REPORT OF THE AUDITOR GENERAL

To the House of Assembly

On Reviews of Departments and Crown Agencies

For the Year Ended
31 March 2007

Auditor General of Newfoundland and Labrador

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Mission Statement

The Office of the Auditor General serves the House of Assembly by providing independent examinations of Government and its entities.

As legislative auditors, we audit financial statements and other accountability documents, evaluate management practices and control systems, and determine compliance with legislative and other authorities.

Our purpose is to promote accountability and encourage positive change in the stewardship, management and use of public resources.

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31 January 2008

The Honourable Roger Fitzgerald, M.H.A.
Speaker
House of Assembly

Dear Sir:

In compliance with the *Auditor General Act*, I have the honour to submit herewith, for transmission to the House of Assembly, my Report on Reviews of Departments and Crown Agencies for the year ended 31 March 2007.

Respectfully submitted,

JOHN L. NOSEWORTHY, CA
Auditor General

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CHAPTER 1
REFLECTIONS OF THE AUDITOR GENERAL

The following comments are made further to my reviews of various Departments and Crown agencies for the year ended 31 March 2007. The report covers a variety of matters and is provided to the Members of the House of Assembly for their consideration. The purpose of the Office of the Auditor General as outlined in the Mission Statement is *"...to promote accountability and encourage positive change in the stewardship, management and use of public resources."* Corrective action on the issues identified in this report will further that goal.

Hospital-Acquired Infections - (Part 2.9)

The Department of Health and Community Services (the Department) provides leadership in health and community service programs and policy development for Newfoundland and Labrador through four regional integrated health authorities (the Authorities). Subsequent to the SARS outbreak in the Spring of 2003, Government appointed a Task Force to review the standards, policies, procedures and resources related to control and prevention of communicable diseases that exist in facilities and medical clinics operated by institutional health boards. In March 2004, the Task Force issued a report titled *"Back to Basics,"* which identified that there was a lack of Provincial direction/standards for best practices in infection control, that limited time and resources have been dedicated to developing and implementing policies and procedures, and that training of hospital personnel was inadequate. Over three years later, none of the recommendation areas have been fully acted upon.

Our audit focused on hospital-acquired infections which were included in the issues addressed in the *Back to Basics* report. We concluded that Government does not know either the number of hospital-acquired infections or the number of deaths resulting from such infections in the Province. This situation has resulted because the Department does not require the Authorities to provide information on hospital-acquired infections, and the Authorities do not accumulate information on hospital-acquired infections using comparable methods. Furthermore, the Authorities do not keep statistics on whether any deaths have resulted from hospital-acquired infections.

Our review indicated that the Department has not developed a Province-wide infection control program relating to the prevention, detection and control of hospital-acquired infections. As a result, there are multiple infection control programs developed by the former health care boards which are currently in use at the four Authorities.

Furthermore, the Department has not made any determination about the adequacy of the various infection control programs currently in use throughout the Province and is not monitoring how such programs are being delivered or their success in preventing, detecting and controlling hospital-acquired infections. Without a determination of program adequacy, including an appropriate assessment of risk and implementation of program monitoring, the Province may not be as well prepared to manage hospital-acquired infections as it should be. This could result in increased risk to the public in contracting hospital-acquired infections.

The following findings identified during our review of the various infection control programs currently in place at the Authorities further illustrate these concerns:

- none of the four Authorities meet the minimum standards for the number of Infection Control Practitioners as recommended by Health Canada;
- only two of the eight former health care boards conducted regular clinical self-audits or equipment/facilities self-audits to assess adherence to infection control practices. The other six former health care boards only conducted self-audits on a reactive basis. The lack of regular self-audits is a concern since issues associated with such items as contaminated gowns, hand washing, and equipment not being cleaned on a regular basis were noted in some Infection Control Committee minutes;
- protective equipment and supplies were not always in place; and
- the Authorities do not always notify discharged patients of their possible exposure to hospital-acquired infections. For example:
    - an improperly cleaned gastrointestinal video scope used on 72 individuals in the former Avalon Health Care Institutions Board; and
    - a scabies outbreak in the former Central East Health Care Board.

MCP Physician Fee for Service Audit Process - (Part 2.11)

The Newfoundland and Labrador Medical Care Plan (MCP) was introduced on 1 April 1969. It is a comprehensive plan of medical care insurance designed to cover the cost of physician services for bona fide residents of the Province. In 2006-07, payments to physicians from the MCP amounted to $289.0 million. Of this amount, approximately $206.1 million or 71.3% was paid to physicians who submitted claims on a Fee For Service (FFS) basis. The focus of this review was the audits of FFS payments conducted by the Audit Services Division (the Division). These payments are made on the basis of claims submitted by physicians for insurable services and are paid through a computerized payment system operated by the MCP.

We concluded that since the transfer of the MCP to the Department of Health and Community Services on 1 April 2000, the Division has not been able to carry out its mandate to ensure that only legitimate and accurate claims are paid to FFS physicians. During the 10 years ending 1 April 2000, there were approximately 438 audits (average of 44 audits per year) of FFS physicians started; however, from 1 April 2000 to 31 March 2007 only 48 audits (average of 7 audits per year) in total were started. The reduction in audit activity came at a time when FFS payments were increasing significantly i.e. from $127.8 million in 2000-01 to $206.1 million in 2006-07 (for a total of

$1.2 billion over the seven year period). We would have expected that as FFS payments increased, audit activity would increase rather than decrease. The extent of the reduction is of concern and was attributed by officials to such things as staffing issues resulting from Government regionalization which transferred MCP claims processing to Grand Falls-Windsor 1 July 2001, and audits placed "on hold" during the Joint MCP Audit Review Committee (Report January 2003). We found the following:

(a) Review of Audit Files - Of the 48 audits which were started since 1 April 2000, 31 were closed and 17 were in progress as at 31 March 2007. Of the 31 closed files, 11 had satisfactory claims documentation, 7 were closed without being completed due to lack of audit resources and 13 were closed for other reasons. It was noted that the 7 files which were closed for lack of resources were flagged for another review after one year; however, this was not done.

(b) Time Frames for Audits - We found that audits took a significant amount of time to complete. For example, some audits took almost 9 years to complete. These delays have resulted in significant issues in recovering FFS overpayments.

(c) Varying Recovery Rates - Although audits conducted by the Division result in significant potential to recover monies owed to the Department, in 2003 the Department implemented an Alternate Dispute Resolution (ADR) negotiation process to settle on an amount to be repaid, rather than require the repayment in full. Prior to 2003, there was no ADR process. Instead, any overpayments were fully recovered unless there was a legitimate misinterpretation of the rate schedule or if legal action resulted in a change in the amount recovered. Since the ADR process was implemented in 2003, the recovery of overpayments has been reduced. The recovery of overpayments through the ADR process for a sample of five audits closed in 2006 resulted in an average recovery of 57.2% of the overpaid amounts. The rate recovered varies on a case by case basis as indicated by the negotiated recovery on a $662,487 overpayment where the recovery was only $175,000 or 26.4%.

Food Premises Inspection and Licensing Program - (Part 2.7)

The Department of Health and Community Services (the Department) has the mandate for the food premises inspection and licensing program (the program). The Department of Government Services, through its Government Service Centres (GSC), conducts inspections and provides enforcement services on behalf of other Government departments. Our review of the food inspection and licensing program indicated that not all of the deficiencies identified in our 2003 report had been addressed by the GSC. In particular:

(a) Licensing of Food Premises - At the time of our review, 442 or 11% of food premises in the GSC database were indicated as operating without a valid licence as required by the *Regulations*. Furthermore, during the year ended 31 December 2006, we found that 35% of the food premises files that we examined in the database had operated without a valid licence for a period of time during the year. As a result, the GSC did not always ensure that food premises were operating with a valid licence as required by the *Regulations*.

(b) Risk Management - We found that food premises are not always assessed for health risk in accordance with the Risk Management Framework that was developed under the MOU between the GSC, the Department and the regional integrated health authorities.

(c) Inspection of Food Premises - For the three year period ending 2006-07, the GSC did not carry out the required number of inspections for moderate and high risk food premises and carried out more inspections than required for low risk and seasonal food premises.

(d) Information Management - We found that the database was incomplete and inaccurate. Information resulting from inspections such as identified health hazards, compliance dates and inspection scores was not captured in the database. In addition, risk assessment score history and calculation detail was not maintained in the database. As a result, important health information was unavailable to the GSC, the Department, and the regional integrated health authorities.

(e) Compliance with the MOU - The MOU is not evaluated on an annual basis as required. As a result, it may not be reflective of current practices and issues relating to food premises inspection and licensing. The GSC does not provide the Department with an annual report of statistical and narrative information on program activity as required under the MOU.

(f) Management of the Program - Monitoring of the program by the GSC was inadequate because the database used to monitor inspection activity was not accurate or complete; risk assessment score detail, inspection score detail, identified health hazards and hazard correction dates were not recorded in the database; and management did not always review completed inspection reports and risk assessment worksheets.

Rental Housing Program - (Part 2.13)

The Rental Housing Program (the Program) is the oldest and largest housing assistance program administered by the Newfoundland and Labrador Housing Corporation (the Corporation). The purpose of the Program is to provide affordable housing to low-income individuals and families. We found that the Corporation is unable to match the client demographics to its rental unit portfolio and as a result has an excess bedroom capacity in many of its units i.e. “over-housed.” The Corporation has 14,077 tenants occupying 6,163 rental units with a total of 16,041 available bedrooms. Therefore, even assuming that each tenant will occupy a separate bedroom, there is still an excess of 1,964 bedrooms. In fact, since 2002, the percentage of units with more bedrooms than occupants has increased from 35% to 40%.

In March 2006 the Corporation completed a Housing Administration Study (the Study) of its Rental Housing Program and identified 48 recommendations in nine areas of the Program. The purpose of the Study was to identify and recommend efficient and effective use of the Corporation's rental housing resources and improvements to client service. The Corporation identified 32 recommendations as priority to be implemented by 1 April 2007.

The Corporation did not fully meet its goal of maximizing the efficiency and effectiveness of its rental housing resources as evidenced by the fact that the Corporation did not comply with all of the 32 recommendations by 1 April 2007. Recommendations which were not complied with covered such areas as: inspections prior to a tenant vacating, inaccurate waitlists, no certified tax returns obtained from new tenants, delayed collection efforts, no agreements to pay arrears, termination notices not always issued after 45 days of arrears, the need for improved contact with tenants and inconsistent applicant assessment among regions.

Adult Custody Program - (Part 2.15)

Adult Custody services are the responsibility of the Director of Corrections and Community Services within the Department of Justice. Services are provided through seven centres comprised of five correctional centres and two detention centres which have a total capacity for 281 inmates, employ 214 permanent staff, 54 temporary staff (full-time equivalent) and are overseen by a Superintendent. For 2006-07, average expenditures per inmate totalled approximately $66,000.

Our review of the Adult Custody Program identified a number of concerns as follows:

(a) Planning and Reporting - Our review indicated there are no long-term goals and objectives relating specifically to adult custody services; there are no operational plans relating to the provision of adult custody services; and centres are not reporting (e.g. overtime, sick leave, training and food services) quarterly to the Superintendent as required by policy. As well, some of the centres do not report semi-annually, and others which do report semi-annually do not include all of the required information; required contingency plans were not in place for all identified critical situations such as natural disaster, loss of utilities, noxious/toxic substance threats and suspicious letter/parcel; and none of the centres have an Emergency Planning Committee in place and, as a result, a statement of training requirements specific to each critical situation has not been developed.

(b) Human Resource Management - As salary costs account for 82% of total expenditures, we would expect adequate controls over staffing, callback and overtime, and sick leave. Our review indicated that callback and overtime, and sick leave are not being adequately monitored and controlled and has increased in the last three years. For example callback and overtime increased by 158% in the last three years, from $455,000 in 2004-05 to $1.17 million in 2006-07 (HMP increased by 291% from $153,000 to $597,000). Sick leave increased by an estimated 33% in the last three years, from $918,000 in 2004-05 to $1.23 million in 2006-07 (HMP increased by 54% from $553,000 to $659,000). In addition, no procedures manual has been developed outlining the objectives, administration procedures and controls related to tracking leave and overtime, centres are not reporting quarterly information to the Superintendent and annual staff performance appraisals are not being performed.

(c) Purchasing and Tendering - Our review indicated that the Department did not comply with the *Public Tender Act* (six purchases totalling $94,473 were not publicly tendered) and the *Financial Administration Act* (18 instances totalling $87,000 where goods and services were ordered and received without the prior issuance of a purchase order). In addition, issues with the on-site food service contracts at four centres were identified, the on-site food service operator is not complying with the food services contracts and the centres are not complying with policies in relation to food service contracts e.g. providing written reports to the Superintendent on nutritional adequacy of meals and menu planning effectiveness.

(d) Inventory and Capital Assets - Our review indicated that there is inadequate control over inventory and capital assets and not all cost information is provided to the Comptroller General as required by Government's financial management policy and procedures.

(e) Information Management and Technology - The Department's IT practices are inadequate in that backups are not tested regularly for data integrity, network passwords are not changed on a regular basis and there is no documented disaster recovery plan. In addition, physical security over adult custody services' files is inadequate in that in some cases inmate records are kept in unlocked file cabinets.

(f) Legislation - The Department is not in compliance with the *Adult Corrections Act* in that the Departmental Board of Corrections has never been established. In addition, the Department is not in compliance with the *Prisons Act* in that the Superintendent does not submit any reports to the Minister containing information pertaining to prisoners released.

Firearms Program - (Part 2.17)

Our review identified weaknesses relating to how the Department of Natural Resources records, monitors and secures its firearms, ammunition, pepper spray, hand cuffs, protective vests and batons used by Conservation Officers. We also found non-compliance with the Department's Firearms Policy. Our conclusion is based on the following:

- Although the Department has a firearms inventory system, it is not used to control sidearms (controlled separately), ammunition or pepper spray. Furthermore, the system was not accurate in that: 16 rifles and shotguns which had either been transferred or returned to the owner were still recorded in the system, 45 rifles and shotguns were either located at a different district office or assigned to a different Conservation Officer, 125 rifles and shotguns had incomplete information as to the firearm make, model, caliber and serial number, and 19 seized rifles and shotguns as well as 5 tranquilizer guns were not recorded in the system.

- The Department has a Firearms Policy; however, it does not address a number of significant areas relating to firearms usage. It does not: address how ammunition and pepper spray should be accounted for; provide guidance for conducting semi-annual firearms policy audits; require periodic reports; require the reporting of damage to rifles and shotguns; and require rifles and shotguns to be returned during periods of leave.

- We identified instances of noncompliance with the Firearms Policy which included: only one of the three regional offices indicated that semi-annual firearms policy audits were conducted and in that case no documentation was retained; no written report had been prepared nor had the police been informed about a missing rifle; instances where Conservation Officers had not reported damaged sidearms to the Regional Compliance Manager; rifles and shotguns were transferred to police agencies without obtaining a receipt; violation reports were not fully completed and not all issued or reissued firearms were inspected by a gunsmith.

- Information on the annual sidearms recertification and use of force training is not maintained in a database and, as a result, the Department does not readily know either when officers are due for recertification or whether officers are currently certified.

- Safety issues were identified where outdated pepper spray was still in use by Conservation Officers.

- Although there has been funding approved since March 2005 for a Firearms Control Officer, the position has not been filled. As a result, it is not clear who has overall responsibility for the recording and control of the Department's firearms and this may have contributed to the issues identified during our review.

Insurance on Motor Vehicles - (Part 2.8)

The Department of Government Services (the Department) is responsible for motor vehicle registration through its Motor Registration Division (MRD). Our review of activities at the MRD as well as fines imposed and collected indicated there is not a significant deterrent for those who choose to operate motor vehicles without insurance. For the period 1 April 2001 to 31 March 2006, there were 5,161 convictions of driving without insurance against 3,518 individuals, which indicates that a significant number of individuals were operating motor vehicles without insurance. We found the following:

(a) Commercial Vehicles - The existence of insurance policies for commercial vehicles was not always verified as required. As a result of our review we determined that staff at the MRD office in Mount Pearl did not receive requests from the Clarenville, Grand Falls-Windsor or Corner Brook offices to verify insurance for registrations made at these offices.

Furthermore, certificates of insurance were not always on file as required. Our review of a sample of 100 registrations indicated that 16 did not have the insurance certificate on file and 17 had an insurance certificate on file but the policy number did not agree with the information contained in the MRD database.

(b) Private Vehicles - There were no controls to prevent individuals from registering vehicles without insurance because MRD did not verify insurance information provided at registration and had no means of verifying the information it received as it did not have online access to insurance industry systems. As well, insurance companies were not required to notify MRD of insurance cancellations. Therefore, MRD was not able to prevent individuals from purchasing insurance when registering a motor vehicle and subsequently cancelling the insurance policy.

(c) Enforcement - We noted that Highway Enforcement Officers were not able to verify whether an insurance card being presented as proof of insurance actually represented a valid, in-force insurance policy. In addition, in cases where proof of insurance was not presented or was invalid, follow-up letters were not always issued by MRD as required to be certain that all warning tickets to provide proof of insurance had been acted upon. Furthermore, in cases where individuals were convicted of operating a motor vehicle without insurance, MRD is not complying with the requirements of the *Act*, in that vehicles were not impounded, nor were drivers' licences suspended. Also, many of the fines imposed remained unpaid. As at 31 March 2006, the balance of unpaid fines relating to operating a motor vehicle without insurance totalled $9.5 million.

Labrador-Grenfell Regional Integrated Health Authority - (Part 2.10)

The Labrador-Grenfell Regional Integrated Health Authority (the Authority) was established on 1 April 2005 when the Authority assumed the operations of the former Health Labrador Corporation and the former Grenfell Regional Health Services Board. Our review identified a number of concerns relating to the operations of the Labrador-Grenfell Regional Health Authority. In particular, after 21 months of integration, as at 31 December 2006, the Authority's financial position continues to deteriorate, it still operated as two separate entities in many areas, continued to follow former board policies/practices and did not have an integrated financial information system. We found the following:

(a) Financial Position - At 31 March 2003, the Authority's accumulated operating deficit was $27.1 million and increased to $34.1 million as at 31 March 2007, an increase of $7.0 million (26%). The Authority's bank indebtedness increased from $11.1 million as at 31 March 2003 to $22.1 million as at 31 March 2007, an increase of $11 million (100%). Furthermore, the increased bank indebtedness resulted in high annual interest costs for the Authority - $1.5 million over the last three fiscal years. This interest bite results in less funds for program delivery.

(b) Financial Operations - Expenditures have increased in each of the last four years, from $103.2 million in 2003-04 to $126.6 million in 2006-07, an increase of $23.4 million (23%). Furthermore, the Authority incurred annual operating deficits totalling $6.6 million over the past 4 fiscal years excluding non-shareable expenses such as severance and vacation pay accruals.

(c) Human Resources - The Authority's human resource practices were not always consistent with those established by Government, hiring and compensation practices were sometimes either inconsistent or in excess of those approved by Government, termination benefits were either not always consistently applied or were in excess of those approved by Government, available leave balances were sometimes exceeded, and overtime payments were sometimes in excess of Government policy.

(d) Purchasing (the *Public Tender Act*) - The Authority did not tender for 15 purchases (31% of 48 reviewed) totalling $1,309,761 which were over $10,000 and did not obtain quotes for 5 purchases (28% of 18 reviewed) totalling $33,997 under $10,000. The Authority has neither tendered nor evaluated its food services contracts (2006 - approximately $2 million) since being integrated in April 2005. In addition, the Authority did not keep tenders in a locked box, date-stamp tender envelopes or document explanations of why rejected tenders did not meet tender specifications.

(e) Travel and Relocation Expenditures - The Authority is not adequately controlling and monitoring its travel and relocation expenditures and is not complying with Government's travel and relocation policies.

(f) Cellular Telephones - The Authority is not adequately monitoring the usage and cost of its 89 cellular telephones (9 months to December 2006 the Board spent approximately $59,000).

(g) Hiring of Consultants - The Authority contravened Government's *Guidelines for the Hiring of External Consultants* for two consulting contracts over $50,000, by not obtaining 3 proposals or conducting a public call for proposals and in one of the two contracts, relating to the provision of orthodontist services, by not obtaining Cabinet approval for the contract.

(h) Capital Assets - Controls over the Authority's capital assets are inadequate and could result in missing assets not being detected. The Authority does not tag all of its assets once received and does not maintain a capital asset ledger. As well, periodic inventory counts are not performed and assets are not reconciled to the Authority's financial records.

Small Business Funding Programs - (Part 2.14)

The Department of Innovation, Trade and Rural Development (the Department) provides programs and services to assist small and medium-sized businesses. Funding programs are intended to support new growth opportunities in the economy such as value-added manufacturing and export activities. For the year ended 31 March 2007, 33 projects totalling $3.5 million were approved from the $10.0 million budget for the Small and Medium-sized Enterprise (SME) Fund and 112 grants totalling $1.1 million were approved from the $1.0 million budget for the Small Business and Market Development (SBMD) Program.

Our review indicated that there were weaknesses in the Department's assessing, approving, disbursing and monitoring of loans and investments under the SME Fund and the SBMD Program. For example:

- we identified 2 instances where loans were provided to businesses which appeared to be non-financially viable;
- in 1 instance a loan was provided to a business which appeared to be in a financial position to access private sector financing;
- complete application information was not always obtained;
- funding was not always approved in accordance with Department policy;
- security was either not always obtained or not always registered;
- adequate documentation was not always provided to support expenses claimed;
- the required applicant investment was not always verified;
- companies provided with funding were not always adequately monitored; and
- companies which had not complied with conditions in previous Offers of Financing were provided additional funding.

We are of the opinion that there is no explicit authority under the *Financial Administration Act* for the Department to make direct investments in companies. During 2005-06, the Department made three such investments totalling $1.05 million to three companies. Furthermore, there are no documented due diligence procedures for approving, disbursing and monitoring such investments. We found inconsistencies between the requirements under the SME Fund and for the three investments. For example:

- none of the three companies were required to repay the investment contingent on either income earned or a maximum seven year period;
- one company was not required to submit documentation to support specific expenditures;
- shareholders for one company who received $500,000 were not required to make new equity investments as part of their contribution to the project; instead, previous investments were accepted;
- shareholders for one company who received $500,000 were not required to provide personal net worth statements; and

- Department officials were not entitled to attend any company meetings for one company even though the company was provided with funding totalling $500,000.

Financial Administration Act - (Part 2.5)

The *Financial Administration Act (*the *Act)* was proclaimed in 1973 and is the primary statute which provides legislative direction and control over the financial administration of the Province. Our review of the *Act* disclosed that it does not provide Government with clear legislative authority for certain transactions and does not provide clear guidance with regards to accounting principles and financial statements. We identified the following:

- Legislation has to be permissive; however, the *Financial Administration Act* does not provide any specific authority to permit investments in private sector companies for innovation and/or economic development purposes. For example, this Annual Report includes information on three equity investments made by the Department of Innovation, Trade and Rural Development totalling $1.05 million where, in our opinion, such investments were made without clear legislative authority.

- The *Act* does not clearly identify that the financial statements of the Province should be its Consolidated Summary Financial Statements prepared in accordance with Generally Accepted Accounting Principles (GAAP). However, notwithstanding the lack of clarity in the *Act*, Government is in full compliance with GAAP and prepares Consolidated Summary Financial Statements: a fact my Office has commended Government for in recent years.

Employment Support Programs - (Part 2.16)

The Department of Municipal Affairs (the Department) provides services and assistance to municipalities throughout Newfoundland and Labrador. The Employment Support Division administered employment support programs during 2005-06 and 2006-07 ranging from short-term employment programs to community enhancement projects.

Community Enhancement Program

The Community Enhancement Program (CEP) is an ongoing employment initiative that replaced the Job Creation Program. The goal of the CEP is to provide funding to community and other groups for community enhancement and other projects. In 2006-07, $4.3 million was used to fund 287 projects (2005-06 - $6.0 million to fund 375 projects). Overall, the Department did not adequately administer the CEP. Significant concerns were noted with regard to how funding was allocated to electoral districts in the Province, how projects were selected and how projects were monitored. In particular:

(a) District Funding Allocation - While Department officials indicated that funding allocations were made by electoral district, this allocation process was never documented. As a result, the Department could not demonstrate the basis for allocating the extent of funding by district. Furthermore, there was not always documentation in project files to demonstrate that MHAs were advised as to the level of funding approved under the CEP for their district. In addition, due to the allocation being by electoral district, the merit of a project was not evaluated on a Province-wide basis.

(b) Project and Applicant Selection - Our review of the project and applicant selection criteria indicated that the Department could not demonstrate: whether the criteria of "relatively short-term" and "small scale" were met; that the funded projects were approved based on recommendations from MHAs; the basis on which additional funding was approved; whether all applications were received before the deadline date; that all approved applicants met the eligibility criteria for the CEP; justification for continuing to provide project funding to sponsor groups who showed non-compliance in prior years; justification for not approving the funding or official notification to the sponsor group that the funding request was not approved.

(c) Project Monitoring - We found that the Department issued contradictory guidelines for 2005-06, did not always follow-up on non-compliance by sponsor groups, did not adequately review the final reports submitted by sponsor groups, released final funding for projects even when required information was not provided or there were documented instances of non-compliance, and released portions of the final payment either before projects were completed or before final reports were received and reviewed.

Other Employment Support Programs

We also identified similar issues with the following employment programs:

- Crab Workers' Support Program
- Fish Plant Workers' Employment Support Program
- Harbour Breton FPI Workers' Employment Support Program
- Community Enhancement Program - Fish
- Fortune Support Program

Equipment Maintenance Program - (Part 2.18)

The Department of Transportation and Works (the Department) is responsible for the construction and maintenance of the Province's road system including management of Government's fleet of vehicles. Our review indicated that there are significant weaknesses in the Department's equipment maintenance program for heavy equipment. For example:

- Despite recent increased investment in heavy equipment, primarily snow clearing equipment, much of the Department's heavy equipment fleet remains past the point where they can continue to operate economically. Although the Department has determined that repair costs become quite significant for heavy trucks 10 years old and greater and heavy equipment 20 years old and greater, our review indicated that:

  - of the 322 heavy trucks, 109 or 34% were 10 years old and greater.

  - of the 284 pieces of other heavy equipment 90 or 32% were 20 years old and greater and 24 of the 90 pieces were 30 years old and greater.

- There is no overall replacement strategy in place for heavy equipment which would assist in optimizing acquisition decisions and in determining the appropriate level of required funding for the future operation of the heavy equipment fleet. Current replacement decisions are made largely on an annual budgetary basis by region without the benefit of an overall analysis and a comprehensive replacement strategy.

  While the Department is expected to be allocated funding to 2010-11 to address most of the current replacement requirements, additional funds will be required to replace vehicles which are not currently past the age identified for replacement.

- The Department did not comply with the spirit of the *Public Tender Act* when it purchased 15 used loaders in June 2006. The terms and conditions of the tender were so specific that only the eventual supplier would be in a position to be awarded the tender. In particular, the Department set a maximum required bid of $2.5 million and reduced the quantity from 16 loaders to 15 to match the number of loaders available from the eventual supplier.

- Due to deficiencies in the Department's Equipment Management System (EMS), it was not possible to assess the costs associated directly with the heavy equipment fleet and whether recent investments in equipment have led to reductions in repair costs or down-time.

  As the result of the issues of completeness and accuracy identified with the Department's EMS, the reliability and usefulness of information contained within the system is limited. The system is not operating as intended and as a result, management lacks the information required to effectively manage the Province's heavy equipment fleet.

Debt Reduction Grant Program - (Part 2.3)

Since 1 August 2002, the Department of Education has administered a Debt Reduction Grant Program (DRGP) through its Student Financial Services Division (the Division). The purpose of the program is to provide debt relief to eligible students with student loans whereby an amount up to the full value of the 40% Provincial portion of a student's loan may be automatically converted to a non-repayable grant after the student graduates. We found that not all eligible students are receiving debt reduction grants as a result of the following:

- Although the Division knew that certain students had graduated and it had the necessary information to assess eligibility for a debt reduction grant, the Division did not perform the procedures necessary to determine grant eligibility. As a result of our review of 15 files in this situation, the Division determined that 7 students (47%) should have received grants totalling $52,591.

- Educational institutions did not provide requested student information and the Division did not follow-up on the outstanding information. As a result of our review of 21 files in this situation, 6 students (29%) should have received grants totalling $46,799.

- Students who did not apply for a student loan in their final year of study were not identified by the Division as being in their final year of study and therefore were not automatically assessed for debt reduction grant eligibility on graduation. In this situation, students were not advised that they had to apply for a debt reduction grant on graduation.

The Division did not comply with the *Student Financial Assistance Regulations* when it paid $2 million in loan remissions to 307 students who had not formally applied. Rather than require a formal application from the students as provided for under the *Regulations* and in order to provide students with the maximum assistance, the Division automatically assessed students for eligibility under both the Loan Remission Program and the Debt Reduction Grant Program. In addition, during our testing of debt reduction grants, we found errors in the information contained in the Student Aid Management Information System.

Designation of Educational Institutions for the Purpose of Student Loans - (Part 2.4)

Educational institutions play a role in retaining students, ensuring students succeed, and ensuring students improve their overall employability, which contributes to the success that students have in repaying their student loans. In order for a student to be eligible for a student loan from Government, the *Student Financial Assistance Regulations* (the *Regulations*) under the *Student Financial Assistance Act* (the *Act*) stipulate that the educational institution they are attending must be formally recognized or "designated" by the Minister (Department of Education).

We have concluded from our review that the Department could not demonstrate whether the Province has developed policies and procedures to ensure that educational institutions comply with the designation requirements for the purposes of student loans under the *Act* and *Regulations*.

Furthermore, the Province did not adopt the National Designation Policy Framework developed in 2004 because of the absence of socio-economic indicators which could be used in assessing the performance of educational institutions in the Province, as provided for under the Framework. In addition, the Province did not develop the policies and procedures or enter into formal agreements with educational institutions as outlined under that Framework. The agreements, which are required to be in place to maintain Federal student loan program designation, should outline for example, student loan repayment performance targets, required information exchange between institutions and the Province and tuition refund policies.

As a result of the inaction on the part of Government and in accordance with the Framework, all educational institutions in the Province may be at risk for de-designation for Federal student loan purposes i.e. students will not be eligible for the 60% Federal portion of a total student loan. Educational institutions at particular risk would be the 11 of 43 institutions whose student loan repayment performance in July 2007 was rated as "poor" (student loan repayment rate less than 48.7%).

Of particular note is that Department officials indicated none of the educational institutions have been advised of their student loan repayment performance, whether improvements are required and whether there is risk of de-designation. In addition, the Province still has not taken action to monitor and work with educational institutions to address student loan repayment performance.

Monitoring of Regional Integrated Health Authorities - (Part 2.12)

Effective 1 April 2005, Government established four regional integrated health authorities (the Authorities) throughout the Province by combining the eight health care institutions and integrated boards with the four health and community services boards. In addition, the Eastern Regional Integrated Health Authority assumed the operations of the St. John's Nursing Home Board and the Newfoundland and Labrador Cancer Treatment and Research Foundation.

The financial position of the Authorities has been deteriorating over the past several years. In an effort to control operating deficits, the Authorities have implemented changes to reduce costs and Government has provided additional funding. As in the past, our Office monitors the financial position and annual operating results of the regional integrated health authorities.

Financial Position

The overall financial position of the Authorities improved slightly in the fiscal year 2006-07 with unfunded liabilities declining $7.7 million (1.5%) from $525.3 million in the fiscal year 2005-06 to $517.6 million in the fiscal year 2006-07. All four Authorities had unfunded liabilities at 31 March 2007. The combined unfunded liabilities of the four Authorities for the fiscal year 2006-07 of $517.6 million is a 5.6% increase from the $490.3 million reported in the fiscal year 2002-03. The unfunded liabilities will eventually have to be funded by Government.

The Eastern Regional Integrated Health Authority accounted for $349.2 million or 67% of the total $517.6 million in unfunded liabilities. Two of the four Authorities, the Central Regional Integrated Health Authority and the Labrador-Grenfell Regional Integrated Health Authority, reported increases in the total unfunded liabilities for 2006-07 over 2005-06.

Operating Deficits

During the year, all four Authorities reported operating deficits totalling $19.2 million. Operating deficits ranged from $400,000 for the Western Regional Integrated Health Authority to $14.8 million for the Eastern Regional Integrated Health Authority. Two Authorities, the Eastern Regional Integrated Health Authority and the Central Regional Integrated Health Authority, reported annual operating deficits higher than that reported for the fiscal year 2005-06.

Upon integration in the fiscal year 2005-06, the Department imposed funding reductions totalling $7 million on the newly integrated Authorities in expectation of administrative/integration cost savings. However, targeted savings did not materialize in fiscal year 2005-06, and administration and support expenditures continued to increase, even in the second year after integration. Since integration, administration and support expenditures for the four Authorities increased from $319.2 million in the fiscal year 2004-05 to $371.0 million in the fiscal year 2006-07, an increase of $51.8 million or 16%.

Monitoring School Districts - (Part 2.2)

The Province has seen a significant change in the school system during the last 10 years. In the 1997-98 school year, there were 391 schools serving 101,608 students and Provincial grants totalled $485.1 million. In the 2006-07 school year, there were 285 schools serving 74,304 students and Provincial grants totalled $596.1 million.

Financial Position

All five school districts had accumulated deficits as at 30 June 2007. The combined financial position of the five school districts at 30 June 2007 shows total accumulated deficits of $98.4 million, an 11% decrease from the $110.7 million reported in 2005. Included in the accumulated deficit is an amount of $104.6 million related to severance pay and leave accruals, less a net accumulated operating surplus of $6.2 million. The accumulated deficits will eventually have to be funded by Government.

The Eastern School District accounted for $54.0 million or 55% of the total $98.4 million in accumulated deficits.

Operating Results

Four of the five school districts reported operating surpluses for the year ended 30 June 2007 with the other district, the Western School District, reporting an operating deficit. The total net operating surplus for all five districts was $2.1 million. Operating surpluses (deficits) ranged from $1.4 million to ($448,000).

Overall, the annual operating surplus has decreased since 2005. Two school districts had operating results which were lower than that reported in 2006.

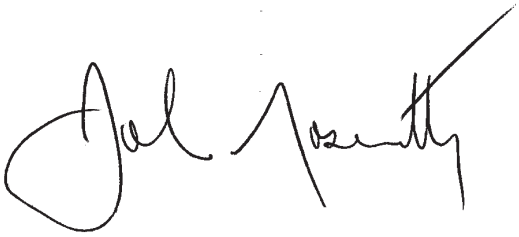
Non-compliance with the Schools Act, 1997

Contrary to the *Schools Act, 1997*, none of the five school districts submitted their annual budgets for the fiscal year 2007-08 to the Minister of Education for approval by 31 October 2007 as required by the Minister.

