and 33% of all lapses exceeded six months. The tables below summarize the frequency and duration of the contact lapses.

Frequency of Lapses of Three Month* Foster Family Contacts		
Number of Lapses per File	**Number of Files**	**Percent**
1	12	16%
2	18	24%
3	22	29%
4	20	27%
5	3	4%
Total	**75**	**100%**

** We used 99 days to allow a reasonable overage of 10% in evaluating the results.*

Duration of Lapses in Three-Month* Foster Family In-Home Contacts		
Duration of Lapses	**Number of Lapses**	**Percent**
100 – 120 days	64	31%
121 – 180 days	75	36%
181 – 270 days	36	17%
271 – 360 days	21	10%
Over 360 days	13	6%
Total	**209**	**100%**

** We used 99 days to allow a reasonable overage of 10% in evaluating the results.*

Recommendation 3.21
The Department of Community Services should meet with all foster families every three months in the foster home as required by standards.

Department of Community Services Response:
The Department agrees with this recommendation. To implement the recommendation, a new five-day training program has been developed for the foster care program. Delivery to foster care social workers and their supervisors will begin in June 2013.

3.89 *New placements* – Foster care standards also require the social worker make contact with foster families within five working days of a child's placement. Our sample included 63 new placements during our audit period. 28 (44%) of those placements, had no contact with the foster family within five working days. This initial contact ensures the foster family understands the Department's involvement and helps identify any concerns of either party early in the placement.

Recommendation 3.22
The Department of Community Services should have initial contact with all foster families within five working days of each child's placement as required by standards.

Department of Community Services Response:
The Department agrees with this recommendation. To implement the recommendation, a new five-day training program has been developed for the foster care program. Delivery to foster care social workers and their supervisors will begin in June 2013.

3.90 *Annual reviews* – An annual review of each foster family is required. 49 (63%) of 78 files had at least one review which was not completed within a reasonable timeframe. This includes ten files for which 18 to 24 months elapsed prior to an annual review, and eight files with the time between reviews exceeding two years. The annual review is important to assist foster families in developing the competencies required for effective foster parenting and to identify any issues related to the family's ability to address the needs of children in care.

Recommendation 3.23
The Department of Community Services should conduct annual reviews of each foster family as required by standards.

Department of Community Services Response:
The Department agrees with this recommendation. To implement the recommendation, a new five-day training program has been developed for the foster care program. Delivery to foster care social workers and their supervisors will begin in June 2013.

3.91 *Issues identified during monitoring activities* – For all files we tested, any issues identified as a result of monitoring were appropriately addressed by the department.

Mi'kmaw Family and Children Services

Conclusions and summary of observations

We determined the Department is fulfilling its obligations under the tri-partite agreement with the Federal government to monitor the operations of Mi'kmaw Family and Children Services. The Department of Community Services has conducted two detailed reviews of Mi'kmaw Family and Children Services and reported the results both to the agency and to the Federal government.

3.92 *Mi'kmaw Family and Children Services* – The Federal government has jurisdiction over the provision of foster care related services to native Canadians living on reserve in Nova Scotia. Under a 2009 agreement among Mi'kmaw Family and Children Services and the Governments of Canada and Nova Scotia, Mi'kmaw Family and Children Services is responsible to provide services consistent with the Children and Family Services Act of Nova Scotia, and related standards. The Province has a limited role; it is only responsible to monitor the agency's activities and report results to the agency and the Government of Canada. Management indicated they have a strong relationship with the agency and are working with them to provide additional support, such as training, where possible.

3.93 The Department of Community Services completed two reviews of Mi'kmaw Family and Children Services in 2010. These reviews covered intake, child protection and children in temporary care. The results were communicated to Mi'kmaw Family and Children Services and the Government of Canada. Based on the results, the Department provided additional training and follow-up file testing was conducted.

Department of Community Services Additional Comments

The Department of Community Services welcomes the Auditor General's report, as an opportunity to make improvements to service delivery.

There is no greater responsibility than to protect vulnerable children who may be at risk of child abuse or neglect. Accordingly, the first responsibility of a child protection worker is to respond to reports of child abuse and neglect. The Department has implemented a Risk Management System, with 9 key decision points, to ensure social workers act quickly and decisively to assure the safety of children.

[OAG note: Paragraph deleted as it misinterpreted our audit conclusions.]

The Department believes [OAG note: wording change to prevent misunderstanding relating to audit conclusions] that social workers understand the formal risk management system, and take the necessary steps to prioritize their work, in order to achieve these critical benchmarks. There is always room for improvement, and the Auditor General's Report sets out important areas where adjustments and changes are needed. Indeed, many of these areas are under way, as noted, in the Department's response to individual recommendations.

4 Transportation and Infrastructure Renewal: Mechanical Branch Management

Summary

The Department of Transportation and Infrastructure Renewal's management of mechanical branch operations is deficient. Management lacks fundamental information needed to effectively manage operations. Oversight of operations is inadequate, which has contributed to a number of the deficiencies identified in this chapter. Controls and processes which are fundamental to ensure inventory is adequately safeguarded and equipment is appropriately repaired and maintained, either do not exist or are ignored. We are concerned with management's lack of action to correct operational problems which they know exist.

Parts and tool inventories are exposed to an unnecessary risk of theft due to the lack of appropriate controls. A significant number of variances are identified during inventory counts when parts on hand differ from inventory records. This is indicative of a poorly controlled inventory system. In most cases, management does not know the reason for these variances.

Management lacks the information needed to effectively monitor repair work. Staff do not always include complete and accurate descriptions of work done on repair jobs or the date the work was performed. Management does not know the hours spent and parts used during all repair jobs as information is not tracked in that manner. There are no standards to indicate how long repairs should take. Without this information, management is unable to determine whether staff are working efficiently and whether parts and labour for repair jobs are reasonable.

We found certain required preventative maintenance was not being completed. There was inadequate evidence to support whether other required repair work was completed. In our 2005 audit report on fleet management at the Department, we recommended that preventative maintenance activities be adequately documented. This recommendation has not been addressed.

The Department is not doing a good job of managing total life cycle agreements. These agreements should limit the province's exposure to repair and maintenance costs on certain equipment. However, not all eligible costs are identified due to insufficient information and inadequate analysis of repairs completed.

We have made a number of recommendations to address the weaknesses identified in this report. These recommendations should be a priority for implementation and are necessary to protect government's significant investment in mechanical branch operations.

4 Transportation and Infrastructure Renewal: Mechanical Branch Management

Background

4.1 The Department of Transportation and Infrastructure Renewal operates six mechanical branches in four districts (Northern, Eastern, Western and Central) across the province. These branches complete large, more complex repairs for vehicles operating in their district. The Miller Lake mechanical branch is the largest branch in the province, serving the Central District. Miller Lake performs repairs for other provincial mechanical branches when they lack the resources or equipment, and is responsible for developing preventative maintenance requirements used by mobile service mechanics across the province.

4.2 Miller Lake is also responsible for managing total life cycle cost agreements related to certain pieces of heavy equipment. These agreements with manufacturers include a guarantee that the five-year accumulated maintenance and repair costs will not exceed a specific dollar amount. At the end of the fifth year, if the total eligible costs exceed the guaranteed amount, the Department can submit a claim to the manufacturer seeking reimbursement of the excess costs.

4.3 Each district has a fleet service coordinator who is responsible for inventory management, on-site repairs, and supervising mobile service mechanics operating in that district. Equipment repairs are completed by shop mechanics at each branch. Mobile service mechanics perform minor repair work and preventative maintenance at Department bases across the district.

4.4 There are approximately 60 shop mechanics, 37 mobile service mechanics, and 20 stock clerks across the province. The Miller Lake and Truro mechanical branches are the largest. Miller Lake has 30 shop mechanics, five mobile mechanics, and seven stock clerks while Truro has five shop mechanics, 11 mobile mechanics, and four stock clerks.

4.5 On March 31, 2012, the branches held inventory valued at $6 million with Miller Lake holding $4.1 million and Truro holding $0.6 million. During 2011-12, staff indicated they spent $25 million to repair and maintain approximately 1000 vehicles, excluding provincial ferries. Miller Lake is responsible for 276 of these vehicles and Truro is responsible for 210.

Audit Objectives and Scope

4.6 In winter 2013, we completed a performance audit of mechanical branch management at Miller Lake and Truro. The audit was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

4.7 The purpose of this audit was to determine whether there were controls, processes and procedures in place to appropriately safeguard inventory and repair and maintain department equipment.

4.8 The objectives of the audit were to assess whether the department:

- has systems and procedures in place to ensure inventory is appropriately safeguarded and controlled;
- has systems and processes in place to ensure repairs are completed appropriately and in accordance with Department standards;
- has systems and processes in place to ensure preventative maintenance is completed consistent with Departmental policies including manufacturer's requirements; and
- is adequately monitoring and obtaining timely reimbursement of total life cycle and guarantee and warranty work.

4.9 Generally accepted criteria consistent with the objectives of the audit did not exist. Audit criteria were developed specifically for this engagement using both internal and external sources. Criteria were accepted as appropriate by Transportation and Infrastructure Renewal senior management.

4.10 Our audit approach included interviews with mechanical branch staff and management; reviews of systems and processes; testing certain processes and key controls; and examination of policies and other documents. Our audit period included activities conducted primarily between August 1, 2009 and August 31, 2012, with tests of controls covering the period August 1, 2011 to August 31, 2012.

Significant Audit Observations

Overall Conclusions

Conclusions and summary of observations

Management's oversight of mechanical branch operations is not adequate. This contributed to many of the deficiencies noted throughout this chapter. Controls and processes which are

fundamental to ensure inventory is safeguarded and equipment is appropriately repaired and maintained either do not exist or are ignored. Key management information such as parts used and labour for specific repairs is not available. Standards have not been established to enable monitoring and assessment of important operational activities. It is unclear how management can know whether operations are effective, efficient and conducted in the most economical manner possible. We have made numerous recommendations to address the weaknesses identified in this chapter. Departmental policy and procedure manuals must be updated to reflect the improvements we have recommended and the Department needs to establish a process to regularly monitor compliance. For significant lasting improvements to be achieved, management must be more effective in their oversight responsibilities.

