Office of the Auditor General

Auditor General's Statement to the Media

Release of May 2013 Report to the Nova Scotia House of Assembly

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Office of the Auditor General of Nova Scotia
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Good morning, ladies and gentlemen. Thank you for coming.

Today I presented to the Members of the legislature my report on performance audits completed in early 2013. The report includes the results of three audits and our review of the government's record in implementing my recommendations dating back to 2007.

Once again, I want to thank my staff for their hard work and diligence, and public servants across government whose cooperation is essential to our work.

In summary, this is what we found.

Firstly, the government's inaction on past recommendations tells us again that senior managers are failing to correct known deficiencies in their programs.

Secondly, our audit of the child welfare program found significant time lapses in activity. This means investigations into abuse and neglect drag on too long. Children in care and foster families are not contacted as regularly as the department's own standards require. The department has indicated it does not intend to act on our recommendation to amend outdated legislation.

Mechanical branch operations at Transportation and Infrastructure Renewal were found to be deficient in several respects. As a result there are significant risks of loss through error and theft, as well as through inadequate control over agreements with suppliers.

And our examination of travel and expense claims in eight agencies, boards and commissions uncovered various control weaknesses. We recommended Treasury Board take action to ensure all agencies, boards and commissions tighten their procedures with regard to expense claims.

Now very briefly, I want to provide you a little more detail on each chapter. My role is to find, and report on, areas in which government can improve its performance. We find areas in which government can do a better job of managing its finances and its operations, and of delivering its programs to Nova Scotians. We identify deficiencies. It is then up to government and its administration to take action.

Our review of government's overall performance in addressing recommendations from two, three, four and five years ago is a case in point. Once again, the government's public update on its actions to make the improvements we recommended contains numerous errors, rendering the update unreliable. While I commend the government for reporting on its performance, the credibility of that reporting is compromised by inaccurate information.

As I said, overall implementation of our past recommendations is poor. Beyond just the numbers, which we highlight in the report and publish on our website, this means that government management is failing to correct deficiencies that they now know to exist in their operations. As examples of the results of this attitude, high risk contaminated sites are not monitored as they should be; health records and registry systems remain at risk of security breaches; mental health and residential care standards are

not implemented; deficiencies in the management of P3 schools persist and may risk student health and safety; priority needs for health care equipment go unmet; nursing homes may not be providing appropriate care; and much-needed fees go uncollected. In short, uncorrected deficiencies impact finances, services, and public health and safety.

This failure to correct known deficiencies suggests a systemic problem with government management meeting its responsibilities. Our review also shows action can be a long time coming. For example, 41% of the recommendations we made in 2010 have been completed; and only 62% of recommendations from 2007 to 2010 have been implemented. 21% of 2007 recommendations have not been addressed and we now take the view that they are unlikely ever to be completed.

Chapter three reports on the child welfare program in the Department of Community Services. While some aspects of this program are adequate, there are certain deficiencies which could negatively impact the children in the program. Notably, there are lapses in the completion of investigations into allegations of child abuse and neglect and in monitoring to ensure the safety and security of children placed in foster homes.

Lapses in this work impair the department's ability to protect children's interests and to support foster families. For context, between April 2010 and the end of September 2012 (a 30-month period) there were almost 26,000 reports of neglect or abuse, about 15,000 of which were investigated. In some 1,900 cases, ongoing services were required, and 819 children were removed from their homes and placed in care.

The child protection manual is 15 years old. It is outdated, is not available on line and is ambiguous in establishing standards for response times. This leads to inconsistencies in approaches to child protection.

The Children and Family Services Act limits the definition of neglect to a child who is physically harmed or in danger of physical harm. This definition is outdated as it ignores emotional or developmental harm.

Further, current legislation provides no authority to investigate abuse or neglect complaints if a child is between the ages of 16 and 18, unless the child is already in care. As a result, children have different levels of protection, depending on their circumstances. The department says these matters will be considered when the act is next amended but, given there are no plans to revise the legislation, that is really no response at all.

Our review discovered that there were sometimes long periods of inactivity during investigations and time lapses well in excess of departmental standards in monitoring children in care. There are also extended delays in qualifying potential foster families, in spite of the department`s expressed concern about the shortage of foster homes in the province.

We also found a significant difference in the attention given to kinship homes, in which foster care is provided by a relative or near acquaintance of the child. Complete assessments of the kinship family were often missing and department staff were not certain which policies applied to kinship homes.

These findings are not rare exceptions. Of the 30 child protection files we tested, 20, or 67 percent, had what we would consider significant deficiencies. We tested another 100 foster family files, and found 53 had deficiencies such as I have just described.

Our review of the operations and management of the mechanical branch at Transportation and Infrastructure Renewal found a large number of operational weaknesses and control breakdowns. Management over the years have not corrected problems they have known about for some time.

Controls and processes to safeguard inventory – parts, tools and other equipment – and to ensure equipment is well-maintained and properly repaired either do not exist or are ignored. Management lack the information they need to properly manage these operations, and their oversight is seriously inadequate. Our audit focused on the operations at the two largest mechanical service centres, at Miller Lake and in Truro.

Significant unexplained variances, both shortages and overages, were found when parts and tools were inventoried, which indicates poor inventory control systems. At Miller Lake, a key card system was implemented to keep a record of who accessed inventory, but staff kept their traditional keys, which continued to work, so the card system was bypassed and useless as a control measure. In a related problem, a key card belonging to a former employee was not deactivated more than a year after the employee left; the system indicated it was used twice after his departure.

The department`s inventory control policy says significant variances in inventory should be investigated, but does not define significant. There was no supporting documentation to indicate that variances had been investigated at Miller Lake; and in Truro no investigations were conducted.

Preventive maintenance is lacking on vehicles and on heavy equipment. This risks not only more expensive repairs later on, but also invalidation of warranty coverage. In a 2005 audit report, we recommended, and the department agreed to, an adequately supported and appropriately documented preventive maintenance program. In the current audit, we selected 27 vehicles and found that the required preventive maintenance was either not completed or not documented on any of them.

There is very little information on repairs or on why some repairs are done in-house while others are outsourced. Of the 29 outsourced repair jobs we examined, a reason was provided only once. There are no standards for the time required to complete repairs, and work orders are not well-maintained so there is very little to indicate that work is charged to the right job.

Such an ineffective operation fails to protect public property or to properly manage the use of public resources.

Finally, in our review of senior management and Board expense claims at eight agencies, boards and commissions we found a variety of weaknesses in basic controls. While these claims were not for large amounts, nevertheless they were often paid without appropriate support and documentation, so that we cannot always say that they were appropriate and should have been paid.

In addition, claim approvals need to be vested in the appropriate authority. We found instances in which approvals came from subordinates; subordinates made expenditures on behalf of their senior managers, and then the claims were approved by those same managers; and claims were paid with no approvals.

Based on the findings in this small sample, I believe there is a need to tighten controls on expense claims across the entire sector.

We have recommended, and Treasury Board has undertaken to ensure, that agencies of government are made aware of their responsibilities related to expense claim management and approvals.

So, thank you. That completes my comments, and I am open to questions.