Also, contrary to the *Schools Act, 1997*, two of the five school districts did not submit their audited financial statements for the fiscal year 2006-07 to the Minister by 23 November 2007 as required by the Minister. The Nova Central School District did not submit its audited financial statements until 24 December 2007 and the Eastern School District did not submit its audited financial statements until 4 December 2007.

Acknowledgements

I acknowledge the cooperation and assistance my Office has received from officials of the various Government departments and Crown agencies during the completion of our audits. I also thank my staff for their continued hard work, professionalism and dedication.



JOHN L. NOSEWORTHY, CA
Auditor General

CHAPTER 2

COMMENTS ON AUDITS AND ADDITIONAL EXAMINATIONS

Highlights

Highlights of a monitoring review of agencies of the Crown in the Province as of 31 March 2007.

Why our Office did this Review

A major role of the Office of the Auditor General is to monitor Crown agencies and provide information to the House of Assembly. Section 14 of the *Auditor General Act* requires the auditor of an agency of the Crown or a Crown controlled corporation to deliver to the Auditor General, after completion of the audit, a copy of the auditor's report, audited financial statements and recommendations to management. These financial statements and management letters along with our Office's audits of Crown agencies provide the basis for our monitoring of all Crown agencies.

Figure 1 summarizes the agencies of the Crown in the Province as at 31 March 2007.

Figure 1
Summary of Agencies of the Crown
As at 31 March

Description	2006	2007
Agencies required to prepare financial statements	65	63
Agencies considered non-financial and did not prepare financial statements	72	72
Total	**137**	**135**

Any expenditures related to the operation of the 72 non-financial entities are included with those of the Government department responsible for the entity and we audit these annually as part of our audit of the Public Accounts of the Province.

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Chapter 2, Part 2.1
MONITORING AGENCIES OF THE CROWN

The report summarizes our observations of the audited financial statements and management letters of Crown agencies that we have either prepared as auditor or received from private auditors. To assist us in this task, we maintain information found in these documents in our computerized system. This system provides the basis for our monitoring of all Crown agencies. Our observations are as follows:

What We Found

Compliance with Section 14
Of the 63 (2006 - 65) entities required to prepare annual financial statements, 30 (2006 - 30) were audited by our Office while 33 (2006 - 35) were audited by private sector auditors.

Statements not released by our Office
As of 8 January 2008, the audit of the financial statements of the following 5 (2006 - 4) entities audited by our Office could not be completed because the entities either had not provided necessary information or were not ready in time to complete the audit:

- C.A. Pippy Park Commission for the year ended 31 March 2007;
- C.A. Pippy Park Golf Course Ltd. for the year ended 31 March 2007;
- Heritage Foundation of Newfoundland and Labrador for the year ended 31 March 2007;
- Newfoundland and Labrador Legal Aid Commission for the years ended 31 March 2005, 31 March 2006 and 31 March 2007; and
- Newfoundland Government Fund Limited for the years ended 31 December 2004, 31 December 2005 and 31 December 2006.

Statements not received from private sector auditors as required
As of 8 January 2008, we had not received the audited financial statements and management letters for 4 of the 33 (2006 - 1 of the 35) entities audited by private sector auditors. These entities include the following:

- Churchill Falls (Labrador) Corporation Limited for the year ended 31 December 2006;
- Gull Island Power Company Limited for the year ended 31 December 2006;
- Lower Churchill Development Corporation Limited for the year ended 31 December 2006; and
- Twin Falls Power Corporation Limited for the year ended 31 December 2006.

For the majority of the remaining 29 entities, we did not receive the audited financial statements and management letters from the private sector auditors on a timely basis. On average, these audits were completed and the auditor's reports signed within 3 months after the year-end. However, in most cases, our Office did not receive the financial statements and related management letters until another 4 months after the audit report date, and often only after follow-up by our Office.

Highlights from audited financial statements
For 2007, 9 (2006 - 9) entities reported a total bank indebtedness of $57 million (2006 - $72 million).
As of 15 December 2006, the *Transparency and Accountability Act* requires all Government entities, including Crown agencies, to report financial information in a manner consistent with generally accepted accounting principles. We found that 2 entities did not comply with Canadian generally accepted accounting principles in that:

- for the year ended 30 April 2007, the Marble Mountain Development Corporation did not record and amortize its capital assets; and
- for the year ended 30 June 2006, the Eastern School District did not record and amortize all of its capital assets, and recognized teachers' severance and accrued vacation pay in its financial statements without an offsetting grant receivable from the Provincial government.

Background

Legislative requirement

A major role of the Office of the Auditor General is to monitor Crown agencies and provide information to the House of Assembly. Section 14 of the *Auditor General Act* requires the auditor of an agency of the Crown or a Crown controlled corporation to deliver to the Auditor General, after completion of the audit, a copy of the auditor's report, audited financial statements and recommendations to management. These financial statements and management letters along with our Office's audits of Crown agencies provide the basis for our monitoring of all Crown agencies.

Agencies of the Crown

Figure 1 summarizes the agencies of the Crown in the Province as at 31 March 2007.

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Summary of Agencies of the Crown
As at 31 March

Description	2006	2007
Agencies required to prepare financial statements	65	63
Agencies considered non-financial and did not prepare financial statements	72	72
Total	**137**	**135**

Source: Office of the Auditor General

Any expenditures related to the operation of the 72 non-financial entities are included with those of the Government department responsible for the entity and we audit these annually as part of our audit of the Public Accounts of the Province.

Detailed Observations

This report summarizes our observations of the audited financial statements and management letters of Crown agencies that we have either prepared as auditor or received from private auditors. To assist us in this task, we maintain information found in these documents in our computerized system. This system provides the basis for our monitoring of all Crown agencies.

Compliance with Section 14

Of the 63 (2006 - 65) entities required to prepare annual financial statements, 30 (2006 - 30) were audited by our Office while 33 (2006 - 35) were audited by private sector auditors.

Statements not released by our Office

As of 8 January 2008, the audit of the financial statements of the following 5 (2006 - 4) entities audited by our Office could not be completed because the entities either had not provided necessary information or were not ready in time to complete the audit:

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Statements not received from private sector auditors

As of 8 January 2008, we had not received the audited financial statements and management letter for 4 of the 33 (2006 - 1 of the 35) entities audited by private sector auditors. These entities include the following:

- Churchill Falls (Labrador) Corporation Limited for the year ended 31 December 2006;
- Gull Island Power Company Limited for the year ended 31 December 2006;
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For the majority of the remaining 29 entities, we did not receive the audited financial statements and management letters from the private sector auditors on a timely basis. On average, these audits were completed and the auditor's reports signed within 3 months after the year-end. However, in most cases, our Office did not receive the financial statements and related management letters until another 4 months after the audit report date, and often only after follow-up by our Office.

1. Highlights from Audited Financial Statements

Introduction

As part of our monitoring of Crown agencies, we review audited financial statements resulting from audits completed either by private sector auditors or by our Office.

Bank indebtedness

For 2007, 9 (2006 - 9) entities reported a total bank indebtedness of $57 million (2006 - $72 million).

Audit qualifications

As of 15 December 2006, the *Transparency and Accountability Act* requires all Government entities, including Crown agencies, to report financial information in a manner consistent with generally accepted accounting principles.

We found that 2 entities had an auditors' report containing a qualification. These entities did not comply with Canadian generally accepted accounting principles as follows:

- For the year ended 30 April 2007, the Marble Mountain Development Corporation did not record and amortize its capital assets.
- For the year ended 30 June 2006, the Eastern School District:
  - did not record and amortize all of its capital assets; and
  - recognized teachers' severance and accrued vacation pay in its financial statements without an offsetting grant receivable from the Provincial government.

2. Highlights from Management Letters

Introduction

As part of our monitoring of Crown agencies, we review management letters resulting from audits completed either by private sector auditors or by our Office.

Status of letters

Figure 2 outlines the status of management letters as of 8 January 2008 for the entities audited either by private sector auditors or by our Office.

Figure 2

Status of Management Letters

Management letters	Private Sector Auditor	Our Office	Total
Letters which identified issues	10	15	25
Letters which indicated no issues identified	2	7	9
No letter issued	11	1	12
Letters not finalized	6	2	8
Letters outstanding or audits not completed	4	5	9
Total	**33**	**30**	**63**

Source: Office of the Auditor General

Common issues

Figure 3 outlines the common issues found in our review of the management letters.

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Figure 3

Common Management Letter Issues

Issue	2006	2007
Non-compliance with Legislation		
Non-compliance with the *Public Tender Act*	0	1
Non-compliance with other legislative authorities	1	2
Internal Control Weaknesses		
Issues with the handling of money and bank accounts such as cash shortages and cheques being issued with only one signature	9	13
Theft of petty cash fund	1	0
Issues with the collection of accounts receivable	10	5
Weaknesses in controls over purchasing of goods and services including purchase orders not being used and purchases not being authorized	9	11
Issues with travel and entertainment claims such as over payment and unauthorized expenses	2	2
Issues with payrolls such as payroll advances and the approval of time sheets	7	8
Weaknesses in controls over capital assets, the most significant of which was a lack of a capital asset ledger	7	7
Other Issues		
Issues regarding the Harmonized Sales Tax	3	7
Computer related issues such as the lack of a disaster recovery plan	4	7
Issues with the board of directors such as frequency of meetings, approval of minutes and minimal activity	5	2

Source: Office of the Auditor General

Highlights

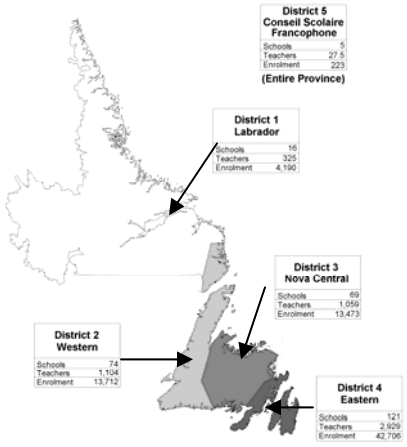
Highlights of a monitoring review of school districts from 1 July 2006 to 30 June 2007.

Why our Office did this Review

As part of our work we continue to monitor the financial position and annual operating results of the Province's school districts.

Figure 1 shows the five current school district boundaries.

Figure 1
Department of Education
School District Boundaries



What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

Chapter 2, Part 2.2
DEPARTMENT OF EDUCATION
Monitoring School Districts

Effective 1 September 2004, 9 of the 11 school districts in the Province were dissolved and three new school districts were created resulting in four English language school districts and one French language school district.

What We Found

Significant change in school system

The Province has seen a significant change in the school system during the last 10 years. In the 1997-98 school year, there were 391 schools serving 101,608 students and Provincial grants totalled $485.1 million. In the 2006-07 school year, there were 285 schools serving 74,304 students and Provincial grants totalled $596.1 million.

Financial Position

All five school districts had accumulated deficits as at 30 June 2007. The combined financial position of the five school districts at 30 June 2007 shows total accumulated deficits of $98.4 million, an 11% decrease from the $110.7 million reported in 2005. Included in the accumulated deficit is an amount of $104.6 million related to severance pay and leave accruals, less a net accumulated operating surplus of $6.2 million. The accumulated deficits will eventually have to be funded by Government.

The Eastern School District accounted for $54.0 million or 55% of the total $98.4 million in accumulated deficits.

Operating Results

Four of the five school districts reported operating surpluses for the year ended 30 June 2007 with the other district, the Western School District, reporting an operating deficit. The total net operating surplus for all five districts was $2.1 million. Operating surpluses (deficits) ranged from $1.4 million to ($448,000).

Overall, the annual operating surplus has decreased since 2005. Two school districts had operating results which were lower than that reported in 2006.

Non-compliance with the *Schools Act, 1997*

Contrary to the *Schools Act, 1997*, none of the five school districts submitted their annual budgets for the fiscal year 2007-08 to the Minister of Education for approval by 31 October 2007 as required by the Minister.

Also, contrary to the *Schools Act, 1997*, two of the five school districts did not submit their audited financial statements for the fiscal year 2006-07 to the Minister by 23 November 2007 as required by the Minister. The Nova Central School District did not submit its audited financial statements until 24 December 2007 and the Eastern School District did not submit its audited financial statements until 4 December 2007.

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Background

Overview

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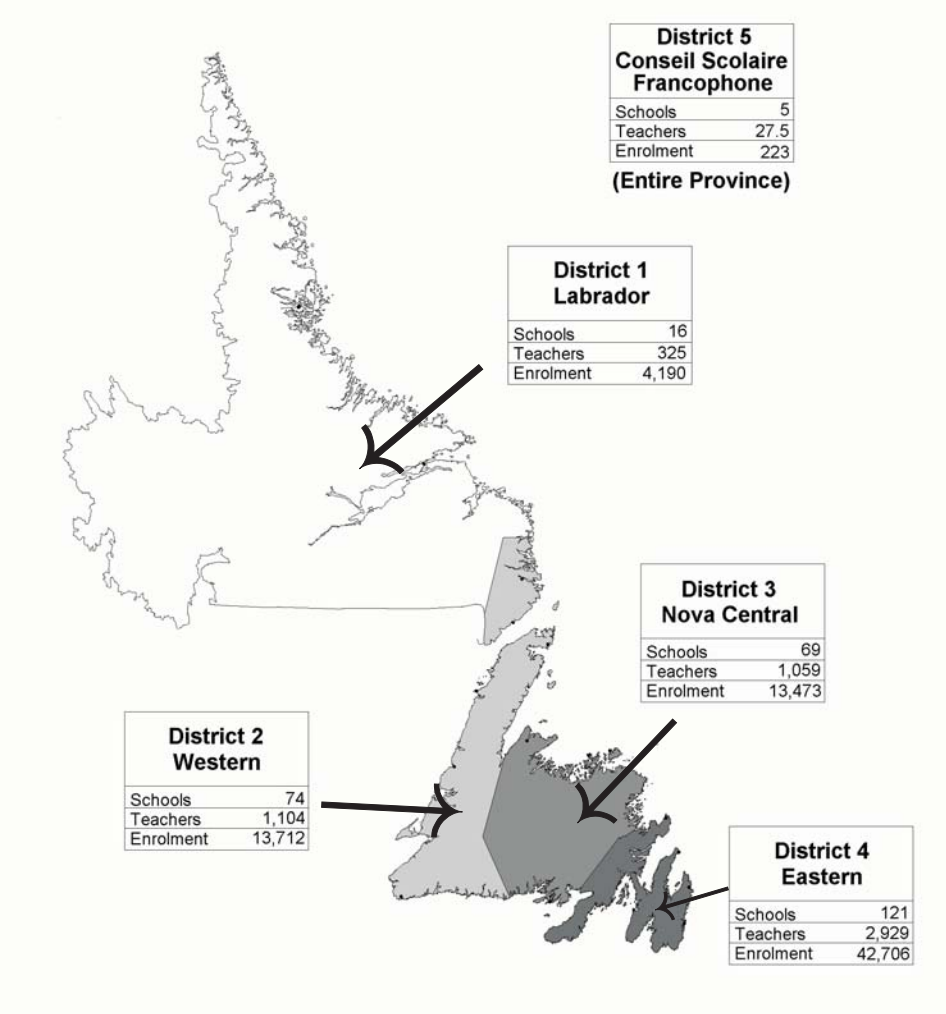

Figure 2 shows the number of schools, students enrolled and total Provincial grants for the last 10 school years.

Figure 2

Department of Education
School Districts
Schools, Students and Grants

School Year	Schools	Students	Provincial Grants $ (000s)
1997-98	391	101,608	485,111
1998-99	365	97,401	489,486
1999-00	343	93,957	489,760
2000-01	337	90,167	499,419
2001-02	326	86,898	528,188
2002-03	317	84,268	554,381
2003-04	305	81,458	636,552
2004-05	303	79,439	538,704
2005-06	294	76,763	578,032
2006-07	285	74,304	596,089

Source: Department of Education Statistics and school districts' financial statements

As part of our work we continue to monitor the financial position and annual operating results of the school districts.

Overall Conclusions

Significant change in school system

The Province has seen a significant change in the school system during the last 10 years. In the 1997-98 school year, there were 391 schools serving 101,608 students and Provincial grants totalled $485.1 million. In the 2006-07 school year, there were 285 schools serving 74,304 students and Provincial grants totalled $596.1 million.

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Also, contrary to the *Schools Act, 1997*, two of the five school districts did not submit their audited financial statements for the fiscal year 2006-07 to the Minister by 23 November 2007 as required by the Minister. The Nova Central School District did not submit its audited financial statements until 24 December 2007 and the Eastern School District did not submit its audited financial statements until 4 December 2007.

Detailed Observations

Our review included an assessment of the financial position and annual operating results of the Province's five school districts.

As a result of the reorganization on 1 September 2004, three of the five new school districts had to prepare financial statements for the 10 month period ending 30 June 2005. The other two school districts prepared financial statements for the 12 month period ending 30 June 2005.

1. Financial Position

Figure 3 outlines information on the financial position of the five school districts.

Figure 3

Department of Education
School Districts
Summary of Financial Position
Years Ended
($ 000's)

	School District					Total		
	Labrador	Western	Nova Central	Eastern	Conseil Scolaire Francophone	2007	2006 Note 1	2005 Note 2
Current Assets								
Cash and investments	$ 1,611	$ 1,494	$ 1,646	$ 13,238	$ 329	$ 18,318	$ 10,808	$ 3,449
Accounts receivable	2,008	1,908	2,159	2,702	139	8,916	11,504	10,179
Summer pay receivable	3,356	10,561	10,087	28,810	261	53,075	42,314	43,208
Other assets	67	238	393	555	27	1,280	1,087	1,069
Total current assets	7,042	14,201	14,285	45,305	756	81,589	65,713	57,905
Trust funds	-	-	644	-	-	644	406	390
Other Assets	-	-	-	342	-	342	1,888	2,262
Capital assets	43,031	158,029	176,174	157,939	8,001	543,174	685,568	673,640
Total assets	$ 50,073	$172,230	$191,103	$ 203,586	$ 8,757	$625,749	$753,575	$ 734,197
Current Liabilities								
Bank indebtedness	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 316
Accounts payable	653	1,519	1,685	7,116	284	11,257	11,462	6,837
Summer pay liability	3,356	10,561	10,087	28,810	261	53,075	52,148	53,294
Deferred revenue	1,162	1,341	356	2,643	111	5,613	4,746	2,691
Current maturities	203	372	1,402	1,589	-	3,566	3,229	2,815
Total current liabilities	5,374	13,793	13,530	40,158	656	73,511	71,585	65,953
Trust funds liability	-	-	644	-	-	644	406	390
Long-term debt	1,095	2,402	8,886	7,478	-	19,861	17,901	17,366
Severance pay and leave	6,153	21,027	20,611	56,648	201	104,640	102,972	103,638
Total liabilities	12,622	37,222	43,671	104,284	857	198,656	192,864	187,347
Equity								
Investment in capital	43,041	155,307	165,887	153,281	7,981	525,497	668,836	657,544
Deficit	**(5,590)**	**(20,299)**	**(18,455)**	**(53,979)**	**(81)**	**(98,404)**	**(108,125)**	**(110,694)**
Total equity	37,451	135,008	147,432	99,302	7,900	427,093	560,711	546,850
Total liabilities and equity	$ 50,073	$172,230	$191,103	$ 203,586	$ 8,757	$625,749	$753,575	$ 734,197

Source: 30 June 2007 audited financial statements
Note 1: Certain 2006 amounts have been reclassified to conform to the financial statements presentation for 2007.
Note 2: 2005 figures include only 10 months for Western, Nova Central, and Eastern due to the restructuring in 2004.
Certain 2005 amounts have been reclassified to conform to the financial statements presentation for 2006.
Retroactive adjustments for accounting errors have resulted in an increase in the deficit for 2005.

As Figure 3 shows, the total accumulated deficit for the school districts decreased from $110.7 million in 2005 to $98.4 million in 2007. The $98.4 million in combined accumulated deficits will eventually have to be funded by Government.

Non-compliance with Department directive

In 2005, the Department of Education (the Department) directed each school district to record a liability for teachers' salaries earned during the school year but not fully paid to teachers until after the school year end. The Department also directed school districts to not record an accounts receivable for the liability.

Our review identified that all five school districts recorded a liability and also recorded an offsetting accounts receivable as shown in Figure 3. As such, none of the school districts complied with the Department's directive.

Accumulated deficits

At 30 June 2007, the five school districts had accumulated deficits totalling $98.4 million. This was comprised of $104.6 million in severance pay and leave accruals less a net accumulated operating surplus of $6.2 million. A summary of these amounts is provided in Figure 4.

Figure 4

Department of Education
School Districts
Accumulated Surplus (Deficit)
Years Ended
($ 000's)

School District	2007				2006			
	Total	Leave/ Severance	Net Summer Pay Liability	Operating	Total	Leave/ Severance	Net Summer Pay Liability	Operating
Labrador	$ (5,590)	$ (6,153)	$ -	$ 563	$ (6,188)	$ (6,183)	$ -	$ (5)
Western	(20,299)	(21,027)	-	728	(19,906)	(20,545)	-	639
Nova Central	(18,455)	(20,611)	-	2,156	(28,430)	(20,350)	(9,834)	1,754
Eastern	(53,979)	(56,648)	-	2,669	(53,532)	(55,721)	-	2,189
Conseil Scolaire Francophone	(81)	(201)	-	120	(69)	(173)	-	104
Total	**$ (98,404)**	**$ (104,640)**	**$ -**	**$ 6,236**	**$ (108,125)**	**$ (102,972)**	**$ (9,834)**	**$ 4,681**

Source: 30 June 2007 audited financial statements and Department of Education information

2. Operating Results

Figure 5 outlines the annual operating results of the five school districts.

Figure 5

Department of Education
School District
Operating Results
Years Ended
($ 000's)

	School District					Total		
	Labrador	Western	Nova Central	Eastern	Conseil Scolaire Francophone	2007	2006 Note 1	2005 Note 2
Revenue								
Provincial grants								
Teachers	$ 28,836	$ 99,817	$ 84,401	$ 245,708	$ 2,366	$ 461,128	$453,777	$428,601
Regular operating	6,201	19,300	18,704	45,830	1,554	91,589	84,106	74,891
Pupil transportation	1,884	7,359	9,994	20,461	320	40,018	37,346	32,891
Other Provincial grants	-	2,656	464	-	234	3,354	2,803	2,321
Total Provincial grants	**36,921**	**129,132**	**113,563**	**311,999**	**4,474**	**596,089**	**578,032**	**538,704**
Federal grants	3,408	-	-	46	1,359	4,813	4,071	3,449
Ancillary services	193	122	57	63	130	565	573	445
Miscellaneous revenue	1,206	494	1,590	1,649	28	4,967	3,701	3,067
Total Revenue	41,728	129,748	115,210	313,757	5,991	606,434	586,377	545,665
Expenditure								
Administration	1,370	2,531	2,963	4,419	429	11,712	11,654	11,548
Instructional	32,988	106,958	89,839	257,623	3,854	491,262	473,914	444,582
Operations and maintenance	4,528	12,827	11,946	29,396	696	59,393	56,934	48,626
Pupil transportation	2,146	7,744	10,288	20,497	322	40,997	37,785	33,836
Ancillary services	181	45	-	70	135	431	497	377
Miscellaneous	-	83	-	88	-	171	103	247
Debt repayment	7	8	33	301	-	349	432	400
Total expenditure	41,220	130,196	115,069	312,394	5,436	604,315	581,319	539,616
Excess of revenue over expenditure	**508**	**(448)**	**141**	**1,363**	**555**	**2,119**	**5,058**	**6,049**
Equity adjustments	99	-	9,834	220	-	10,153	417	(10,121)
Net transfer to capital	(9)	55	-	(2,030)	(567)	(2,551)	(2,906)	(2,263)
Decrease (increase) in deficit	$ 598	$ (393)	$ 9,975	$ (447)	$ (12)	$ 9,721	$ 2,569	$ (6,335)

Source: 30 June 2007 audited financial statements.
Note 1: Certain 2006 amounts have been reclassified to conform to the financial statements presentation for 2007.
Note 2: 2005 figures include only 10 months for Western, Nova Central, and Eastern due to the restructuring in 2004.
Certain 2005 amounts have been reclassified to conform to the financial statements presentation for 2006.
Retroactive adjustments for accounting errors have resulted in an increase in the deficit for 2005.

As Figure 5 shows, four of the five school districts reported operating surpluses for the year ended 30 June 2007 with the other district, the Western School District, reporting an operating deficit. The total net operating surplus for all five districts was $2.1 million. Operating surpluses (deficits) ranged from $1.4 million for the Eastern School District to ($448,000) for the Western School District. The Figure also shows that in 2007, Provincial funding totalled $596.1 million. This accounted for approximately 12% of the expenditures budgeted by the Province.

Overall, the annual operating surplus reflected in Figure 5 has decreased since 2005. Two school districts (the Western School District and the Nova Central School District) had operating results which were lower than that reported in 2006.

Non-compliance with the *Schools Act, 1997*

The *Schools Act, 1997* requires each school district to submit its annual budget to the Minister at a date determined by the Minister. For the fiscal year 2007-08, the Minister set 31 October 2007 as the date for submitting annual budgets. Figure 6 shows the date of the budget submission for each of the five school districts.

Figure 6

Department of Education
School Districts
Budget Submissions

School District	Date 2007-08 Budget Received
Labrador	5 November 2007
Western	20 November 2007
Nova Central	13 December 2007
Eastern	21 December 2007
Conseil Scolaire Francophone	2 November 2007

Source: Department of Education

As Figure 6 shows, none of the five school districts submitted their annual budget by 31 October 2007.

The *Schools Act, 1997* also requires each school district to submit its audited financial statements to the Minister at a date determined by the Minister. For the fiscal year 2006-07, the Minister set 23 November 2007 as the date for submitting audited financial statements. However, the Nova Central School District and the Eastern School District did not submit their audited financial statements by 23 November 2007. The Nova Central School District did not submit its financial statements until 24 December 2007 and the Eastern School District did not submit its financial statements until 4 December 2007.

Department's Response

Financial Position

The five school districts have accumulated deficits of $98.4M as at 30 June 2007 offset by a commitment from Government to fund the portion of these deficits attributable to severance pay and leave awards totaling $104.6M.

The Department notes that it has been a long standing practice to direct districts to record a liability for teacher salaries earned during the school year but not fully paid until after year-end and not to record an accounts receivable for the liability. All districts complied with recording the liability; however, it is the professional opinion of the district auditors, that it would be appropriate to record the offsetting accounts receivable. The Department will be discussing this issue further with the districts' auditors and the Comptroller General to determine how compliance may be achieved in future.

Operating Results

The Department is pleased that the districts recorded a net operating surplus of $2.1M as of June 30, 2007.

Non-Compliance with the Schools Act, 1997.

The Department concurs with the Auditor General's comments that school districts did not submit their budgets by the date set by the Minister and two of the five districts did not submit their audited financial statements by the date set by the Minister. The Department continues to work with school districts concerning the timelines of budget submissions and financial statements.

Highlights

Highlights of a review of the Debt Reduction Grant Program administered by the Student Financial Services Division of the Department of Education for the fiscal years 2002-03 to 2005-06.

Why our Office did this Review

The objectives of our review were to determine whether: students receive debt reduction grants in accordance with established eligibility criteria; the Department has adequate systems and procedures to ensure students receive debt reduction grants to which they are entitled; and the Department complies with the *Student Financial Assistance Act* and *Regulations.*

What our Office Recommends

We recommend that the Department should:

- ensure that all students are assessed for a debt reduction grant upon graduation;
- follow-up on a timely basis regarding outstanding student information requested from educational institutions;
- advise students who did not apply for a loan in their final year of study that they must apply for a debt reduction grant;
- continue with its efforts to have the *Student Financial Assistance Regulations* amended to properly authorize loan remission payments to students who had not applied to the loan remission program; and
- ensure that the Student Aid Management Information System (SAMS) database is accurately updated with information received from educational institutions and with information generated from debt reduction grant assessment procedures.

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email oag@gov.nl.ca.

Chapter 2, Part 2.3
DEPARTMENT OF EDUCATION
Debt Reduction Grant Program

Since 1 August 2002, the Department of Education has administered a Debt Reduction Grant Program (DRGP) through its Student Financial Services Division (the Division). The purpose of the program is to provide debt relief to eligible students with student loans whereby an amount up to the full value of the 40% Provincial portion of a student's loan may be automatically converted to a non-repayable grant after the student graduates. This program was preceded by the Loan Remission Program (1995 to 2004). The Loan Remission Program and the DRGP were administered concurrently during a two year transition period which ended on 31 July 2004.

Debt reduction grants are calculated on a semester by semester basis and paid when the student graduates from their program of study. Figure 1 outlines details of the financial assistance paid for the fiscal years 2002-03 to 2006-07.

Figure 1
Financial Assistance
Fiscal years 2002-03 to 2006-07
($ millions)

	2002-03	2003-04	2004-05	2005-06	2006-07	Total
Debt Reduction Grants	$ -	$ -	$ 1.4	$ 5.2	$ 6.8	$ 13.4
Number of Students	-	1	502	918	1,223	2,644
Loan Remissions	$ 5.6	$ 4.8	$ 4.7	$ 1.7	$ .5	$ 17.3
Number of Students	634	564	549	279	65	2,091
Total	**$ 5.6**	**$ 4.8**	**$ 6.1**	**$ 6.9**	**$ 7.3**	**$ 30.7**
Total	**634**	**565**	**1,051**	**1,197**	**1,288**	**4,735**

Source: Department of Education

What We Found

We found that not all eligible students are receiving debt reduction grants as a result of the following:

- Although the Division knew that certain students had graduated and it had the necessary information to assess eligibility for a debt reduction grant, the Division did not perform the procedures necessary to determine grant eligibility. As a result of our review of 15 files in this situation, the Division determined that 7 students (47%) should have received grants totalling $52,591.
- Educational institutions did not provide requested student information and the Division did not follow-up on the outstanding information. As a result of our review of 21 files in this situation, 6 students (29%) should have received grants totalling $46,799.
- Students who did not apply for a student loan in their final year of study were not identified by the Division as being in their final year of study and therefore were not automatically assessed for debt reduction grant eligibility on graduation. In this situation, students were not advised that they had to apply for a debt reduction grant on graduation.

The Division did not comply with the *Student Financial Assistance Regulations* when it paid $2 million in loan remissions to 307 students who had not formally applied. Rather than require a formal application from the students as provided for under the *Regulations* and in order to provide students with the maximum assistance, the Division automatically assessed students for eligibility under both the Loan Remission Program and the Debt Reduction Grant Program. In addition, during our testing of debt reduction grants, we found errors in the information contained in the Student Aid Management Information System.

Background

Since 1 August 2002, the Department of Education has administered a Debt Reduction Grant Program (DRGP) through its Student Financial Services Division (the Division). The purpose of the program is to provide debt relief to eligible students with student loans whereby an amount up to the full value of the 40% Provincial portion of a student's loan may be automatically converted to a non-repayable grant after the student graduates. This program was preceded by the Loan Remission Program (1995 to 2004). The Loan Remission Program and the DRGP were administered concurrently during a two year transition period which ended on 31 July 2004.

Debt reduction grants are calculated on a semester by semester basis and paid when the student graduates from their program of study. As at 31 March 2007, the Province had paid 2,644 students approximately $13.4 million from the DRGP. The Department has also paid 2,091 students approximately $17.3 million under the Loan Remission Program. Figure 1 outlines details of the financial assistance paid for the fiscal years 2002-03 to 2006-07.

Figure 1

Financial Assistance
Fiscal years 2002-03 to 2006-07
($ millions)

	2002-03	2003-04	2004-05	2005-06	2006-07	Total
Debt Reduction Grants	$ -	$ -	$ 1.4	$ 5.2	$ 6.8	$ 13.4
Number of Students	-	1	502	918	1,223	2,644
Loan Remissions	$ 5.6	$ 4.8	$ 4.7	$ 1.7	$ .5	$ 17.3
Number of Students	634	564	549	279	65	2,091
Total	**$ 5.6**	**$ 4.8**	**$ 6.1**	**$ 6.9**	**$ 7.3**	**$ 30.7**
Total	**634**	**565**	**1,051**	**1,197**	**1,288**	**4,735**

Source: Department of Education

In addition, as at 31 March 2007, a contingent liability for future possible debt reduction grant payments of $24.3 million was reported in the Province's Public Accounts, with a provision that actual payments were expected to total $18.2 million.

In order to qualify for a debt reduction grant, a student, in most cases, must attend an educational institution in Newfoundland and Labrador and:

- graduate from a program of study that is not fewer than 80 weeks in duration;
- borrow from the student loan program, more than $165 per week for a period of study;
- pass 80% of a full course load in the period of study;
- apply and qualify for student loans for not less than 50% of the program of study duration; and
- graduate within 10 years of commencing a program of study.

Student Aid Management Information System

The Division has a Student Aid Management Information System (SAMS) which contains student information used in assessing eligibility for student loans and debt reduction grants.

Audit Objectives and Scope

Audit objectives

The objectives of our review were to determine whether:

- students receive debt reduction grants in accordance with established eligibility criteria;
- the Department has adequate systems and procedures to ensure students receive debt reduction grants to which they are entitled; and
- the Department complies with the *Student Financial Assistance Act* and *Regulations.*

Debt Reduction Grant Program

Audit scope

We interviewed officials at the Student Financial Services Division of the Department of Education, reviewed Department policies and procedures and analyzed information in the Student Aid Management Information System.

We completed our review in November 2007.

Overall Conclusions

Not all eligible students are receiving debt reduction grants. The situation resulted from the following:

- Although the Division knew that certain students had graduated and it had the necessary information to assess eligibility for a debt reduction grant, the Division did not perform the procedures necessary to determine grant eligibility. As a result of our review of 15 files in this situation, the Division determined that 7 students (47%) should have received grants totalling $52,591.

- Educational institutions did not provide requested student information and the Division did not follow-up on the outstanding information. As a result of our review of 21 files in this situation, 6 students (29%) should have received grants totalling $46,799.

- Students who did not apply for a student loan in their final year of study were not identified by the Division as being in their final year of study and therefore were not automatically assessed for debt reduction grant eligibility on graduation. In this situation, students were not advised that they had to apply for a debt reduction grant on graduation.

The Division did not comply with the *Student Financial Assistance Regulations* when it paid $2 million in loan remissions to 307 students who had not formally applied. Rather than require a formal application from the students as provided for under the *Regulations* and in order to provide students with the maximum assistance, the Division automatically assessed students for eligibility under both the Loan Remission Program and the Debt Reduction Grant Program.

During our testing of debt reduction grants, we found errors in the information contained in the Student Aid Management Information System (SAMS).