4.11 Management lacks fundamental information needed to effectively manage operations. For example, there is no detailed information regarding the work completed on specific repairs and management does not know the hours and parts charged to all jobs. Additionally, management does not know whether preventative maintenance work is completed as required. There are no standard timeframes for types of repairs which would allow the Department to measure staff efficiency. In our 2005 Report on fleet management, we recommended that maintenance activities be adequately documented; this has not been addressed.

4.12 In 2008, the provincial Internal Audit and Risk Management Centre recommended inventory control improvements at Miller Lake and Truro. During our audit, we identified similar issues and repeated some of the same recommendations.

4.13 The Miller Lake and Truro mechanical branches have a poor control culture. We found many instances in which controls did not exist or were ignored. In certain cases, management were aware controls were being ignored but did not take steps to ensure they were operating as intended. Departmental policies and procedures must be followed and management must take steps to ensure compliance.

4.14 Throughout this chapter, we identify several significant deficiencies resulting from a lack of management oversight. As noted in the scope section, this audit included a detailed examination of the Miller Lake and Truro mechanical branches. The number and nature of our findings supports the need for the Department to assess the remaining four branches and implement the recommendations in this chapter as needed. Departmental policy and procedure manuals need to be updated to reflect the findings in this chapter and establish clear expectations of staff.

Recommendation 4.1
The Department should assess all mechanical branch operations and implement the recommendations in this chapter where similar conditions exist.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will implement the recommendations in all Mechanical Branches where similar conditions exist.

Recommendation 4.2
The Department should update its policies and procedures to reflect operational practices and the recommendations in this chapter.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will strike a Provincial Policy & Procedure Committee to address the recommendations. This committee will meet on an ongoing basis to address P&P opportunities.

4.15 *Quality assurance process* – There is no quality assurance process such as reviewing a sample of repair jobs, examining vehicles to determine if adequate preventative maintenance work was completed, and monitoring the quality and accuracy of electronic work orders. A quality assurance process involves planned and systematic actions to provide confidence the system is performing as required. This would give management assurance that repairs and maintenance are completed appropriately and policies and procedures are followed.

Recommendation 4.3
The Department should implement a quality assurance process to regularly monitor operational activities and controls.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will develop a new Policy for Quality Assurance in conjunction with our new Fleet Management Tool, ARI (Automotive Resources International).

Inventory Stewardship

Conclusions and summary of observations

Management does not have adequate controls and processes to safeguard and monitor parts and tools inventories. We identified significant weaknesses which unduly expose expensive parts and tools to theft. At Miller Lake, a key-card system was established to restrict and monitor access to inventory. However, staff still have the original key which renders the new system ineffective. At Truro, the inventory stockroom doors are unlocked during the day allowing unauthorized access to inventory. There are insufficient controls to ensure inventory distributions are valid and recorded. Numerous unexplained variances identified during inventory counts indicate a poorly controlled inventory system. Although there are regular comparisons of inventory in the records to physical inventory, there are no established criteria to investigate inventory variances. As well, there is no evidence to support which variances were investigated. At Truro, staff told us count variances were not investigated.

4.16 *Information system* – The Department uses the inventory management module of the province's Corporate Financial Management System to track inventory activities including issues, receipts, and adjustments to inventory levels.

4.17 *Receiving inventory* – There are adequate controls in place to ensure inventory received is properly recorded. Accounting staff ensure purchase order details agree to physical goods received and recorded before the invoice is processed for payment.

4.18 *Approval for tool purchases* – At Miller Lake, we noted a key control in monitoring the tool inventory was not working as intended. All tool purchases are required to be approved by management; however, we found this is not occurring. We tested 14 tool purchases and found six which were not properly approved or had no evidence of proper approval. One form was not signed, one was approved by a stock clerk who did not have authority to authorize a purchase, and four did not have an order form authorizing the purchase. Failure to approve tool purchases limits management's ability to monitor these expenditures.

4.19 In Truro, verbal approval is given to purchase items between $1,000 and $5,000. As a result, there is no evidence to support these approvals.

Recommendation 4.4
The Department should approve tool purchases and retain documented support for the approval.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will develop a Policy for the purchase of tools for its Mechanical Branches, following the Procurement thresholds and appropriate sign offs.

4.20 *Inventory access* – At Miller Lake, access to the stockroom and warehouse is restricted using electronic key-cards. The key-card system records who accesses the stockroom and when. Before these key-cards were used, staff had keys to the stockroom. These keys were not collected once the new system was implemented; they can bypass the electronic key-card readers rendering this control ineffective. As well, it is possible the keys have been copied. To address these concerns, the stockroom door locks should be changed and keys stored in a secure area to ensure the electronic key-card readers cannot be bypassed.

4.21 One access card, assigned to an employee who no longer works at the facility, could not be located. The key-card system indicates it was used twice after the employee left. More than a year later, this card had not been deactivated. As long as it is active, there is a risk that it can be used for unauthorized access to the stockroom.

Recommendation 4.5
The Department should deactivate all inventory stockroom electronic key-cards issued to former employees at Miller Lake and moving forward, should deactivate key cards when employees leave.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department has reviewed the list of Electronic Key holders and has deactivated all cards no longer necessary. Complete.

Recommendation 4.6
The Department should change stockroom door locks and store keys in a secure location at Miller Lake.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department is reviewing the current key/card holders and will be retrieving all outstanding keys and cards. Locks will be changed and cards will be accounted for and stored securely.

4.22 Two inventory clerks have stockroom access cards but based on their duties, there is no operational need for such access. Inventory access should be restricted to staff whose duties require such access.

Recommendation 4.7
The Department should evaluate which staff require access to parts and tool inventories at Miller Lake. Only those with an operational need should have access.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department is conducting an access review for the stockroom and tool room and access will be restricted to those who have an operation need.

4.23 In December 2012, a crime prevention review was completed at Miller Lake by the Transportation and Infrastructure Renewal coordinator of security services. The report included recommendations related to protecting and safeguarding the facility. For example, having the commissionaire check manifests of trucks entering and leaving the property, repairing fencing around the facilities, having all pedestrians and vehicles sign-in at the guardhouse, and erecting surveillance cameras at the guardhouse. Management indicated they intend to address these recommendations by the end of 2013.

Recommendation 4.8
The Department should implement the recommendations from its December 2012 crime prevention review at Miller Lake.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department is in the process of tendering/requesting quotes, to address the opportunities noted in the CPTED Audit (Crime Prevention Through Environmental Design.)

4.24 In Truro, the stockroom door is unlocked during the day. There is the possibility a staff member could enter the stockroom and remove inventory.

Recommendation 4.9
The Department should restrict inventory access to authorized personnel at the Truro mechanical branch.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department is developing an authorized personnel list. Only people on the list will have access to the Inventory.

4.25 *Access to shared tools and supplies* – On average, Miller Lake spends $53,000 annually on shared tools and supplies. These items are stored in a locked room; the fleet service coordinator and the shop supervisors have keys.

4.26 In January 2012, the full-time staff member responsible for the tool room retired. Prior to that time, tools were engraved with identification numbers, a tool listing was maintained, and tools were signed out for use. Since then, sign-out sheets have not been used consistently, new tools are no longer given an identification number, and a tool listing has not been maintained. During our audit, we observed that staff have unsupervised access to the tool room.

4.27 Truro spends approximately $20,000 annually on shared tools and supplies. These items are not held in a secure area, unique identification numbers are not used, and tools are not signed out for use.

4.28 Neither branch maintains an updated list of shared tools and supplies or requires these items be signed out. Effectively, there are limited controls over shared tools and supplies.

Recommendation 4.10
The Department should store shared tools and supplies in a secure area with limited access. The Department should also maintain an inventory of shared tools and supplies and require staff to sign tools out for use.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. Tool Inventory and controls are in place in Miller Lake and the Department will work with the other Mechanical Branches to ensure a similar process and accountability is in place.

4.29 *Inventory distributions* – The Department's inventory policy has controls to ensure inventory distributions are valid and recorded in the inventory records. However, we found these controls are not operating as required.

4.30 All distributions from inventory are to be documented and recorded in the inventory records. Paper inventory distribution documents are sequentially numbered so management can verify all forms are accounted for. These forms should be used to update the parts inventory records.

4.31 We requested 60 distribution forms to determine whether the records were updated accurately and on a timely basis. We identified a number of deficiencies.

- Inventory distribution forms are sequentially numbered but they are not tracked.
- Only 45 of the 60 distribution forms we requested could be provided. The rest could not be located.
- Management told us parts are removed from inventory without a distribution form.
- Of the 18 distributions tested at Miller Lake, 16 were recorded in a timely manner. Two forms were not dated so we were unable to determine if they were entered in a timely manner.
- Of the 27 distributions tested at Truro, 16 were recorded in a timely manner while nine were not. The average delay in posting the remaining nine transactions was 15 days; the longest posting delay was 33 days. Two forms were not dated, so we could not determine if these were entered in a timely manner.

4.32 There are insufficient controls to ensure inventory distributions are recorded on distribution forms accurately. The inventory coordinator told us that inaccurate information on inventory distribution forms contributes to inventory count variances at Miller Lake. Inventory records would also be inaccurate if distributions are not recorded in a timely manner. As well, there is a risk that the inventory does not get charged to equipment covered by a total life cycle cost agreement and is missed in its annual eligibility claim. This issue is discussed later in this chapter.

Recommendation 4.11
The Department should track and maintain inventory distribution forms.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The inventory distribution forms will be reviewed, and Policy will be written to ensure their tracking and maintenance.

Recommendation 4.12
The Department should update parts inventory within one week of distributing the part.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. Policy will be developed to ensure parts inventory is updated in a timely manner.

Recommendation 4.13
The Department should record all parts distributed on a distribution form.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. As noted in recommendation 4.11 the forms will be reviewed and Policy developed.

4.33 The distribution form provides a signature space for the mechanic requesting the part from inventory. We examined 45 distributions and found 30 were not signed by the mechanic. Stock clerks will often write the mechanic's name on the form. Stewardship of inventory is greatly improved when individuals are required to note the specific repair job and sign indicating they removed the part from inventory. Parts charged to repair jobs could then be reconciled to distribution forms as necessary.