Detailed Observations

Overview

Effective 1 August 2002, the Newfoundland and Labrador Debt Reduction Grant Program was implemented to replace the Loan Remission Program that was set to expire 31 July 2004. Both debt reduction assistance programs were administered concurrently during a two year transition period ending 31 July 2004. Students were paid assistance from the program that gave them the greatest benefit during this period.

Students were advised by the Department that there was no application process for the Debt Reduction Grant Program. Instead, students were automatically assessed for eligibility by the Student Financial Assistance Division.

Information required by the Student Aid Division

In order to assess students for debt reduction grant eligibility, the Division required that educational institutions confirm the following information:

- that students who indicated they were in their final year of study actually graduated from their program of study;
- that the program of study from which students graduated was not fewer than 80 weeks in duration; and
- that students had passed at least 80% of a full course load during each semester needed to complete their program of study.

The Division, in turn, determined whether the student:

- borrowed at least $165 per week of semester study under the Canada and Newfoundland Student Loan Programs; and
- applied and was deemed eligible for student loans for at least half of the normal length of their program of study.

Grant amounts for which a student may be eligible

Students who borrowed under the Canada and Newfoundland Student Loan Programs could receive a debt reduction grant on completion of an eligible program of study, as follows:

- up to the total amount borrowed under the Newfoundland Student Loan Program for those semesters where they successfully complete 100% of a full course load; or
- up to one half of the total amount borrowed under the Newfoundland Student Loan Program for those semesters where they successfully complete 80% of a full course load.

If a student was eligible for a debt reduction grant, the Department through the Student Loan Corporation of Newfoundland and Labrador, applied the grant directly against the student's loan. Where the loan balance owed by a student was less than the amount of the grant to which the student is entitled, the remaining balance was paid directly to the student.

During the period 1 August 2002 to 24 March 2006, 4,349 students were assessed to determine whether they were eligible to receive a debt reduction grant. The Division determined that 1,759 of the 4,349 students were eligible to receive approximately $7.5 million in debt reduction grants.

Eligible students were not receiving debt reduction grants

Students who have Graduated

A report obtained from the Division's Student Aid Management Information System (SAMS) indicated that, as at 24 March 2006, 389 students who had graduated from their program of study, some dating back to December 2002, had not been assessed for debt reduction grant eligibility.

We reviewed 30 of the 389 students to determine why they had not been assessed. We found the following:

- 15 (50%) students were not assessed because they were "overlooked" by the Division. We found that information required to assess the 15 students was available; however, the Division overlooked the students when carrying out eligibility assessment procedures. As a result of our review, the Division assessed the 15 students and determined that:

- 7 students were eligible to receive debt reduction grants totalling $52,591; and
- 8 students were not eligible for a debt reduction grant.

- 7 (24%) students were not assessed because the Division did not have all the information required to assess eligibility. The Division failed to complete follow-up procedures to clarify incomplete information previously received from the students' educational institution. As a result of our review, the Division performed follow-up procedures and determined that:
  - 3 of the 7 students were eligible to receive a debt reduction grant totalling $21,968;
  - 1 of the 7 students had not yet been assessed because the educational institution had not provided all of the required information; and
  - 3 of the 7 students were not eligible for a debt reduction grant.
- 4 (13%) students were not assessed because the students had not graduated from their program of study. The Division indicated that the graduation data was keyed into the database in error.
- 3 (10%) students who appeared to not have been assessed, had in fact been assessed. In 2 cases, the students had received a loan remission instead of a debt reduction grant. In the third case, the student had been assessed and paid a debt reduction grant. The Division indicated that a clerk failed to update the database to reflect that assessments had been completed in these 3 cases.
- 1 (3%) student was not assessed because the student had not provided the Division with all the required information.

Students were not being assessed for grants on a timely basis

Students in their Final Year of Study

A report obtained from the Division's SAMS indicated that, as at 24 March 2006, information was requested from educational institutions on behalf of 690 students who indicated they were in their final year of study; however, there was no indication in SAMS whether the student graduated and/or whether the student was assessed for debt reduction grant eligibility.

We reviewed 20 of the 690 students to determine whether the Division had obtained the student information from the educational institution and whether the student was assessed for a debt reduction grant. Our review indicated the following:

- For 10 (50%) students, the Division had not received the requested information from the educational institution and therefore did not assess the students for a debt reduction grant. As a result of our review the Division determined the following with respect to these 10 students:
  - For 2 students, when our review concluded, the Division had not been able to determine whether the students graduated or were eligible for a debt reduction grant.
  - For 3 students, the Division determined that the student had graduated and had been paid assistance from the Loan Remission Program.
  - For 3 students, the Division subsequently confirmed that the students had not yet graduated and therefore were not eligible for a debt reduction grant.
  - For 2 students, the Division subsequently confirmed graduation status and found the students were eligible to receive debt reduction grants totalling $19,108.
- For 4 (20%) students, information requested was received from the educational institution; however, the information was incomplete and the Division had not yet requested additional information to assess the student for a debt reduction grant. As a result of our review the Division requested the additional information which resulted in the following:
  - For 3 students, grants were denied because, while the students did graduate, they did not meet all the eligibility criteria.
  - For 1 student, the Division determined that the student was eligible to receive a debt reduction grant totalling $5,723.
- For 6 (30%) students, information received from the educational institution indicated that the student had not graduated and therefore was not eligible for a debt reduction grant.

Not all students eligible for a grant were identified

Students were advised by the Department that there was no application process for the Debt Reduction Grant Program because students were automatically assessed for eligibility by the Student Financial Assistance Division.

Our review indicated that students who did not apply for a student loan in their final year of study were not identified by the Division as being in their final year of study and therefore were not automatically assessed for debt reduction grant eligibility on graduation. Officials at the Division indicated that in these cases, the student had to apply for a debt reduction grant. However, we found that these application procedures were not communicated to students, and that students therefore did not know they were required to apply for a debt reduction grant in these circumstances.

Non-compliance with Legislation

During the transition period for the Loan Remission Program and the Debt Reduction Program from 1 August 2002 to 31 July 2004, the Division automatically assessed the eligibility of all students under both programs to ensure that students received the maximum debt reduction assistance available to them. Until that time, and as outlined in the *Student Financial Assistance Regulations*, in order to be considered for assistance under the Loan Remission Program, students were required to submit a formal application.

The Division indicated that it had paid 307 students approximately $2 million in loan remissions when they did not apply. Our review indicated that the Division did not have the authority to pay students loan remissions when they had not applied. As a result, these students received loan remissions to which they were not entitled under the legislation.

Furthermore, we found that legal advice provided to the Division indicated that retroactive regulatory amendments would be required to properly authorize loan remission payments to students who had not applied to the Loan Remission Program. At the time of our review, the Division indicated that proposed retroactive regulatory amendments were awaiting approval by the Minister.

Recommendations

The Department should:

- ensure that all students are assessed for a debt reduction grant upon graduation;
- follow-up on a timely basis regarding outstanding student information requested from educational institutions;
- advise students who did not apply for a loan in their final year of study that they must apply for a debt reduction grant;
- continue with its efforts to have the *Student Financial Assistance Regulations* amended to properly authorize loan remission payments to students who had not applied to the loan remission program; and
- ensure that the Student Aid Management Information System (SAMS) database is accurately updated with information received from educational institutions and with information generated from debt reduction grant assessment procedures.

Department's Response

The Department acknowledges the processing and administration errors noted by the Auditor General. The Department will immediately review its grant administration activities and within three months will establish a plan to correct these deficiencies. The plan will include the routine reporting of grant administration functions to the Department executive.

The Department notes that the Auditor General findings reveal that while there were 389 applications not assessed, 2,644 applications were assessed during the four year period reviewed.

Specifically, the Department will ensure the remaining 389 applications, which were not assessed, will be processed and eligible students will be contacted and provided with their grants. For students in their final year of study, the Department has improved communications by including a notice in the 2006/07 student application guide. The notice, which advises students in their final year of study to contact the Division, will also be communicated to student unions. Other student focused media materials such as newspapers, correspondence, etc. will also include this information.

Highlights

Highlights of a review of the designation of educational institutions for the purpose of student loans for the period 2004-05 to 2006-07.

Why our Office did this Review

The objectives of our review were to determine whether the Department: is monitoring educational institutions to assess whether they are complying with designation requirements under the *Student Financial Assistance Act* and *Regulations;* has adopted the National Designation Policy Framework relating to the student loan program; and has established and is complying with educational institution designation policy and procedures.

What our Office Recommends

We recommend that the Department should:

- Develop policies and procedures to ensure that educational institutions comply with the designation requirements for the purposes of student loans under the *Student Financial Assistance Act* and *Regulations.*
- Consider adopting the National Designation Policy Framework. In connection with this the Department should: develop socio-economic indicators to be used in assessing the performance of educational institutions in the Province, as provided for under the Framework; and develop policies and procedures and enter into formal agreements with educational institutions as outlined under the Framework.
- Advise all educational institutions in the Province of their student loan repayment performance.

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email oag@gov.nl.ca.

Chapter 2, Part 2.4
DEPARTMENT OF EDUCATION
Student Loan Program - Designation of Educational Institutions

Educational institutions play a role in retaining students, ensuring students succeed, and ensuring students improve their overall employability, which contributes to the success that students have in repaying their student loans. In order for a student to be eligible for a student loan from Government, the *Student Financial Assistance Regulations* under the *Student Financial Assistance Act* stipulate that the educational institution they are attending must be formally recognized or "designated" by the Minister (Department of Education).

The Designation Policy Framework introduced in 2004 is a guide for all jurisdictions in Canada in the development of their educational institution designation policies and procedures. The Framework supports government in working with educational institutions to improve the performance and accountability of the student loan portfolio.

The Framework outlines the criteria that should be established to determine whether an educational institution should be and continue to be designated. These criteria are supported by performance standards such as student loan portfolio repayment and default rates, institution administrative compliance and student program completion and employment rates.

Educational institutions that do not meet performance standards of the Framework must take action to improve their performance or face sanctions, including possible de-designation. However, jurisdictions may determine that the role an educational institution plays in fulfilling regional, socio-economic or cultural provincial policy priorities should be taken into account in assessing institutions that do not meet performance standards. Under the Framework, the Province is required to advise, monitor and assist institutions in taking the appropriate action to ensure compliance.

What We Found

We have concluded from our review that the Department could not demonstrate whether the Province has developed policies and procedures to ensure that educational institutions comply with the designation requirements for the purposes of student loans under the *Student Financial Assistance Act* and *Regulations*.

Furthermore, the Province did not adopt the National Designation Policy Framework developed in 2004 because of the absence of socio-economic indicators which could be used in assessing the performance of educational institutions in the Province, as provided for under the Framework. In addition, the Province did not develop the policies and procedures or enter into formal agreements with educational institutions as outlined under that Framework. The agreements, which are required to be in place to maintain Federal student loan program designation, should outline for example, student loan repayment performance targets, required information exchange between institutions and the Province and tuition refund policies.

As a result of the inaction on the part of Government and in accordance with the Framework, all educational institutions in the Province may be at risk for de-designation for Federal student loan purposes i.e. students will not be eligible for the 60% Federal portion of a total student loan. Educational institutions at particular risk would be the 11 of 43 institutions whose student loan repayment performance in July 2007 was rated as "poor" (student loan repayment rate less than 48.7%).

Of particular note is that Department officials indicated none of the educational institutions have been advised of their student loan repayment performance, whether improvements are required and whether there is risk of de-designation. In addition, the Province still has not taken action to monitor and work with educational institutions to address student loan repayment performance.

Background

Educational institutions play a role in retaining students, ensuring students succeed, and ensuring students improve their overall employability, which contributes to the success that students have in repaying their student loans. Educational institutions, therefore, are important to any effort by Government to effectively manage the financial risks inherent in a student loan program. During the period of our review, student loans were funded by the Federal Government (60%) and the Provincial Government (40%). As at 31 March 2007, there were 27 educational institutions designated for student loan purposes, some of which had more than one campus.

In order for a student to be eligible for a student loan from Government, the *Student Financial Assistance Regulations* under the *Student Financial Assistance Act* stipulate that the educational institution they are attending must be formally recognized or "designated" by the Minister (Department of Education).

The Province, through the Student Loan Corporation of Newfoundland and Labrador (SLCNL) has a significant investment in student loans. Figure 1 shows a summary of student loans outstanding at the SLCNL for the three year period ending 31 March 2007.

Figure 1

Student Loans Outstanding
Fiscal Years Ending 31 March
($ millions)

	2004-05		2005-06		2006-07	
Loan Status	**Students**	**$**	**Students**	**$**	**Students**	**$**
Class A: in school, not in repayment	13,300	$ 83.1	11,749	$ 81.7	10,942	$ 75.3
Class B: out of school, in repayment						
- Current, up to date	11,379	68.2	13,208	75.7	14,690	81.6
- Interest relief						
Hardship, no payments due	3,358	27.9	3,488	28.7	3,214	26.2
- Delinquent,						
In arrears, 1 - 270 days	3,418	20.1	2,207	13.6	2,275	14.7
Total Class B	18,155	116.2	18,903	118.0	20,179	122.5
In default						
- In arrears > 270 days	3,412	20.5	5,447	31.8	6,801	39.3
Interest receivable	-	2.6	-	4.5	-	7.1
Total	**34,867**	**$ 222.4**	**36,099**	**$ 236.0**	**37,922**	**$ 244.2**

Source: Student Loan Corporation of Newfoundland and Labrador

As Figure 1 shows, as at 31 March 2007, 6,801 students had defaulted on loans totalling $39.3 million. This represents an increase of 3,389 students and $18.8 million in defaulted loans over the period ended 31 March 2005. In addition, the Department reported that, as at 31 March 2007, guaranteed loans purchased from chartered banks prior to establishment of the SLCNL for 4,341 students and totalling approximately $35.6 million, were also in default. Therefore, as at 31 March 2007 there were 11,142 students in default totalling $74.9 million (average of approximately $6,700 per student).

Chronology of designation requirements

Although in 2002 the Province established legislation under the *Student Financial Assistance Act* and *Regulations* governing the designation and monitoring of educational institutions, the Department deferred establishing formal designation policy and procedures pending the outcome of a joint Federal/Provincial Pan Canadian Designation Policy Framework which was being developed.

In 2003, the Council of Ministers of Education approved a National Designation Policy Framework (the Framework) to facilitate a common approach to designating educational institutions for student loans in jurisdictions across Canada.

In 2004, Federal, Provincial and Territorial Ministers formally announced the launch of the Framework.

In 2005, the Federal Government identified the Student Financial Services Division of the Province's Department of Education as the appropriate authority to exercise and perform the powers, duties and functions under the *Canada Student Financial Assistance Act* in accordance with the Framework.

Departmental officials indicated that the Province has not adopted the Framework and developed policy and procedures because, in the view of the Province, the Framework is not complete in relation to the development of specific socio-economic indicators that would be used in assessing the designation of institutions. For example, officials indicated that using the Framework to de-designate an institution in a small region without consideration of the socio-economic realities would not be prudent.

Audit Objectives and Scope

Audit objectives

The objectives of our review were to determine whether the Department:

- is monitoring educational institutions to assess whether they are complying with designation requirements under the *Student Financial Assistance Act* and *Regulations*;
- has adopted the National Designation Policy Framework relating to the student loan program; and
- has established and is complying with educational institution designation policy and procedures.

Audit scope

We interviewed officials at the Department of Education, reviewed the relevant legislation and the National Designation Policy Framework.

We completed our review in November 2007.

Overall Conclusions

The Department could not demonstrate whether the Province has developed policies and procedures to ensure that educational institutions comply with all of the designation requirements for the purposes of student loans under the *Student Financial Assistance Act* and *Regulations*. In particular, the Department does not monitor institutions to determine whether acceptable default prevention plans are in place.

Furthermore, the Province did not adopt the National Designation Policy Framework developed in 2004 because of the absence of socio-economic indicators which could be used in assessing the performance of educational institutions in the Province, as provided for under the Framework. In addition, the Province did not develop the policies and procedures or enter into formal agreements with educational institutions as outlined under that Framework. The agreements, which are required to be in place to maintain Federal student loan program designation, should outline for example, student loan repayment performance targets, required information exchange between institutions and the Province and tuition refund policies.

As a result of the inaction on the part of Government and in accordance with the Framework, all educational institutions in the Province may be at risk for de-designation for Federal student loan purposes i.e. students will not be eligible for the 60% Federal portion of a total student loan. Educational institutions at particular risk would be the 11 of 43 institutions whose student loan repayment performance in July 2007 was rated as "poor" (student loan repayment rate less than 48.7%).

Of particular note is that Department officials indicated none of the educational institutions have been advised of their student loan repayment performance, whether improvements are required and whether there is risk of de-designation. In addition, the Province still has not taken action to monitor and work with educational institutions to address student loan repayment performance.

Detailed Observations

Overview

In 2002, the Province introduced the *Student Financial Assistance Regulations* (the *Regulations*) under the *Student Financial Assistance Act*. The *Regulations* state that in order to qualify for and maintain a designation as an educational institution, the institution must, among other things:

- provide information and counselling to students with respect to their eligibility for financial assistance;
- have a refund policy acceptable to the Minister for students who withdraw before completing their program;
- where applicable, comply with the requirements of the *Private Training Institutions Act* i.e. have been in continuous operation for one year and graduated a class of students, have a security bond in an appropriate amount, submit audited annual financial statements to the Minister, hire instructors approved by the Minister, etc.
- have a grade 12 or equivalent entrance requirement or a mature student policy in place that is acceptable to the Department; and
- have a default prevention plan that is acceptable to the Department.

Designation Policy Framework

The Designation Policy Framework introduced in 2004 is a guide for all jurisdictions in Canada in the development of their educational institution designation policies and procedures. The Framework supports government in working with educational institutions to improve the performance and accountability of the student loan portfolio.

In accordance with the Designation Policy Framework, the Province is responsible for:

- adhering to provisions of the Framework;
- implementing a process for the initial designation and ongoing monitoring of educational institutions (implementing designation policy and procedures); and
- establishing formal agreements with educational institutions to govern their designation.

The Framework outlines the criteria that should be established to determine whether an educational institution should be, and continue to be, designated. These criteria are supported by performance standards such as student loan portfolio repayment and default rates, institution administrative compliance and student program completion and employment rates.

Educational institutions that do not meet performance standards of the Framework must take action to improve their performance or face sanctions, including possible de-designation. However, jurisdictions may determine that the role an educational institution plays in fulfilling regional, socio-economic or cultural provincial policy priorities should be taken into account in assessing institutions that do not meet performance standards. Under the Framework, the Province is required to advise, monitor and assist institutions in taking the appropriate action to ensure compliance.

Findings

The detailed findings that support our conclusions are contained in the following section:

Department does not monitor compliance with *Regulations*

Our review indicated that the Department could not demonstrate whether all procedures under the *Student Financial Assistance Regulations* to monitor institutions for compliance with the *Regulations* were fully established and carried out.

The Department does monitor private training institutions for compliance with the requirements of the *Private Training Institutions Act*. However, they do not monitor whether institutions had acceptable default prevention plans in place. Although Department officials indicated that it does monitor institutions to determine whether: requirements to provide information and counselling to students are met; there is a refund policy acceptable to the Minister; and there is a grade 12 or equivalent entrance requirement, officials could not demonstrate that this monitoring was taking place.

Furthermore, the Department indicated that the *Regulations* do not reflect the educational institution designation requirements under the Designation Policy Framework of 2004. For example, all institutions must:

- provide independent assurance of institutional integrity;
- provide a financial guarantee; and
- meet portfolio, institutional and student performance standards.

Designation Policy Framework not implemented

We found that the Framework of 2004 has not been formally approved by the Minister of Education for implementation in Newfoundland and Labrador. The Department indicated that once the Framework is approved by the Minister, designation policies and procedures will be formally established subject to approval of the Lieutenant-Governor in Council. As a result, the Province is not meeting its responsibilities under the Framework.

No formal agreements in place with educational institutions

In September 2005, the Federal Government informed the Department that should an educational institution not be compliant with the mandatory provisions of the Framework, it would deem the institution to not be designated for the purpose of Federal Student Loans. Furthermore, the Federal Government stated that, *"for greater certainty, these provisions with which educational institutions must comply include requiring them to enter into a formal agreement with the appropriate authority as a condition for their designation"*.

At the time of our review, the Department had not entered into agreements with any educational institutions as required under the Framework. Department officials indicated that a draft agreement did exist; however, it had not been approved by the Minister. As a result, educational institutions are not aware of their role and responsibilities under the Framework and could be at risk of de-designation for the purposes of Federal student loans.

Significant number of educational institutions have "poor" student loan repayment performance

The Framework provides a mechanism to assess financial risk posed by individual educational institutions to a student loan program. Student loan repayment data is used to measure student loan portfolio performance relating to individual schools.

Student loan repayment targets were set in 2004 based on national student loan repayment targets, as follows:

Figure 2

National Student Loan Repayment Targets

Student Loan Repayment Rate Target	Student Loan Portfolio Performance	Institution Risk Zone	Improvement Required
> 70.2%	Good	Green	None
48.7% - 70.2%	Average	Yellow	Increase by 3%
< 48.7%	Poor	Red	Move to Yellow

Source: Designation Policy Framework

As Figure 2 shows, students who meet the required monthly payments on their student loan are considered to be in "good" standing. Educational institutions with less than 70.2% of its students' loans in good standing must take action within a required period of time to meet the required targets or face sanctions, including possible de-designation, unless it is determined by the Province that significant improvement in student loan repayment performance has occurred. Also, the Province may consider the role that an educational institution plays in fulfilling regional, socio-economic, or cultural provincial policy priorities when assessing performance.

Figure 3 indicates the initial assessment for student loan repayment performance for designated educational institutions in the Province as at 31 July 2004 and updated at 31 July 2006 and 31 July 2007.

Figure 3

Student Loan Repayment Performance
Number of campuses by Institution type
As at 31 July 2004, 2006 and 2007*

	Initial Assessment 2004				Assessment 2006				Assessment 2007			
Student Loan Repayment Performance	**MUN**	**CNA**	**Private College**	**Total**	**MUN**	**CNA**	**Private College**	**Total**	**MUN**	**CNA**	**Private College**	**Total**
Good	2	8	0	**10**	3	11	1	**15**	3	11	7	**21**
Average	1	7	2	**10**	0	5	9	**14**	0	3	8	**11**
Poor	0	1	23	**24**	0	0	15	**15**	0	2	9	**11**
Total	**3**	**16**	**25**	**44**	**3**	**16**	**25**	**44**	**3**	**16**	**24**	**43**

Source: Student Financial Services Division
*There was no assessment required under the Framework in 2005

As Figure 3 shows, in 2004, 24 of 44 (55%) educational institutions had "poor" student loan repayment performance and were therefore in the Framework's "red" risk zone. Although in 2007 the number decreased to 11 of 43 (26%), this still represents a significant number of institutions at risk of de-designation. In both years, the poor performance ratings were mainly attributed to loans through private colleges (2004 - 23 of 24; 2007 - 9 of 11). As of 31 July 2007, 9 of 24 or 38% of the provincial private colleges and 2 of 16 or 13% of the College of the North Atlantic campuses designated for student loans were rated as "poor" in student loan repayment performance.

Province has not taken action to address student loan repayment performance

The Framework requires that institutions in the "red" risk zone improve their student loan repayment rates to "average" and reduce their risk to "yellow" by July 2008 or face possible de-designation for purposes of student loans. The Framework also requires that the Province advise, assist and monitor institutions in taking the appropriate action to improve student loan repayment performance.

However, we found that none of the 24 educational institutions that were in the "red" risk zone on 31 July 2004, had been advised by the Province that they had "poor" student loan repayment performance and what actions would be required of them to prevent de-designation from occurring in 2008-09. Furthermore, as of November 2007 the Province still had not taken any action to monitor and work with educational institutions to address student loan repayment performance.

The Department of Education should:

- Develop policies and procedures to ensure that educational institutions comply with the designation requirements for the purposes of student loans under the *Student Financial Assistance Act* and *Regulations.*

- Consider adopting the National Designation Policy Framework. In connection with this the Department should:

  - develop socio-economic indicators to be used in assessing the performance of educational institutions in the Province, as provided for under the Framework; and

  - develop policies and procedures and enter into formal agreements with educational institutions as outlined under the Framework.

- Advise all educational institutions in the Province of their student loan repayment performance. In particular, for educational institutions where improvement is required the Department should advise, assist, and monitor these institutions in taking the appropriate action to improve student loan repayment performance.

Department's Response

The Department acknowledges the national designation framework is one of a suite of initiatives to monitor how students and graduates are performing following their participation in post-secondary institutions. Other processes exist to track student outcome and the performance of institutions including student and graduate surveys, program accreditation and monitoring of private training. The national framework document is a guide intended to support provincial processes. The Department notes the Auditor General's report finds repayment rates at Provincial post-secondary institutions have improved without implementation of the national designation framework. The Department has not received official notification from the Federal minister's office responsible for student loans of the Federal government's intent to withdraw providing Federal student loans to students in this Province.

In consultation with Federal and Provincial governments, the Department will continue to work to identify appropriate social and economic indicators in support of the national designation framework. Upon development of these indicators and in consultation with stakeholders, options will be presented to Cabinet in relation to the processes for monitoring of educational institutions.

Highlights

Highlights of a review of the *Financial Administration Act*.

Why our Office did this Review

We performed a review of the *Financial Administration Act* to assess whether it still provided clear legislative direction in view of the many changes in the public sector environment (e.g. investment in private sector companies for economic development and innovation purposes, and changes in accounting principles) since it was proclaimed in 1973.

What our Office Recommends

We recommend that consideration be given to amending the *Financial Administration Act* to:

- provide explicit authority for investments in private sector companies for innovation and/or economic development purposes; and
- clearly identify that the financial statements of the Province should be its Consolidated Summary Financial Statements prepared in accordance with Generally Accepted Accounting Principles (GAAP).

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.5
DEPARTMENT OF FINANCE
Financial Administration Act

The *Financial Administration Act (*the *Act)* was proclaimed in 1973 and is the primary statute which provides legislative direction and control over the financial administration of the Province. In particular the *Act* provides direction relating to the following:

- the role, responsibility and authority of Treasury Board;
- legislative controls over public money;
- legislative controls over public disbursements;
- legislative controls over public debt; and
- the Public Accounts of the Province (i.e. financial statements).

When the *Financial Administration Act* was proclaimed in 1973, it included many of the same provisions contained in the *Consolidated Revenue and Audit Act* of 1899, which formed the genesis for the *Financial Administration Act*. As a result, although there have been a number of amendments to the *Act*, parts of the legislation still reflect an era when:

- there were few Crown agencies;
- Government, for the most part, administered its programs directly through its departments;
- Government did not provide grants or support directly to private sector entities; and
- there were no generally accepted accounting principles for governments.

In addition to the *Financial Administration Act* there are two other acts which provide legislative direction respecting the financial operations of Government, its departments and Crown agencies. These are:

- the annual *Supply Act* which provides legislative authority for the spending of Public Money as outlined in the annual Estimates presented by Government or as a result of additional special requests approved by the Legislature; and
- the *Transparency and Accountability Act* which provides direction to Government relating to the development and tabling of annual plans and annual reports on its operations.

These three acts are designed to create a system of accountability and control by providing legislative direction to Government respecting the appropriate use of public money and the expectation that Government will report back to the House of Assembly on how public money was spent and what was achieved relative to approved plans. Because of the many changes which have taken place in the way Government operates and in the accounting and reporting standards which it has adopted, it is now time to consider updating the legislative direction provided by the *Financial Administration Act* to reflect current practices.

What We Found

Our review of the *Financial Administration Act* disclosed that it does not provide Government with clear legislative authority for certain transactions and does not provide clear guidance with regards to accounting principles and financial statements.

- Legislation has to be permissive; however, the *Financial Administration Act* does not provide any specific authority to permit investments in private sector companies for innovation and/or economic development purposes. For example, this Annual Report includes information on three equity investments made by the Department of Innovation, Trade and Rural Development totalling $1.05 million where, in our opinion, such investments were made without clear legislative authority.
- The *Act* does not clearly identify that the financial statements of the Province should be its Consolidated Summary Financial Statements prepared in accordance with Generally Accepted Accounting Principles (GAAP). However, notwithstanding the lack of clarity in the *Act*, Government is in full compliance with GAAP and prepares Consolidated Summary Financial Statements: a fact my Office has commended Government for in recent years.

Background

Introduction

The *Financial Administration Act (Act)* was proclaimed in 1973 and is the primary statute which provides legislative direction and control over the financial administration of the Province. In particular the *Act* provides direction relating to the following**:**

- the role, responsibility and authority of Treasury Board;
- legislative controls over public money;
- legislative controls over public disbursements;
- legislative controls over public debt; and
- the Public Accounts of the Province (i.e. financial statements).

When the *Financial Administration Act* was proclaimed in 1973, it included many of the same provisions contained in the *Consolidated Revenue and Audit Act* of 1899, which formed the genesis for the *Financial Administration Act*. As a result, although there have been a number of amendments to the *Act*, parts of the legislation still reflect an era when:

- there were few Crown agencies;
- Government, for the most part, administered its programs directly through its departments;
- Government did not provide grants or support directly to private sector entities; and
- there were no generally accepted accounting principles for governments.

In addition to the *Financial Administration Act* there are two other acts which provide legislative direction respecting the financial operations of Government, its departments and Crown agencies. These are:

- the annual *Supply Act* which provides legislative authority for the spending of Public Money as outlined in the annual Estimates presented by Government or as a result of additional special requests approved by the Legislature; and

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These three acts are designed to create a system of accountability and control by providing legislative direction to Government respecting the appropriate use of public money and the expectation that Government will report back to the House of Assembly on how public money was spent and what was achieved relative to approved plans.

Because of the many changes which have taken place in the way Government operates and in the accounting and reporting standards which it has adopted, it is now time to consider updating the legislative direction provided by the *Financial Administration Act* to reflect current practices.

Scope

Review of the *Act*

We performed a review of the *Act* to assess whether it still provided clear legislative direction in view of the many changes in the public sector environment (e.g. investment in private sector companies for economic development and innovation purposes, and changes in accounting principles) since it was proclaimed.

Overall Conclusion

Our review of the *Financial Administration Act* disclosed that it does not provide Government with clear legislative authority for certain transactions and does not provide clear guidance with regards to accounting principles and financial statements.

- Legislation has to be permissive; however, the *Financial Administration Act* does not provide any specific authority to permit investments in private sector companies for innovation and/or economic development purposes.

  For example, this Annual Report includes information on three equity investments made by the Department of Innovation, Trade and Rural Development totalling $1.05 million where, in our opinion, such investments were made without clear legislative authority.

- The *Act* does not clearly identify that the financial statements of the Province should be its Consolidated Summary Financial Statements prepared in accordance with Generally Accepted Accounting Principles (GAAP). However, notwithstanding the lack of clarity in the *Act*, Government is in full compliance with GAAP and prepares Consolidated Summary Financial Statements: a fact my Office has commended Government for in recent years.

Detailed Observations

Findings

Findings from our review are outlined in the following sections:

1. Innovation and Investment Activities
2. Financial Statements of the Province

1. Innovation and Investment Activities

It is generally acknowledged that legislation has to be permissive, i.e. a public servant can only do what legislation directs them to do.

In recent years, Government has been providing investments in private sector companies for innovation and/or economic development purposes. For example, this Annual Report includes information on three equity investments totalling $1.05 million made by the Department of Innovation, Trade and Rural Development during 2005-06 as follows:

Company	Investment
Knowledge-based IT Company A	$ 500,000
Knowledge-based IT Company B	500,000
High-technology R&D Company	50,000
Total	**$ 1,050,000**

Source: Government's financial management system

Although the *Financial Administration Act* provides direction relating to budgets and payments for "*goods and services*", there is no provision for the concept of the use of public money for investment in private sector companies for innovation and/or economic development purposes. In fact, the *Act* only permits the Minister of Finance to invest in stocks or bonds issued by or guaranteed by Canada, the provinces or a chartered bank. As a result, the *Act* does not provide any specific authority to permit investments in private sector companies.

The *Supply Act* is another Act which provides legislative authority for the spending of public money. However, the *Supply Act* only approves Government's estimates in "*defraying certain expenses of the Public Service*", and does not explicitly refer to investments in private sector companies. Furthermore, it is unlikely that an investment could be considered an expense as contemplated in the *Supply Act*. Therefore, there is no specific authority in the *Supply Act* to support investments in private sector companies.

We note that the *Supply Acts* and *Financial Administration Acts* of Ontario and British Columbia both specifically allow investments in private sector companies for innovation and/or economic development purposes.

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2. Financial Statements of the Province

Generally Accepted Accounting Principles (GAAP) for Governments have been developed and adopted since the creation of the Public Sector Accounting Board (PSAB) by the Canadian Institute of Chartered Accountants in 1981. GAAP recognizes that a Government's consolidated summary financial statements provide the most comprehensive accounting of its financial position and results of operations.

When the *Financial Administration Act* was enacted in 1973, there was no GAAP for Government and the financial statements were based on the Consolidated Revenue Fund on a cash basis of accounting. Therefore, to reflect the thinking of the day, section 58 of the *Act* provides that the Comptroller General shall maintain the accounts of the Consolidated Revenue Fund (referred to in the section as the "Accounts of the Province"), while section 59 requires the preparation of the Public Accounts (financial statements) to include the state of the public debt, the revenues and expenditures and other statements that may be required to show the financial position of the Province. There is no concept of GAAP in the *Act,* i.e. Consolidated Summary Financial Statements prepared on an accrual basis of accounting in accordance with generally accepted accounting principles for governments in Canada.

Even though there is a lack of clarity in the *Act*, Government is in full compliance with GAAP and prepares Consolidated Summary Financial Statements: a fact my Office has commended Government for in recent years. Government's financial statements now include all Crown agencies along with the Consolidated Revenue Fund, all on an accrual basis of accounting. The issue, therefore, is that the *Act* has not kept pace with the development and acceptance of generally accepted accounting principles for governments in Canada and does not reflect the current reality of Government's financial reporting.

We found that the legislation in other provincial jurisdictions requires preparation of the financial statements of the province which comply with generally accepted accounting principles.

Recommendation

We recommend that consideration be given to amending the *Financial Administration Act* to:

- provide explicit authority for investments in private sector companies for innovation and/or economic development purposes; and

- clearly identify that the financial statements of the Province should be its Consolidated Summary Financial Statements prepared in accordance with Generally Accepted Accounting Principles (GAAP).

Department's Response

Innovation and Investment Activities

Generally, while I see merit in reviewing the whole FAA, given the timeframe since its last major revision, I have great concerns that your report may be interpreted that Government is not complying with legislation. I cannot agree with such an interpretation.