Recommendation 4.14
The Department should implement a process to ensure all parts inventory distribution forms identify the specific repair job and are signed by the mechanic receiving the part.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. Mechanics will sign the form and note the job it is to be used for. This will be developed in Policy as well.

4.34 *Inventory adjustments* – The inventory coordinator has physical access to inventory and can process adjustments. There is no requirement for inventory adjustments to be approved. As a result, this person could remove inventory from the stockroom and adjust inventory records so this would not result in a count variance. The risk of theft could be reduced if someone who is not responsible for inventory periodically reviewed inventory adjustments for appropriateness.

4.35 Miller Lake processes all inventory adjustments for the province. We were told adjustments from other districts require that district's approval before processing. We identified 14 inventory adjustments completed for the Truro mechanical branch which were not approved by the Truro fleet service coordinator. Properly authorized inventory adjustments are an important control to help ensure inventory records are complete and accurate and inventory is not stolen.

Recommendation 4.15
The Department should approve all inventory adjustments. Additionally, adjustments should be reviewed periodically by someone independent of the inventory adjustment process.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department has separated the duties of the inventory coordinator to create an independent person in the process. All adjustments will be reviewed and approved by the appropriate Management personnel.

4.36 *Obsolete inventory* – Transportation and Infrastructure Renewal's equipment and mechanical inventory policy requires *"at least once per year, parts for write-off be submitted to the fleet director for approval."* However, the fleet director does not approve write-offs. Inventory adjustments should be reviewed and approved to ensure they are reasonable.

Recommendation 4.16
The Department should implement a process to ensure inventory write-offs are properly approved as required by Department policy.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. Department policy will be followed for all inventory write-offs.

4.37 *Periodic inventory counts* – During an inventory count, staff count the physical inventory available and compare it to the inventory records. Inventory counts at most mechanical branches occur on an annual basis around fiscal year end. At Miller Lake, partial inventory counts are completed every two weeks such that each item is counted twice a year. The inventory coordinator is responsible for supervising the inventory counts and also has the ability to change inventory records. This increases the risk of inventory being stolen.

Recommendation 4.17
The Department should change system access so that supervisors with responsibility for inventory counts cannot also change inventory records.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will review the access control for the Inventory Coordinator to address the fundamental access control issue. The Department will isolate duties where necessary.

4.38 Following each inventory count, a variance report is prepared which shows, by item, any overage or shortage of inventory, including the number of items and dollars

involved. These reports are provided to management to review and discuss. The Department's inventory control policy indicates significant variances should be investigated but does not define significant. The percentage of count variances in a sample of 12 reports we reviewed were high enough to suggest the inventory control system is ineffective. This was the case for all counts we examined. The variances showed both overages and shortages for items. Management cannot know which inventory is in stock based on the results of the inventory counts.

- Miller Lake – We examined count results for August 2012 and found that there were errors in 141 items, which represents 16% of the total items counted. The March 2012 count report showed errors in 255 items, which represents 18% of the total items counted.

- Truro – The March 2011 count report showed errors in 588 items, which represents 30% of the total items counted. The March 2012 count report showed errors in 510 items or 26% of the total items counted.

4.39 *Miller Lake* – The variance reports we examined at Miller Lake included very few explanations of specific variances. The inventory coordinator told us he investigates some variances but typically only makes a note if he can explain a variance. As a result, there is no support to indicate which variances were investigated. Management told us items are discussed which may lead to further investigation but this is not specifically documented.

4.40 Management informed us that variances could be caused by many things, such as recording the wrong number for inventory distributions, not recording a distribution, or inventory stored in the wrong location on shelves. They also indicated they are focused on the higher dollar variances. However, because inventory is not always stored in the correct locations in the stockroom, the inventory items may not be properly valued. Dollar variances may be misleading providing an inaccurate picture of the actual physical inventory on hand.

4.41 Operational changes were made in the summer of 2011 to attempt to address count differences. These included assigning staff responsibility for specific inventory sections and changes in how stockroom items are selected for counts. However, as discussed above, the percentage of errors remained high.

4.42 *Truro* – Inventory count variances are provided to the fleet service coordinator annually. The fleet service coordinator indicated he has not investigated variances and does not know why they are occurring.

Recommendation 4.18
The Department should establish criteria to investigate inventory count variances.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. Policy will be developed to address inventory count variances, siting criteria for investigation including thresholds.

4.43 *Test counts* – We performed test counts at Miller Lake and Truro to assess the accuracy of inventory records. We examined 20 items at Miller Lake and found two had fewer physical assets than the inventory records indicated. This resulted in an inventory shortage of $6,378. One variance related to four heavy equipment tires valued at $6,191. Management was unable to determine the reasons for these differences.

4.44 We examined 20 items at Truro and found eight differences between inventory records and the physical assets. Staff provided the following explanations for these variances.

- Five variances resulted from items distributed from inventory but not yet recorded.
- One variance was because the items were in the wrong location.
- One item was not supposed to be in inventory.
- One item was returned to inventory but the inventory adjustment had not been processed yet.

4.45 In total, we identified $889 in missing inventory and $517 in excess inventory. Of the five variances with distributions not recorded, three were still not fully recorded approximately one month after we completed our count.

Recommendation 4.19
The Department should establish a process to investigate variances which includes action required, documentation and approvals.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. Policy will be developed to address the investigation of variances and Provincial guidelines will be followed.

Equipment Repair Management

Conclusions and summary of observations

Transportation and Infrastructure Renewal does not have adequate systems and processes to ensure repairs are completed appropriately. Management lacks fundamental information needed to effectively manage repair work. For example, they do not have complete and

accurate information on the work carried out for each repair job, or the dates the work was performed. Management do not know both the hours and parts used for specific repair jobs which significantly reduces their ability to effectively oversee branch operations. We identified control weaknesses and controls which were not operating as intended. If addressed, these controls would help to ensure information is accurate and complete. There are no standard timeframes for repairs. There is no requirement to document why repair jobs are carried out by external vendors versus internal staff. When examining vendor approvals, we found proper approval was not obtained.

4.46 *Management information* – Transportation and Infrastructure Renewal uses the plant maintenance module of the province's Corporate Financial Management System as its electronic job costing system to record information on vehicle repair work. We expected each repair job would have a work order, including dates and a detailed description of the work completed, as well as hours and parts charged to the job. However, this was not available for all the repair jobs we examined. The information system is not complete, accurate and it does not track all relevant information. As a result, management has inadequate information to effectively manage vehicle repairs. This lack of information makes it extremely difficult to assess the reasonableness of hours and parts charged to jobs, to monitor staff efficiency, and to ensure all eligible costs incurred are claimed under total life cycle cost agreements. As well, documenting the dates when work was completed could aid in diagnosing problems with vehicles if it is known what other jobs were carried out and when. This information may also provide insight into the quality of repairs performed at the various branches. This lack of essential operational information should be unacceptable to management.

4.47 Mobile service mechanics document work completed on their time sheets. Shop mechanics are supposed to complete a paper work order for each repair job and provide details of the work completed each day. Management is to review the paper work order to determine if the details of the work done are reasonable based on the job request and sign off on the paper work order. The details of the work done and the applicable days, from the paper work order, are then supposed to be entered into an electronic work order.

4.48 *Electronic work order testing* – We reviewed the processes and controls to ensure adequate repair information is documented and found these failed to operate as intended. We tested information available electronically regarding the work done and completion dates for repair jobs. Our sample included tracing hard copy support to the information system, as well as tracing system details back to supporting paper documents.

- 40% of the paper work orders we selected supporting electronic work orders could not be provided.
- 22% of paper work orders examined did not have a description of the work completed and 11% did not note the date work was done.

- For those paper work orders which documented work completed, 57% did not have the information entered into the electronic work order and 19% did not have the date the work was done entered into the electronic work order.
- 83% of paper work orders did not have the same details in the electronic work order as in the paper work order. For 23%, the date the work was completed did not agree with the date noted in the electronic work order.
- None of the paper work orders were reviewed by management.
- 10% of mobile service mechanic time sheets had greater details of work completed than the electronic work order. 23% of electronic work orders had no date or an incorrect date compared to the time sheet.
- 33% of electronic work orders did not include sufficient details regarding the nature of the work completed.

4.49 At Miller Lake, management are aware that paper work orders are not completed by all staff. They are also aware the description of work for each job is not entered in the information system. At Truro, management are aware information on completed forms is not sufficiently detailed. No effective action was taken to address these important information issues.

4.50 Completing paper work orders and ensuring required information is recorded in the information system in a timely manner are necessary steps to improve the operational information available to management.

Recommendation 4.20
The Department should establish standards detailing the nature and type of information to be documented on paper work orders, including dates work was completed and timelines for retention of the work orders.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will develop standards to ensure accountability.

Recommendation 4.21
The Department should implement a process to ensure electronic work orders include accurate and complete information which is updated in a timely manner.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will ensure Mechanics update the work orders accurately and Maintenance Planners enter that information in a timely manner.

4.51 At Truro, hours are charged to specific repair jobs on a work order. At Miller Lake, hours are charged to work orders and not to specific repair jobs. A work order can include more than one job. As a result, management does not know the hours spent on each repair job. In order to know what parts were used on each job, there should only be one job for each work order.

Recommendation 4.22
The Department should implement a process to ensure parts and labour hours are charged to specific repair jobs.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. "Standing Orders" for repair jobs will be closed ensuring new orders are created specific to the repair at hand.

4.52 Management told us they are concerned with how parts and shop supplies taken from inventory are recorded to repair jobs. For example, mobile service mechanics may charge more oil than used to one job, and use the extra oil on other vehicles as needed without charging the oil to that vehicle. We confirmed this during our testing. As a result, the actual repair costs may be higher or lower than they appear.

Recommendation 4.23
The Department should implement a process to ensure only the actual parts and shop supplies used for a repair are recorded to the job.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. Our new Fleet Management/Garage Management System ARI (Automotive Resources International) will allow us to accurately and efficiently record all parts and supplies to specific jobs. The department will develop policy to ensure this is followed.

4.53 Work orders are not always closed once a job is completed. For example, open work orders are created for certain repairs such as brake work. These work orders are left open and, in this instance, all brake-related jobs for a vehicle would be charged to the work order. This could lead to parts or labour charged to jobs after the work has been completed. We examined 60 work orders and found 57 were open. Of the 57, six work orders were opened in 2004 and twelve were opened between 2006 and 2009.

Recommendation 4.24
The Department should close electronic work orders once repair jobs are complete so that no additional postings can be made.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. "Standing Orders" for repair jobs will be closed, so that no additional posting will be made.

4.54 The following are additional control weaknesses we identified concerning the accuracy of data in the information system for completed jobs.

- There are insufficient controls to ensure hours worked are charged to the correct job. We identified two of six jobs for which the hours were charged to the wrong job.
- Mobile service mechanics have procurement cards which they can use to purchase parts for jobs. These purchases are not traced to work orders to ensure the item was reasonable for the job involved.
- There are insufficient controls to ensure procurement card purchases are charged to the correct work order. We tested 30 transactions and identified three which were charged to the wrong work order.
- Shop mechanics can request parts be ordered for a job when the item is not in inventory. However, there are insufficient controls to ensure the correct work order is charged. We tested 13 transactions at Miller Lake and could not determine if the proper work order was charged for two transactions. The work order number was not noted on one authorization form and one form could not be provided. We tested 15 transactions at Truro and found we could not determine if the proper work order was charged in all instances as the requests are done verbally and there is no written record.
- Stock clerks and the inventory coordinator have the ability to purchase, receive, and charge parts to a work order when a mechanic has not ordered the part. This increases the risk that parts are charged to a work order but not used on that job.
- There are insufficient controls to ensure work orders are accurately charged for inventory distributions.
- Inventory distributions are not properly recorded to work orders. This was discussed earlier in the chapter.

4.55 A periodic reasonableness review by management of the hours and parts charged to jobs, and sign-off of the final work order by mechanics, would help to address the issues discussed above.

Recommendation 4.25
The Department should require management to perform a periodic reasonableness review of the hours and parts charged to jobs.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. Our new Fleet Management/Garage Management tool (ARI) will provide us with the ability to review hours and parts charged to jobs throughout the Department. This will allow managers the ability to show accountability and the reasonableness of the work performed.

Recommendation 4.26
The Department should require mechanics to sign off on the final work orders for which they are responsible.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. Mechanics are required to sign off on their final work orders. Complete.

4.56 At Miller Lake, mechanics must get authorization for part purchases, regardless of the amount. This control is not operating as intended. We tested 13 parts purchased and found one purchase had no authorization form; in another instance, the form was not signed.

4.57 Truro requires verbal approval of purchases between $1,000 and $5,000. This does not provide evidence of approval and is another example of different processes at Miller Lake and Truro. This is discussed later in this chapter.

Recommendation 4.27
The Department should revise approval policies and practices to purchase parts for repair jobs so they are consistent among districts. Approval should be documented.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will develop Policies for the approval of parts for repair jobs. The Department will follow Procurement guidelines to ensure consistent application of the thresholds and signing authority required.

4.58 At Miller Lake, when stock clerks receive a part ordered for a specific job, the staff person who requested the part signs the packing slip to indicate receipt. However, in Truro, staff are not required to sign the packing slip when they pick up the part. Accountability for the use of parts is greatly enhanced when staff are required to sign indicating receipt of parts for repairs.

Recommendation 4.28
The Department should require staff to sign indicating receipt of parts used for specific repair jobs.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. Staff are required to sign for the receipt of parts. Policy will be developed if necessary to ensure accountability.

4.59 Most repair requests from mobile service mechanics are verbal. There is a risk that a job request is not communicated accurately. When vehicles return from repairs at a mechanical branch, it is not always possible to inspect the vehicle without removing

parts. Providing the mobile service mechanic with a detailed work order would confirm the repair was completed and agreed to the work requested. This information should be available as recommendations in this chapter are implemented.

4.60 *Standards* – There are no time standards established for staff, such as time required to complete various repair jobs. Standards could help in monitoring staff efficiency.

Recommendation 4.29
The Department should implement and monitor time standards for repair activities.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will develop standards to ensure consistency among work activities. The department will use peer review (other provincial jurisdiction), staff involvement and industry standards (Mitchel Book) to ensure accuracy.

4.61 *Outsourced repair work* – Outsourced repair work occurs when a vehicle is taken to an external garage. There are no guidelines regarding when to outsource work and no requirement to document the reason. Management told us repairs are outsourced only when Department mechanics are busy or do not have the ability or equipment to complete the work. We examined 29 outsourced repairs and found the reason for outsourcing was not documented for 28 repairs. Noting reasons would aid in analyzing whether it is more cost effective for the Department to do the work versus outsourcing.

Recommendation 4.30
The Department should establish a policy outlining when it is appropriate to purchase outside repair work, including requirements for documented rationale.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Province is currently developing guidelines to ensure outside repair work is used appropriately and requirements are documented as necessary.

4.62 Repairs in excess of $1,000 require management approval. Accordingly, management should be aware of outsourced repairs and should approve the purchase.

4.63 Miller Lake and Truro have different repair cost approval practices. At Miller Lake, the area manager is to provide written approval for repairs between $1,000 and $10,000. However, in Truro, the area manager is to provide verbal approval for repairs between $1,000 and $5,000, and written approval between $5,000 and $10,000. Verbal approval provides no evidence the approval was given or when.

4.64 We selected a sample of eight outsourced repair purchases in excess of $1,000 and found the following.

- Two were properly approved.
- One was approved after the invoice date.
- One was approved after the repair work was completed. This was noted as an emergency but was approved three weeks after the invoice date.
- Four purchases required verbal approval which staff told us was not obtained.

Recommendation 4.31
The Department should revise its policies and practices for outsourced repair approvals so they are consistent among districts. This should include a requirement for documented approval.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Province is currently developing guidelines to ensure outside repair work is used appropriately and requirements are documented as necessary.

4.65 *Mechanic qualifications* – Transportation and Infrastructure Renewal does not track mechanics' licenses to ensure they remain valid. Licenses expire every five years but can be renewed by paying a fee as long as the individual remains in good standing. A mechanic could lose his or her license; management would not be aware of this because they do not track licenses. We selected a sample of 16 mechanics and found they all had valid truck and transport licenses.

4.66 There are a few mechanics who are not required to have truck and transport licenses; they are restricted in the work they can do on vehicles. We tested a sample of their work and found it was allowed within the restrictions.

Recommendation 4.32
The Department should track mechanics' licenses to ensure they remain valid.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will document, verify and track all Mechanics Licenses through our training software STEMS. STEMS will be reviewed on a regular basis.

Preventative Maintenance

Conclusions and summary of observations

The Department does not have adequate systems and processes to ensure preventative maintenance is completed in accordance with manufacturers' requirements. There is no monitoring to ensure preventative maintenance is completed as required. We found

manufacturers' maintenance requirements were not accurately reflected in the documents provided to staff who are responsible for completing the work. We found all required preventative maintenance was not being completed. We also found inadequate documentation to support the maintenance work completed. In 2005, we recommended that maintenance activities be adequately supported by appropriate documentation. This recommendation has not been addressed.

4.67 *Background* – Preventative maintenance is designed to ensure vehicles are properly maintained to help ensure they are operating safely, to extend the operating life, and to reduce down-time resulting from unscheduled repairs. If manufacturers' preventative maintenance requirements are not completed, it could result in voided warranties and total life cycle cost agreements. It is also important to have adequate documentation to support that vehicle maintenance was completed. If adequate maintenance records are not maintained, the terms of the total life cycle cost agreements allow the manufacturers to void the agreement with the Department.

4.68 *Manufacturers' maintenance requirements* – For regularly scheduled preventative maintenance, Miller Lake staff are responsible for documenting the manufacturers' preventative maintenance requirements for each vehicle in a preventative maintenance book. Mobile service mechanics are to document the type of maintenance work and date completed to provide support that preventative maintenance was carried out.

4.69 We selected 30 vehicles and three service intervals for each vehicle to determine whether the preventative maintenance books accurately reflected the manufacturer's requirements.

- 18 preventative maintenance books did not accurately reflect the manufacturers' requirements.
- Two books accurately reflected the requirements.
- Four vehicles did not have a book or were missing service intervals from the book.
- Five books did not have support for the manufacturers' requirements.
- One vehicle did not have a book or support for the manufacturer's requirements.

Recommendation 4.33
The Department should revise mechanical branch preventative maintenance practices so that they accurately reflect manufacturers' maintenance requirements.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The department will review all manufacturers maintenance requirements to ensure we are meeting their standard in our own Preventative Maintenance Program.

4.70 *Monitoring* – The fleet service coordinators are not adequately monitoring whether preventative maintenance is completed and documented. The Miller Lake coordinator told us that he started examining preventative maintenance books monthly, in spring 2012, during visits to the Department's bases. However, he does not document this review. He told us that mechanics do not always complete preventative maintenance books. He said he instructed them to complete this task; however, no action was taken when they did not comply. The fleet service coordinator in Truro does not review preventative maintenance books. Neither fleet service coordinator inspects a sample of vehicles to determine if preventive maintenance work is being completed.

4.71 *Testing* – We selected 27 vehicles and found that required preventative maintenance work was not fully completed and was not adequately documented for all 27 vehicles. Of 68 service intervals tested:

- nine service intervals were completely filled out in the preventative maintenance books; and
- 59 service intervals were not filled out or were partially filled out.

4.72 Preventative maintenance work is to be documented in the Department's information system so there is a total history of the work completed on vehicles. We identified 81 service intervals for which we knew service was needed and tried to trace the service to the information system. We found 42 service intervals. We could not determine if the other 39 were included as there were no kilometres or hours noted to allow us to determine which service interval was completed.

4.73 We asked mobile service mechanics whether all service requirements were met for the 68 service intervals we examined. They told us 76% were not fully completed.

Recommendation 4.34
The Department should implement a process to ensure required preventative maintenance is completed, including maintaining proper documentation supporting the maintenance performed.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department's new Fleet/Garage Management system will allow us to easily document and review all preventative maintenance performed on any of our equipment.