You have stated that "Legislation has to be permissive; however, the Financial Administration Act does not provide any specific authority to permit investments in private sector companies for innovation and/or economic development purposes." *You have also indicated that the FAA provides direction relating to* "goods and services" *but no provision for investment in private sector companies. Also, that the* Supply Act *provides no specific authority for such investments.*

Our legislation is not prescriptive; it is based on sound principles and must be viewed as a whole. Section 22 of the FAA allows for the issue of Public Money under the authority of the Legislature. In addition, Section 23 describes the appropriation process. The subheads and subdivisions referenced in that section clearly show in each fiscal year the purpose for which Public Money is appropriated and the Estimates are tabled in the Legislature and support the Supply Bill.

There has been a long history of the Province making investments in private sector companies. The 2006-08 Strategic Plan of the Department of Innovation, Trade and Rural Development, which is a public document, prepared pursuant to the Transparency and Accountability Act, *specifically identifies Provincial dollars invested in client enterprises and innovation activities as indicators of performance. The main object of expenditure "Loans, Advances and Investments" has existed for decades. Some examples from the 1980's include The Lake Group, Baie Verte Mines, North Atlantic Fisheries Limited, etc. No previous Auditor General has identified concerns in this area.*

We believe there is sufficient general authority in the FAA to authorize Government to make investments, when considered as a whole, including the budgetary process. When we consider all the checks, balances and the rigid procedures in place to control Government spending, typically starting in August of each year to complete the Estimates of expenditures for each department leading to the Budget Speech and tabling the Estimates in the Legislature and the passage of supply, it is difficult to say no authority can be found in the FAA to permit investments to private enterprise or any other type of expenditure as noted in the Estimates. It is not necessary or indeed possible to name each individual term, reason or event upon which the legislature will grant supply. We have consulted with the Department of Justice on this matter and this is a position which they currently and consistently in the past have supported.

In addition, the Department of Justice advised us of a judicial decision regarding interpretation of legislation found in paragraph 21 of the **Archean**[1] *decision, as follows:*

[1] *Archean* Resources Ltd. V. *Her Majesty*, 215 NPEI 124 at para. 21

"Legislation, by virtue of its nature, the manner in which it comes into being, and by virtue of the fact that it generally operates prospectively, must of necessity be expressed in generalized language. Not every fact scenario that could be potentially engaged by the subject of the legislation can be anticipated. Even the most detailed legislative provision cannot purport to address specifically all situations that might potentially be affected or caught by its reach."

You have commented that the Supply Acts and Financial Administration Acts of Ontario and British Columbia both specifically allow investments in private sector companies. However, this is not consistent with many other jurisdictions in Canada, where the provision of supply is in more general terms and specific types of appropriation items are not identified. Because other provinces may have different legislation, this in no way implies we are acting without legislative authority.

You have indicated that the FAA only permits investment in stocks or bonds issued by or guaranteed by Canada, the provinces or a charter bank, which appears to be a reference to Section 15 of the FAA. In my view Section 15 has nothing to do with the cash estimates of expenditures for departments, but relates to cash management issues of what financial instruments the Consolidated Revenue Fund is held in. No appropriations are required for such transactions.

I also note that the various schedules of the Executive Council Act *outline the legislated mandate of the various departments of Government.*

Financial Statements of the Province

You have stated that, "The Act does not clearly identify that the financial statements of the Province should be its Consolidated Summary Financial Statements prepared in accordance with Generally Accepted Accounting Principles (GAAP)." *However, you have also noted that Government has been in full compliance with GAAP.*

Paragraph 59(2) of the FAA provides, "The Public Accounts shall show…those other accounts and statements that may under good accounting practice be required to show the financial positions of the province…". *In that respect we have complied with the legislation and do prepare financial statements in accordance with GAAP as you have indicated.*

In addition, subsection 19(5) of the Transparency and Accountability Act *states* "The comptroller general shall include…in accordance with generally accepted accounting principles, the audited financial statements of a public body with the Public Accounts required to be prepared by section 59 of the Financial Administration Act".

Therefore, in my view, summary consolidated financial statements, in accordance with GAAP, is already contemplated in current legislation.

Summary

The FAA in its current form contains many principles that are still valid in today's environment and it still serves us well in providing direction and control over Public Money. While there is some merit in considering amendments to reflect language changes, terminology or possibly consolidate various legislative requirements, this is not seen as a high priority at this time.

Highlights

Highlights of a monitoring review of the expenditures of the Consolidated Revenue Fund the fiscal years 2006 and 2007.

Why our Office did this Review

As part of our audit of the financial statements of the Consolidated Revenue Fund (CRF), we perform tests and reviews of the expenditures made by the various departments for years ended 31 March.

Monitoring Categories Explained

- **Grants and Subsidies:** Government has established programs which provide these funds to various Crown agencies, private corporations and individuals. Payments are made to health boards, school boards, the College of the North Atlantic and Memorial University, and certain Crown agencies for operational funding. Other grants and subsidies are paid to private corporations and individuals in accordance with Government programs.
- **Property, Furnishings and Equipment:** This category generally includes capital items such as equipment purchased for use by Government departments as well as funding provided by the Department of Health and Community Services to the various hospital and health and community services boards for the purchase of equipment.
- **Purchased Services:** This category includes such services as heat and light, general maintenance, printing, vehicle rentals and repairs, advertising, and insurance.
- **Professional Services:** Professional services generally includes the fees and expenses of those engaged in a specialty profession such as accountants, doctors, lawyers, and engineers who provide a service, a report or advice to Government.
- **Allowances and Assistance:** These expenditures include costs relating to such items as: allowances for Members of the House of Assembly, social assistance allowances paid to individuals, out of court settlements, and allowances paid on behalf of individuals to organizations.
- **Transportation and Communications:** Expenditures include costs relating to such items as: postage, freight, ambulance and air services, telecommunication services and travel for ministers, government employees and others.

Chapter 2, Part 2.6

MONITORING EXPENDITURES OF THE CONSOLIDATED REVENUE FUND

During the past year, we obtained expenditure information from Government's financial management information system relating to all expenditures of the Consolidated Revenue Fund, which for the year ended 31 March 2007 totalled $5.0 billion. We performed a general review and analysis of amounts paid relating to: grants and subsidies; property, furnishings and equipment; purchased services; professional services; allowances and assistance; and transportation and communications. Details of the expenditures in each of these categories are provided as follows:

What We Found

Grants and Subsidies

For the year ended 31 March 2007, grants and subsidies amounted to approximately $2.61 billion or approximately 52.7% of the total expenditures of the Consolidated Revenue Fund. Grants and subsidies are shown in the report by category, department and by type of entity. Also shown in the report are the names of all entities which received grants and subsidies funding in excess of $10 million for the fiscal year ended 2007 with comparative figures for 2006.

Property, Furnishings and Equipment

For the year ended 31 March 2007, payments for property furnishings and equipment totalled $17 million. Shown in the report are the names of all entities which received payments in excess of $1 million for the fiscal year ended 2007 with comparative figures for 2006.

Purchased Services

Payments for purchased services totalled $216 million for the year ended 31 March 2007. Also shown in the report are the entities which received payments in excess of $1 million for the fiscal year ended 2007 with comparative figures for 2006.

Professional Services

The report shows, by department, payments for professional services for the year ended 31 March 2007 which totalled $304 million. These figures are shown in the report by department. Also summarized are payments of professional services to show all entities or individuals who received payments in excess of $600,000 for the fiscal year ended 2007 with comparative figures for 2006.

Allowances and Assistance

Payments for allowances and assistance totalled $361 million for the year ended 31 March 2007. Also summarized in the report are payments of allowances and assistance to show all entities which received payments in excess of $500,000 for the fiscal year ended 2007 with comparative figures for 2006.

Transportation and Communications

Payments for transportation and communications totalled $40 million for the year ended 31 March 2007. Also summarized in the report are the payments for transportation and communications to show all entities which received payments in excess of $100,000 for the fiscal year 2007 with comparative figures for 2006.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca.

Introduction

As part of our audit of the financial statements of the Consolidated Revenue Fund (CRF), we perform tests and reviews of the expenditures made by the various departments. Figure 1 outlines expenditures, by category, recorded in the Consolidated Revenue Fund financial statements for the years ended 31 March.

Figure 1

Consolidated Revenue Fund Expenditures
By Category
Years Ended 31 March
($ Millions)

Consolidated Revenue Fund Expenditures							
Category	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Salaries and Employee Benefits	337	361	378	371	356	385	371
Retirement Costs	(13)	3	96	104	120	102	146
Transportation and Communications (See Figures 13, 14)	36	37	38	38	31	35	40
Supplies	57	54	58	57	56	70	84
Professional Services (See Figures 9, 10)	194	198	204	248	258	285	304
Purchased Services (See Figures 7, 8)	240	250	218	135	135	197	216
Property, Furnishings and Equipment (See Figures 5, 6)	44	49	15	32	9	48	17
Allowances and Assistance (See Figures 11, 12)	334	343	352	370	346	354	361
Grants and Subsidies (See Figures 2, 3, 4)	1,829	1,985	2,128	2,230	2,479	2,429	2,614
Debt Expenses	878	874	905	1,012	881	877	711
Information Technology	26	26	26	21	19	-	-
Amortization (tangible capital assets)	-	-	-	89	83	88	87
Bad Debts	28	11	8	26	2	4	12
Total	**3,990**	**4,191**	**4,426**	**4,733**	**4,775**	**4,874**	**4,963**

Source: Consolidated Revenue Fund financial statements

During the past year, we obtained expenditure information from Government's financial management information system relating to all expenditures of the Consolidated Revenue Fund. We performed a general review and analysis of amounts paid relating to: grants and subsidies; property, furnishings and equipment; purchased services; professional services; allowances and assistance; and transportation and communications. Details of the expenditures in each of these categories are provided as follows:

Grants and Subsidies

Government has established programs which provide grants or subsidies to various Crown agencies, private corporations and individuals. These payments are made to health boards, to school boards, to the College of the North Atlantic and Memorial University of Newfoundland, and to certain Crown agencies for operational funding. Other grants and subsidies are paid to private corporations and individuals in accordance with Government support programs.

During the year we continued our process of monitoring and reviewing payments made for grants and subsidies. Figure 2 shows, by department, payments made for grants and subsidies for the year ended 31 March 2007 totalling $2.61 billion with comparative figures for the year ended 31 March 2006.

As the Figure indicates for the year ended 31 March 2007, grants and subsidies amounted to approximately $2.61 billion or approximately 52.7% of the total expenditures of the Consolidated Revenue Fund. For the year ended 31 March 2006, payments for grants and subsidies were approximately $2.43 billion and represented approximately 49.8% of the total expenditures of the Consolidated Revenue Fund.

Figure 2

Grants and Subsidies Expenditures
By Department
Years Ended 31 March
($000's)

Grants and Subsidies Expenditure by Department		
Department	**2006**	**2007**
Health and Community Services	1,382,142	1,499,049
Education	826,867	877,510
Municipal Affairs	133,267	130,672
Tourism, Culture and Recreation	12,739	17,864
Human Resources, Labour and Employment	16,907	16,641
Natural Resources	13,556	14,519
Newfoundland and Labrador Housing Corporation	9,650	14,320
Innovation, Trade and Rural Development	10,687	13,327
Finance	3,090	10,352
Justice	7,991	8,830
Transportation and Works	3,531	5,797
Executive Council	1,878	2,388
Fisheries and Aquaculture	849	1,386
Labrador and Aboriginal Affairs	4,970	637
Environment and Conservation	469	411
Legislature	77	89
Government Services	62	62
Total	**2,428,732**	**2,613,854**

Source: Government's Financial Information System

We also summarized the payments of grants and subsidies by the type of entity for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006. The results of this summary are outlined in Figure 3.

Figure 3

Grants and Subsidies Expenditures
By Type of Entity
Years Ended 31 March
($000's)

Types of Entities Receiving Grants and Subsidies		
Type of Entity	**2006**	**2007**
Health and Community Services Boards and Related Entities	1,293,481	1,397,004
School Boards - Teachers Payroll	386,699	382,683
Memorial University of Newfoundland	211,318	238,809
School Boards and Related Entities - Other Payments	141,876	150,527
Municipalities	133,267	130,663
College of the North Atlantic	65,858	77,161
Hospitals and Health Services Boards	65,765	73,457
Educational Agencies and Post Secondary Education Support	43,541	59,969
Economic Renewal, Labour Market and Industry Support	24,763	23,379
Newfoundland and Labrador Housing Corporation	9,650	14,320
Culture and Heritage	8,846	11,815
Newfoundland and Labrador Hydro	9	10,010
Provincial Information and Library Resources Board	8,336	8,749
Newfoundland and Labrador Legal Aid Commission	7,647	8,480
Agriculture Development	7,696	7,344
Transportation grants	3,253	5,501
Canada-Newfoundland Offshore Petroleum Board	3,882	4,250
Recreation and Sport	2,359	4,228
Other Miscellaneous Grants	2,703	3,206
Labrador Agreement and Native Peoples Support	7,468	1,699
Newfoundland and Labrador Film Development Corporation	315	600
Total	**2,428,732**	**2,613,854**

Source: Government's Financial Information System

Figure 4 provides the names of all entities which received grants and subsidies funding in excess of $10 million for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006.

Figure 4

Grants and Subsidies Expenditures
Payments in Excess of $10 million
Years Ended 31 March
($000's)

Entities Which Received in Excess of $10 Million		
Entity	**2006**	**2007**
Eastern Regional Integrated Health Board	756,392	849,642
Teachers Payroll	216,306	382,683
Memorial University of Newfoundland	211,318	238,809
Central Regional Integrated Health Board	196,036	215,595
Western Regional Integrated Health Board	189,496	209,319
Labrador-Grenfell Regional Integrated Health Board	86,390	104,714
College of the North Atlantic	65,858	77,161
Eastern School District	61,207	66,148
Newfoundland and Labrador Municipal Financing Corporation - Payments to Municipalities	48,668	43,924
Royal Bank - Social Assistance	50,379	32,658
Nova Central School District	26,990	29,563
Western School District	26,368	27,505
Student Loan Corporation	27,314	27,007
Canadian Blood Services	21,033	20,878
City of St. John's	7,726	14,467
Newfoundland and Labrador Housing Corporation	9,650	14,320
Newfoundland and Labrador Hydro	9	10,010
District #1 School Board	11,000	-
Health Care Corporation of St. John's	11,402	-
Grants $10 million and less paid to over 4,500 entities in 2007 (2006 - over 4,800 entities)	405,190	249,451
Total	**2,428,732**	**2,613,854**

Source: Government's Financial Information System

Property, Furnishings and Equipment

The Property, Furnishings, and Equipment category generally includes capital items such as equipment purchased for use by Government departments. This category also includes funding provided by the Department of Health and Community Services to the various hospital and health and community services boards for the purchase of equipment. During the year ended 31 March 2007, the Province paid $15.8 million (2006 - $35.3 million) to the hospital and health and community services boards for equipment which is included in the property, furnishings and equipment category. As indicated in Figure 1, payments for property, furnishings and equipment totalled $17.5 million for the year ended 31 March 2007. Figure 5 shows, by department, payments made for property, furnishings and equipment for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006.

Figure 5

Property, Furnishings and Equipment Expenditures
By Department
Years Ended 31 March
($000's)

Property, Furnishings and Equipment Expenditures by Department		
Department	**2006**	**2007**
Transportation and Works	10,954	17,377
Health and Community Services	35,306	15,808
Executive Council	5,151	5,199
Justice	1,350	2,402
Natural Resources	4,469	2,296
Education	6,532	2,144
Environment and Conservation	574	534
Government Services	872	506
Human Resources, Labour and Employment	591	332
Legislature	95	288
Tourism, Culture and Recreation	828	249
Fisheries and Aquaculture	251	229
Municipal Affairs	91	221
Innovation, Trade and Rural Development	80	98
Finance	109	66
Public Service Commission	3	31
Business	50	28
Labrador and Aboriginal Affairs	3	8
Accrual adjustment for acquisition of tangible capital assets	(19,194)	(30,343)
Total	**48,115**	**17,473**

Source: Government's Financial Information System

We also summarized the payments for property, furnishings and equipment to show all entities which received payments in excess of $1 million for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006. These entities are listed in Figure 6.

Figure 6

Property, Furnishings and Equipment Expenditures
Payments in Excess of $1 million
Years Ended 31 March
($000's)

Entities Which Received in Excess of $1 Million		
Entity	**2006**	**2007**
Eastern Regional Integrated Health Board	19,355	8,159
Western Star Trucks Nfl d. Ltd.	5,287	5,463
Bell Aliant - IT Equipment	-	3,803
Toromont Cat	-	3,058
Western Regional Integrated Health Board	11,353	2,311
Avalon Ford Sales Ltd.	1,315	2,172
Central Regional Integrated Health Board	2,767	1,503
College of the North Atlantic	1,500	1,500
xwave Solutions	1,101	1,420
Cox Hanson O'Reilly Matheson - In Trust	4,100	1,117
Clinidata - Healthline Program Services	-	1,002
J W Allen Co. Ltd	1,084	708
Newfoundland and Labrador Hydro	1,796	497
Harvey & Co. Ltd.	1,145	446
Hickman Motors Ltd.	1,004	254
Roebothan, McKay and Marshall	1,100	-
Payments $1 million and less to over 500 entities in 2007 (2006 - over 500 entities)	14,402	14,403
Adjustment for acquisition of tangible capital assets	(19,194)	(30,343)
Total	**48,115**	**17,473**

Source: Government's Financial Information System

Purchased Services

Purchased services includes such services as heat and light, general maintenance, printing, vehicle rentals and repairs, advertising, and insurance. As indicated in Figure 1, payments for purchased services totalled $216 million for the year ended 31 March 2007 ($197 million 31 March 2006). Figure 7 shows, by department, payments made for purchased services for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006.

Figure 7

Purchased Services Expenditures
By Department
Years Ended 31 March
($000's)

Purchased Services Expenditures by Department		
Department	**2006**	**2007**
Transportation and Works	154,646	183,236
Education	24,189	31,443
Health and Community Services	3,596	14,235
Natural Resources	12,324	14,095
Tourism, Culture and Recreation	11,650	11,563
Justice	7,372	7,542
Executive Council	5,099	5,314
Environment and Conservation	4,136	3,914
Government Services	3,059	3,459
Human Resources, Labour and Employment	2,699	3,292
Municipal Affairs	3,279	2,161
Legislature	1,401	1,701
Innovation, Trade and Rural Development	1,553	1,643
Finance	1,243	1,155
Fisheries and Aquaculture	980	988
Public Service Commission	162	183
Labrador and Aboriginal Affairs	140	149
Business	116	104
Consolidated Fund Services	1	48
Accrual adjustment for acquisition of tangible capital assets	(40,844)	(70,353)
Total	**196,801**	**215,872**

Source: Government's Financial Information System

We also summarized the payments for purchased services to show all entities which received payments in excess of $1 million for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006. These entities are listed in Figure 8.

Figure 8

Purchased Services Expenditures
Payments in Excess of $1 million
Years Ended 31 March
($000's)

Entities Which Received in Excess of $1 Million		
Entity	**2006**	**2007**
Johnson Construction Ltd.	14,045	15,264
Labrador Marine Inc.	10,856	13,688
Humber Valley Paving Limited	4,717	9,056
Island Aggregates & Ready Mix	4,201	8,315
Target Marketing	5,851	7,386
Nortech Construction Company	4,670	7,375
Newfoundland Power	6,716	7,243
Penney Paving	4,279	6,686
Concord Paving Limited	3,318	6,504
Weirs Construction Ltd	367	6,477
J-1 Contracting Limited	5,351	6,319
Municipal Construction Ltd.	6,948	5,776
Bluebird Investments	1,916	5,657
St. John's Dockyard Limited	4,947	4,876
Farrells Excavating Ltd.	2,951	4,647
B&M Paving (1983) Ltd.	1,197	4,437
Brook Enterprises Inc.	590	4,431
Eastern Contracting Ltd.	1,948	3,988
RDN Construction	17,124	3,764
Marco Services Ltd.	43	3,417
xwave Solutions	2,484	3,094
College of the North Atlantic	3,996	2,968
Nova Central School District	1,020	2,923
Marsh Canada Ltd.	4,008	2,502
Federal - Provincial Contractors - Holdback Account	1,562	2,417
RSM Mining Services Inc.	1,905	2,397
Mariner Engineering & Construction	34	2,343
Granco Construction Ltd.	383	2,130

Figure 8 (cont'd)

Entities Which Received in Excess of $1 Million		
Budgells Equipment Rental Ltd.	1,023	2,096
Eastern School District	1,210	2,036
Irving Oil	892	2,018
Marine Contractors Ltd.	1,502	1,841
EFCO Enterprises	712	1,716
Western School District	576	1,675
Can-AM Constructions 2004 Ltd.	646	1,652
Corner Brook Pulp & Paper Ltd.	589	1,638
Terra Nova Industries Ltd.	1,648	1,553
Puddister Trading Company Ltd.	1,295	1,517
10122 Newfoundland Ltd.	1,606	1,510
Air-Tite Sheet Metal Ltd.	809	1,484
Kelloways Construction Ltd.	990	1,456
Mike Kelly & Sons Ltd.	644	1,438
Airways Contracting	257	1,427
Atlantic Roofing Co (1996) Ltd.	939	1,251
Puddister Shipping Ltd.	864	1,234
Trident Construction Limited	2,602	1,196
Atlantic Catering Ltd.	1,162	1,173
Island Roofing Company Ltd.	1,028	1,153
Newfoundland and Labrador Hydro	1,107	1,102
Steers Insurance Limited	1,328	1,064
West Coast Excavating and Equipment	73	1,054
Fortis Properties	1,010	1,006
Hydro-Guard Roofing Systems	389	1,006
Ultramar Canada Inc.	2,449	981
Colby Construction Ltd.	1,128	893
Pyramid Construction	2,181	554
Power Vac Services	1,895	444
Clarenville Drydock Inc.	2,480	309
AMEC Earth & Environmental Ltd.	1,081	281
Star Line Inc.	2,522	20
Bristol Communications Ltd.	1,389	1
Cougar Engineering & Construction	1,050	-
Sanexen Environmental Services	1,070	-
Payments $1 million and less to over 5,100 entities (2006 - over 5,000)	37,228	20,013
Total	**196,801**	**215,872**

Source: Government's Financial Information System

Professional Services

Professional services generally include the fees and expenses of those engaged in a specialty profession such as accountants, doctors, lawyers, and engineers who provide a service, a report or advice to Government. As indicated in Figure 1, payments for professional services totalled $304 million for the year ended 31 March 2007 ($285 million 31 March 2006). Figure 9 shows, by department, payments made for professional services for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006.

Figure 9

Professional Services Expenditures
By Department
Years Ended 31 March
($000's)

Professional Services Expenditures by Department		
Department	**2006**	**2007**
Health and Community Services	209,604	216,551
Justice	49,154	53,210
Executive Council	15,357	20,562
Education	3,804	5,118
Natural Resources	2,532	2,994
Transportation and Works	1,937	2,970
Consolidated Fund Services	338	2,643
Environment and Conservation	1,046	1,469
Business	134	1,458
Human Resources, Labour and Employment	1,770	1,302
Tourism, Culture and Recreation	538	1,276
Innovation, Trade and Rural Development	823	1,104
Municipal Affairs	868	1,042
Finance	547	664
Legislature	532	661
Labrador and Aboriginal Affairs	3	411
Fisheries and Aquaculture	281	269
Public Service Commission	193	202
Government Services	158	133
Accrual adjustment for acquisition of tangible capital assets	(4,512)	(10,262)
Total	**285,107**	**303,777**

Source: Government's Financial Information System

We also summarized the payments of professional services to show all entities or individuals who received payments in excess of $600,000 for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006. These entities or individuals are listed in Figure 10.

Figure 10

Professional Services Expenditures
Payments in Excess of $600,000
Years Ended 31 March
($000)'s

Entities or Individuals Which Received in Excess of $600,000		
Entity	**2006**	**2007**
Receiver General for Canada (e.g. RCMP Contract)	46,992	49,663
Medical Practice Associates	15,706	15,779
xwave Solutions	9,972	10,939
HSC Associated Radiologists	4,164	5,679
LeMarchant Medical	3,505	4,513
Bell Aliant	-	3,752
Eastern Regional Integrated Health Board	5,356	3,488
Nephrology Partnership	2,918	2,755
Pediatric Diagnostic Imaging	1,814	2,312
Labrador-Grenfell Regional Integrated Health Board	1,940	1,690
Central Regional Integrated Health Board	741	1,416
Hearn Fougere Architects	600	1,265
Atlantic Engineering Consultants	176	1,242
Target Marketing Inc.	114	1,242
Zedit Solutions Incorporated	402	1,040
Dr. Kevin N. Melvin	972	963
SGE Acres Limited	739	934
MTS Allstream Inc.	116	898
BAE-Newplan Group Ltd.	1,131	860
Dr. Thomas E. Poole Professional	752	808
Dr. Eric W. Stone	750	805
Dr. Michael Furey	714	761
Dr. Craig MacDonald Jewer	332	758
Dr. M & S Kathirgamanathan Professional	738	755
Retina Services Professional	680	724
EWA-Canada Ltd.	178	712
Dr. Eng T. Tjan	713	702
Dr. Palinder Kamra	770	701
Dr. Chandra Sekhar Professional	248	678

Figure 10 (cont'd)

Entities or Individuals Which Received in Excess of $600,000		
Entity	**2006**	**2007**
Dr. Kenneth J. Burrage	689	665
Dr. Thomas G. Hogan	633	655
Dr. John McNicholas Professional	620	630
Dr. Richard B Lush	113	629
Dr. James Sheridan Professional	601	609
Dr. Zohair Tomi	367	607
Dr. Calvin Maccallum Professional	585	604
Dr. Yog anathan Wijayanayagam	590	603
Dr. Jan Van Wijk Professional	303	602
Dr. Richard Harley Professional	600	517
Dr. Surender Singh Manhas	626	498
Dr. Viki Sahajpal	700	423
Dr. Peter D. Hollett	640	370
Dr. Tony Batten	608	261
Carbonear General Hospital	385	-
Payments $600,000 and less to over 2,100 entities or individuals (2006 - over 2,100 entities or individuals)	173,814	178,270
Total	**285,107**	**303,777**

Source: Government's Financial Information System

Allowances and Assistance

Allowances and assistance expenditures include costs relating to such items as: allowances for Members of the House of Assembly, social assistance allowances paid to individuals, out of court settlements, and allowances paid on behalf of individuals to organizations. As indicated in Figure 1, payments for allowances and assistance totalled $361 million for the year ended 31 March 2007 ($354 million 31 March 2006). Figure 11 shows, by department, payments made for allowances and assistance for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006.

Figure 11

Allowances and Assistance Expenditures
By Department
Years Ended 31 March
($000's)

Allowances and Assistance		
Department	**2006**	**2007**
Human Resources, Labour and Employment	218,482	224,136
Health and Community Services	117,682	120,856
Legislature	5,648	5,030
Education	4,604	4,504
Justice	6,970	3,897
Municipal Affairs	215	1,606
Finance	186	441
Transportation and Works	153	373
Government Services	59	124
Executive Council	20	20
Natural Resources	37	11
Accrual adjustment for acquisition of tangible capital assets	-	(57)
Total	**354,056**	**360,941**

Source: Government's Financial Information System

We also summarized the payments of allowances and assistance to show all entities which received payments in excess of $500,000 for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006. These entities are listed in Figure 12.

Figure 12

Allowances and Assistance Expenditures
Payments in Excess of $500,000
Years Ended 31 March
($000's)

Payments in Excess of $500,000		
Entity	**2006**	**2007**
Social Assistance Account	178,092	182,690
Bell Aliant - Drug Program	-	76,108
xwave - Drug Program	106,212	31,274
Eastern Regional Health Board	3,320	2,618
Minister of Finance (Ontario) - M.C.P.	1,983	2,102
Collins and Associates In Trust	-	2,100
Provincial Treasurer of Alberta - M.C.P.	-	1,943
Kennedy Belbin - In Trust	-	1,400
Medical Services Insurance	1,213	1,322
The Salvation Army - Wiseman Centre	597	836
Bay St. George Community Employment Corporation	720	746
Humber Valley Co mmunity Employment Corporation	-	601
College of the North Atlantic	-	516
Vera Perlin Society	1,062	309
Minister of Finance for Alberta - M.C.P.	890	220
Roebothan, McKay, Marshall (In Trust)	2,430	48
Structured Settlements Group Inc.	2,000	-
Country Ribbon Inc.	1,000	-
Miscellaneous amounts $500,000 and less paid to over 3,400 entities or individuals (2006 - over 3,400 entities or individuals)	54,537	56,108
Total	**354,056**	**360,941**

Source: Government's Financial Information System

Transportation and Communications

Transportation and communications expenditures include costs relating to such items as: postage, freight, ambulance and air services, telecommunication services and travel for ministers, government employees and others. As indicated in Figure 1, payments for transportation and communications totalled $40 million for the year ended 31 March 2007 ($35 million 31 March 2006). Figure 13 shows, by department, payments made for transportation and communications for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006.

Figure 13

Transportation and Communications
Expenditures By Department
Years Ended 31 March
($000's)

Transportation and Communications		
Department	**2006**	**2007**
Transportation and Works	6,656	7,143
Natural Resources	5,356	5,403
Justice	3,626	4,262
Executive Council	3,746	4,164
Environment and Conservation	2,591	3,224
Education	2,624	3,184
Human Resources, Labour and Employment	2,165	2,396
Government Services	2,308	2,261
Health and Community Services	1,453	1,638
Tourism, Culture and Recreation	1,273	1,426
Innovation, Trade and Rural Development	1,060	1,062
Fisheries and Aquaculture	1,013	1,056
Municipal Affairs	731	793
Legislature	591	706
Finance	624	643
Labrador and Aboriginal Affairs	417	388
Business	50	198
Public Service Commission	240	62
Accrual adjustment for acquisition of tangible capital assets	(1,179)	-
Total	**35,345**	**40,009**

Source: Government's Financial Information System

We also summarized the payments for transportation and communications to show all entities which received payments in excess of $100,000 for the year ended 31 March 2007 with comparative figures for the year ended 31 March 2006. These entities are listed in Figure 14.

Figure 14

Transportation and Communications Expenditures
Payments in Excess of $100,000
Years Ended 31 March
($000's)

Entities Which Received in Excess of $100,000		
Entity	**2006**	**2007**
Universal Helicopters Nfld. Ltd	3,330	3,212
Rogers Telecom	-	2,701
xwave	1,655	2,517
Canada Post Corporation	905	1,951
Bell Aliant	-	1,891
Postage by Phone	2,374	1,606
Aliant Communications Inc.	2,207	1,264
Canadian Helicopters Limited	367	1,000
Aliant Mobility Limited	1,055	961
Labrador Marine	806	851
Newfoundland Helicopters Limited	447	768
Harveys Travel	490	578
Bell Island Radio Equipment Lease	-	434
Legrows Travel	279	395
Newfoundland and Labrador Hydro	372	372
Supermarine Aircraft	271	369
City of St. Johns	459	339
Provincial Airlines Limited	543	322
Millenium Express	124	156

Figure 14 (cont'd)

Entities Which Received in Excess of $100,000		
Entity	**2006**	**2007**
Eastern Regional Integrated Health Authority	-	141
Central Regional Integrated Health Authority	-	126
Globalstar Canada Satellite Company	105	120
Sameday Right Way	106	119
Exploits Valley Air Services	105	116
Persona Communications	-	110
Mokami Travel Service Limited	-	100
Newfoundland and Labrador Air Transport Ltd.	108	21
Sprint Canada Inc.	1,106	-
GT Group Telecom Services Corporation	2,012	-
Miscellaneous amounts $100,000 and less paid to over 7,200 entities or individuals (2006 - 7,000 entities or individuals)	16,119	17,469
Total	**35,345**	**40,009**

Source: Government's Financial Information System

Highlights

Highlights of a review of the Food Premises Inspection and Licensing Program for the period 1 January 2004 to 31 March 2007.

Why our Office did this Review

The objectives of our current review were to determine whether the GSC and/or the Department: was complying with food premises inspection and licensing requirements; was complying with the MOU; was monitoring the food inspection and licensing program; and had addressed the deficiencies identified in our 2003 report.

What our Office Recommends

We recommend the GSC should:

- comply with the *Food Premises Regulations*;
- ensure risk assessment worksheets are accurately completed as required under the MOU;
- comply with Department policy as it relates to the food inspection and licensing program;
- ensure information resulting from inspections is input into the database promptly. Inspection reports should be placed in the food premises file;
- provide the Department with an annual report as required;
- monitor inspection activity more closely to ensure that inspections are properly scheduled and carried out; and
- staff the vacant Environmental Health Officer positions.

Furthermore, the Department should develop a policy to address the situation where the same critical health hazards continue to recur in consecutive inspections. The GSC, Department and the regional integrated health authorities should evaluate the MOU annually as required.

What the Departments Said

To provide balance to this report and to ensure full disclosure, the Departments were asked to formulate a response to our findings and conclusions. The Departments' responses, verbatim, are included at the end of this report. Readers are encouraged to consider the Departments' comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.7

DEPARTMENT OF GOVERNMENT SERVICES

Food Premises Inspection and Licensing Program

The Department of Health and Community Services (the Department) has the mandate for the food premises inspection and licensing program (the program). The Department's legislative responsibility for protecting the health of the public in the area of food safety is outlined in the *Food Premises Regulations* (the *Regulations*) under the *Food and Drug Act*.

The Department of Government Services, through its Government Service Centres (GSC), provides the general public and the business community with access to one-stop services for their convenience when applying for various permits, licenses, certificates and approvals. The GSC conducts inspections and provides enforcement services on behalf of other Government departments. Through Environmental Health Officers located at its network of offices throughout the Province, the GSC works in conjunction with the Department, and the regional integrated health authorities in implementing the food premises inspection and licensing program and other health programs. In 1995 a Memorandum of Understanding (MOU) was signed and revised in 1999 to establish responsibilities and accountabilities among the responsible parties as they relate to mandated programs and services of the Department, including the food premises inspection and licensing program.

What We Found

Our review of the food inspection and licensing program indicated that not all of the deficiencies identified in our 2003 report had been addressed by the GSC. In particular:

Licensing of Food Premises: At the time of our review, 442 or 11% of food premises in the GSC database were indicated as operating without a valid licence as required by the *Regulations*. Furthermore, during the year ended 31 December 2006, we found that 35% of the food premises files that we examined in the database had operated without a valid licence for a period of time during the year. As a result, the GSC did not always ensure that food premises were operating with a valid licence as required by the *Regulations*.

Risk Management: We found that food premises are not always assessed for health risk in accordance with the Risk Management Framework that was developed under the MOU between the GSC, the Department and the regional integrated health authorities.

Inspection of Food Premises: For the three year period ending 2006-07, the GSC did not carry out the required number of inspections for moderate and high risk food premises and carried out more inspections than required for low risk and seasonal food premises.