4.74 *Prior audits* – In our 2005 audit report of fleet management at the Department of Transportation and Public Works, we recommended *"maintenance activities be adequately supported by appropriate documentation."* As discussed above, management has failed to address the inadequate documentation of preventative maintenance activities.

Management of Supplier Warranties and Guarantees

Conclusions and summary of observations

The Department is not adequately monitoring warranty terms and total life cycle cost agreements. Detailed warranty information is not maintained for vehicles. The Department is behind in its annual submission of eligible costs under the total life cycle cost agreements which allows the manufacturers the option to disallow these eligible costs. Additionally, the Department is not ensuring all eligible costs under total life cycle cost agreements are identified. Data available in the information system is insufficient to claim certain costs. We identified potentially eligible costs which the Department missed.

4.75 *Warranties* – Vehicles include factory warranties and may also have an extended warranty if one was purchased. Transportation and Infrastructure Renewal does not maintain a list of vehicles covered under warranties or general coverage. Only some extended warranty information is entered in the Department's information system. As well, the information is not sufficiently detailed for staff to determine which items are covered under warranty. Staff may contact the vehicle dealer to obtain detailed warranty information. Failure to ensure warranty information is available to staff could result in the Department paying for or completing repairs which should be covered under warranty.

4.76 We selected a sample of ten vehicles and examined 17 repairs which appeared to be eligible under the manufacturer's warranty. We also asked staff whether the items could have been claimed under an existing warranty. Of the 17 repairs, we identified the following.

- Three repairs were covered by a manufacturer's warranty, but the Department completed these repairs at a cost of $616.
- Three repairs did not have sufficient information entered in the repair descriptions to determine whether the work would have been covered under a manufacturer's warranty. The total cost of these repairs was $761.

Recommendation 4.35
The Department should make detailed vehicle warranty information readily available to staff.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Departments new Fleet/Garage Management System will allow all information to be shared with authorized staff. Furthermore the Departments Equipment Maintenance Coordinator will ensure records are recorded timely and accurately into ARI.

4.77 *Total life cycle cost agreements* – Total life cycle cost agreements include a manufacturer's guarantee that the five-year accumulated maintenance and repair

costs will not exceed a specific dollar amount. Each year, within 30 days of the anniversary date of the vehicle being put into service, Department and manufacturer's representatives review and agree to all eligible expenses for the preceding year. At the end of the fifth year, if the approved accumulated cost of repairs and maintenance exceed the guaranteed amount, the Department can submit a claim to the manufacturer seeking reimbursement of the excess costs. Total life cycle cost agreements are only included in heavy equipment purchases, such as graders or loaders, and were first introduced in 2006. 2011 was the first year in which any eligible costs could be claimed. As of March 31, 2012, 59 vehicles were covered by these agreements.

4.78 The last annual eligible expenses were submitted to the manufacturer's representatives in January 2012. We were informed the staff position responsible for monitoring and preparing total life cycle agreement eligible costs was vacant for approximately 15 months. Manufacturers provided a grace period at the end of January 2012, extending the 30-day deadline to agree on annual eligible costs. However, the manufacturers can terminate the grace period at their leisure and have the ability to disallow eligible costs since the 30-day deadline was not met. Five vehicles reached the end of the fifth year of their agreements in August 2012. The total eligible costs for those vehicles at the end of the agreements had not been determined at the time we wrote this chapter.

Recommendation 4.36
The Department should submit annual total life cycle cost claims and final payment claims to manufacturers within 30 days of the contracted timeframe of vehicles as required.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will ensure TLC claims and costs are submitted in a timely manner.

4.79 *Cost tracking spreadsheet* – Department staff use an excel spreadsheet to track eligible repair and maintenance costs per vehicle for the five-year period under total life cycle cost agreements. The spreadsheet includes, by vehicle, the guaranteed cost for repairs and maintenance, eligible costs agreed upon to date, and the net difference. We selected three agreements and checked whether the guaranteed costs in the spreadsheet were accurate. We found the maintenance and repair guarantee amounts were overstated by $6,200 for 13 pieces of equipment. These errors mean the Department could fail to seek reimbursement for accumulated repair and maintenance costs at the end of the fifth year if costs exceed the correct guarantee amount but are below the overstated amount.

Recommendation 4.37
The Department should implement a process to ensure guarantee details per total life cycle cost agreements are accurately reflected in the tracking spreadsheet.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will ensure guarantee details are submitted accurately into ARI/SAP.

4.80 *Claim testing* – In January 2012, the Department submitted three requests for reimbursement totaling $22,298 for heavy equipment which had reached the end of its five-year agreements. All three claims were submitted within 30 days as required under the agreements. We found an error in two of the three claims. The Department failed to include $1,885 of eligible expenses previously approved by the manufacturer resulting in the Department failing to obtain a refund of all eligible expenses.

4.81 *Eligibility of costs* – We selected a sample of 15 pieces of heavy equipment currently under total life cycle cost agreements and reviewed the most recent annual cost claim. We also reviewed all repair and maintenance expenses recorded in the system for that equipment during the applicable year. We identified 138 jobs for which costs may be eligible under the agreements. Staff were interviewed to determine whether all 138 jobs claimed were eligible. We found the following.

- 22 of 138 jobs should have been claimed but were missed. The total cost of these jobs was $3,461 in parts and $11,999 in labour.
- For 51 of 138 jobs, there was insufficient information in the system supporting the nature and costs of the repair, or it was unclear whether costs were eligible under the agreements. These costs were not claimed but may have been eligible. The total value of these jobs was $9,548 in parts and $23,610 in labour.
- 31 of 138 jobs were properly included on the claim.
- 34 of 138 jobs were deemed to be ineligible.

4.82 The labour and parts costs noted above are based on amounts recorded in the Department's system which may not be the amounts finally approved by the manufacturer. Additionally, based on discussions in other sections of this chapter, the accuracy of the information in the Department's system related to parts and labour is questionable.

4.83 Failure to ensure all eligible costs are claimed limits the usefulness of total life cycle cost agreements and increases the Department's exposure to incurring unnecessary equipment maintenance and repair costs.

Recommendation 4.38
The Department should include all eligible costs under total life cycle cost agreements in claims to manufacturers.

Transportation and Infrastructure Renewal Response:
The Department agrees with the recommendation of the Auditor General. The Department will ensure all eligible costs are included/submitted to manufacturers.

Transportation and Infrastructure Renewal Response

Thank-you for your report of April 2013 outlining the recent audit of our Mechanical Branches in Truro and Miller Lake. The findings of the report and the discussions with your staff have certainly been helpful and will serve as the basis of our Mechanical Branch improvements. Upon our initial review of the report, we find that we are in total agreement with the recommendations as put forward.

The details of the report support Governments newest initiative, a state of the art Fleet Management and Garage Management Tool provided to us by Automotive Resources International (ARI.) This tool will support our efforts to respond to the recommendations in a timely and efficient manner. Furthermore the report supports our development of a TIR Provincial Policy and Procedure Committee, which will aid in the review and development of new and existing P&P, leading to increased efficiencies and increased accountabilities.

The Department is looking forward to the implementation of your recommendations and the benefits that will follow. We recognize that this report supports responsible management of personnel as well as the fleet assets and operations of the Province.

In closing I would like to acknowledge the cooperation of your office and your staff during the course of this review.

5 Agencies, Boards and Commissions: Travel and Other Expenses

Summary

We tested travel and other expenses of senior management and board members at eight entities and found weaknesses in controls over expense claims, as well as other areas for improvement. Numerous claims were paid which lacked appropriate support. Without support, such as receipts or details and purpose of the expenditure, we cannot provide assurance that the expenses claimed were appropriate. We recommended only complete expense documentation be accepted and processed for payment.

We found some claims at certain entities were not approved for payment and we recommended all claims be approved. We also found inappropriate approval processes, such as board chair claims approved by the senior executive, senior executive claims approved by subordinates, claims approved by peers, and self-approval of claims. We recommended appropriate approval relationships be established.

Improvements are needed to travel policies at some entities which do not follow government policies. We recommended these entities review and update their policies. We also identified a potential for mileage savings and recommended this be considered when entities make travel arrangements.

Although we found a few instances of inappropriate expense claims they were for insignificant amounts.

The types of weaknesses we identified at the eight entities we visited likely exist at other provincial agencies, boards and commissions. We recommended Treasury Board Office communicate with agencies, boards and commissions that they evaluate their own systems and processes in light of our observations and recommendations and make the improvements required.

5 Agencies, Boards and Commissions: Travel and Other Expenses

Background

5.1 Provincial agencies, boards and commissions are separate entities which operate outside the traditional government structure while providing various services to the Nova Scotia public. Such entities are commonly created through legislation, regulation, or incorporation under the Nova Scotia Companies Act.

5.2 There are over 50 provincial agencies, boards and commissions which were set up to provide services such as health care, education, financial assistance and support to specific economic or cultural sectors. These entities operate with some autonomy from government but are still accountable to their responsible ministers.

Audit Objective and Scope

5.3 In February 2013, we completed a performance audit of travel and other expenses of senior management and board members at selected provincial agencies, boards and commissions, covering the period from April 2011 to September 2012.

5.4 The objective for this assignment was to determine whether travel, hospitality and other related expenses incurred by or on behalf of senior management and board members are appropriate, adequately supported, properly authorized, and in accordance with legislation, policies and guidelines.

5.5 The audit was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

5.6 Audit criteria were developed specifically for this audit and were discussed with, and accepted as appropriate by, senior management at the selected agencies, boards and commissions we visited for detailed audit work.

5.7 Our audit approach included examination of policies and documents, interviews with management and staff, and sample testing of expense claims.

5.8 The following entities were selected for our audit.

Film Nova Scotia (now Film and Creative Industries Nova Scotia)
Hants Regional Development Authority
Nova Scotia Innovation Corporation
Nova Scotia Liquor Corporation
Nova Scotia Primary Forest Products Marketing Board
Strait-Highlands Regional Development Agency
Sydney Tar Ponds Agency
Waterfront Development Corporation

5.9 The recommendations throughout this report are applicable to certain of the entities we audited. The entities are noted in the recommendation or in brackets following the recommendation. For a summary listing of the recommendations and the entities they apply to, see Appendix 5.1 at the end of this chapter. Auditee responses follow the appendix.

Significant Audit Observations

Support for Expense Claims

Conclusions and summary of observations

We found many expense claims without appropriate support, such as receipts, evidence of payment, detailed support or purpose of the expense. We were unable to determine whether items claimed in these instances were appropriate. Making payments without receipts is a poor business practice and significantly increases the risk for reimbursement of ineligible expenses. We recommended only complete expense documentation be accepted and processed for payment.

5.10 *Unsupported expense claims* – Claims processing controls start with claimants ensuring their expenses and claims are appropriate and adequately supported. Incomplete or inadequate documentation significantly increases the risk of claiming items in error or making an inappropriate claim.

5.11 We assessed the adequacy of claims documentation submitted at the entities we audited based on good practices such as submission of original receipts, evidence of payment, and purpose of the expenditure. We found numerous instances in which support for expenses did not provide sufficient information to determine if the claim was appropriate. We noted the following inadequacies with documentation.

- Receipts were not submitted. Receipts provide evidence that the expense was incurred and appropriate.
- Evidence of payment was not included. This provides support that the expense was incurred by the claimant.

- Supporting documentation, such as detailed meal receipts, was not provided. Detailed receipts enable the approver to verify what was purchased and that no inappropriate items were claimed.
- The purpose for travel or meals claimed was not noted. This assists the approver in determining whether the expenses claimed related to approved entity business and are eligible for reimbursement.

5.12 The following table shows all the entities we tested had instances of inadequate documentation.

Entity	No Receipts	No Evidence of Payment	No Detailed Support	Purpose of Expenditure Not Noted
Film Nova Scotia	5 claims	–	20 claims	–
Hants Regional Development Authority	2 claims	1 claim	25 claims	21 claims
Nova Scotia Innovation Corporation	7 claims	1 claim	56 claims	13 claims
Nova Scotia Liquor Corporation	19 claims	21 claims	173 claims	165 claims
Nova Scotia Primary Forest Products Marketing Board	–	6 claims	1 claim	8 claim
Strait-Highlands Regional Development Agency	–	–	19 claims	223 claims
Sydney Tar Ponds Agency	–	18 claims	–	–
Waterfront Development Corporation	34 claims	5 claims	53 claims	8 claims

5.13 Proper documentation is important to both prevent inappropriate expenses and protect senior management and board members against allegations of improper expense claims. Due to the lack of appropriate documentation, we could not determine whether those items claimed were appropriate.

Recommendation 5.1
Complete documentation, including detailed receipts, evidence of payment and purpose for the expenditure, should be provided to support claims for reimbursement. Claims without complete support should not be processed for payment. [This recommendation applies to all entities tested.]

Approval and Payment Processes

Conclusions and summary of observations

We found some claims at Waterfront Development Corporation and Nova Scotia Primary Forest Products Marketing Board were not approved for payment; we recommended all claims be approved. At several entities we found inappropriate approval processes, such as senior executive claims approved by subordinates, senior managers approving other senior

manager's claims, and self-approval of claims. We recommended appropriate approval processes be established. In some instances, other staff, such as executive assistants, may incur expenditures on behalf of senior managers. We recommended expenses claimed by senior managers be reviewed, along with related expenses incurred on their behalf, to ensure they are appropriate.

5.14 *Internal controls* – Appropriate controls are necessary to ensure the accuracy of claims processes and to ensure that claims paid are in compliance with policies and guidelines. Such controls include checking claims for accuracy, supporting documentation and evidence of payment. Appropriate controls also include requiring proper approval of claims prior to processing for payment.

5.15 At most of the entities we tested, we found claims were approved and paid. However, at Waterfront Development Corporation we noted nine instances (47% of credit card claims tested) for which there was no approval of expenses purchased through a corporate credit card. Waterfront Development Corporation does not use a claim form for credit card purchases. Senior managers submit only the credit card statement and credit card transaction receipts for approval. All expenses, whether claimed through a claim form or corporate credit card statement should be signed by an approver as indication of approval for the expense.

Recommendation 5.2
Waterfront Development Corporation should develop a process to ensure all expense claims, including claims through corporate credit cards, are signed by an approver as indication of approval for the expense.

5.16 At Nova Scotia Primary Forest Products Marketing Board, we found claims for board members' per diems are not reviewed and approved prior to payment. The office manager prepares the claim forms based on information provided by board members and meeting minutes. These forms are submitted for payment without review and approval by the board chair. Review and approval of claims is an important control for detecting inappropriate expenses and should always be required before payment is made.

Recommendation 5.3
Nova Scotia Primary Forest Products Marketing Board should implement a process whereby per diem claims for board members are reviewed and approved by the board chair prior to submission for payment.

5.17 *Approval processes* – Approval of expense claims can be an effective control when a person in a senior position approves the expenses of a subordinate. At certain entities, the approval processes were not appropriate.

- Board chair expense claims were approved by the senior executive, not by a Minister or other board member.

- Senior executive expense claims were approved by management subordinates.
- Senior managers approved claims of their peers.
- Corporate card expense claims were self-approved by the senior executive, not the board chair.

5.18 These approval processes are not appropriate and increase the risk that expense claims will not be adequately scrutinized and inappropriate expenses may be paid.

Recommendation 5.4
Appropriate approval processes should be established in approving expense claims. [This recommendation applies to Film Nova Scotia, Hants Regional Development Authority, Nova Scotia Innovation Corporation, Nova Scotia Liquor Corporation.]

5.19 *Expenditures by other individuals* – The approval process is not an effective control if members of senior management approve their own expenses. We found instances in which subordinates made expenditures on behalf of senior managers and then submitted the expense claim for approval to the senior manager for whom the expenditure was made. When expenditures are made by another individual on behalf of senior management, approval for that expenditure should be obtained from someone other than the person for whom the expenditure was made.

Recommendation 5.5
Expenses incurred by other individuals on behalf of senior management should be approved by a person other than the senior manager for whom the expenditure was made. [This recommendation applies to Nova Scotia Innovation Corporation, Nova Scotia Liquor Corporation.]

5.20 *Related travel expenses* – The effectiveness of the approval process is reduced if all related travel expenses for a business trip are not included on the claim. We found determining the appropriateness of expenditures more challenging for entities at which another individual incurred and claimed expenditures on behalf of senior management. We found one instance in which such a situation resulted in a claim discrepancy which was not detected until our audit. Expenses incurred by another individual on behalf of a senior manager should be reviewed along with the senior manager's claim for related expenses.

Recommendation 5.6
Senior management expense claims should be reviewed together with related expenses incurred by other individuals on their behalf prior to making payments. [This recommendation applies to Nova Scotia Innovation Corporation, Nova Scotia Liquor Corporation.]

5.21 *Personal expenses* – Senior management and board members may travel on behalf of the entities they represent and claim all business-related expenses in accordance with their policies. Additional expenses, such as costs for a spouse to travel with the employee or board member are not eligible. While it may be practical and convenient for the travel arrangements for an accompanying spouse to be made at the same time as the employee, it is important that the additional costs are removed and not included on the employee's claim. This is best accomplished if there are clear rules, guidelines and processes on identifying and deducting these expenses. We found claim discrepancies at Nova Scotia Liquor Corporation in which incomplete or incorrect amounts were deducted for non-employee travel expenses.

Recommendation 5.7
The Nova Scotia Liquor Corporation should establish rules, guidelines and processes for identifying and deducting non-eligible travel expenses from employee and board member claims.

5.22 *Timeliness* – Our detailed testing identified instances in which expenses were not claimed in a timely manner. Specifically, the following issues were identified.

- Mileage incurred over several months was claimed on one claim. Mileage claims should be submitted with related travel expenses on a timely basis in order for the approver to determine if the mileage and related expenses claimed are appropriate.
- Credit card claims were submitted one to three months late. Credit card claims should be submitted in a timely manner to provide proper support for the expenditures made.

Recommendation 5.8
Claims for mileage should be submitted with related expenses in a timely manner. [This recommendation applies to Nova Scotia Innovation Corporation, Nova Scotia Liquor Corporation.]

Recommendation 5.9
Credit card expense claims should be submitted in a timely manner. [This recommendation applies to Waterfront Development Corporation.]

Appropriate Expenses

Conclusions and summary of observations

Some senior managers made claims for ineligible travel expenses and items previously claimed. Although the circumstances and nature of the expenses were not of concern, we have recommended all such amounts be recovered. We also identified a potential for

significant savings if travel arrangements by senior management were coordinated and we recommended this be considered.

5.23 *Assessing appropriateness* – We referred to the policies and guidelines in effect at each entity to assess the appropriateness of senior management and board member expenditures. While most expense items were within the established rules, we noted instances in which claimed expenditures were not in accordance with policies.

5.24 *Ineligible expenses* – Government travel policies outline the conditions when an employee is considered in travel status for work and when meal expenses can be claimed. For entities following government travel policies this means, for example, employees who return home after 6:30 pm when travelling for work may claim for a supper meal. Likewise, if travelling for business more than an hour before the normal time to arrive at work, an employee may claim for breakfast. We noted 25 instances totaling $356 in which meals were claimed when the person did not meet the criteria to claim meal expenses.

5.25 At some entities which follow their own travel policies, we could not determine whether certain claims for meal expenses were appropriate or not because their policies do not clearly state the timeframes and conditions within which meal expenses can be claimed. Recommendation 5.13 later in this chapter addresses this issue.

5.26 *Double payments* – A double payment occurs when a person receives reimbursement for an expense which had previously been claimed. We examined a sample of expense claims for the period from April 2011 to September 2012 for double payments. The number of claims for double payments was low. For the eight entities included in the audit, we identified nine duplicate claims totaling $354.

5.27 Although the circumstances and nature of the expenses were not of concern, expenses previously claimed and paid are not eligible for reimbursement a second time and therefore should be recovered.

Recommendation 5.10
Payments made for ineligible expenses or expenses already claimed should be recovered. [This recommendation applies to Nova Scotia Innovation Corporation, Nova Scotia Primary Forest Products Marketing Board, Strait-Highlands Regional Development Agency, Sydney Tar Ponds Agency.]