Information Management: We found that the database was incomplete and inaccurate. Information resulting from inspections such as identified health hazards, compliance dates and inspection scores was not captured in the database. In addition, risk assessment score history and calculation detail was not maintained in the database. As a result, important health information was unavailable to the GSC, the Department, and the regional integrated health authorities.

Compliance with the MOU: The MOU is not evaluated on an annual basis as required. As a result, it may not be reflective of current practices and issues relating to food premises inspection and licensing. The GSC does not provide the Department with an annual report of statistical and narrative information on program activity as required under the MOU.

Management of the Program: Monitoring of the program by the GSC was inadequate because the database used to monitor inspection activity was not accurate or complete; risk assessment score detail, inspection score detail, identified health hazards and hazard correction dates were not recorded in the database; and management did not always review completed inspection reports and risk assessment worksheets.

Background

The Department of Government Services, through its Government Service Centres (GSC), provides the general public and the business community with access to one-stop services for their convenience when applying for various permits, licenses, certificates and approvals. The GSC conducts inspections and provides enforcement services in areas of public health, public safety and environmental protection on behalf of other Government departments. Some of the services offered by the GSC include:

- commercial building plan approvals
- day care inspections
- electrical permits and inspections
- elevator inspections and approvals
- food establishment inspections and licensing
- motor registration services
- personal care home inspections
- small game and angling licenses
- water supply testing

Food premises inspection and licensing program

The Department of Health and Community Services (the Department) has the mandate for some of the programs and services delivered by the GSC, including the food premises inspection and licensing program. In this regard, the GSC works in conjunction with the Department, and the Regional Integrated Health Authorities in implementing the food premises inspection and licensing program and other health programs.

In 1995 a Memorandum of Understanding (MOU) was signed and revised in 1999 to establish responsibilities and accountabilities among the responsible parties as they relate to mandated programs and services of the Department, including the food premises inspection and licensing program.

Legislation

The Department's legislative responsibility for protecting the health of the public in the area of food safety is outlined in the *Food Premises Regulations* (the *Regulations*) under the *Food and Drug Act* (the *Act*). The food premises inspection and licensing program is carried out by the Environmental Health Officers (EHO) located in the GSC's network of offices located throughout the Province.

GSC locations

Figure 1 shows the location of GSC offices and the number of EHOs assigned to each region across the Province:

Figure 1

GSC Locations

Region	No. of EHOs	Regional Office	Area Office	Field Office
Avalon	13	St. Johns	Harbour Grace	-
Eastern	5	Clarenville	-	Grand Bank, Marystown
Central	8	Gander	Grand Falls-Windsor	Lewisporte, Springdale
Western	8	Corner Brook	-	Stephenville, St. Anthony, Port aux Basques
Labrador	2	Happy Valley - Goose Bay	-	Labrador City
Total:	**36**	**5**	**2**	**8**

Source: Government Service Centre

Definition of food premises

Food premises is defined as a place where food is prepared, manufactured, handled, cut, processed, packaged, displayed, stored, offered for sale, sold, or served and includes hotels, restaurants, catering vehicles, mobile preparation premises, temporary facilities, retail food stores, tents, booths, ships, cold stores, bakeries, breweries, bottling establishments, drinking establishments, dairies, creameries, pasteurizing plants, meat packing premises, and locker plants and premises.

Food premises inspection and licensing program

Food premises are inspected by EHOs to determine compliance with the *Act, Regulations* and the Department's policies, procedures and standard health guidelines. Licenses are issued to food premises annually when it is determined that they comply with the requirements of the *Act* and *Regulations*.

Since 1 April 2003 the frequency of food premises inspections has been dependent on the level of health risk assigned by EHOs to each food premise. The level of health risk is determined using a Risk Management Framework. For example, food premises assigned a:

- low health risk require one inspection every two years;
- moderate health risk require two inspections a year; and
- high health risk require four inspections a year.

Seasonal food premises inspections are not based on the Risk Management Framework but require at least one inspection per year.

Number of food premises by risk category

Figure 2 shows the total number of food premises by risk category and the number of annual inspections required as at 31 March 2007.

Figure 2

Number of Food Premises by Risk Category and Annual Inspections Required As at 31 March 2007

Region	Risk Category				
	Low	Moderate	High	Seasonal	Total
Avalon	319	1,190	54	99	1,662
Eastern	136	237	21	60	454
Central	343	372	20	168	903
Western	237	412	41	118	808
Labrador	45	168	19	14	246
Total Premises	**1,080**	**2,379**	**155**	**459**	**4,073**
Inspection frequency	1 per 2 yrs	2 per year	4 per year	1 per year	
Total inspections required per year	**540**	**4,758**	**620**	**459**	**6,377**

Source: Government Services Centre

As Figure 2 shows, as at 31 March 2007 there were a total of 4,073 food premises that require 6,377 inspections per year.

Our 2003 Annual Report

In our 2003 Annual Report to the House of Assembly, we presented our findings on the food premises inspection and licensing program. We concluded at that time that many of the significant weaknesses identified in the food premises inspection and licensing program during our earlier 1998 review had not been corrected. In particular, the GSC:

- was not complying with the *Regulations* in that food premises were operating without valid licenses;
- was not inspecting food premises at the required frequency;
- database was neither current nor accurate;
- was not complying with Department policy and procedures;
- did not adequately monitor food premises inspection and licensing activity; and
- was not providing the Department with the required reports on program activities as required.

Audit Objective and Scope

Audit objectives

The objectives of our current review were to determine whether the GSC and/or the Department:

- was complying with food premises inspection and licensing requirements;
- was complying with the MOU;
- was monitoring the food inspection and licensing program; and
- had addressed the deficiencies identified in our 2003 report.

Audit scope

We completed our review in December 2007. Our review covered the period 1 January 2004 to 31 March 2007 and included an analysis of food premises inspection and licensing.

We reviewed a sample of food premises files and reviewed inspection reports for compliance with the *Act* and *Regulations*, the MOU, and established policies, procedures and guidelines. We also held discussions with Department and GSC officials.

Overall Conclusions

Our review of the food inspection and licensing program indicated that not all of the deficiencies identified in our 2003 report had been addressed by the Government Services Centres (GSC). In particular:

Licensing of Food Premises

At the time of our review, 442 or 11% of food premises in the GSC database were indicated as operating without a valid licence as required by the *Food Premises Regulations*. Furthermore, during the year ended 31 December 2006, we found that 35% of the food premises files that we examined in the database had operated without a valid licence for a period of time during the year. As a result, the GSC did not always ensure that food premises were operating with a valid licence as required by the *Food Premises Regulations*.

Risk Management

The Memorandum of Understanding (MOU) requires that food premises be assessed for health risk annually (low risk - every two years) and that inspections of food premises be carried out at the required frequency to control the assessed health risk. We found that food premises are not always assessed for health risk in accordance with the Risk Management Framework that was developed under the MOU. For the year ending 31 December 2006, we found there was no risk assessment worksheet completed for 36% of the food premises files examined. As a result, we could not determine whether the food premises was low, moderate or high risk and whether the number of inspections carried out was appropriate to manage the health risk posed to the general public. Furthermore, we found that when risk assessment worksheets were completed, 30% were completed incorrectly, resulting in inappropriate risk scores and in some cases the food premises was placed in the wrong risk category.

Inspection of Food Premises

For the three year period ending 2006-07, the GSC did not carry out the required number of inspections for moderate and high risk food premises and carried out more inspections than required for low risk and seasonal food premises.

We found that in 28% of the files examined, where the food premises was licensed in 2005, there was no evidence in the file to indicate that the premises was assessed for risk by an Environmental Health Officer (EHO). As a result, we could not determine the required inspection frequency for these premises for the year and whether the inspections actually carried out for these premises were sufficient to control the health risk posed to public. Furthermore, in files examined where a food premises was assessed for risk and the required inspection frequency was established, we found that 22% of the food premises licensed in 2005 were not inspected in accordance with the required frequency.

A significant number of moderate and high risk food premises were not inspected in a uniform manner throughout the licence year. While the GSC has a computer system that schedules the annual inspection of food premises in a uniform manner, EHOs are not always carrying out inspections on the dates that are scheduled.

We found that in 218 of 224 inspection reports reviewed where a critical health hazard was identified, the EHO did not indicate on the inspection report whether the critical hazard was corrected or controlled on completion of the inspection as required by Department of Health and Community Services (the Department) policy.

We found five food premises where critical health hazards occurred in two consecutive inspections and the total critical hazard score in the second inspection was less than 48, however the food premises was not closed as required by Department policy (critical hazards included cold holding of foods at too high a temperature, improper cooking and holding of food, and cross-contamination of food).

A significant number of food premises had the same health hazards recurring in consecutive inspections indicating that these hazards are not being corrected. In one food premises, we found that two critical health hazards identified had recurred in eight consecutive inspections (critical hazards included cold holding of foods at too high a temperature and thermometer not present or not working). The Department has no policy that addresses the situation where the same critical health hazard recurs more than once.

We found that in 176 of 285 inspection reports reviewed where a non-critical health hazard was identified, the EHO did not provide a compliance date in which the hazard should be corrected and there was no indication on the inspection report that the hazard was corrected during the inspection as required by Department policy.

We found that EHOs failed to properly calculate the inspection score in 36 of 517 inspection reports that we reviewed. In most cases, the EHO failed to correctly add the inspection scores on the report.

Information Management

We found 21 of the 517 inspection reports that we reviewed were not recorded in the database. We also found 25 inspections recorded in the database for which there was no corresponding inspection report in the food premises file. As a result, the database was incomplete and inaccurate.

Information resulting from inspections such as identified health hazards, compliance dates and inspection scores was not captured in the database during our review. In addition, risk assessment score history and calculation detail was not maintained in the database. As a result, important health information was unavailable to the GSC, the Department, and the Regional Integrated Health Authorities.

Compliance with the Memorandum of Understanding (MOU)

The MOU is not evaluated on an annual basis as required. The last review of the MOU occurred in 2001. As a result, the MOU may not be reflective of current practices and issues relating to food premises inspection and licensing.

The GSC does not provide the Department with an annual report of statistical and narrative information on food premises inspection and licensing program activity as required under the MOU.

Management of the Food Premises Inspection and Licensing Program

Effective monitoring of the food premises inspection and licensing program by the GSC was inadequate because the database used to monitor inspection activity was not accurate or complete; risk assessment score detail, inspection score detail, identified health hazards and hazard correction dates were not recorded in the database; and management did not always review completed inspection reports and risk assessment worksheets.

For the year ending 31 December 2006, the GSC carried out its food premises inspection and licensing program with only 30 or 84% of the 36 approved EHO positions being staffed. This contributed to the GSC not always completing inspections in accordance with the required frequency and not always carrying out inspections in a uniform manner.

Detailed Observations

Findings

This report provides detailed findings and recommendations in the following sections:

1. Licensing of Food Premises
2. Risk Management
3. Inspection of Food Premises
4. Information Management
5. Compliance with Memorandum of Understanding
6. Management of the Food Premises Inspection and Licensing Program.

1. Licensing of Food Premises

Food premises operating without a valid licence

The *Regulations* state that "*A person shall not operate a food premises without a licence.*" As of 6 March 2007, 442 (11%) of the 4,073 food premises in the GSC database were indicated as operating without a valid license. GSC officials indicated that 195 of the 442 were actually approved for licensing by an EHO; however, the license was not yet issued to the food premises because the GSC administration had not yet processed the paperwork for the licenses. In many cases, several months had passed between approval for licensing and the actual license being issued.

Our review also included an examination of a sample within each region, of license renewal documentation pertaining to the operation of a total of 100 food premises for the period 1 January 2004 to 31 December 2006.

Figure 3 shows the number of food premises of the 100 sampled that were required to renew their license and the number of food premises that operated without a valid license for a period of time during the three year period ending 31 December 2006.

Figure 3

Number of food premises operating without valid licence
Three year period ending 31 December 2006

Region	Number of premises operating without a valid licence		
	2004	2005	2006
Avalon	6	14	12
Eastern	2	1	2
Central	0	3	2
Western	1	1	9
Labrador	5	4	6
Total	**14**	**23**	**31**
No. of premises required to renew licence	78	79	88
Percentage operating without licence	**18%**	**29%**	**35%**

As Figure 3 shows, for the year ended 31 December 2006, 31 of 88 or 35% (23 of 79 or 29% in 2005, 14 of 78 or 18% in 2004) of food premises examined continued to operate for a period of time following the expiry of the previous license because the license renewal inspection was not carried out before the expiry of the previous license. We found that for 25 of the 31 food premises that were on the Island portion of the Province:

- 20 of these food premises were operating without valid licenses for a period of up to three months following expiry of the previous license; and
- in 5 instances there was no license renewal at all.

In 6 of the 31 food premises that were in the Labrador region, we found that:

- 5 of the food premises were operating without a valid licence for a period of more than three months following expiry of the previous license; and
- in 1 instance there was no licence renewal at all.

Similar issues were identified during our review in 2003 when we found that 31% of food premises tested had operated without a valid license for a period of time.

Conclusions

At the time of our review, 442 or 11% of food premises in the GSC database were indicated as operating without a valid licence. Furthermore, during the year ended 31 December 2006, we found that 35% (29% in 2005, 18% in 2004) of food premises that we examined had operated without a valid licence for a period of time during the year. As a result, the GSC did not always ensure that food premises were operating with a valid licence as required by the *Regulations*.

Recommendation

The GSC should comply with the *Food Premises Regulations*.

2. Risk Management

Introduction

In March 2003, in accordance with the MOU, the Department introduced the Inspection Frequency Risk Management Initiative. The goal of the initiative was to reduce the likelihood of food-borne illness originating from food premises in Newfoundland and Labrador. This would be accomplished by focusing inspection activities on moderate to high risk food premises and critical hazards in food premises that, if not controlled or eliminated, may lead to food-borne illness.

The Risk Management Framework developed by the Department includes a risk assessment guide to help EHOs assess food premises for risk to determine the inspection frequency in connection with the risk. Each year during license renewal, EHOs are required to complete a risk assessment worksheet (RAW) whereby food premises are evaluated in relation to six risk subgroups to determine the overall risk score of a food premises. Figure 4 shows the six risk sub-groups and corresponding scoring ranges.

Figure 4

Risk sub-groups and score ranges

Risk Sub Group	Min/Max Risk Score	Example of high risk score	Example of low risk score
Types of foods and intended uses	5/50	Raw meat, shellfish	Fruit, ice cream, pizza
Food preparation and processing (handling of food)	5/80	Full service restaurant	Fast food restaurant
Management/employee food safety knowledge	0/15	Untrained employees	Trained employees
Food safety management systems	0/15	No documented food management program	Documented food management program
Population at risk	10/35	Serves to the young and elderly (day care and health care facilities)	Serves less than 250 meals per day and employs < 10 people
Inspection history: critical hazards and inspection score	0/60	Low inspection scores - repeated critical health hazard violations	High inspection scores - few health hazard violations
Total score	**20/255**		

Source: Department of Health and Community Services

Food premises inspection frequency for a given year is determined by the risk score (risk category) assessed by the EHO. Figure 5 shows the inspection frequency required for each risk category.

Figure 5

Inspection frequency by risk category

Risk Category	Risk Score	Inspection Frequency
Low	Less than 70 points	One inspection every 2 yrs
Moderate	Between 70 and 140 points	Two inspections per year
High	Greater than 140 points	Four inspections per year

Source: Department of Health and Community Services

A high risk score (> 140) may include food premises that:

- serve high risk foods such as raw meat or shellfish;
- have complicated menus with a high degree of food preparation (full service restaurants);
- have no food safety management system in place;
- have little staff training in food hygiene;
- serve to high risk patrons such as children and the elderly; and
- have a history of low inspection scores (numerous health hazard violations).

In order to control the health risk posed by high risk food premises, EHOs are required to carry out four inspections in a uniform and representative manner over a one year period. At the end of the year, the food premises must be reassessed for health risk.

Risk assessments not found or found to be incorrect

Our review included an examination of a sample within each region, of Risk Assessment Worksheets (RAWs) pertaining to the operation of a total of 100 food premises for the period 1 January 2004 to 31 December 2006. Our review indicated that RAWs were not always found in the files and when they were, there were instances where the risk was calculated incorrectly.

Figure 6 shows, of 100 food premises sampled where risk was required to be assessed or was otherwise assessed, the extent to which RAWs were not found in the files and where Environmental Health Officers (EHOs) incorrectly calculated risk scores.

Figure 6

Risk Assessment Worksheet not found or risk found to be calculated incorrectly
Three year period ending 31 December 2006

Region	2004		2005		2006	
	Not Found	Incorrect	Not Found	Incorrect	Not Found	Incorrect
Avalon	11	11	11	9	12	8
Eastern	5	0	1	2	1	3
Central	1	2	0	5	0	3
Western	9	5	9	1	14	2
Labrador	5	1	4	1	5	1
Total	**31**	**19**	**25**	**18**	**32**	**17**
Number of premises where risk assessment required or risk otherwise assessed	76		79		88	
Percentage of food premises where RAW not found or found incorrect	41%	42%	32%	33%	36%	30%

As Figure 6 shows, for the three year period ending 31 December 2006, no RAW was found in the files for 32 of 88 or 36% (25 of 79 or 32% for 2005, 31 of 76 or 41% for 2004) of food premises files examined. As a result, we could not determine whether the risk category assigned to these food premises was appropriate. Furthermore, we found that when RAWs were completed, 17 of 56 or 30% (18 of 54 or 33% for 2005, 19 of 45 or 42% for 2004) were completed incorrectly, resulting in the food premises being assigned an inappropriate risk score and in some cases being assigned the wrong risk category.

When RAW's are not completed or when RAW's are inaccurately completed, food premises can be placed in the wrong risk category resulting in inappropriate annual inspection frequencies. For example, a high risk food premises that was inappropriately assigned moderate risk would only be inspected two times per year instead of the required four times per year, thereby increasing the health risk to the general public. A low risk food premises that was inappropriately assigned moderate risk would be inspected two times per year instead of the required only once every two years, thereby causing inefficient use of the EHO's time.

Conclusions

The MOU requires that food premises be assessed for health risk annually (low risk - every two years) and that inspections of food premises be carried out at the required frequency to control the assessed health risk. We found that food premises are not always assessed for health risk in accordance with the Risk Management Framework that was developed under the MOU.

For the year ending 31 December 2006, we found there was no risk assessment worksheet completed for 36% (32% for 2005, 41% for 2004) of the food premises files examined. As a result, we could not determine whether the food premises was low, moderate or high risk and whether the number of inspections carried out was appropriate to manage the health risk posed to the general public.

Furthermore, we found that when risk assessment worksheets were completed, 30% (33% for 2005, 42% for 2004) were completed incorrectly, resulting in inappropriate risk scores and in some cases the food premises was placed in the wrong risk category.

Recommendation

The GSC should ensure risk assessment worksheets are accurately completed as required under the MOU.

3. Inspection of Food Premises

Overview

Food premises are inspected to determine compliance with the *Regulations* in accordance with the MOU and Department policies, procedures and standard health guidelines. Food premises inspections are carried out by Environmental Health Officers (EHOs) located in the various Government Service Centre (GSC) offices across the Province.

Figure 7 shows the total number of food premises inspected, by risk category, during the three year period ending 31 March 2007. The Figure also shows the number of inspections that are required to be carried out during the period and the approximate percentage of inspections completed by risk category.

Figure 7

Food premises inspections by risk category
For the Fiscal Years 2004-05 to 2006-07

Food premises risk category	No. of food premises at beginning of the fiscal year	No. of annual inspections required per premises	Total number of inspections required	Total number of inspections carried out	Percentage of required inspections completed
2004-05*					
Low	1,125	1 every 2 yr	563	852	151%
Moderate	2,175	2	4,350	3,466	80%
High	246	4	984	580	59%
Seasonal	286	1	286	520	182%
***Total**	**3,832**		**6,183**	**5,418**	
2005-06					
Low	1,170	1 every 2 yr	585	985	168%
Moderate	2,366	2	4,732	3,876	82%
High	237	4	948	537	57%
Seasonal	467	1	467	539	115%
Total	**4,240**		**6,732**	**5,937**	
2006-07					
Low	1,110	1 every 2 yr	555	831	150%
Moderate	2,466	2	4,932	4,646	94%
High	179	4	716	590	82%
Seasonal	481	1	481	509	106%
Total	**4,236**		**6,684**	**6,576**	

Source: Government Service Centre.
* does not include data for the Labrador Region - data not available.

As Figure 7 shows, for the three year period ending 2006-07, the GSC did not carry out the required number of inspections for moderate and high risk food premises (less than 100%) and carried out more inspections than required for low risk and seasonal food premises (more than 100%).

Our findings are contained in the following sections:

A. Inspection Frequency
B. Critical Health Hazards
C. Food Premises Inspection Report (FPIR)

3A. Inspection Frequency

Inspection frequencies not met or not determinable

Our review included an examination of a sample within each region, of a total of 100 food premises files for the period 1 January 2004 to 31 December 2006 and found that the GSC has not always inspected food premises in accordance with the Risk Management Framework specified in the MOU. In particular, we found instances where food premises were not assessed for risk and we therefore could not determine the required inspection frequency. In addition, when food premises were assessed for risk we found that inspections were not always carried out at the required frequency.

Figure 8 shows, the number of food premises of the 100 sampled where the required inspection frequency was not met or the required inspection frequency was not determinable for food premises that were licensed in 2004 and 2005.

Figure 8

Number of food premises where required inspection frequency not met or the required frequency was not determinable
Food premises licensed in 2004 and 2005 calendar years

Region	Food premises licensed in 2004				Food premises licensed in 2005			
	No. of Premises	Inspection Frequency			No. of Premises	Inspection Frequency		
		Could not determine	Not met	Met		Could not determine	Not met	Met
Avalon	35	11	9	15	42	11	7	24
Eastern	9	5	0	4	9	1	1	7
Central	13	1	1	11	13	0	1	12
Western	13	9	3	1	17	9	4	4
Labrador	5	5	0	0	7	4	1	2
Total	**75**	**31**	**13**	**31**	**88**	**25**	**14**	**49**
% of total # of premises		41%	17%	42%		28%	16%	56%
% of premises determinable			30%	70%			22%	78%

As Figure 8 shows, for food premises licensed in 2005, 25 of 88, or 28% (31 of 75, or 41% for 2004) there was no evidence in the file to indicate that the premises was assessed for risk by an EHO. As a result, we could not determine the required inspection frequency for these premises for the year and whether the inspections actually carried out for these premises was sufficient to control the health risk posed to public.

Figure 8 also shows that when food premises were assessed for risk and the required inspection frequency was established, EHOs did not always meet the required inspection frequency. For food premises licensed in 2005, we found that 14 out of 63 or 22% (30% for 2004) of the food premises were not inspected in accordance with the required frequency.

These numbers suggest an improvement over 2003 when we found that approximately 40% of food premises were not being inspected at the required frequency. However, we are unable to make a true determination of whether there has been improvement since 2003 because of the significant number of premises in the sample where required inspection frequencies could not be determined.

Inspection frequency not uniform

The Risk Management Framework requires that annual inspections of moderate and high risk food premises be carried out in a uniform manner throughout the licence year so that inspection results are representative of how food premises are operating throughout the entire licence year. Our review indicated that a significant number of moderate and high risk food premises were not inspected in a uniform manner throughout the licence year. We found that while the GSC has a computer system that schedules the annual inspection of food premises in a uniform manner, EHOs are not always carrying out inspections on the dates that are scheduled.

3B. Critical Health Hazards

Introduction

Critical health hazards are aspects of food premises operations which pose an immediate public health risk. Some examples of critical health hazards would be:

- the cold holding of hazardous foods is not at or below 4 degrees C;
- the cooking and hot holding of hazardous foods is not at or above 60 degrees C;

- indicating thermometers are not kept in hazardous food temperature controlled storage areas;
- ready-to-eat foods are not kept separate from raw foods during handling and storage;
- there is unsatisfactory hand washing; and
- food handlers have a disease or condition that may spread through food.

Non-critical health hazards are aspects of food premises operations that are not considered an immediate public health risk. However, the nature and number of hazards and the length of time that such hazards exist, all contribute to the public health risk associated with the food premises. Some examples of non-critical health hazards would be:

- hand wash basins in food preparation area not adequately supplied;
- staff and public washrooms not supplied with adequate supplies of liquid soap and disposable paper towels;
- food handlers are not properly attired;
- food contact surfaces are not in good repair;
- unsatisfactory dishwashing and sanitization; and
- unsatisfactory housekeeping.

Critical health hazards are not being corrected

Department policy states that, *"Critical hazards identified during an inspection have to be corrected or controlled prior to completion of the inspection. Where this cannot be achieved the food premises should be closed immediately."* The policy goes on to state that EHOs are required to specifically indicate on the Food Premises Inspection Report (FPIR) when a critical hazard(s) is corrected during the inspection. Our review indicated that:

- in 218 of 224 FPIRs reviewed where a critical health hazard was identified, the EHO did not indicate on the inspection report whether the critical hazard was corrected or controlled on completion of the inspection. As a result, we could not determine whether these food premises should have been closed because a critical health hazard was not corrected or controlled at the time of the inspection.

Department policy also states that, *"Where critical hazards are identified during an inspection and the next (second) inspection reveals critical hazards and the total critical hazard score is less than 48 in the second inspection, the food premises is to be closed."* The policy goes on to state that food premises are to remain closed until the hazards are corrected and the food premises has provided the EHO with a written plan of action to address the food safety concerns identified by the EHO. Our review indicated that:

- 6 of the 100 food premises examined had an instance where critical health hazards occurred in two consecutive inspections and the total critical hazard score in the second inspection was less than 48; however, 5 of the 6 food premises were not closed as required by policy. In addition, for these 5 food premises there was no indication in the FPIR that the hazards were corrected on completion of the inspection or that a written plan of action was provided to the EHO to allow the food premises to continue operating. Critical hazards included cold holding of foods at too high a temperature, improper cooking and holding of food, and cross-contamination of food.

Furthermore, our review indicated that in 37 out of 100 food premises examined, there were 57 critical hazards that recurred again in the following inspection. In 18 of the 37 food premises, 22 critical hazards had recurred in the following two inspections and in 1 of the 18 food premises 2 critical hazards had recurred in eight consecutive inspections (critical hazards included cold holding of foods at too high a temperature and thermometer not present or not working).

The Department has no policy that addresses the situation where the same critical health hazard recurs more than once. Similar issues were identified during our review in 2003.

Non-critical health hazards are not being corrected

Departmental policy states that, *"A compliance date must be placed in the appropriate column of Part B of the FPIR for all non-critical deficiencies observed during the inspection and recorded on the FPIR. The exception being those deficiencies corrected at the time of the inspection."* Our review indicated that in:

- 176 of 285 FPIRs reviewed where a non-critical health hazard was identified the EHO did not provide a compliance date in which the hazard should be corrected and there was no indication on the FPIR that the hazard was corrected during the inspection.

Departmental policy also states that, *"For premises without conditions which are or may become a menace to health, but with repeated non-critical deficiencies which the EHO has not been successful in getting corrected, the EHO should consider…sending a registered letter to the owner/operator of the food premises stating that"* among other things, that repeated non-critical deficiencies have been observed over consecutive inspections, that deficiencies have not been corrected as per instructions by the EHO, and that a new license will not be issued until the deficiencies have been corrected.

Our review indicated that in 43 out of 100 food premises examined, there were 96 non-critical hazards identified that had recurred again in the following inspection. In 26 of the 43 food premises, 47 non-critical hazards had recurred in the following two inspections and in 15 of the 26 food premises, 22 non-critical hazards had recurred in the following three or more inspections.

In these situations, we found no instances where an EHO had sent a registered letter to the food premises operator stating that repeated non-critical hazards were not being corrected and that a new licence would not be issued until the hazards were corrected. Similar issues were identified during our review in 2003.

3C. Food Premises Inspection Report (FPIR)

FPIR scores not always accurate

Environmental Health Officers (EHOs) are required to complete a Food Premises Inspection Report (FPIR) upon the conclusion of their inspection of a food premise. The FPIR includes a checklist of health hazard areas each of which is assigned an individual score, the total of which adds to 100. When a food premises is found to not be in compliance with the requirements of the health hazard area, the individual score associated

with the health hazard is deducted from the total score of 100. Inspection scores are used by EHOs when assessing the health risk of a food premises, therefore it is important that inspections be scored accurately.

We found that EHOs failed to properly calculate the inspection score in 36 of 517 inspection reports that we reviewed. In most cases, the EHO failed to correctly add the inspection scores on the report, however in some cases we found that EHOs were not deducting points for health hazards that existed but were corrected during the inspection.

Conclusions

For the three year period ending 2006-07, the GSC did not carry out the required number of inspections for moderate and high risk food premises (less than 100%) and carried out more inspections than required for low risk and seasonal food premises (more than 100%).

We found that in 28% of the files examined where the food premises was licensed in 2005 (41% for 2004) there was no evidence in the file to indicate that the premises was assessed for risk by an EHO. As a result, we could not determine the required inspection frequency for these premises for the year and whether the inspections actually carried out for these premises were sufficient to control the health risk posed to public. Furthermore, in files examined where a food premises was assessed for risk and the required inspection frequency was established, we found that 22% of the food premises licensed in 2005 (30% for 2004) were not inspected in accordance with the required frequency.

A significant number of moderate and high risk food premises were not inspected in a uniform manner throughout the licence year. While the GSC has a computer system that schedules the annual inspection of food premises in a uniform manner, EHOs are not always carrying out inspections on the dates that are scheduled.

We found that in 218 of 224 inspection reports reviewed where a critical health hazard was identified, the EHO did not indicate on the inspection report whether the critical hazard was corrected or controlled on completion of the inspection as required by Department policy.

We found five food premises where critical health hazards occurred in two consecutive inspections and the total critical hazard score in the second inspection was less than 48, however the food premises was not closed as required by Department policy.

We found that in 176 of 285 inspection reports reviewed where a non-critical health hazard was identified, the EHO did not provide a compliance date in which the hazard should be corrected and there was no indication on the inspection report that the hazard was corrected during the inspection as required by Department policy.

A significant number of food premises had the same health hazards recurring in consecutive inspections indicating that these hazards are not being corrected. In one food premises, we found that two critical hazards identified had recurred in eight consecutive inspections. The Department has no policy that addresses the situation where the same critical health hazard recurs more than once.

We found that EHOs failed to properly calculate the inspection score in 36 of 517 inspection reports that we reviewed. In most cases, the EHO failed to correctly add the inspection scores on the report.

Recommendations

The GSC should comply with Department policy as follows:

- ensure that inspections are carried out in accordance with the uniform frequency required in the Risk Management Framework;
- EHOs should indicate on the inspection report when critical health hazards are corrected or controlled;
- food premises should be closed where required;
- food premises should be a given compliance date by which identified non-critical health hazards are to be corrected;
- inspection report scores should be accurately calculated.

Furthermore, the Department of Health and Community Services should develop a policy to address the situation where the same critical health hazards continue to recur in consecutive inspections.

4. Information Management

Introduction

The Department requires that the GSC maintain an up-to-date database of inspection and licensing information for all the food premises for which it is responsible.

Database incomplete and inaccurate

For the period 1 January 2004 to 31 December 2006, we reviewed 517 inspection reports in connection with the 100 food premises in our sample. Our review indicated that 21 of the 517 inspection reports were not recorded in the database. Furthermore, we found 25 inspections recorded in the database for which there was no corresponding inspection report in the food premises file.

Similar issues with database accuracy and completeness were identified during our review in 2003.

Inspection and risk assessment information unavailable to management

The Department's Inspection Data Records Policy dated January 2003 states that *"the Government Service Center will move forward in the development of the AMANDA system* (database) *to enable inspection results, particularly critical hazard violations, to be entered into an electronic information system."* The policy goes on to state that this information should be provided to the Department and the Regional Integrated Health Boards on a regular basis. Our review indicated that:

- information resulting from inspections such as identified health hazards, compliance dates and inspection scores was not captured in the database; and
- risk assessment score history and calculation detail was not maintained in the database.

However, GSC officials indicated that changes to the database enabled the capturing of this information effective 27 November 2007. As a result, prior to 27 November 2007, important health information was unavailable to the GSC, the Department, and the Regional Integrated Health Authorities.

Conclusions

We found 21 of the 517 inspection reports that we reviewed were not recorded in the database. We also found 25 inspections recorded in the database for which there was no corresponding inspection report in the food premises file. As a result, the database was incomplete and inaccurate.

Information resulting from inspections such as identified health hazards, compliance dates and inspection scores was not captured in the database. In addition, risk assessment score history and calculation detail was not maintained in the database during our review. As a result, important health information was unavailable to the GSC, the Department, and the Regional Integrated Health Authorities.

Recommendations

The GSC should ensure information resulting from inspections is input into the database promptly. Inspection reports should be placed in the food premises file.

5. Compliance with Memorandum of Understanding (MOU)

Introduction

Effective 1 April 1995, the GSC, the Department of Health and Community Services and the former Health and Community Services Boards entered into an MOU which, among other things, outlined their respective responsibilities with respect to the inspection and licensing of food premises. In July 1999, the MOU was revised and included the former Health Labrador Corporation and the former Grenfell Regional Health Services Board.

MOU not reviewed annually as required

In order to ensure the MOU is reflective of current practices and issues the parties agreed to evaluate the MOU on an annual basis. However, a Department official indicated that there has been no review of the MOU since 2001. Furthermore, the official indicated that an annual review of the MOU has not been a priority since 2004 when a recommendation was made in a report ("Investing in Health: Public Health Capacity in Newfoundland") to reintegrate the food inspection and licensing program back into the health and community services system. At the time of our

report, no decision was made regarding the reintegration of GSC environmental health services with the health and community services system.

GSC not providing Department with annual report

The MOU requires that the GSC provide the Department with an annual report of statistical and narrative information on program activities at the end of each fiscal year. However, the Department has not received any annual reports from the GSC. This situation has not improved since our review in 2003.

Conclusions

The MOU is not evaluated on an annual basis as required. The last review of the MOU occurred in 2001. As a result, the MOU may not be reflective of current practices and issues relating to food premises inspection and licensing.

The GSC does not provide the Department with an annual report of statistical and narrative information on food premises inspection and licensing program activity as required under the MOU.

Recommendations

The GSC, Department of Health and Community Services, and the Regional Integrated Health Authorities should evaluate the MOU annually as required.

The GSC should provide the Department with an annual report as required.

6. Management of the Food Premises Inspection and Licensing Program

Introduction

In order for any program to be effective, it must be monitored by management to ensure that service standards and performance targets are met.

Inspection and licensing not effectively monitored

Our review indicated that effective monitoring of the food premises inspection and licensing program by the GSC was inadequate because:

- the database used to monitor inspection activity was not accurate or complete;
- risk assessment score detail, inspection score detail, identified health hazards and hazard correction dates were not recorded in the database; and
- management did not always review completed inspection reports and risk assessment worksheets.