5.28 *Late fees* – Businesses often charge late fees when payment for goods or services is not timely, generally after 30 days. In our sample, we identified payments for late fees totaling $272 for 17 claims as a result of untimely payment. While the total amount may not seem significant, reimbursement for late fees does not reflect best practices or best use of funds.

Recommendation 5.11
Late fees and other such avoidable expenses should not be eligible for reimbursement. [This recommendation applies to Nova Scotia Innovation Corporation.]

5.29 *Travel savings* – One way an entity can reduce travel-related costs is to consider having those attending the same meetings or conferences travel together in one vehicle, where appropriate, to reduce the mileage claimed. We noted a number of instances in which two or three members of senior management travelled on the same day to attend the same meeting. In all cases, each individual attending the meeting travelled separately and claimed mileage for the trip. We determined there were nine trips with a potential savings of $3,416 in mileage claims by the senior managers attending these meetings. We believe cost savings are possible if senior management gives due consideration to coordinating travel arrangements to reduce unnecessary mileage claims.

Recommendation 5.12
Senior management should consider coordinating travel arrangements to reduce unnecessary mileage claims. [This recommendation applies to Sydney Tar Ponds Agency.]

Policy Framework

Conclusions and summary of observations

We found no significant differences between government travel policies and those followed by some of the entities we tested. However, we identified policy weaknesses related to travel status and mileage rates at those entities that did not follow government travel policies. We recommended policies be reviewed and updated to provide guidance in those areas. We found policies were not adequately communicated at some entities and we recommended this be addressed.

5.30 *Policies* – Government travel and other policies are included in Management Manuals 100 to 500 and provide a framework for government employees. Government departments and offices are required to follow these policies, which are available on the government website. Crown corporations, agencies, boards and commissions are to use government policies to the extent there is no conflict with their legislation or contracts. Where possible and appropriate, they are asked to embrace the intent of the government policies.

5.31 To assess the appropriateness of expenditures by senior management and board members at the eight entities we selected, we relied on each entity's policies and guidelines over our audit period. Three entities follow the government travel policies while five have developed their own. Although we found no significant differences

between government travel policies and those established by the five entities, we did note the following deficiencies in some policies.

- No minimum travel distance specified before meal expenses can be claimed
- Standard class for air travel not specified
- Approval process for board member claims not outlined
- Itemized receipts not required with claims
- No guidance on when staff may claim for meals when not on travel status
- Mileage rates not updated for several years

5.32 Policies provide a framework for staff to know when expenses can be incurred and claimed for reimbursement. To be effective, policies should be comprehensive, covering relevant types of expenditures and general circumstances in which they may be incurred.

Recommendation 5.13
Policies should be reviewed and updated, including guidance on minimum travel distances and claiming staff meal expenses, standard class for airfare, approval process for board member claims, and requirement for itemized receipts. [This recommendation applies to Hants Regional Development Authority, Nova Scotia Innovation Corporation, Nova Scotia Liquor Corporation, Strait-Highlands Regional Development Agency.]

5.33 *Communication of policies* – To provide guidance on eligible travel and other expenses, policies should be communicated in sufficient detail to applicable staff and board members. At some entities, policies were not provided to board members or communication of policies lacked important details to ensure compliance This lack of complete policy information may be a contributing factor to the number of discrepancies we found in those entities' claims.

Recommendation 5.14
Policies should be communicated in sufficient detail to staff and board members to provide guidance on eligible travel and other expenses. [This recommendation applies to Nova Scotia Innovation Corporation, Nova Scotia Primary Forest Products Marketing Board, Waterfront Development Corporation.]

Overall Observations

5.34 While we found few instances of inappropriate expense claims, such as double payments or ineligible expenses, we identified numerous instances of inadequate documentation to support expenses claimed. We also found approval relationships

which were not appropriate and other process controls which could be improved. We found expenditures made on corporate credit cards at the Waterfront Development Corporation were not appropriately approved for payment. This represents the breakdown of a fundamental key control which exposes the Corporation to an unnecessary level of risk related to the payment of inappropriate expenditures.

5.35 We tested a sample of claims at eight of the numerous provincial agencies, boards and commissions. The types of weaknesses we identified at these entities are likely to be found at some of the entities we did not audit. Other agencies, boards and commissions should evaluate their own systems and processes in light of our observations and recommendations and make any improvements required.

Recommendation 5.15
Treasury Board Office should communicate to all provincial agencies, boards and commissions that they use the observations and recommendations in this chapter to evaluate their own systems and processes for travel and other expenses, by and on behalf of, senior management and board members, and make improvements as required.

Appendix 1

Recommendations by Entity

Recommendation	Film Nova Scotia	Hants Regional Development Authority	Nova Scotia Innovation Corporation	Nova Scotia Liquor Corporation	Nova Scotia Primary Forest Products Marketing Board	Strait-Highlands Regional Development Agency	Sydney Tar Ponds Agency	Waterfront Development Corporation
Recommendation 5.1 Complete documentation	X	X	X	X	X	X	X	X
Recommendation 5.2 Approval of credit card claims								X
Recommendation 5.3 Approval of per diem claims					X			
Recommendation 5.4 Approval process	X	X	X	X				
Recommendation 5.5 Approval of expenses made on behalf of senior managers/board			X	X				
Recommendation 5.6 Review related expenses			X	X				
Recommendation 5.7 Reimbursement guidelines and processes				X				
Recommendation 5.8 Timely submission of mileage claims			X	X				
Recommendation 5.9 Timely submission of credit card expense claims								X
Recommendation 5.10 Recover ineligible expenses			X		X	X	X	
Recommendation 5.11 Late fees not eligible			X					
Recommendation 5.12 Coordinate travel arrangements							X	
Recommendation 5.13 Update policies		X	X	X		X		
Recommendation 5.14 Communicate policies			X		X			X

Film Nova Scotia Response

Recommendation 5.1
Complete documentation, including detailed receipts, evidence of payment and purpose for the expenditure, should be provided to support claims for reimbursement. Claims without complete support should not be processed for payment.

Agreed. Claims for reimbursement will not be processed for payment without complete documentation.

Recommendation 5.4
Appropriate approval processes should be established in approving expense claims.

Agreed. Board chair expense claims will be approved by an executive of the board of directors effective April 1, 2013.

Hants Regional Development Authority Response

Recommendation 5.1
Complete documentation, including detailed receipts, evidence of payment and purpose for the expenditure, should be provided to support claims for reimbursement. Claims without complete support should not be processed for payment.

In some instances expenses had been approved without the appropriate itemized receipt.

Moving forward, care will be taken to ensure the appropriate itemized receipt is attached to the expense claim prior to approval.

As a "best practice", in the future an itemized receipt will be required with each expense along with proof of payment. Policies will be revised to reflect the need for the submission to include itemized receipts as proof of expense and where applicable debit/credit card receipts will be attached as proof of payment. All expense claims will continue to require approval before payout as outlined in the Hants RDA Bylaw, Policies and Procedures.

Recommendation 5.4
Appropriate approval processes should be established in approving expense claims.

The importance of having an appropriate approval process for sign-off on any expenses is recognized. Under the current Hants RDA Bylaws, Policies and Procedures (Ministerial approved May 2008), board members submit expense claims to the Executive Director for approval. The Executive Director expense claims require the approval of the Chair, or

Hants Regional Development Authority Response (continued)

in the Chair's absence, another Executive Officer. It has always been the responsibility of both the Board member and the Executive Director to ensure that accurate information is provided on the Statement of Travel Expenses.

Following the recommendations from the Auditor's office, all expense claims submitted by board members as well as the Executive Director's will now require two Executive Officer's signatures for approval for payment.

Recommendation 5.13
Policies should be reviewed and updated, including guidance on minimum travel distances and claiming staff meal expenses, standard class for airfare, approval process for board member claims, and requirement for itemized receipts.

The current Bylaws, Policies and Procedures indicate that mileage is compensated at the provincial rate. As noted in the OAG Audit, mileage paid to Board of Directors and Hants RDA staff was at a rate other than the provincial rate. The mileage rate used by the organization did not reflect the changing provincial rate, but remained at a constant rate of 40.92 over the three year period.

The Auditor's recommendation is recognized and moving forward closer attention will be given to the change in the provincial rate and reimbursement will reflect the rate change. Bylaws, Polices and Procedures will be reviewed with Board and staff to ensure that all are aware of the policies for reimbursement of expenses.

Conclusion
The report by the auditors is recognized as an opportunity to improve the current policies and procedures or "best practices" within our organization and steps will be taken to ensure the changes to Bylaws, Policies and Procedures are adjusted and implemented to reflect the Office Auditor General Audit recommendations in the time remaining.

Nova Scotia Innovation Corporation Response

Innovacorp appreciates the thorough review by the Auditor General of the travel and other expenses of its senior management and board members. We agree with the Auditor General's findings with respect to expenses reviewed covering the period from April 2011 to September 2012. During the first quarter of the 2013-14 fiscal year, Innovacorp will develop and implement enhanced controls and expense management policy improvements to address the findings contained in this report.

Editor's note: The following recommendations apply to this entity.

Recommendation 5.1
Complete documentation, including detailed receipts, evidence of payment and purpose for the expenditure, should be provided to support claims for reimbursement. Claims without complete support should not be processed for payment.

Recommendation 5.4
Appropriate approval processes should be established in approving expense claims.

Recommendation 5.5
Expenses incurred by other individuals on behalf of senior management should be approved by a person other than the senior manager for whom the expenditure was made.

Recommendation 5.6
Senior management expense claims should be reviewed together with related expenses incurred by other individuals on their behalf prior to making payments.

Recommendation 5.8
Claims for mileage should be submitted with related expenses in a timely manner.

Recommendation 5.10
Payments made for ineligible expenses or expenses already claimed should be recovered.

Recommendation 5.11
Late fees and other such avoidable expenses should not be eligible for reimbursement.

Recommendation 5.13
Policies should be reviewed and updated, including guidance on minimum travel distances and claiming staff meal expenses, standard class for airfare, approval process for board member claims, and requirement for itemized receipts.

Recommendation 5.14
Policies should be communicated in sufficient detail to staff and board members to provide guidance on eligible travel and other expenses.

Nova Scotia Liquor Corporation Response

The NSLC is pleased to accept the performance audit report of senior management and Board travel and other expenses that found no inappropriate expenses or significant variations from policy were identified. The NSLC accepts that improvements in our documentation, processes, and related policies can be made and we will have implemented all recommendations by the publishing date of the report, with communication to appropriate levels within the organization.

In connection with your performance audit of senior management and board members travel and other expenses at Nova Scotia Liquor Corporation, please note our responses below:

Recommendation 5.1
Complete documentation, including detailed receipts, evidence of payment and purpose for the expenditure, should be provided to support claims for reimbursement. Claims without complete support should not be processed for payment.

Recommendation 5.13
Policies should be reviewed and updated, including guidance on minimum travel distances and claiming staff meal expenses, standard class for airfare, approval process for board member claims, and requirement for itemized receipts.

The NSLC will revise their travel policy to clarify that both itemized receipts and evidence of payment are required for all meal and entertainment expenses. The accounts payable staff will perform additional pre-approval procedures in advance of payment to ensure that all claims are fully supported with the appropriate receipts, notations on purpose of expenditure, and names of all individuals in attendance. Claims lacking complete support will not be processed.

Recommendation 5.4
Appropriate approval processes should be established in approving expense claims.

Recommendation 5.5
Expenses incurred by other individuals on behalf of senior management should be approved by a person other than the senior manager for whom the expenditure was made.

The NSLC will modify their travel approval policy to require that:
- Board Chair expenses require approval of the Audit Committee Chair.
- All expenses incurred on behalf of senior executives require approval of the CEO (or the Board Chair in the case of the CEO expense), regardless of which corporate credit holder incurred the expense.

Nova Scotia Liquor Corporation Response (continued)

Recommendation 5.6
Senior management expense claims should be reviewed together with related expenses incurred by other individuals on their behalf prior to making payments.

Recommendation 5.8
Claims for mileage should be submitted with related expenses in a timely manner.

The NSLC will revise their travel policy to clarify that all out of pocket expenses (including mileage) related to a particular trip must be claimed on a single submission.

Recommendation 5.7
The Nova Scotia Liquor Corporation should establish rules, guidelines and processes for identifying and deducting non-eligible travel expenses from employee and board member claims.

The NSLC will modify the travel policy to clarify that personal portion of travel expenses must be processed in advance of travel under the individuals' own credit card. We will discontinue the process of seeking employee reimbursement subsequent to the trip.

Timelines:
The NSLC will fully implement and communicate the changes to the travel policy by May 15, 2013.

Nova Scotia Primary Forest Products Marketing Board Response

As the current Chairman of the Primary Forest Products Marketing Board (the "Board"), I recognize my responsibility to ensure the Board's practices in dealing with travel and other expense claims by members and staff are in compliance with accepted practice. While I was not directly involved with the audit, my instructions to staff were that the Auditor General should be accommodated in every way possible. I have been assured by the Auditor General's staff that they received full cooperation from Board staff in the course of the audit.

Upon reviewing the Auditor General's "Confidential Draft" Report I acknowledge that there are obvious improvements which can be made in the manner in which the Board deals with its expense claims. I can confirm that the Final Report will be brought to the attention of the full Board at our next meeting with the intention of implementing the recommendations made therein insofar as such recommendations apply to the Board. Regarding those items that applied specifically to the PFMB which are 5.1, 5.3, 5.10 and 5.14:

Nova Scotia Primary Forest Products Marketing Board Response (continued)

Recommendation 5.1
Complete documentation, including detailed receipts, evidence of payment and purpose for the expenditure, should be provided to support claims for reimbursement. Claims without complete support should not be processed for payment.

I/we will to the best of our ability require complete documentation; including detailed receipts etc. and those claims without such complete support will not be forwarded for processing.

Recommendation 5.3
Nova Scotia Primary Forest Products Marketing Board should implement a process whereby per diem claims for board members are reviewed and approved by the board chair prior to submission for payment.

I accept the recommendation regarding this item and have recently implemented such.

Recommendation 5.10
Payments made for ineligible expenses or expenses already claimed should be recovered.

This matter will be reviewed and your recommendation will be taken under advisement.

Recommendation 5.14
Policies should be communicated in sufficient detail to staff and board members to provide guidance on eligible travel and other expenses.

Regarding this recommendation, the Chair has already instructed me to obtain an updated policy on eligible travel and other expenses to be made available to the members at our next board meeting sometime in the near future.

Strait-Highlands Regional Development Agency Response

Of the fourteen (14) recommendations contained in the draft Audit Report there are two (2) recommendations that apply specifically to Strait-Highlands Regional Development Agency (S-HRDA), 5.1 and 5.13.

Recommendation 5.1
Complete documentation, including detailed receipts, evidence of payment and purpose for the expenditure, should be provided to support claims for reimbursement. Claims without complete support should not be processed for payment.

Strait-Highlands Regional Development Agency Response (continued)

In reference to the seventeen (17) claims identified under "No Detailed Support", the majority of these refer to meals at hotels which were added to the room without attaching the detailed meal receipt to the Travel Expense Claim. Corrective Action – All meals charged to a hotel room will require the detailed meal receipt being attached to the Expense Claim. Generally, S-HRDA's meal allowance is a per diem.

In reference the 225 claims under "Purpose of Expenditure Not Noted", the majority (222) of these claims refer to the purpose of travel. All of these claims were created from our electronic calendar (Lotus Notes program) which shows details of meetings (date, time, duration, purpose). Corrective Action – S-HRDA will either (1) print and attach calendar information to S-HRDA's existing Travel Claim, or (2) revise Travel Expense Claim and provide both "Destination" and "Purpose" of trip. S-HRDA correction action is to implement the second (2) option starting April 1, 2013.

Recommendation 5.13
Policies should be reviewed and updated, including guidance on minimum travel distances and claiming staff meal expenses, standard class for airfare, approval process for board member claims, and requirement for itemized receipts.

We will conduct a partial review of the S-HRDA Travel Policy due to S-HRDA's impending closure (July 22, 2013). Corrective action – Suggested improvements will be implemented where practical for the four remaining months of operation.

OAG Comment: There is a third recommendation which applies to this entity. [Recommendation 5.1 – Payments made for ineligible expenses or expenses already claimed should be recovered.] We understand the entity addressed this recommendation during the audit.

Overall Comments:
After review of the Provincial Bill C-10 that established the RDAs, and the contract from NS Economic and Rural Development and Tourism pertaining to the annual core funding, there are no references to the Office of the Auditor General having authority to conduct audits. We believe that it does have such authority, but suggest that in future Acts and in annual contracts, this information be included as a clause in the Act or contract.

Further, most small agencies, boards and/or commissions do not have professional accountants on staff. It would be helpful if the Province were to develop a practical "Tool Kit" regarding Travel Expense Policy, Procedures, Claim Forms, etc., for such organizations as a guide. The Provincial Travel Expense Policy Guide is somewhat cumbersome for a small organization.

Sydney Tar Ponds Agency Response

Recommendation 5.1
Complete documentation, including detailed receipts, evidence of payment and purpose for the expenditure, should be provided to support claims for reimbursement. Claims without complete support should not be processed for payment.

We agree. The items documented as 18 claims without evidence of payment relate to one individual's expense claims which would have generated 9 payment receipts. In each case, detailed receipts of the related expense were provided and it was clear the individual would have incurred and settled the related amount.

All Agency employees have been reminded that payment receipts are required to receive reimbursement for expenses. Subsequent to the date of this document, the Agency will not approve any expenses without receiving a related proof of payment receipt.

Recommendation 5.10
Payments made for ineligible expenses or expenses already claimed should be recovered.

We agree. The Agency will recover, where practical, the small amount related to per diems claimed for evening meals in advance of 6:30 PM. The evening meal policy has been communicated to all Agency employees. Subsequent to the date of this document, no evening meal claims will be approved unless it is clear the individual was still traveling at 6:30 p.m.

Recommendation 5.12
Senior management should consider coordinating travel arrangements to reduce unnecessary mileage claims.

We agree with the desired outcome of this recommendation; however, often times this is difficult to implement because of varied business and personal obligations of the senior managers. It will likely be necessary for the Province to consider a policy statement in this area to encourage the suggested car pooling practice.

Treasury Board Office Response

Recommendation 5.15
Treasury Board Office should communicate to all provincial agencies, boards and commissions that they use the observations and recommendations in this chapter to evaluate their own systems and processes for travel and other expenses, by and on behalf of, senior management and board members, and make improvements as required.

Treasury Board Office agrees with this recommendation and will send a communication to the provincial agencies, boards and commissions that fall within the Government Reporting Entity.

Waterfront Development Corporation Response

The Office of the Auditor General's review of our processes regarding travel and other expenses resulted in good recommendations, which we are implementing.

Recommendation 5.1
Complete documentation, including detailed receipts, evidence of payment and purpose for the expenditure, should be provided to support claims for reimbursement. Claims without complete support should not be processed for payment.

We shall add the requirements for including itemized receipts and evidence of payment in our claims process.

Recommendation 5.2
Waterfront Development Corporation should develop a process to ensure all expense claims, including claims through corporate credit cards, are signed by an approver as indication of approval for the expense.

We agree with the recommendation to add one more approval process for our credit card payments. We wish to clarify, however, that our credit card is used for purchases of goods and services under $1000 for the entire organization. The process for approving these expenses falls under our Internal Control policy and these expenses were approved; this category of expenses was also outside the scope of this audit. As a result, we believe the number of instances and amounts for travel expenses cited in the Report is overstated.

Recommendation 5.9
Credit card expense claims should be submitted in a timely manner.

We shall ensure credit card expenses are submitted in a timely manner.

Waterfront Development Corporation Response (continued)

Recommendation 5.14
Policies should be communicated in sufficient detail to staff and board members to provide guidance on eligible travel and other expenses.

We shall ensure all employees are routinely provided details on these policies to provide guidance on eligible travel and other expenses.

These recommendations will lead to improvements that will strengthen our system of internal controls, reduce our exposure to risk, and enable our staff and board to work effectively in carrying out our organizational mandate.