While management did indicate it was monitoring inspections to ensure that required inspection frequencies were being met, we found that EHOs were not always carrying out inspections on the dates that were scheduled. Furthermore, during the fiscal years 2004-05 and 2005-06, management indicated that inspections were not always scheduled and carried out in the appropriate number or in a uniform manner because of administration issues relating to the payment of licence fees that were billed to food premises. As a result, we found instances where the required inspection frequencies were not met and where inspections were not carried out in a uniform manner throughout the year.

Vacant staff positions

The GSC has a total of 36 Environmental Health Officers (EHO) that carry out the inspection and licensing of food premises. Figure 9 shows the number of positions approved for EHOs in each region/office and the extent that those positions were staffed during the three year period ending 31 December 2006.

Figure 9

EHO positions approved and staffed
Years ending 31 December

Region	Approved EHO Positions	2004		2005		2006	
		Positions staffed	% staffed	Positions staffed	% staffed	Positions staffed	% staffed
Avalon	13	12.2	94%	11.6	89%	12.4	95%
Eastern	5	4.9	98%	4.8	96%	3.9	78%
Central	8	8	100%	8	100%	8	100%
Western	8	7.2	90%	6.8	85%	5.8	73%
Labrador	2	.8	40%	.2	10%	0	0%
Total	**36**	33.1	92%	31.4	87%	30.1	84%

Source: Government Service Center

As Figure 9 shows, for the year ending 31 December 2006, the GSC carried out its food premises inspection and licensing program with 30 or 84% (31 or 87% in 2005, 33 or 92% in 2004) of the 36 approved EHO positions being staffed. This contributed to the GSC not always completing inspections in accordance with the required frequency and not always carrying out inspections in a uniform manner. This problem was particularly significant in the Western and Labrador region where EHOs from the Western region had to travel to Labrador to perform inspections in that region. Officials of the GSC indicated that vacant EHO positions in the Province are difficult to fill and that public advertisement for the filling of these positions has often resulted in no employment applications being submitted.

Conclusions

Effective monitoring of the food premises inspection and licensing program by the GSC was inadequate because the database used to monitor inspection activity was not accurate or complete; risk assessment score detail, inspection score detail, identified health hazards and hazard correction dates were not recorded in the database; and management did not always review completed inspection reports and risk assessment worksheets.

For the year ending 31 December 2006, the GSC carried out its food premises inspection and licensing program with only 30 or 84% of the 36 approved EHO positions being staffed. This contributed to the GSC not always completing inspections in accordance with the required frequency and not always carrying out inspections in a uniform manner.

Recommendations

The GSC should:

- monitor inspection activity more closely to ensure that inspections are properly scheduled and carried out; and
- staff the vacant EHO positions.

Response - Department of Government Services

Overall Response

The Department of Government Services acknowledges that there are improvements required in some of the areas identified during the review. We would like to note that a number of improvements and initiatives have already been undertaken which will address several of the concerns raised as they take full effect.

Licensing of Food Premises

A number of policy and program changes were implemented beginning in 2003 which had a direct effect on the timing of licence issue.

- *A process of staggering the renewal dates for licences throughout the year was begun.*
- *A new "risk management" approach was adopted which required a detailed risk assessment scoring of each premises on an annual basis.*

- *In 2004, government introduced a licensing fee for food premises and there were a large number of cases where fees were not paid on time resulting in licences being withheld. However, these premises continued to operate as there were no health concerns. The fee was subsequently eliminated by government in 2006.*
- *The permitting and licensing database (AMANDA) was encountering a number of technical limitations.*

All of these changes and issues occurring within a relatively short period of time had an effect on the timing of the actual production of licence documents for some premises during the period which is the subject of your review. It should be noted, however, that regardless of whether the actual licence document was issued, inspections continued to be done on these premises and food safety was not compromised. Most of these issues have now been addressed and should result in a significant improvement in performance in this area in future, although it is expected that there will be some residual impact given that the upgrades to AMANDA were only brought on-stream at the end of November 2007.

Risk Management

We agree that there is a need to ensure that all required Risk Assessment Worksheets (RAWs) are completed properly and filed on a timely basis. It should be noted that not all premises require a RAW for example, in the case of a new food premises, a risk assessment is not required to be conducted until after two consecutive regular inspections. Seasonal premises do not require risk assessments at all, given that they are only open for part of the year and have a fixed inspection frequency. The specifics of the premises reviewed by your auditor will be further investigated by our managers to determine whether this had any effect on the number of files without completed worksheets and will ensure assessments are completed where required.

The recently introduced improvements and upgrades to the AMANDA system will provide for enhancement to the Risk Management assessment process by allowing the automatic generation of risk scores during the data entry process. This should address the issue of unintentional errors in calculating the risk assessment scores. In cases where your auditor indicated inaccurate risk scores changed the risk category, four cases should have been higher and six should have been rated lower risk. In all cases, these establishments would have been scheduled for at least two inspections. In some cases, your auditor indicated he changed the score based on his interpretation of our policy. These cases will be reviewed in further depth to verify the correct rating.

Inspection of Food Premises

The Department recognizes that it did not achieve 100% inspection frequency in all of its regions, particularly in 2004-05 and 2005-06. However, substantive improvement was achieved in 2006-07 as indicated by the tables in your report, with a 94% achievement in the "moderate risk" category, 82% in the "high risk" category and 106% in the seasonal category. The 150% completed inspections in the "low risk" category reflects a situation where, although these premises only require one inspection every two years, they are also likely to be facilities which require other inspections on either an annual basis, such as for tobacco compliance, or water sampling which is done monthly in some cases. If an inspector is in a rural community on a periodic basis to conduct these other inspections, they will often complete a food inspection as well. In the case of low risk premises, these inspections are done relatively quickly. It is more efficient in some cases to do these inspections at that point rather than return a couple of months later according to the schedule. This can result in some "over-coverage" of such establishments.

It should also be noted that there can be some "residual" statistical error due to the fact that a premises can change from one risk category to another during the year, whereas the number of premises, against which the inspection frequency requirement is measured, is only reported at the beginning and end of each year. We are working with our database system to try and refine these calculations to the extent possible.

It should also be noted that the target of four inspections per year for a "high" risk premises is the only such standard in the country - the highest number required in any other province that we could determine during a recent review is three. The appropriateness of this standard has been raised with the Department of Health and Community Services and further discussions are planned. Prior to 2003, such premises were only required to be inspected twice per year.

While the AMANDA system does provide a suggested scheduling of inspections during the year in order to create some uniformity within the process, having a particular inspection completed after the scheduled date does not necessarily present a public health risk. Inspectors are given latitude in completing their workloads in the context of their various responsibilities and travel schedules throughout their assigned areas. Monitoring of "To Do" lists are regularly undertaken by managers to ensure that inspections are completed in as timely a manner as possible.

With respect to the recording and correction of "critical" hazards, as defined by policy, it is agreed that documentation in this area should be improved. However, investigation and follow-up discussions with our inspectors regarding the particular instances of food premises with repeat critical hazard issues or consecutive critical hazard scores of less than 48, led to the conclusion that inspectors properly used their professional judgment in dealing with the issues involved.

For example, in two cases inspectors allowed a premise to close voluntarily overnight to correct any deficiencies which were serious enough to warrant such action. In others, the hazards were corrected at the time of inspection. A number of them related to the accuracy of thermometers in various cooling units/refrigerators where the actual unit was confirmed to be at the correct temperature by the inspector's independent measurement. In some cases, the same "critical hazard" category was noted but for a different reason (e.g. the problem was not with the same unit). These situations, while requiring immediate attention, did not present a serious public health risk and were not, in the inspector's professional opinion, sufficient cause to close the business. This type of judgment call is permitted under the Food Premises Regulations. Ensuring consistency in our policies in this area will be undertaken in consultation with Health and Community Services to ensure that inspectors are properly empowered to make these decisions.

Information Management

Challenges with the original AMANDA database were identified some time ago as a key factor which needed to be addressed to improve program management in a number of Government Service Centre programs. Funding was obtained through the Office of the Chief Information Officer (OCIO) to upgrade this system beginning in 2007-08. An extensive review of business practices has been undertaken and a number of improvements have already been made. These changes were brought on stream at the end of November 2007. A number of other upgrades and improvements are planned for the 2008-09 fiscal year, subject to budgetary appropriations, including the introduction of technology to allow the capture and entry of inspection data in the field.

All inspection specifics previously tracked on paper are now being tracked electronically for both the Standard Food Inspection and the Risk Score Assessment. Inspectors are required to indicate electronically, for every inspection completed, their finding for each of the individual items they review/inspect on site. Based on their entries, the system automatically calculates the rating for that inspection. The risk score is also automatically calculated based on the electronic entries related to the details of the annual risk score inspection.

Other changes to the system include the creation of a separate electronic licence folder which will organize the information in a much more coherent and efficient manner. It allows users to view the current Risk Score and Assessment at a glance, as well as to quickly determine what it was in any previous year. It will also allow the tracking of any inspections conducted in the 12 month period during which the licence was valid and the historical tracking of all data elements captured in the information fields. The previous practice of using a single electronic folder that was modified each year prevented this historical tracking.

We anticipate that these and other planned database improvements will greatly enhance the accuracy and management of our inspection system.

Compliance with the Memorandum of Understanding (MOU)

The Department of Government Services conducted an extensive review of its role and mandate between 2005 and 2006, during which it examined a number of its MOUs with other departments, including Heath and Community Services (HCS). These MOUs are now under active revision in preparation for discussions with our partner departments. We expect these discussions to be underway shortly. While the Department has been providing Regional Health Authorities with actual data on our inspection frequencies on a monthly basis, and has been developing draft annual reports since 2004-05, these reports have not been developed into final products owing to concerns about the accuracy of the database system. However, a draft report of the 2006-07 fiscal year is currently under review by management and will be forwarded to HCS in the near future. It is intended that regular meetings between senior management and executive of both departments be reinstated under the auspices of a revised MOU in 2008.

Management of the Food Premises and Licensing Program

As previously noted, the Department has undertaken a number of initiatives and measures to improve database capability and management of the food inspection and licensing program. We believe the evidence points to significant improvement in the program as a result, particularly in the 2006-07 fiscal year, and are continuing to address the challenges outlined in your audit in a diligent manner.

One of the key responses to overall program management is the re-establishment of a Division of Program & Support Services (formerly Support Services), approved in the 2007-08 Budget. This will restore and consolidate much needed capacity in the areas of policy and program development, information systems management, and reporting and performance management in a number of program areas, including

Environmental Health. Although it will take some time for the division to be fully staffed and operational, it should result in improvement to our programs and systems over the next several months and into the future.

A major contributing factor to the challenges in this program area, has been the shortage of qualified environmental health staff as noted in your report. There is a country-wide shortage of these inspectors which continues to present difficulty in recruitment and retention for these positions in this province. The Department has been in an almost continual state of recruitment efforts for a number of years. Qualified staff are often attracted to higher paying positions out of province or move into positions opening in more urban areas of the province, leaving more rural areas vacant on a frequent basis.

To help address this, the Department began a bursary program in 2006-07 to fund the placement of three Environmental Health students at the University of Cape Breton and has continued this initiative with a further placement of two more students in 2007-08. The goal of this program is to secure graduates for employment in rural areas of the province starting in the fall of 2008. In addition, government's Special Recruitment Challenges program has been used by the Department to allow for the placement of environmental health officer (EHO) interns doing practicum placements as a requirement for certification. This program has enabled the Department to hire six interns over the past two years, of which four have either accepted positions or are in the process of being offered positions within the Department.

Recent recruitment activities have also resulted in the Department being able to successfully staff the funded permanent position in Labrador. This will enable the Labrador area to have a dedicated EHO which will enhance the Department's ability to provide for the delivery of the Environmental Health program in that region. Over the past three years, this service has been provided by inspectors from the Island portion of the province on a rotating basis. A second position earmarked for Labrador some years ago has not been able to be filled. However, based on the existing workload, one position should be sufficient to cover the demand. We will be examining ways to augment service to this region should future demand require it.

In addition, following a workload analysis in a number of key program areas of the Department in 2006-07, the creation of six new technical positions were approved in the 2007-08 Budget. This should allow some of the lower level duties currently performed by EHOs, such as routine water sample collection, to be reassigned thereby enabling EHOs to spend more time on higher level functions such as food inspections and food safety training for operators.

Response - Department of Health and Community Services

1. Compliance with the Memorandum of Understanding (MOU)

The Department agrees with the recommendation of the Auditor General that the parties to the MOU carry out an annual evaluation of the MOU. The Department will work with the Department of Government Services and the Regional Health Authorities to complete this evaluation during 2008-09 and annually thereafter.

2. Inspection of Food Premises - Policy to Address Reoccurrence of Same Critical Hazard

The Department appreciates the recommendation to develop a policy with respect to situations whereby the same critical health hazards continue to reoccur in consecutive inspections of food premises. The Department currently has policy in place to deal with situations where inspectors identify critical hazards in inspections of food premises. This policy would also be applied if the same critical hazards occur in consecutive inspections; however, the Department will review the current policy direction on critical hazards as part of its ongoing review of all food safety related policies during fiscal year 2008-2009.

Highlights

Highlights of a review of insurance on motor vehicles for the fiscal year ended 31 March 2006.

Why our Office did this Review

The objectives of our review were to determine: what systems were in place to prevent the operation of motor vehicles without insurance; what systems were in place to ensure the detection of the operation of motor vehicles without insurance; and whether penalties for operating a motor vehicle without insurance were being enforced as provided by legislation.

What our Office Recommends

The Department should review activities at the Motor Registration Division to determine the extent to which they prevent or detect the operation of motor vehicles without insurance.

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

♦ ♦ ♦ ♦ ♦

To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.8
DEPARTMENT OF GOVERNMENT SERVICES
Insurance on Motor Vehicles

The Department of Government Services (the Department) is responsible for motor vehicle registration through its Motor Registration Division (MRD). The main office of MRD is located in Mount Pearl, with district offices located in Clarenville, Harbour Grace, Grand Falls-Windsor, Corner Brook and Wabush.

Motor vehicles are insured so that if a driver causes a motor vehicle accident, damages resulting from that accident will be covered. The *Highway Traffic Act* (the *Act*) states that*"[a] person shall not operate, or, being the owner, allow another person to operate, a motor vehicle on a highway unless there is in-force in respect of the motor vehicle a policy of insurance."* The penalty for driving without insurance is a fine of between $2,000 and $4,000 for the first offence and between $3,000 and $5,000 for the second and subsequent offences. In addition to the monetary fines, the *Act* requires the Registrar of Motor Vehicles to suspend an operator's driver's license and impound the vehicle for 90 days.

What We Found

Our review of activities at the Motor Registration Division as well as fines imposed and collected indicated there is not a significant deterrent for those who choose to operate motor vehicles without insurance. For the period 1 April 2001 to 31 March 2006, there were 5,161 convictions of driving without insurance against 3,518 individuals, which indicates that a significant number of individuals were operating motor vehicles without insurance.

Commercial Vehicles: The existence of insurance policies for commercial vehicles was not always verified as required. As a result of our review we determined that staff at the MRD office in Mount Pearl did not receive requests from the Clarenville, Grand Falls-Windsor or Corner Brook offices to verify insurance for registrations made at these offices.

Furthermore, certificates of insurance were not always on file as required. Our review of a sample of 100 registrations indicated that 16 did not have the insurance certificate on file and 17 had an insurance certificate on file but the policy number did not agree with the information contained in the MRD database.

Private Vehicles: There were no controls to prevent individuals from registering vehicles without insurance because MRD did not verify insurance information provided at registration and had no means of verifying the information it received as it did not have online access to insurance industry systems. As well, insurance companies were not required to notify MRD of insurance cancellations. Therefore, MRD was not able to prevent individuals from purchasing insurance when registering a motor vehicle and subsequently cancelling the insurance policy.

Enforcement: We noted that Highway Enforcement Officers were not able to verify whether an insurance card being presented as proof of insurance actually represented a valid, in-force insurance policy. In addition, in cases where proof of insurance was not presented or was invalid, follow-up letters were not always issued by MRD as required to be certain that all warning tickets to provide proof of insurance had been acted upon. Furthermore, in cases where individuals were convicted of operating a motor vehicle without insurance, MRD is not complying with the requirements of the *Act*, in that vehicles were not impounded, nor were drivers' licences suspended. Also, many of the fines imposed remained unpaid. As at 31 March 2006, the balance of unpaid fines relating to operating a motor vehicle without insurance totalled $9.5 million.

Background

The Department of Government Services is responsible for motor vehicle registration through its Motor Registration Division (MRD). The main office of MRD is located in Mount Pearl, with district offices located in Harbour Grace, Clarenville, Grand Falls-Windsor, Corner Brook and Wabush.

Motor vehicles are insured so that if a driver causes a motor vehicle accident, damages resulting from that accident will be covered. The *Highway Traffic Act* (the *Act*) states that *"[a] person shall not operate, or, being the owner, allow another person to operate, a motor vehicle on a highway unless there is in-force in respect of the motor vehicle a policy of insurance."*

The penalty for driving without insurance is a fine of between $2,000 and $4,000 for the first offence and between $3,000 and $5,000 for the second and subsequent offences. In addition to the monetary fines, the *Act* requires the Registrar of Motor Vehicles to suspend an operator's driver's license and impound the vehicle for 90 days.

Commercial and private vehicles

Commercial vehicles are those vehicles referenced in the *Ambulance, Bus, School Bus, Taxi and Commercial Motor Vehicles Insurance Regulations (*the *Regulations)* and include ambulances, buses, school buses and taxis. Under the *Regulations*, insurance companies are required to provide MRD with a "certificate of insurance" (certificate). The certificate must show the policy number, all commercial vehicles to which the policy applies, and the name and address of the insured. In addition, the insurance companies are required to notify MRD of the cancellation or expiry of any policy for which a certificate has been issued.

Private vehicles are considered to be vehicles other than those vehicles referenced in the *Regulations*. When registering a private vehicle, owners are required to provide MRD with the name of the insurance company and the policy number.

Audit Objectives and Scope

Audit objectives

The objectives of our review were to determine:

- what systems were in place to prevent the operation of motor vehicles without insurance;
- what systems were in place to ensure the detection of the operation of motor vehicles without insurance; and
- whether penalties for operating a motor vehicle without insurance were being enforced as provided by legislation.

Audit scope

Our review of activities relating to insurance on motor vehicles included interviews with MRD officials, a review of activities at the MRD for the fiscal year ended 31 March 2006, as well as a determination of fines imposed and collected for operating a motor vehicle without insurance. We completed our review in March 2007.

Overall Conclusions

Our review of activities at the Motor Registration Division as well as fines imposed and collected indicated there is not a significant deterrent for those who choose to operate motor vehicles without insurance.

For the period 1 April 2001 to 31 March 2006, there were 5,161 convictions of driving without insurance against 3,518 individuals, which indicates that a significant number of individuals were operating motor vehicles without insurance.

Commercial Vehicles

The existence of insurance policies for commercial vehicles was not always verified as required. As a result of our review we determined that staff at the MRD office in Mount Pearl did not receive requests from the Clarenville, Grand Falls-Windsor or Corner Brook offices to verify insurance for registrations made at these offices.

Furthermore, certificates of insurance were not always on file as required. Our review of a sample of 100 registrations indicated that 16 did not have the insurance certificate on file and 17 had an insurance certificate on file but the policy number did not agree with the information contained in the MRD database.

Private Vehicles

There were no controls to prevent individuals from registering vehicles without insurance because MRD did not verify insurance information provided at registration and had no means of verifying the information it received as it did not have online access to insurance industry systems.

As well, insurance companies were not required to notify MRD of insurance cancellations. Therefore, MRD was not able to prevent individuals from purchasing insurance when registering a motor vehicle and subsequently cancelling the insurance policy.

Enforcement

We noted that Highway Enforcement Officers were not able to verify whether an insurance card being presented as proof of insurance actually represented a valid, in-force insurance policy. In addition, in cases where proof of insurance was not presented or was invalid, follow-up letters were not always issued by MRD as required to be certain that all warning tickets to provide proof of insurance had been acted upon.

Furthermore, in cases where individuals were convicted of operating a motor vehicle without insurance, MRD is not complying with the requirements of the *Act*, in that vehicles were not impounded, nor were drivers' licences suspended. Also, many of the fines imposed remained unpaid. As at 31 March 2006, the balance of unpaid fines related to operating a motor vehicle without insurance totalled $9.5 million.

Detailed Observations

Overview

The following organizations play a role in ensuring motor vehicles are operating with insurance:

- The Motor Registration Division (MRD) of the Department of Government Services is responsible for ensuring vehicles are insured before they are registered.
- Police forces and MRD Highway Enforcement Officers are responsible for detection of drivers operating without insurance.
- Traffic Court Division of the Department of Justice is responsible for prosecution of drivers operating without insurance.
- Insurance companies are required to notify MRD whenever an insurance policy comes into force, is cancelled or expires for commercial vehicles such as ambulances, buses, school buses and taxis.

To ensure compliance with the *Act*, sufficient controls must be in place to prevent and detect the operation of motor vehicles without insurance. Also, penalties should be enforced to dissuade the operation of motor vehicles without insurance.

Controls over uninsured drivers

There are two types of controls in place to minimize the existence of uninsured drivers operating vehicles on Provincial roads.

- preventive controls to prevent registration of a motor vehicle without an insurance policy; and
- detective controls to detect operation of motor vehicles where a valid insurance policy is not in effect.

1. Preventive Controls

The controls in place to prevent registration of a motor vehicle without an insurance policy differ between commercial vehicles and private vehicles.

A. Commercial Vehicles

Introduction

Commercial vehicles are those vehicles referenced in the *Ambulance, Bus, School Bus, Taxi and Commercial Motor Vehicles Insurance Regulations (*the *Regulations)*. Commercial vehicles include ambulances, buses, school buses and taxis.

As at 31 March 2006, commercial vehicles were required to carry insurance as follows:

- third party liability to an amount of at least $200,000; and
- passenger insurance:
  - $1,000,000 for vehicles with seating capacity from one to 21; and
  - $2,000,000 for vehicles with seating capacity of 22 or more.

The *Regulations* stipulate that insurers of commercial vehicles must file a certificate of insurance with MRD which shows the policy in effect, the name and address of the insured and all vehicles to which the policy applies. Certificates of insurance are filed at MRD in Mount Pearl.

The *Regulations* also require that insurance companies notify MRD in writing of the cancellation or expiry of a policy for which a certificate of insurance has been issued.

Verification of insurance policy not always carried out

Commercial vehicles may be registered in person at MRD, at banking institutions, by mail and through the Internet at which time insurance policy information is required.

MRD officials indicated that the insurance policy was verified for all registrations made through the MRD office in Mount Pearl.

Since certificates of insurance are maintained at MRD in Mount Pearl, staff in Mount Pearl are often requested by district offices to verify insurance. Staff in Mount Pearl indicated that the Harbour Grace and Wabush offices contact the office on a regular basis; however staff did not receive verification requests from Clarenville, Grand Falls-Windsor and Corner Brook.

As a result, insurance policy information is not verified for all commercial vehicles as required.

Insurance certificates not on file or information inaccurate

We reviewed 100 registrations for ambulances, buses, school buses and taxis to test whether insurance certificates that were required to be on file at MRD were filed. Figure 1 shows the number of insurance certificates that were either not on file or had an incorrect policy number.

Figure 1

Insurance Certificates for Commercial Vehicles
Fiscal Year 2005-06

	Ambulance	Bus	School bus	Taxi	Total
Sample size	8	13	40	39	**100**
Insurance certificate not on file	2	2	7	5	**16**
Insurance certificate on file, policy number incorrect	1	2	4	10	**17**

As Figure 1 shows, 16 registrations did not have the insurance certificate on file and 17 had an insurance certificate on file that had an incorrect policy number.

B. Private Vehicles

Introduction

Private vehicles are considered to be vehicles other than those vehicles referenced in the *Ambulance, Bus, School Bus, Taxi and Commercial Motor Vehicles Insurance Regulations (*the *Regulations)*. Private vehicles are vehicles other than ambulances, buses, school buses and taxis.

No control over registration of uninsured private vehicles

There are no controls to prevent individuals from registering private vehicles without insurance. Owners of private vehicles are required to provide MRD with an insurance policy number and insurance company name upon registration of the vehicle. However, during our review we determined that:

- MRD does not verify insurance information and has no means of verifying the information it receives as it does not have online access to insurance industry systems.

  Therefore, there is no control to prevent an individual, who is prepared to provide false information, from obtaining a motor vehicle registration without insurance.

- MRD is not able to prevent individuals from purchasing insurance when registering a motor vehicle and subsequently cancelling the insurance policy because insurance companies are not required to notify MRD when an insurance policy for a private vehicle is cancelled.

  As a result, there is no control to detect or prevent an individual from cancelling their insurance policy after registering a private vehicle.

2. Detective Controls

A. Identification of Uninsured Vehicles

Introduction

Identification of the operation of uninsured private and commercial vehicles is usually only possible by the intervention of a police officer or a MRD Highway Enforcement Officer. MRD officials indicated that uninsured drivers may be detected when one of these traffic officers stops a driver for any reason and asks to see their driver's licence, registration and proof of insurance.

Proof of insurance not verified

According to the *Act*, individuals are required to produce proof of insurance when requested by a traffic officer. An official at MRD indicated that in the case of Highway Enforcement Officers, they also used to be able to contact MRD from the road to have an insurance company contacted where they were suspicious about the proof of insurance being presented. However, this was considered disruptive to normal duties at MRD and the practice has since been discontinued. As a result, Highway Enforcement Officers do not have an effective means of verifying whether an insurance card being presented as proof of insurance actually represents a valid, in-force insurance policy.

When a motorist has been requested to produce proof of insurance and is unable to provide proof at the time of request, a warning ticket is issued by the traffic officer. According to the *Act*, the motorist is given 48 hours to produce proof that a policy of insurance is in force for the motor vehicle. The established process is as follows:

- the original copy of the warning ticket is forwarded to MRD for data entry into the database;
- a second copy is forwarded to data entry for matching with the original when proof of insurance is presented;
- a follow-up letter is issued weekly for any unmatched warning tickets in the system;

- a Highway Enforcement Officer makes an on-site visit to the motorist's home or business and either verifies insurance is in force or removes the plates from the vehicle; and

- a traffic ticket is issued for driving without insurance if proof of insurance is not presented during the visit.

Warning tickets not always acted upon

MRD officials indicated that warning tickets issued by traffic officers were not always forwarded for data entry. In addition, follow-up letters were not always issued as required, to be certain that all warning tickets to provide proof of insurance had been acted upon.

B. Enforcement of Legislation

Introduction

Individuals who are charged with operating a motor vehicle without insurance are prosecuted by the Traffic Court Division of the Department of Justice. Effective 8 June 2004, upon conviction, a fine of between $2,000 and $4,000 may be imposed for a first offence. A fine of between $3,000 and $5,000 may be imposed for subsequent convictions. Prior to 8 June 2004, a fine of between $1,000 and $2,000 was imposed for a first offence; while a fine of between $2,000 and $4,000 was imposed for subsequent convictions.

Figure 2 shows the fines imposed for operating a motor vehicle without insurance for fiscal years 2001-02 to 2005-06. The Figure also shows the average fine and total unpaid balances for each fiscal year.

Figure 2

Number and Value of Fines
Fiscal Years 2001-02 to 2005-06

Fiscal Year	Number of convictions	Value of fines imposed ($ Millions)	Average fine ($)	Balance unpaid ($ Millions)
2005-06	934	$2.1	2,248	$9.5
2004-05	947	1.7	1,795	8.2
2003-04	1,135	1.2	1,057	6.9
2002-03	1,187	1.2	1,011	6.1
2001-02	958	1.0	1,044	5.2
Total	**5,161**	**$7.2**		

Source: Data obtained from Fines Administration Division, Department of Justice, and Motor Registration Division, Department of Government Services

Fines not collected

As Figure 2 shows, a large amount of the fines imposed are not collected. As a result, fines for driving without insurance may not be a deterrent as fines are not always paid.

A detailed analysis of the statistics in Figure 2 indicated:

- there were 5,161 convictions against 3,518 individuals;
- of the 5,161 convictions there were 2,504 multiple convictions (more than one) against 861 individuals, representing $3.6 million of the $7.2 million imposed; and
- a total of 56 individuals were convicted between 6 and 14 times (for 425 total convictions) in the past five years representing $0.6 million of the $7.2 million imposed.

MRD does not comply with *Act*

Upon conviction of operating a motor vehicle without insurance, MRD is required under the *Act* to suspend the driver's licence for a period of 90 days and direct the seizure and impoundment of the motor vehicle for a period of 90 days.

MRD staff indicated that the Division had never suspended a driver's license or directed the impoundment of the vehicle related to the lack of insurance. Therefore, MRD is not complying with requirements under the *Act*.

Recommendation

The Department should review activities at the Motor Registration Division to determine the extent to which they prevent or detect the operation of motor vehicles without insurance.

Department's Response

The Department of Government Services is currently working on enhancing the systems of controls used to verify commercial and private vehicles are insured. I offer the following specific comments on issues raised in your report:

1. Preventative Controls

A. Commercial Vehicles:

Verifications of insurance

Although the offices in Harbour Grace and Wabush contact the lead office in Mount Pearl to verify a certificate of insurance is on file, the regional offices in Clarenville, Grand Falls-Windsor and Corner Brook do request proof of the required insurance for commercial vehicles beyond the regular insurance card held by the registrant. Copies of the letters or other acceptable proof of public passenger insurance are kept on file.

In relation to the 16 files noted where insurance certificates were not on file, the Department will be implementing a regular commercial vehicle insurance information report for all buses, school buses, ambulances and taxis for which changes (e.g. initial registrations, transfers, renewals) have been made in the MRD database during a specified time frame. This information will be compared against the information contained in the manual insurance files for commercial vehicles. In cases where there are discrepancies, the Department will contact the registrant requesting updated information within 30 days. Where proof of insurance is not provided, a plate seizure order will be issued and the plates confiscated by our Highway Enforcement Officers. This audit process will ensure that over time, all of the registered commercial vehicles are targeted, insurance manually verified and the proper documentation filed.

Also it is important to note that in some of the 17 cases where the policy number did not agree with the MRD database, there were temporary or "binder" numbers on file. Insurers will issue this temporary number to allow the registration of the vehicle until such time as a certificate of insurance is issued by the head office of the insurer. The policy number issued does not always correspond with the temporary or "binder number", but insurance was in place in these cases.

B. Private Vehicles:

Control over registration with insurance

The system of controls to ensure individuals registering vehicles have insurance is not unique to Newfoundland & Labrador. Similar systems are used in other provinces and territories that do not have government-run insurance schemes. Only the Province of Ontario has an on-line insurance verification program linked to the private insurance industry. Ensuring that every vehicle operated on public roadways carries the necessary legislated limits of insurance is not practically manageable without on-line access to insurance providers.

Departmental officials have held discussions with other Atlantic Provinces' Registrars of Motor Vehicles regarding the possibility of pursuing a joint initiative to implement an on-line insurance verification program.

Such an on-line system, however, would take time to establish. Consequently, in addition to measures currently in place to verify proof of insurance, the Department will consult with the insurance industry on the feasibility of a cooperative monthly audit of a select number of private vehicles to confirm compliance with insurance requirements and ensure the information provided on policies is accurate and the policy has not been cancelled after a vehicle is registered. As happens now in any situation where insurance cannot be verified, if the identified insurer indicates a policy has been cancelled, the Department will contact the registrant requesting updated information within 30 days. Where proof of insurance is not provided, a plate seizure order will be issued.

2. Detective Controls

A. Identification of Uninsured Vehicles:

Proof of insurance verification

An insurance company must submit to MRD a Notice of Cancellation within ten days in respect to ambulances, buses, school buses and commercial motor vehicles. The regulations states:

"Every insurer shall notify in writing the registrar of the cancellation or expiration of a policy for which a certificate of insurance has been issued in accordance with this section at least 10 days before the effective date of cancellation or expiration and, in the absence of that notice of cancellation or expiration, the policy shall remain in full force and effect".

In the absence of a Notice of Cancellation, the policy remains in full force and effect from a legal perspective.

With respect to detection, there are processes in place to contact the registrant when MRD receives notification of cancellation of insurance from the insurance company related to commercial vehicles. Each registrant is notified, in writing, of the receipt of cancellation notice and is given 30 days to provide other proof of insurance or to return the plates to the Division. In cases where proof of insurance is not provided, a plate seizure order is issued and the plates are confiscated by our Highway Enforcement Officers.

Also if proof of insurance is not provided at a road-stop inspection, the driver is given 48 hours to provide proof of insurance and, if they fail to do so, a ticket is issued for failure to produce that an insurance policy is in force. This is the case for both commercial and private vehicles.

With respect to Highway Enforcement Officers verifying insurance information for either commercial or private vehicles, the time involved in making an inquiry respecting insurance coverage can be extensive and therefore very demanding on limited resources with competing priorities. In addition, with ever increasing privacy restrictions on releasing personal information, without a formal arrangement in place, many insurers will not release insurance information relative to their clients without written permission.

By implementing the audit on commercial vehicles, which can be done immediately, and exploring an audit process for private vehicles as well as on-line verification for all vehicles as noted previously in this letter, the Department is working to improve insurance verification.

Warning tickets

Where the vehicle registration is found to have lapsed, as an alternative follow-up procedure, MRD inactivates the registration of the vehicle, thus preventing a person from renewing the registration until such time as the condition identified in the warning ticket is rectified. This would account for the cases you identified where there is no follow-up letter issued with respect to a warning ticket.

B. Enforcement of Legislation

Fines

In evaluating the data provided in your report regarding the number and value of fines for fiscal years 2002-03 to 2005-06, we note that there has been a positive trend downward on the total number of convictions for driving with no insurance. This may be seen as a positive indicator that the fines imposed are a deterrent for many individuals. Further analysis indicates that annually the total number of convictions for no insurance represents less than 1% of the driving population.

Of the 56 repeat offenders sampled, you requested detailed information on 13 of these individuals. We note none of these 13 have valid driver's licences and five never held a driver's licence. In addition, seven of the 13 are already suspended for other reasons. These multi-conviction offenders are a very small percentage of the population and are not indicative that existing deterrents are not sufficient.

There are provisions contained in the Highway Traffic Act that prohibit the registration of vehicles or issuance of a driver's licence where there are outstanding fines. The MRD system is interactive in real time with the Ticket Management System. Before processing any transaction MRD will collect the total amount of outstanding fines or accept a clearance letter from the Department of Justice for individuals who have made arrangements for payment plans.

The Department of Justice is developing an Inter-Agency Protocol for quickly implementing new provisions in the Provincial Offences Act which strengthen the court's ability to enforce compliance with the imposition of court-ordered fines. In essence, the court will have the power to require the person in default to file a statement of finances. If there is a failure to comply or if there is a failure to make payments ordered by the court, the person in default may be held in contempt and incarcerated for periods ranging up to six months imprisonment.

Compliance with the Highway Traffic Act

Legislation requiring the suspension of uninsured drivers and impoundment of vehicles came into force on August 1, 2004.

While an initial attempt was made to implement this requirement, and a limited number of suspensions were issued, a number of difficulties arose including extensive use of resources to track vehicles, limited infrastructure to impound vehicles and the absence of appeal mechanisms in circumstance where the driver is not the owner. MRD's strategy at this point is three-fold, to: implement the suspension of the driver's license and vehicle registration where the driver of the vehicle is the owner; develop workable mechanisms to implement suspensions where the driver is not the owner; and review the requirement for vehicle seizure and impoundment to determine if implementation is feasible and what other strategies may achieve the same goal.

Highlights

Highlights of a review of hospital-acquired infections at the Department of Health and Community Services for the period January 2004 to September 2007.

Why our Office did this Review

The objectives of the audit were to: review the role and responsibilities of the Department as it relates to hospital-acquired infection control; determine the incidence of hospital-acquired infections; determine whether the Authorities and their predecessor organizations had the basic requirements of an infection control program in place to prevent, detect, contain and treat hospital-acquired infections and monitor trends; and review the implementation status of recommendations contained in the Provincial Task Force Report, *Back to Basics*.

What our Office Recommends

Following are highlights of recommendations included in the Report that the Department should address. The Department should:

- develop Province-wide policies and standards for hospital-acquired infection control and monitor compliance to those by the Authorities;
- provide leadership and work with the Authorities to develop and implement Province-wide policies and procedures for infection control;
- ensure that the numbers of ICP positions in the Province meet minimum Health Canada recommendations;
- determine whether surveillance activities and clinical self-audits are carried out, reviewed and acted upon on a consistent and timely basis; and
- discuss with the Authorities their capacity to provide statistical information for management of hospital-acquired infections on a Province-wide basis.

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca.

Chapter 2, Part 2.9

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

Hospital-Acquired Infections

The Department of Health and Community Services (the Department) provides leadership in health and community service programs and policy development for Newfoundland and Labrador through four regional integrated health authorities (the Authorities). The Authorities deliver services to residents of the Province and oversee community service programs and facilities in their area.

What We Found

Subsequent to the SARS outbreak in the Spring of 2003, Government appointed a Task Force to review the standards, policies, procedures and resources related to control and prevention of communicable diseases that exist in facilities and medical clinics operated by institutional health boards. In March 2004, the Task Force issued a report titled *"Back to Basics,"* which identified that there was a lack of Provincial direction/standards for best practices in infection control, that limited time and resources have been dedicated to developing and implementing policies and procedures, and that training of hospital personnel was inadequate. Over three years later, none of the recommendation areas have been fully acted upon.

Our audit focused on hospital-acquired infections which were included in the issues addressed in the *Back to Basics* report. We concluded that Government does not know either the number of hospital-acquired infections or the number of deaths resulting from such infections in the Province. This situation has resulted because the Department does not require the Authorities to provide information on hospital-acquired infections, and the Authorities do not accumulate information on hospital-acquired infections using comparable methods. Furthermore, the Authorities do not keep statistics on whether any deaths have resulted from hospital-acquired infections.

Our review indicated that the Department has not developed a Province-wide infection control program relating to the prevention, detection and control of hospital-acquired infections. As a result, there are multiple infection control programs developed by the former health care boards which are currently in use at the four Authorities. Furthermore, the Department has not made any determination about the adequacy of the various infection control programs currently in use throughout the Province and is not monitoring how such programs are being delivered or their success in preventing, detecting and controlling hospital-acquired infections. Without a determination of program adequacy, including an appropriate assessment of risk and implementation of program monitoring, the Province may not be as well prepared to manage hospital-acquired infections as it should be. This could result in increased risk to the public in contracting hospital-acquired infections.

The following findings identified during our review of the various infection control programs currently in place at the Authorities further illustrate these concerns:

- none of the four Authorities meet the minimum standards for the number of Infection Control Practitioners as recommended by Health Canada;
- only two of the eight former health care boards conducted regular clinical self-audits or equipment/facilities self-audits to assess adherence to infection control practices. The other six former health care boards conducted self-audits on a reactive basis. The lack of regular self-audits is a concern since issues associated with such items as contaminated gowns, hand washing, and equipment not being cleaned on a regular basis were noted in some Infection Control Committee minutes;
- protective equipment and supplies were not always in place; and
- the Authorities do not always notify discharged patients of their possible exposure to hospital-acquired infections. For example: an improperly cleaned gastrointestinal video scope used on 72 individuals in the former Avalon Health Care Institutions Board; and a scabies outbreak in the former Central East Health Care Board.

Background

The Department of Health and Community Services (the Department) provides leadership in health and community service programs and policy development for Newfoundland and Labrador through 4 regional integrated health authorities (the Authorities). The Authorities deliver services to residents of the Province and oversee community service programs and facilities in their area. The 4 Authorities were formed on 1 April 2005 when the Department reorganized 14 health care and health and community services boards.

Figure 1 provides the details of how the 14 organizations were reorganized into the four Authorities. The intent of the reorganization was to provide better coordination and planning for the health care needs within regions of the Province and to reduce duplication.

Figure 1

Reorganized Boards

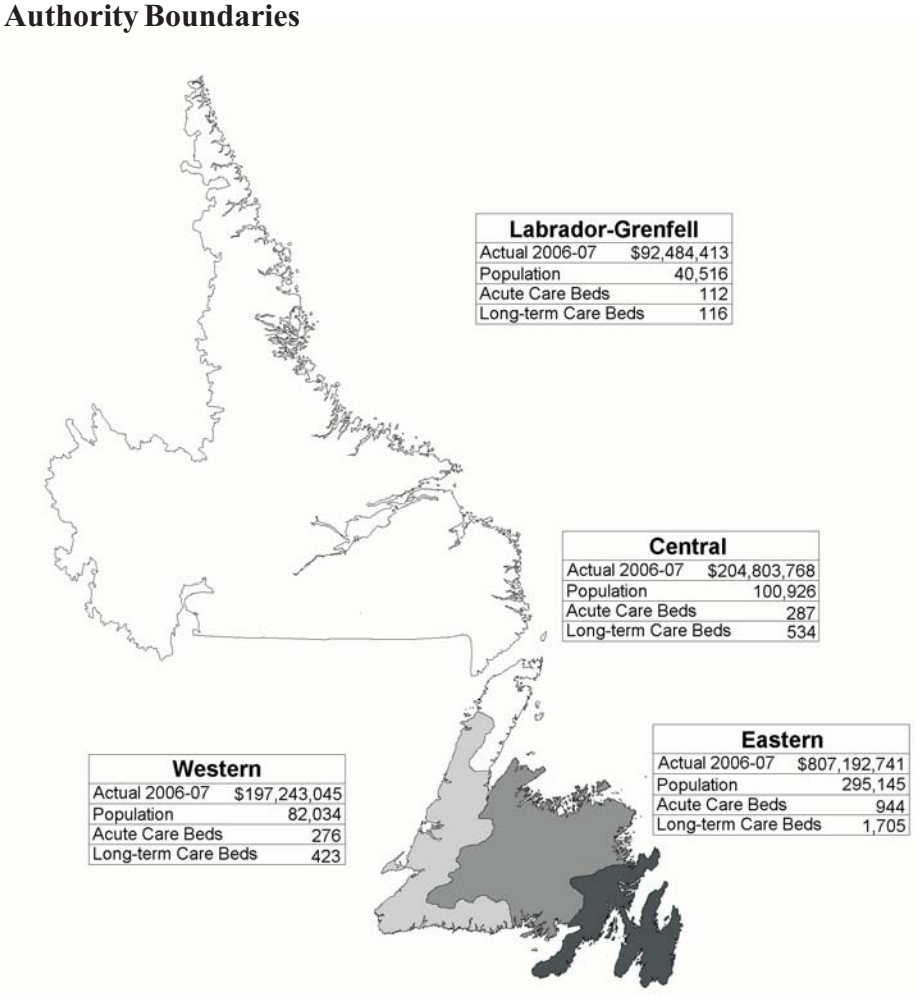
Authority	Former Board
Eastern	Health Care Corporation of St. Johns. *
	St. John's Health and Community Services Board.
	St. John's Nursing Home Board.
	Avalon Health Care Institutions Board.*
	Peninsulas Health Care Corporation.*
	Eastern Health and Community Services Board.
	Newfoundland Cancer Treatment and Research Foundation.
Central	Central West Health Care Institutions Board.*
	Central East Health Care Institutions Boards.*
	Central Regional Health and Community Services Board.
Western	Western Health Care Corporation.*
	Western Regional Health and Community Services Board.
Labrador-Grenfell	Health Labrador Corporation.*
	Grenfell Regional Health Services Board.*

Source: Department of Health and Community Services
*Referred to as "former health care boards" in this document.

Figure 2 shows the four current Authority boundaries as well as statistics for each region including actual expenditures for 2006-07, population, number of acute care beds and number of long-term care beds.

Figure 2

Department of Health and Community Services
Authority Boundaries



As Figure 2 shows, the four Authorities represent the Eastern, Central, Western and Labrador-Grenfell regions of the Province. They provide 1,619 acute care beds and 2,778 long-term care beds in the Province for a population of over 500,000.

Hospital-acquired infections costly to Canadians

In November 2002, Commissioner Roy J. Romanow Q.C. released his final report, *Building on Values: The Future of Health Care in Canada*. Data assembled by the lead author of that report indicated that Canadians contract more than 200,000 hospital-acquired infections annually and that these infections result in between 8,500 and 12,000 deaths in Canada each year. The report also estimated the direct costs of hospital-acquired infections in Canada to be approximately $1 billion annually.

Hospital-acquired infections

Hospital-acquired infections are caused by bacteria, viruses, fungi or parasites and are generally defined as infections that were neither present nor incubating prior to the patient being admitted to the hospital but occurred after the patient was admitted for other conditions. This definition also includes infections acquired by patients in the hospital but not appearing until after discharge. Any infectious disease can become known as a hospital-acquired infection if the disease was contracted in a hospital.

Status of infection control in Newfoundland and Labrador

In September 2003, in the aftermath of the SARS (Severe Acute Respiratory Syndrome) experience in Ontario and British Columbia, the Province's Minister of Health and Community Services announced a Task Force with a mandate to

"...review the standards, policies, procedures and resources related to control and prevention of communicable diseases that exist in facilities and medical clinics operated by institutional health boards and the ambulance system in the Province of Newfoundland and Labrador."

This mandate encompassed emerging infections such as SARS.

The Task Force held focus groups and meetings with over 500 representatives including senior administrators, physicians, program managers and front line workers from the 14 health care and health and community services boards across Newfoundland and Labrador to get a clear understanding of their infection control capabilities.

***Back to Basics* Report**

The Task Force report, *Back to Basics*, released in March 2004, is the most current review of Provincial infection control practices. The Report found that there was a lack of Provincial direction/standards for best practices in infection control, that limited time and resources has been dedicated to developing and implementing policies and procedures, and that training of hospital personnel was inadequate.

The *Back to Basics* report contained recommendations in seven areas:

1. the appointment of a Provincial Infection Control Expert Team;
2. the development of a Provincial Clinical Rapid Response Team;
3. support for Infection Control Practitioners;
4. education and workplace standards for health care workers;
5. "real-time" infection surveillance;
6. structural/environmental issues; and
7. communications.

Audit Objectives and Scope

Audit objectives

The objectives of the audit were to:

- review the role and responsibilities of the Department as it relates to hospital-acquired infection control;
- determine the incidence of hospital-acquired infections;
- determine whether the Authorities and their predecessor organizations had the basic requirements of an infection control program in place to prevent, detect, contain and treat hospital-acquired infections and monitor trends; and
- review the implementation status of recommendations contained in the Provincial Task Force Report, *Back to Basics*.

Audit scope

Our review of hospital-acquired infections included interviews with officials from the:

- four Authorities;
- Department of Health and Community Services;
- Newfoundland and Labrador Centre for Health Information (NLCHI); and
- Newfoundland and Labrador Public Health Laboratory (NLPHL).

We also reviewed policies, procedures and systems related to infection control, minutes of infection control committee meetings at hospitals for the period from January 2004 to September 2007 and the *Back to Basics* Report. We completed our review in November 2007.

Overall Conclusions

Subsequent to the SARS outbreak in the Spring of 2003, Government appointed a Task Force to review the standards, policies, procedures and resources related to control and prevention of communicable diseases that exist in facilities and medical clinics operated by institutional health boards. In March 2004, the Task Force issued a report titled *"Back to Basics,"* which identified that there was a lack of Provincial direction/standards for best practices in infection control, that limited time and resources have been dedicated to developing and implementing policies and procedures, and that training of hospital personnel was inadequate. This is the most current review of Provincial infection control practices. Over three years later, none of the recommendation areas have been fully acted upon.

Our audit focused on hospital-acquired infections which were included in the issues addressed in the *Back to Basics* report. Hospital-acquired infections are caused by bacteria, viruses, fungi or parasites and are generally defined as infections that were neither present nor incubating prior to the patient being admitted to the hospital but occurred after the patient was admitted for other conditions. This definition also includes infections acquired by patients in the hospital but not appearing until after discharge. Any infectious disease can become known as a hospital-acquired infection if the disease was contracted in a hospital.

We concluded that Government does not know either the number of hospital-acquired infections or the number of deaths resulting from such infections in the Province. This situation has resulted because the Department does not require the regional integrated health authorities (the Authorities) to provide information on hospital-acquired infections and the Authorities do not accumulate information on hospital-acquired infections using comparable methods. Furthermore, the Authorities do not keep statistics on whether any deaths have resulted from hospital-acquired infections.

Our review indicated that the Department has not developed a Province-wide infection control program relating to the prevention, detection and control of hospital-acquired infections. As a result, there are multiple infection control programs developed by the former health care boards which are currently in use at the four Authorities.

Furthermore, the Department has not made any determination about the adequacy of the various infection control programs currently in use throughout the Province and is not monitoring how such programs are being delivered or their success in preventing, detecting and controlling hospital-acquired infections.

Without a determination of program adequacy, including an appropriate assessment of risk and implementation of program monitoring, the Province may not be as well prepared to manage hospital-acquired infections as it should be. This could result in increased risk to the public in contracting hospital-acquired infections.

The following findings identified during our review of the various infection control programs currently in place at the Authorities further illustrate these concerns:

- none of the four Authorities meet the minimum standards for the number of Infection Control Practitioners as recommended by Health Canada i.e. 5.6 Infection Control Practitioner full-time equivalent positions still required 3 years after the *Back to Basics* report issued;

- only two of the eight former health care boards conducted regular clinical self-audits or equipment/facilities self-audits to assess adherence to infection control practices. The other six former health care boards only conducted self-audits on a reactive basis. The lack of regular self-audits is a concern since issues associated with such items as contaminated gowns, hand washing, and equipment not being cleaned on a regular basis were noted in some Infection Control Committee minutes;

- protective equipment and supplies were not always in place; and
- the Authorities do not always notify discharged patients of their possible exposure to hospital-acquired infections. For example:
  - an improperly cleaned gastrointestinal video scope used on 72 individuals in the former Avalon Health Care Institutions Board; and
  - a scabies outbreak in the former Central East Health Care Board.

Detailed Observations

Overview

The basic components of an infection control program in acute and long-term care facilities include Infection Control Committees (ICCs), Infection Control Practitioners (ICPs), infection control policies and procedures, infection surveillance and compilation of associated statistics, education and training of personnel, facility hygiene, self-audit practices and consultation with Infection Control Practitioners (ICPs) in the construction and renovation of facilities.

In the four Authorities, all aspects of infection control activities including surveillance, prevention and control were being managed by Infection Control Committees (ICCs) as follows:

- 3 at the Eastern Health Authority;
- 2 at the Central Health Authority;
- 1 at the Western Health Authority; and
- 2 at the Labrador-Grenfell Health Authority.

When we completed our site visits in September 2006, the Authorities had not yet fully consolidated their infection control programs. Therefore, our review focused on the infection control programs that had been operated by the eight former health care boards. In October 2007, we requested that the Department and each of the Authorities provide an update as to infection control in their areas. Our findings are discussed in the following sections:

1. Role and responsibilities of the Department;
2. Statistics related to hospital-acquired infections;
3. Infection control in Newfoundland and Labrador;
4. Implementation of the *Back to Basics* Report recommendations; and
5. Other issues.

1. Role and Responsibilities of the Department

Introduction

The Department of Health and Community Services provides leadership in health and community services programs and policy development for the Province. For example, one of the Department's lines of business is to *"provide direction and support to agencies and regional boards to deliver a continuum of programs and services within available resources."*

Therefore, this would imply that, hospital-acquired infection control in place at the Authorities falls under the Department's leadership and policy development mandate. Given this mandate to oversee hospital-acquired infection control in the Province, we would expect the Department to develop policy and establish standards for hospital-acquired infection control to ensure consistency among the Authorities in terms of:

- infection control programs;
- sufficient staff to carry out and manage the infection control programs;
- resources for training;
- surveillance activities and data collection;
- monitoring of results;
- reporting on regional and provincial statistics; and
- disease outbreak preparedness at the institution level.

Department not monitoring or ensuring consistent infection control practice in the Province

When we began our review in January 2006 Department officials referred us to the Authorities for information on infection control. Even though the *Back to Basics* Report noted that there was a lack of Provincial direction/standards for best practices in infection control, the Department is still not providing a leadership role in policy development related to hospital-acquired infection control standards nor does it have any responsibility for the infection control programs in place within the health care institutions in the Province.

Department officials indicated that there is no one at the Department who is responsible for establishing policies or standards with respect to hospital-acquired infection control and that no Provincial monitoring program is in place. Infection control officials at the Authorities indicated that this lack of direction and support from the Department is an issue. These officials further indicated that there are times when they have requested direction and support as it relates to policy development from the Department but have not always received such.

During our review, the Department's lack of involvement in hospital-acquired infection control in the Province was apparent as policies and standards for the Province had not been developed. In addition, statistics about infection control that were available from the ICCs at the Authorities were not requested or reviewed by the Department. As a result, the Department was not informed about infection rates and trends and the potential impact on the residents of the Province.

Conclusions

At the time of our review we concluded that the Department did not know the extent of hospital-acquired infections and whether there were procedures in place to address infection control.

Recommendation

The Department should develop Province-wide policies and standards for hospital-acquired infection control and monitor compliance by the Authorities to those policies and standards.

2. Statistics related to Hospital-Acquired Infections

Introduction

In completing the review of hospital-acquired infections, we expected to obtain statistics as to the number of infections acquired in the Province's health care institutions as well as the number of deaths that had occurred as a result of these infections. Furthermore, we expected that the statistical information would be available by infection type, by year, by institution and in the case of surgery related infections, by surgeon.

In order to obtain these statistics we requested information from the Department and the Authorities. We also made inquiries of the Newfoundland and Labrador Centre for Health Information (NLCHI).

No Province-wide Hospital-acquired infection statistics

The Department could not provide any statistics on hospital-acquired infections. Department officials indicated that they do not monitor these statistics and therefore do not request this information from the Authorities.

All of the Authorities carry out infection control surveillance and maintain hospital-acquired infection statistics as a part of their infection control programs. Our review indicated that surveillance methods and the statistical records maintained are not always consistent from one Authority to another. As a result, these statistics are incomplete and inconsistent. Therefore, even if the Department requested information on hospital-acquired infections from the Authorities, the statistics currently compiled by the Authorities are not gathered using a Province-wide standard since there is no Province-wide policy on how these statistics should be accumulated.

When the Department and the Authorities could not provide statistics on hospital-acquired infections, we contacted the Newfoundland and Labrador Centre for Health Information (NLCHI). The NLCHI collaborates with the Province's health care system to ensure that quality health information is available for health care, system-wide planning, research, and policy development.

While NLCHI was able to provide statistics on infections in the Province in general, they did not have any information specific to hospital-acquired infections. Department officials indicated that the NLCHI does not have a mandate, nor is their data collection process designed to allow for the accumulation of information to report on hospital-acquired infections.

Death statistics from hospital-acquired infections not available

The Authorities do not maintain statistics on deaths resulting from hospital-acquired infections. Although the NLCHI uses information from death certificates to compile information on deaths in the Province, the information compiled does not identify the number of deaths resulting from hospital-acquired infections.

The death information in Figure 3 does not distinguish between those deaths attributed to infections contracted in a hospital and those contracted outside the hospital; however, they do provide information and related trends on deaths from infections in the population as a whole.

Figure 3

Deaths by Infection Type
Fiscal Years 2001-02 to 2005-06

Infection Type	2001-02	2002-03	2003-04	2004-05	2005-06	Total
Blood	56	53	83	66	91	349
Respiratory	11	9	9	16	8	53
Urinary Tract Infections	4	6	7	5	14	36
Acute abdomen	8	5	2	7	5	27
Pancreatitis	3	6	5	3	3	20
Intestinal (C. difficile)	-	-	-	1	2	3
Other	6	14	16	11	10	57
Total	**88**	**93**	**122**	**109**	**133**	**545**

Source: NLCHI (death certificates)

As Figure 3 shows, for the fiscal years 2001-02 to 2005-06, NLCHI reported 545 deaths in the Province that listed "infection" as the immediate cause of death. This included any deaths from hospital-acquired infections. Deaths caused by infections increased by 51.1% between 2002 (88) and 2006 (133). Because neither NLCHI nor the Authorities could provide separate statistics for deaths caused by hospital-acquired infections, the Department was not able to monitor trends in deaths that resulted from hospital-acquired infections.

Increasing concern over antibiotic resistant bacteria

A senior infection control official at the Eastern Health Authority expressed concern over antibiotic resistant infections. Some of these infections stem from common bacteria normally resident in the hospital environment that have become increasingly resistant to standard antibiotics. This resistance occurs because of the inappropriate and overuse of these drugs. As a result, much stronger medications are required to treat the infection and in some cases these infections become impossible to treat.

The most common of these antibiotic resistant bacterial infections are:

- Methicillin-Resistant Staphylococcus Aureus (MRSA);
- Vancomycin-Resistant enteroccocci (VRE)

In addition to these antibiotic resistant infections, C. *difficile* is another serious infection that results from the inappropriate and overuse of antibiotics.

There are numerous research articles and statistics related to these antibiotic resistant infections and C. *difficile*. However, very few provide statistics on a Province-wide basis. The increasing significance of these infections and related statistics is evidenced by the fact that Health Canada will require that MRSA and C. *difficile* cases be reported to them effective January 2008 and that these statistics will be required for the next round of hospital accreditations.

MRSA

A senior infection control official at the Eastern Health Authority also advised that Newfoundland and Labrador has the highest incidence of antibiotic use in Canada. The official says that despite this, the occurrence of these infections in this Province appeared to be lower than in the larger centers, possibly due to lower patient contact as a result of lower population densities. However, the MRSA situation in the Province is now getting worse, for example we noted in the Eastern Health Authority ICC minutes of 28 May 2007 that:

"MRSA rates are now on par with the national average and a strategy is needed to reduce incidence of MRSA, including controlling antibiotic use, ongoing education, increased attention to cleaning of equipment and the environment."

C. *difficile*

There was significant statistical information available on the occurrence of C. *difficile* infections; however, most was related to specific hospitals or regions of Canada. A prospective six month surveillance by the Canadian Nosocomial Infection Surveillance Program in 34 hospitals in all regions of Canada during the period 1 November 2004 to 30 April 2005 indicated that 1,847 patients had C. *difficile* associated diarrhea resulting in 326 having severe outcomes including:

- 18 colectomy surgeries;

- 37 admitted to intensive care; and
- 103 deaths that were either directly or indirectly related to C. *difficile*.

Figure 4 shows the incidence of C. *difficile* in the Province from 2002 to 2006.

Figure 4

Incidence of C. *difficile*
Newfoundland and Labrador
Fiscal years 2001-02 to 2005-06

2001-02	2002-03	2003-04	2004-05	2005-06
8	11	26	60	69

Source: NLCHI

The statistics in Figure 4 were compiled by NLCHI, at our request, and included patients diagnosed with C. *difficile* after being admitted to the hospital for another ailment or condition. This criterion allowed for the selection of patients that likely acquired the infection while in the hospital. While this is only an approximation of the C. *difficile* cases, the criterion were applied consistently for each of the years and the indicated trend is likely a fair representation of the incidence of this infection in the Province's hospitals.

As shown in Figure 4, C. *difficile* infections increased each year from 2002 to 2006. Furthermore, as Figure 3 shows, C. *difficile* was determined to be the cause of death in one instance in 2005 and two in 2006. This demonstrates that incidences of C. *difficile* are on the rise in the Province.

Conclusions

The Department could not provide any statistics on hospital-acquired infections. Department officials indicated that they do not monitor these statistics and therefore do not request this information from the Authorities. Even if the Department were to request this information, it would not be able to rely on the statistics due to inconsistencies in infection control policies and procedures in place at the Authorities.

While NLCHI was able to provide statistics on infections in the Province in general, they did not have any information specific to hospital-acquired infections. Department officials indicated that the NLCHI does not have a mandate, nor is their data collection process designed to allow for the accumulation of information to report on hospital-acquired infections.

Recommendation

The Department should discuss with the Authorities their capacity to provide statistical information for management of hospital-acquired infections on a Province-wide basis.

3. Infection Control in Newfoundland and Labrador

Introduction

An infection control program is designed to prevent, detect, contain and treat hospital-acquired infections. Programs include Infection Control Practitioners (ICPs), Infection Control Committees (ICCs), infection control policies and procedures, infection surveillance and gathering of associated statistics, education and training of hospital personnel, facility hygiene, self-audit practices and consultation on facility construction and renovation.

The goal of an infection control program is to establish an environment that promotes and secures the lowest possible rate of infection and protects patients, staff and visitors from unnecessary risks of contracting an infection.

Detailed Findings

The detailed findings of our review are contained in the following sections.

A. Infection Control in Newfoundland and Labrador
B. Infection Control Policies and Procedures
C. Infection Control Committees
D. Infection Control Practitioners
E. Surveillance
F. Clinical Self-Audits
G. Equipment/Facilities Hygiene

A. Infection Control in Newfoundland and Labrador

No Province-wide infection control program

At the time of our review, there was no Province-wide infection control program in place. Department officials indicated that, while the former health care boards (now the Authorities) had infection control processes in place, they had never coordinated efforts to develop a standardized program. Instead, each of the former health care boards and in some cases individual hospitals had developed their own processes.

There is no one at the Department who is responsible for establishing policies or standards with respect to hospital-acquired infection control and no Provincial monitoring program is in place. As a result infection control practices administered within the four Authorities were not being held to a common standard.

In October 2006, the Department hired a Provincial Infection Control Nurse Specialist. During 2007, the Provincial Infection Control Nurse Specialist headed up a Provincial infection control network which included ICPs from each of the Authorities. While several Province-wide policies have been developed, they relate to community based infection control issues and not those for hospitals. As a result, this new position is currently not providing the leadership and support required by the Authorities in preventing and controlling hospital-acquired infections.

The *Back to Basics* Report found that there was a lack of Provincial direction/standards for best practices in infection control. Infection control officials at the Authorities indicated that this lack of direction and support from the Department is still an issue. These officials further indicated that there are times when they have requested direction and support as it relates to policy development from the Department but have not always received such. One infection control official from an Authority, after asking the Provincial Infection Control Nurse Specialist

for guidance on policy development for triage protocol for critical care during a pandemic, was referred to policies from other provinces. This official stated that *"I think this issue underlines the difficulties we have in obtaining clear direction for our infection control programs on a provincial level"*.

During our review, the Department's lack of involvement in hospital-acquired infection control in the Province was apparent. Policies and standards for the Province had not been developed. In addition, statistics about infection control that were available from the Infection Control Committees at the Authorities were not requested or reviewed by the Department. As a result, the Department was not informed about infection rates and trends and the potential impact on the residents of the Province.

B. Infection Control Policies and Procedures

No overall policies and procedures

Policies and procedures for infection control are fundamental for guiding an infection control program. We would have expected that there would be one overall infection control manual to be used by all Authorities which would outline basic policies and procedures to be used. At the time of our site visits in 2006 we found that three of the four Authorities had multiple infection control manuals in effect (the former Western Health Care Corporation had one manual). As a result, former health care boards within the same Authority had been operating with standards and practices for infection control that were inconsistent with other former health care boards. At the time of our review, officials indicated that the Authorities were in the process of consolidating infection control manuals in their regions.

C. Infection Control Committees

Introduction

Hospital officials indicated that Infection Control Committees (ICCs) at the Authorities are typically comprised of a physician, preferably the infection control officer or hospital pathologist as the chair, the Infection Control Practitioner (ICP), representatives from all clinical departments, and representatives from other departments such as occupational health, catering, cleaning, facilities/buildings and management.

The ICCs, through the medical advisory committees, are responsible for:

- endorsing and approving all infection control policies, procedures and guidelines;
- providing advice and support on the implementation of policies and procedures; and
- collaborating with the infection control team(s) to develop the infection control program and monitor its progress.

Membership in ICCs inconsistent and meetings infrequent

When we completed our site visits in September 2006, ICCs were in place in what was the eight former health care boards included in the four Authorities; however, not all had terms of reference in place to guide the operation of the ICCs. Terms of reference would address such issues as membership, meeting quorums, accountability and meeting frequency. At the time of our update in October 2007 we noted that terms of reference for ICCs had been developed for all of the newly organized Authorities. We reviewed ICC meeting minutes for the eight former health care boards and regional ICC meetings for the Authorities for the period January 2004 to September 2007. Our review disclosed the following details:

- 1 instance where the ICC chair was not a physician (former Health Labrador Corporation). All of the other ICCs were chaired by a physician.
- 1 instance (14 June 2005) where a formal meeting could not be held because the "physician/chair" was not in attendance (former Central East Health Care Institutions Board).
- 4 instances where an alternate chairperson conducted the meeting because the "physician/chair" was not in attendance (2 meetings 13 September 2005 and 25 January 2006 - former Central East Health Care Institutions Board, 2 meetings 23 October 2006 and 27 November 2006 - former Grenfell Regional Health Services Board)
- 2 instances where the minutes of meetings for 27 June 2005 and 19 June 2006 could not be located even though there were references in subsequent minutes that meetings had been held on those dates (former Grenfell Regional Health Services Board).

Furthermore, there were significant time gaps between meeting

minutes for the former Grenfell Regional Health Services Board. For example, there were no minutes on file for the period August 2004 to June 2005 and from June 2005 to February 2006, indicating that either the committee had not met on a regular basis or that the minutes from those meetings were missing. According to officials, the permanent ICP was off on long-term sick leave and the minutes could not be located by their replacement.

- In those instances where attendance at ICC meetings was well documented we observed that there was significant absenteeism. For example, at the Western Health Authority there were four meetings during the period 23 March 2006 and 20 September 2007. During the period there were 16 persons who were continuous members. Of these 16 continuous members:

  - 1 member did not attend any meetings;
  - 5 members attended only 1 meeting; and
  - 1 member attended 2 meetings.

In addition to the foregoing we noted that not all ICC meetings included representation from all departments impacted by infection control. For example, the ICC member listing for the former Central East Health Care Institutions Board in Gander did not have a representative from the Pharmacy Department. Also, the 28 May 2007 ICC meeting of the former Grenfell Regional Health Services Board stated, *"pharmacist has joined our committee"*. Since antibiotic use and resistance to them is a significant infection control issue, we would have expected that the Pharmacy Department would have been represented at all meetings.

D. Infection Control Practitioners

Introduction

A key member of the infection control team is the Infection Control Practitioner (ICP) whose main responsibility is monitoring infection control at the assigned facilities. Health Canada recommendations for the minimum number of ICPs that should be on staff in acute and long-term care facilities are as follows:

- 1 ICP for every 175 acute care beds; and
- 1 ICP for every 250 long-term care beds.

Figure 5 shows the number of ICPs recommended by Health Canada that

should be in place in the Province. The figure compares these amounts with actual resources to determine the additional number of full-time equivalents (FTEs) required.

Figure 5

Infection Control Resources
As at September 2007

	Beds		Number of FTEs		
Authority	**Acute Care**	**Long Term**	**Health Canada**	**Actual Sept 2007**	**Additional Requirement**
Labrador-Grenfell	112	116	1.104	0.938	0.166
Western	276	423	3.269	2.375	0.894
Central	287	534	3.776	2.000	1.776
Eastern	944	1,705	12.213	9.500	2.713
	1,619	**2,778**	**20.362**	**14.813**	**5.549**

Source: the Authorities and Health Canada recommendations

Inadequate number of ICPs in the Province

As Figure 5 shows, at the time of our review, there were 14.8 full-time equivalent ICPs in Newfoundland and Labrador. Our review also showed that none of the four Authorities met the minimum Health Canada recommendations for the number of ICPs required to carry out infection control related duties. To meet Health Canada recommendations the Province requires an additional 5.6 FTE ICPs.

In facilities where the number of beds is fairly small, this calculation can result in a small allocation of time for infection control activities. For example, the Captain William Jackman Memorial Hospital is a small centre in Labrador City/Wabush. This hospital has 6 beds allocated to long-term care and 14 to acute care. Using the Health Canada recommendations, the hospital was allocated approximately 3.75 hours per week for infection control. The ICP at this site indicated that *"this was barely enough time to return e-mails that had been received from the prior week."*

E. Surveillance

Introduction

All of the facilities in the Province involved with acute and long-term care have surveillance components to their infection control programs. Surveillance activities are overseen by ICPs and are designed exclusively for monitoring hospital-acquired infections. Its purpose is to compile timely information on infection rates and trends, detect outbreaks, make informed evaluations of and changes in clinical practice, and assist the targeting of preventative efforts.

Our review indicated that surveillance activities should include the following:

- review of daily admission records for indications of infections and to determine whether appropriate isolation procedures were followed;
- review of emergency room visit records to detect patients that may have become infected while in the hospital but the symptoms of which may not have become evident until after discharge;
- communication with home care nurses for indications of post discharge infections;
- review of surgical procedure records;
- review of daily microbiology reports for positive infection cultures;
- review of pharmacy records of antibiotics used; and
- continual process of visiting the various wards and rooms to view infection control activity and patients and to discuss cases with nursing and medical staff.

Statistics resulting from these surveillance activities should be reviewed by the ICCs.

Surveillance procedures not always followed

Although we found that ICPs conducted some surveillance activities to identify hospital-acquired infections, in many cases the documented procedures were not always followed. For example we noted the following at the Authorities:

- Eastern Health Authority (minutes of the ICC at the former Avalon Health Care Institutions Board)

  Long-term care statistics were normally calculated on a monthly basis; however, during a three year period (2003-2005), none were calculated at various points for a total of seven months. Furthermore, the monthly reporting was reduced to reporting three times a year in 2005. The minutes noted that staff had difficulty in keeping the long-term care statistics up to date because of the additional time taken to manage infection issues such as the Norwalk Virus and influenza outbreaks.

  An infection control official at this Authority advised that according to the Canadian Patient Safety Institute, when rates have been stable for a period of time it is acceptable to collect rates every 3 to 4 months. This allows time for Infection Control Practitioners to spend time at other priority projects and not spend all their time on surveillance and related statistics. Despite this, the incidents of reduced surveillance and compilation of related statistics noted during our review were not related to a professional assessment of stable infection control rates, rather they were related to the lack of available resources. Also, this raises the issue of the effective use of resources and the need for the more frequent surveillance in low risk areas in the first place.

- Central Health Authority (minutes of the ICC at the former Central East Health Care Institutions Board**)**

  Concern was expressed in the minutes by the ICC representative from the Fogo Island Hospital about the lack of visits by the ICP to the facility.

  The ICP for this board was stationed at the James Payton Memorial Hospital; however, there were five acute and long-term care facilities and nine clinics at other locations in the region. We found that no other board employee in the region had been allocated time to accumulate statistics and monitor infection control as was the case with boards in other regions. As a result, there was no one to monitor infection control activity on a daily basis. Officials advised that this was brought to the attention of management but no further resources were provided.

- Western Health Authority (minutes of the ICC at the former Western Health Care Corporation)

  Our review of the infection rate charts at the Western Memorial Regional Hospital indicated that the long-term care statistics were delayed for seven months during the fiscal year 2005-06 because of the time taken to deal with the Norwalk and influenza outbreaks. According to officials, the surveillance had continued during the period and the charts were subsequently updated.

- Labrador-Grenfell Health Authority

  - We were advised by officials at the Authority that it was the intent that the ICP at Goose Bay visit the clinics on the Labrador coast at least once a year; however, this does not always occur because of workload issues.

  - The Captain William Jackman Memorial Hospital is a 20-bed facility that had only a modest allocation of staff to monitor infection control activities. For example, at the time of our visit on 30 March 2006, the ICP had only been in place since 1 March 2006. This individual did not have the infection statistics for any periods prior to January 2006 and was uncertain that they were receiving all of the infection referrals from hospital staff.

Hospital infection control statistics not comparable

Two (Health Care Corporation of St. John's and Central East Health Care Institutions Board) of the eight former health care boards used a targeted approach to record infection statistics. The other six former boards used a global approach.

Whether a hospital used global or targeted methods for surveillance of hospital-acquired infections impacted the number of infections reported. Under global surveillance the ICP reported all infections identified while under targeted, the ICP only compiles statistics on specific procedures that were targeted for surveillance.

As a result of these inconsistencies, the statistical information compiled by the ICPs cannot be relied upon by the Department for analysis by region or Province-wide.

These findings demonstrated gaps in the surveillance system and in the statistical reporting processes among the former health care boards. As a result, surveillance statistics on hospital-acquired infections were either incomplete or not available to the ICCs on a timely basis and may have hampered the ICC's ability to identify significant trends.

Inadequate documentation of conclusions related to infection review

The actual calculated rates for hospital-acquired infections were compiled by the ICPs and submitted to the ICCs for their review.

In our review of the ICC minutes from the eight former health care boards, all referenced reviewing the infection control statistics. However, the extent of the review and their conclusions were not always clearly articulated in the minutes. We noted instances where infection rates were rising but the minutes did not include any discussion related to that issue. Given that the ICC had responsibility to manage infection control, we would have expected that a conclusion or some course of action would have been documented. Furthermore, documentation of information would be crucial in the case of patient litigation resulting from hospital-acquired infection.

Physician-specific statistics inadequate

Surveillance activities include operating rooms where there is a high risk of infections occurring during surgery. Physician-specific statistics were compiled by ICP officials from six of the eight former health care boards at least once a year. Our review found that:

- 2 former health care boards did not calculate the individual surgeon's infection rates because they did not have a computerized system to provide the information and indicated it would have been too time consuming to do the calculations manually; and

- 6 former health care boards provided statistics to the surgeon of patients that had contracted infections. However, the infection rates were not always compared over time or expressed as a proportion of procedures performed; therefore, they were not as valuable a tool in identifying infection trends and problem areas.

As a result, surgeons were either not aware of their infection rate or were not able to assess their rates over time to identify trends in their own rates in relation to other physicians.

F. Clinical Self-Audits

Introduction

Clinical self-audits performed by ICPs involve the ongoing audit of infection control practices among all health care staff to identify where basic infection control standards are not being adhered to and/or whether further training is required. Clinical self-audits are focused on the infection control practices of health care personnel versus surveillance which is focused on monitoring infections among patients. Basic infection control practices in this regard would include:

- disinfection or sterilization of medical instruments and equipment;
- reviews of basic infection control practices (e.g. hand washing); and
- reviews of sterile technique in the operating rooms, intensive care units and other critical care areas.

Basic infection control practice was not always followed

Our review indicated that only two of the eight former health care boards regularly conducted self-audits. During our review of ICC minutes and from discussions with ICPs we found evidence that basic practices were not always followed. For example:

- The ICP at Gander (former Central East Health Care Institutions Board) indicated that staff were reusing gowns after they had been contaminated through use in an isolation setting. When the ICP returned on a subsequent occasion, the practice had continued despite the fact that re-use of contaminated gowns was a direct contravention of basic infection control practices.
- Minutes of a 29 September 2006 meeting of the ICC in Carbonear (former Avalon Health Care Institutions Board) referenced a "near-miss" form that was prepared by an employee who *"witnessed two other staff members coming out of an isolation room with gowns and gloves on when the apparel should have been removed in the room before they came outside."* This could have resulted in the spread of the infection to other parts of the hospital.

- Minutes of a 9 March 2005 meeting of the ICC in Goose Bay (former Health Labrador Corporation) made the following reference to an audit of basic infection control practice: *"During audits of basic infection control practices it was noted that there were still areas in which teaching of basic hand hygiene, standard precautions and personal protective equipment as well as isolation practices were required."*

- Minutes of a 29 September 2006 meeting of the ICC committee in Carbonear (former Avalon Health Care Institutions Board) made reference to, *"a member of the medical staff is wearing gloves from areas within the O.R. and Case Room without removing or changing them."*

- ICC minutes indicated that while all of the sites had carried out some audits, most were reactive in nature resulting from a specific identified infection problem or infection risk.

- The ICP at the Central Health Authority indicated in January 2008 that; *"I recently conducted a hand hygiene audit in our dialysis unit and found the rate low at 40%"*.

It was clear from the ICC minutes and discussions with ICPs that while some training was being provided in basic infection control practices such as standard precautions, hand washing and disinfection of common equipment, it was not routine. We did note that when instances of non-adherence to standard precautions were identified the offending parties were notified and where necessary, training was carried out by the ICP.

G. Equipment/Facilities Hygiene

Introduction

Good hygiene in institutional facilities is another key element in preventing hospital-acquired infections. This typically included staff involved in cleaning, housekeeping, sterilization of medical instruments and medical equipment, supplies, collection and disposal of clinical waste, and kitchen hygiene. In the event of a serious outbreak these frontline staff would be integral to containing the spread of infection. Officials from many of these areas were represented on the ICCs.

Our review indicated that only two of the eight former health care boards regularly inspected equipment/facilities hygiene.

Little evidence of continual monitoring

The ICC minutes contained evidence of the ICCs dealing with complaints, awarding of contracts and other issues related to facility hygiene; however, there was little evidence that they were continually monitoring that staff adhered to established standards.

We learned of several instances where proactive audits involving facility hygiene were completed. Infection control self-audits of patient/resident service areas were undertaken by the ICPs at the Central Health Authority (from November 2003 to February 2004 and August 2006 to June 2007) and Labrador-Grenfell Health Authority (spot audits in Labrador during the period 2005 to 2007). The audits identified a number of issues including:

- absence of clearly defined cleaning schedules;
- soiled equipment found in clean utility room;
- evidence of excessive dust and unclean floors in patient rooms;
- cleaning staff observed not cleaning isolation rooms appropriately;
- shared equipment such as blood pressure cuffs and lift devices were not being cleaned on a regular basis;
- high level disinfection and sterilization of equipment such as laryngoscope blades and foot care instruments was consistently performed incorrectly throughout the region due to lack of knowledge regarding the proper cleaning, disinfecting and rinsing techniques; and
- appropriate separation of waste was not performed in that antibiotic and other medication vials were not appropriately discarded.

Records indicate that details of the exceptions noted were provided to the applicable managers.

No policy of routine equipment/ facility audits

We found that proactive audits such as those carried out at the Central Health Authority and the Labrador-Grenfell Health Authority were the exceptions. The ICC minutes indicated that most other audits were reactive in response to specific problems or events. We found that that there was no policy of routine equipment/facility audits in place to ensure that facility/equipment hygiene standards were being met.

Officials at the former Avalon Health Care Institutions Board in Carbonear indicated that in February 2005 the ICC learned that a gastrointestinal video scope purchased in November 2004 was not being adequately disinfected. At the time of the purchase, hospital staff had been informed by the supplier that this scope was the same as those already in use. As a result, the same disinfection methods were used. Subsequently, it was discovered that the new scope had an additional water channel that required high level disinfection in the scope washer; however, it was only being manually cleaned. The ICC and senior hospital officials had the scope tested at an independent lab which determined that chances of the spread of infection were not significant in this instance. Officials indicated that in instances where the risk of infection is determined to be low, patients are not informed. The gastrointestinal video scope was used in procedures on 72 individuals. None were informed of the possible health issues.

Conclusions

As a result of our review we have concluded that there were no consistent Province-wide infection control policies and procedures in place. This included a standardized system to prevent, detect, contain and treat hospital-acquired infections. Infection control programs varied from region to region and hospital to hospital. As a result, the Department cannot be sure that hospital-acquired infections are as low as they could be in the Province and as a result may not be prepared to manage a major infection outbreak in the Province.

The Province did not have the number of Infection Control Practitioners as recommended by Health Canada. At the time of our review, the Department needed to fund 5.6 additional full-time equivalent staff members to infection control in order to meet minimum staffing recommendations. As a result, the Province may not have sufficient resources to monitor an infection control program.

Recommendations

The Department should:

- provide leadership and work with the Authorities in the development and implementation of Province-wide policies and procedures for infection control;
- ensure that the numbers of ICP positions in the Province meet minimum Health Canada recommendations;
- determine whether surveillance activities are carried out on a consistent and timely basis, reviewed and documented by the ICCs and, where appropriate, deficiencies acted upon;
- determine whether routine clinical self-audits are conducted and documented and that results are reviewed and steps taken to ensure that basic hygiene and infection control practices are being carried out by all health care staff; and
- establish minimum requirements for the Authorities to carry out and report on regular audits of equipment/facilities hygiene.

4. Implementation of the *Back to Basics* Report Recommendations

Overview

In September 2003, as a result of the Severe Acute Respiratory Syndrome (SARS) experience in Ontario and British Columbia, the Newfoundland and Labrador Minister of Health and Community Services announced a Task Force on the Prevention and Control of Communicable Diseases in Health Institutions and Ambulance Services. The Task Force was given a mandate to:

- review the standards, policies, procedures and resources related to control and prevention of communicable diseases that exist in facilities and medical clinics operated by Institutional Health Boards and the ambulance system in the Province of Newfoundland and Labrador; and
- assess our ability to meet the challenges that new emerging infectious diseases such as SARS will create.

The resulting report, *Back to Basics* (the Report), issued in March 2004 included findings that there was a lack of Provincial direction/standards for best practices in infection control, that limited time and resources had been dedicated to developing and implementing policies and procedures and that training of hospital personnel was inadequate. The Report also documented concerns that basic infection control procedures such as hand washing and changing gloves before and after patient contact were not consistently practiced by managers or staff. During our review, officials at the Authorities often referred to the Report as being a document that should be acted upon and there was evidence that the Authorities were looking at the recommendations. At the same time, there was no evidence that any one at the Department level was reviewing the Report until October 2006.

Recommendations of *Back to Basics* Report not implemented

When we commenced our review of hospital-acquired infections, Department officials often referred us to the *Back to Basics* report. The Report contained recommendations in seven areas:

1. the appointment of a Provincial Infection Control Expert Team;
2. the development of a Provincial Clinical Rapid Response Team;
3. support for Infection Control Practitioners;
4. education and workplace standards for health care workers;
5. "real-time" infection surveillance;
6. structural/environmental issues; and
7. communications.

We found that over the three years since the *Back to Basics* Report was released, none of the recommendation areas have been fully acted upon. Following are our findings related to the seven recommendation areas:

Provincial Infection Control Expert Team

The Report recommended that a Provincial Infection Control Expert Team be appointed consisting of a dedicated Infection Control Practitioner (ICP), a part-time physician expert and representation from Provincial health care boards with expertise in infection control. The roles and responsibilities of the Expert Team as outlined in the *Back to Basics* report were broad and included infection control activity in community and institutional areas.

In October 2006, the Department hired a Provincial Infection Control Nurse Specialist who, according to Department officials, was responsible for infection control at the community level. This is consistent with the Department's position, as outlined by senior Department officials, that they were responsible for disease and infection control in the community and that responsibility for hospital-acquired infection prevention and control rests entirely with the Authorities.

Some of the infection control practitioners at the Authorities assumed that the appointment of the Provincial Infection Control Nurse Specialist was the dedicated infection control practitioner recommended in the B*ack to Basics* report. One senior infection control official stated, *"In my opinion, all institutionally based infection control practitioners were disappointed to discover that the Provincial Nurse Specialist's job description was to be related to community based and not institutionally based infection control programs."* Senior Department Public Health officials confirmed to us that this position indeed related to infection control at the community level and that this position had been planned prior to the *Back to Basics* Task Force being initiated.

As a result, none of this recommendation as it relates to hospital-acquired infection, prevention and control has been implemented to date.

Provincial Clinical Rapid Response Team
The Report recommended that a Provincial Clinical Rapid Response Team be established in cooperation with the Emergency Measures Organization which would assist boards during major infectious disease outbreaks to ensure a coordinated, effective, quality response to emergencies.

The Department has not established a Provincial Clinical Rapid Response Team in cooperation with the Emergency Measures Organization. However, Department officials indicated that, "*This work has been covered by the creation of four regional positions of Emergency Health Coordinators"*. In connection with this, a senior infection control official at one of the Authorities felt it was important to note that, *"for the most part, these positions are designed as emergency planners and may not have the required clinical expertise required to participate in a clinical response team"*.

Infection Control Practitioners
The Report recommended that the ICP human resource numbers be revised to meet minimum Health Canada recommendations and also that professional development opportunities for ICPs be increased.

While the Department has taken some action in providing professional development opportunities for ICPs, the Province does not meet Health Canada recommendations in terms of the number of Infection Control Practitioner Full-Time Equivalents (FTE). Our review indicated that:

- as shown in Figure 5, the recommended number of ICPs was 20.4; the Province required an additional 5.6 FTE positions to meet this number. Department budget and board services officials advised that they have been unsuccessful in obtaining additional funding to increase the number of ICP positions to meet the minimum number recommended by Health Canada. We were advised by Department budget officials that although a funding request had been submitted in the 2007-08 budget process, no additional funding for the Authorities for infection control was provided; and

- the Provincial Infection Control Nurse Specialist advised that all ICPs in the Province were being encouraged to obtain the CIC infection control designation. Also, the Public Health Division at the Department started an infection control online training program (Webber Training) early in 2007. This training program is funded by the Department and is available to all of the ICPs at the various Authorities. However, an infection control official from the Labrador-Grenfell Health Authority indicated that their region was at a disadvantage because of the cost of travel for ICPs to attend workshops and other training that usually takes place in other centres in the Province. As a result of this, only one of the three ICPs can attend.

Health Care Worker Education and Standards

The Report recommended that budgetary allocations be put in place to develop in-house training courses for health care workers and service providers and that mandatory continuing professional infection control education be coordinated among the former health care boards.

Although the Department has funded in-house training courses for health care workers and service providers, the training is not mandatory. For example, the online Webber Training program provided to ICPs is available to all health care workers; However, one ICP observed, *"if I see sessions that are of interest to other departments I will extend an invitation to these people to attend. When these sessions have been offered to other staff there has been little attendance."*

In addition, we could not determine which training was provided because at the time of our site visits to the Authorities, none of the ICPs maintained summary reports of staff training for use in monitoring health care worker education and standards; therefore, we had only anecdotal information as to the extent of training provided to health care workers.

Surveillance
The Report recommended that adequate resources be provided to support real time surveillance of targeted infectious diseases of concern.

Although there was no definition in the Report of "adequate" resources or "real-time" surveillance, there is surveillance carried out by electronic laboratory reporting through online access to the Public Health Laboratory. As of November 2007 the laboratory reporting system had been extended to the Eastern, Central and Western Health Authorities. Public Health Laboratory officials advised that the extension of this capability to locations covered by the Labrador-Grenfell Health Authority is pending.

Structural/Environmental Issues
The Report recommended that ICPs be consulted in new construction and renovations of health care facilities, that intensive care facilities be reviewed, and that negative pressure rooms be assessed, including the ability of all Emergency Departments to identify critical issues affecting the effective segregation of infectious patients.

While the ICPs are being consulted on construction and renovation projects, and the Authorities have commenced assessing negative pressure rooms, we were unable to determine whether intensive care facilities were in the process of being reviewed.

In the case of ICPs being consulted, there were concerns as to any positive impact on the control of hospital-acquired infections as a result of these consultations. These concerns were made clear by a physician who chairs a regional infection control committee who indicated that:

"Our institution and many hospitals in other parts of the Province are not designed with modern requirements of infection prevention and control in mind. Even renovations carried out in the last number of years, while helpful, do not offer ease of isolation nursing for these clients with infectious diseases or with multi-drug resistant organisms."

The physician went on to say:
"Whenever plans for renovations or new structures are put forward our recommendations are incorporated into the initial phases of planning, however the personnel who finally sign off on the plans at government level appear to have little or no understanding of the impact of the lack of proper infection prevention and control facilities. As a result, much of the input for infection prevention and control practice gets discarded and in the end get written out of the plans, usually on the basis of cost. These infection prevention and control requirements usually revolve around density of patients, single rooms for patients, single patient toilet facilities and hand-washing facilities in all areas of the wards."

In the case of negative pressure rooms, our review of the ICC minutes for all of the Authorities indicated that action was being taken related to address the adequacy of Negative Pressure Room resources. However at the time of our site visits in 2006, two of the Authorities had not carried out evidence based needs assessments.

Communications
The Report recommended that the Department develop a single communications plan in conjunction with the Emergency Measures Organization. The plan would be used in the event of a pandemic or serious communicable disease outbreak.

Department officials indicated that the Department has not approached the Emergency Measures Organization to develop a single communications plan.

Conclusions

As a result of our review, we have concluded that, over three years since the *Back to Basics* Report was released, none of the recommendation areas have been fully acted upon. This may impact on the Province's ability to be prepared to manage an outbreak of infections or communicable diseases at the institutional level.

Recommendation

The Department should continue to give consideration to the recommendation areas contained in the *Back to Basics* Report.

5. Other Issues

Overview

During our review, issues in three other areas came to our attention as follows:

A. fit testing of respirators;
B. scabies outbreak in three hospitals; and
C. outbreak preparedness.

A. Fit Testing of Respirators

Introduction

When providing care to patients with respiratory infections spread by the airborne route, health care workers are required to wear a properly fitted and approved face mask. To prevent spread of infection in the hospital, the face masks must fit according to guidelines and trained employees are required to perform qualitative fit tests on users to determine and ensure the proper fit of the respiratory equipment.

Fit testing activity

Qualified trainers were present at all of the former health care boards when fit testing was being carried out. The testing was managed by either ICPs or occupational health and safety officials. The guidelines for fit testing involved the employee being:

- fit tested prior to the mask being used (upon hiring);
- retested every two years;
- retested when there was a change in the type of mask; and
- retested when there was a change in facial structure such as weight gain or loss or change in facial hair.

Records were being maintained to ensure that all applicable employees were being fit tested.

Fit testing status

Figure 6 shows the status of the fit testing of employees and physicians at the four Authorities at 30 September 2007.

Figure 6

Personal Mask Fit Testing Status
30 September 2007

The Authorities	Employees to be Tested	Employees Tested	% Tested	Physicians to be tested	Physicians Tested	% Tested
Eastern	7,452	3,563	47.8%	465	99	21.3%
Central	3,085	2,082	67.5%	145	68	46.9%
Western	2,843	2,040	71.8%	122	34	27.9%
Labrador/ Grenfell	1,200	674	56.2%	57	28	49.1%
Total	**14,580**	**8,359**	**57.3%**	**789**	**229**	**29.0%**

Source: The Authorities

Fit testing not consistently carried out

As Figure 6 shows physicians had an average satisfactory testing rate of only 29.0%. The overall rate of employees satisfactorily tested was only 57.3%.

Officials were unable to explain the low participation rates; however, it was a concern. For example, the minutes of an ICC meeting in January 2006 at the former Central East Health Care Institutions Board, when reporting the results of a mock disaster at the Notre Dame Bay Memorial Health Centre noted there was concern regarding, *"the number of physicians not fit tested."* In another instance an official in Gander told us of a situation in February 2007 where, "*a female patient arrived in the ER* (passenger on an overseas flight) *presenting with severe respiratory illness as some staff as well as the ER physician was not properly fit tested for N95 masks."* This obviously raised the issue of preparedness.

Figure 6 also indicates that the percentage of employees tested at the Eastern Health Authority was lower than in the other three Authorities. These lower rates were impacted by the fact that the Eastern Health Authority discontinued fit testing the respirator mask for a period of time. Officials at the Eastern Health Authority advised us that the necessity of fit testing was being questioned by some ICPs due to a lack of evidence to support it. They indicated that they were only using the mask for tuberculosis patients and that "fit checking" (versus fit testing) was adequate. Fit checking is where the user checks the fit of the mask each time it is used. With respect to this issue, a senior Public Health official at the Department was of the opinion that the whole issue of fit testing and

use of the N95 masks was initiated by suppliers to promote the sale of their products.

Regardless of the uncertainty as to the need for fit testing the N95 masks, as noted in Figure 6 the fit testing process is scheduled to be continued for a large number of health care workers.

This demonstrates how, without a clear Province-wide policy, it was possible that some hospital employees, including physicians, may not be adequately prepared to address the spread of infection in the event of an outbreak. Either that or resources are being wasted on fit testing employees unnecessarily.

B. Scabies Outbreak in Three Hospitals

Scabies outbreak caused panic among staff

Scabies is a common skin infection/irritation that causes small itchy bumps and blisters due to tiny mites that burrow into the human skin to lay their eggs. The infection is easily spread and the most common symptom is severe itching.

During our site visit to Gander (former Central East Health Care Institutions Board), we were made aware of a scabies outbreak that had occurred. According to the ICC minutes of 20 January 2006, the outbreak began a month earlier when a patient arrived at the James Payton Memorial Hospital from the Central Newfoundland Regional Health Centre (Grand Falls). The patient had a rash and while they were not considered infectious, precautions were initiated by hospital staff. The patient was sent to St. John's a week later where a diagnosis of Norwegian scabies was made. After another week, the patient was returned to the James Payton Memorial Hospital where new lesions were noted.

According to the ICP, a total of 177 staff members and 3 in-patients in 3 hospitals who had contact with the patient were given treatment for scabies; 43 of these staff members developed rashes. There was no system in place to notify other discharged patients who may have been exposed to this infection. Furthermore, there was no information available on the number of discharged patients who actually developed scabies.

One of the physicians involved in treating staff and assessing the situation, "*felt the outbreak was managed well overall, but felt the nature of the illness caused panic among staff*". He also noted, *"that an undiagnosed rash should be a red flag to staff".*

Another physician at the meeting stated that *"physicians circumvented the infection process by saying the patient was not infectious. In similar cases, removal of isolation precautions should not be done by physicians without consultation with Infection Control."*

While we were advised that this incident did not involve a life threatening infection, it is highlighted here as an example of what can happen if infection control practices and procedures are not strictly followed.

C. Outbreak Preparedness

One of the strengths identified in the *Back to Basics* report was that all of the former health care boards had disaster planning committees and most boards had held mock disaster practices.

Inadequate quantities of personal protective equipment and supplies

The ICC minutes of the former health care boards included details related to mock disaster exercises and actual infection outbreaks. However, we found evidence that there were inadequate quantities of personal protective equipment and supplies on hand to effectively deal with a particular situation. The minutes indicated the following:

- *"lack of stocked materials e.g. masks;"* 25 January 2006 when referring to a mock disaster exercise at the Notre Dame Bay Centre (former Central East Health Care Institutions Board);
- *"we ran out of personal protective equipment;"*17 March 2005 when referring to an outbreak of influenza in Gander (former Central East Health Care Institutions Board);
- *"certain supplies were an issue during outbreaks. In particular masks, nebulizers and alcohol hand wash became unavailable;"* 3 March 2005 when referring to outbreaks at the Baie Verte Peninsula Health Centre and the Connaigre Peninsula Community Health Centre (former Central West Health Care Institutions Board); and
- *"we ran out of masks last week. This is a concern in the event of an outbreak (surge capacity);"* 9 January 2004 when referring to Corner Brook (former Western Health Care Corporation).

In addition, a comprehensive Post Novovirus Outbreak Debriefing Sessions report (April 2005) prepared by the former Peninsulas Health Care Corporation outlined many opportunities for improvement including; *"a master list of supplies/inventory required for outbreak management including minimums and maximums for departmental and ward stock."*

Conclusions

The Department does not have a Province-wide policy on fit testing. As a result, the level of fit testing at the Authorities may not be adequate.

As a result of the experience with the scabies outbreak and indicated shortages of personal protective equipment, the Department and the Authorities may not be as well prepared to manage an outbreak as they should be.

Recommendations

The Department should:

- establish a Province-wide policy for fit testing;
- set standards and/or monitor hospital-acquired infection prevention and control processes; and
- address the issues raised regarding the level of infection control supplies.

Department's Response

The Department concurs with many of the recommendations of the Auditor General's Report and has taken steps to address the challenges identified.

In Newfoundland and Labrador the 2004 report "Back to Basics" investigated this province's preparedness to prevent and control communicable diseases by examining the capacity of our health care facilities to meet the challenges of infection control. This report makes a number of recommendations, which are being considered and prioritized for action within the Department of Health and Community Services and many initiatives are already underway to respond to the recommendations of this report.

The Department's approach is to develop infection prevention and control guidelines and standards for use by institutional care facilities and the public community. The practical and specific infection control measures including adherence to quality standards remains the mandate of the Regional Health Authorities (RHA). Adherence to these operational standards of practice is further supported through the health facility accreditation process which is embraced by each Regional Health Authority.

The Department of Health and Community Services has considered the recommendations and would like to provide the following in response:

1. ***The Department should develop Province-wide policies and standards for hospital-acquired infection control and monitor compliance by the Authorities to those policies and standards.***

In October 2006 a process was put in place, with regional input, to develop consistent provincial infection control guidelines. To date three priority guidelines have been approved and distributed. Others are in various stages of development. The Department in collaboration with RHAs will develop a monitoring framework.

2. ***The Department should discuss with the Authorities their capacity to provide statistical information for management of hospital-acquired infections on a Province-wide basis.***

RHAs are currently working with the Department to develop a regional/provincial surveillance system for organisms associated with hospital-acquired infections. Surveillance for specific Multi-Drug Resistant Organisms will be implemented in 2008. Other types of surveillance will be considered in the future.

3. The Department should provide leadership and work with the Authorities in the development and implementation of Province-wide policies and procedures for infection control.

An Infection Control Nurse Specialist was hired in October 2006 to provide provincial leadership in the department. A Provincial Infection Control Committee (PIC-NL) has been established with representation from within each Regional Health Authority. This committee meets monthly and provides leadership in all areas of infection control.

4. The Department should ensure that the numbers of ICP positions in the province meet minimum Health Canada recommendations.

The Department has reviewed the Canadian recommendations for Infection Control Practitioner positions with consideration of the specific regional needs of the province. Currently there are 14 Infection Control Practitioners of the 20 recommended by Health Canada. Department is seeking additional funding through the 2008-09 budget process to increase the number of IC practitioners.

5. The Department should determine whether surveillance activities are carried out on a consistent and timely basis, reviewed and documented by the Infection Control Committees and, where appropriate, deficiencies acted upon.

RHAs are responsible for surveillance activities within their institutions. Monthly reports to the province on aggregate data from the surveillance system are being developed and an implementation plan is underway. In addition the province is working in cooperation with other jurisdictions in Canada on a national electronic surveillance system (Panorama) that will address many of our communicable disease surveillance needs.

6. The Department should determine whether routine clinical self-audits are conducted and documented and that results are reviewed and steps are taken to ensure that basic hygiene and infection control practices are being carried out by all health care staff.

RHAs through their Infection Control Committees are responsible for ensuring that quality infection control activities are carried out by their staff and that staff are trained in infection control practices and procedures.

7. The Department should establish minimum requirements for the Authorities to carry out and report on regular audits of equipment/facilities hygiene.

The Department will establish standards and guidelines for infection control practices. Facility and equipment audits for hygiene are a responsibility of the RHAs through their Infection Control Committees.

8. The Department should continue to give consideration to the Back to Basics Report.

The Department has actioned many of the recommendations of the "Back to Basics" Report and continues to prioritize the other recommendations for implementation.

9. The Department should establish a Province-wide policy for fit testing.

The Department has provided direction to the RHAs on the use of N95 masks according to national infection control recommendations. N95 masks are currently not recommended for general infection control within health care institutions and are recommended for use only for specific conditions and procedures. Fit testing of N95 masks is a policy under Occupational Health and Safety Division, Department of Government Services.

10. The Department should set standards and/or monitor hospital-acquired infection prevention and control processes.

Refer to #1, 2, 5, 7 items above.

11. The Department should address the issues raised regarding the level of infection control supplies.

The RHAs are responsible for ensuring that they keep adequate supplies on hand to meet infection control guidelines.

Highlights

Highlights of a review of the financial position and operations of the Labrador-Grenfell Regional Integrated Health Authority for the period 1 April 2005 to 31 December 2006.

Why our Office did this Review

The objectives of our review were to assess whether the Authority was: adequately monitoring its financial position and operations; recruiting and compensating its employees in accordance with Authority and Government policy; properly approving, monitoring and controlling its expenditures; complying with the *Public Tender Act* and *Regulations*; and adequately monitoring its capital assets.

What our Office Recommends

Following are highlights of recommendations included in the Report that the Authority should address. The Authority should:

- address its accumulated operating deficits and increasing bank indebtedness;
- fully integrate its two financial systems;
- comply with Government's personnel procedures and compensation practices;
- comply with the *Public Tender Act* and *Regulations*;
- ensure its purchasing, travel and other expenses comply with Government policy and that these policies are communicated to staff;
- ensure the need, usage and cost of cellular telephones is adequately monitored;
- comply with Government's *Guidelines for the Hiring of External Consultants*; and
- develop and implement policies and procedures governing capital assets.

What the Authority Said

To provide balance to this report and to ensure full disclosure, the Authority was asked to formulate a response to our findings and conclusions. The Authority's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Authority's comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.10

LABRADOR-GRENFELL REGIONAL INTEGRATED HEALTH AUTHORITY

The Labrador-Grenfell Regional Integrated Health Authority (the Authority) was established on 1 April 2005 when the Authority assumed the operations of the former Health Labrador Corporation and the former Grenfell Regional Health Services Board. The Authority is governed by the *Hospitals Act* (a new *Regional Health Authorities Act* outlining health and community services to be provided by regional health authorities has not been proclaimed). For 2006-07, the Authority spent $126.6 million in shareable expenditures and had $125.8 million in revenue. The $125.8 million in revenue consisted of Provincial operating grants totalling $105.0 million, Federal program revenues of $9.9 million, $8.7 million relating to user fees and recoveries, and $2.2 million in other revenue.

What We Found

Our review identified a number of concerns relating to the operations of the Labrador-Grenfell Regional Integrated Health Authority. In particular, after 21 months of integration, as at 31 December 2006, the Authority's financial position continues to deteriorate, it still operated as two separate entities in many areas, continued to follow former board policies/practices and did not have an integrated financial information system.

Financial Position: At 31 March 2003, the Authority's accumulated operating deficit was $27.1 million and increased to $34.1 million as at 31 March 2007, an increase of $7.0 million (26%). The Authority's bank indebtedness increased from $11.1 million as at 31 March 2003 to $22.1 million as at 31 March 2007, an increase of $11 million (100%). Furthermore, the increased bank indebtedness resulted in high annual interest costs for the Authority - $1.5 million over the last three fiscal years. This interest bite results in less funds for program delivery.

Financial Operations: Expenditures have increased in each of the last 4 years, from $103.2 million in 2003-04 to $126.6 million in 2006-07, an increase of $23.4 million (23%). Furthermore, the Authority incurred annual operating deficits totalling $6.6 million over the past 4 fiscal years excluding non-shareable expenses such as severance and vacation pay accruals.

Human Resources: The Authority's human resource practices were not always consistent with those established by Government, hiring and compensation practices were sometimes either inconsistent or in excess of those approved by Government, termination benefits were either not always consistently applied or were in excess of those approved by Government, available leave balances were sometimes exceeded, and overtime payments were sometimes in excess of Government policy.

Purchasing - the *Public Tender Act*: The Authority did not tender for 15 purchases (31% of 48 reviewed) totalling $1,309,761 which were over $10,000 and did not obtain quotes for 5 purchases (28% of 18 reviewed) totalling $33,997 under $10,000. The Authority has neither tendered nor evaluated its food services contracts (2006 - approximately $2 million) since being integrated in April 2005. In addition, the Authority did not keep tenders in a locked box, date-stamp tender envelopes or document explanations of why rejected tenders did not meet tender specifications.

Travel and Relocation Expenditures: The Authority is not adequately controlling and monitoring its travel and relocation expenditures and is not complying with Government's travel and relocation policies.

Cellular Telephones: The Authority is not adequately monitoring the usage and cost of its 89 cellular telephones (9 months to December 2006 the Board spent approximately $59,000).

Hiring of Consultants: The Authority contravened Government's *Guidelines for the Hiring of External Consultants* for two consulting contracts over $50,000, by not obtaining 3 proposals or conducting a public call for proposals and in one of the two contracts, relating to the provision of orthodontist services, by not obtaining Cabinet approval for the contract.

Capital Assets: Controls over the Authority's capital assets are inadequate and could result in missing assets not being detected. The Authority does not tag all of its assets once received and does not maintain a capital asset ledger. As well, periodic inventory counts are not performed and assets are not reconciled to the Authority's financial records.

Background

Overview

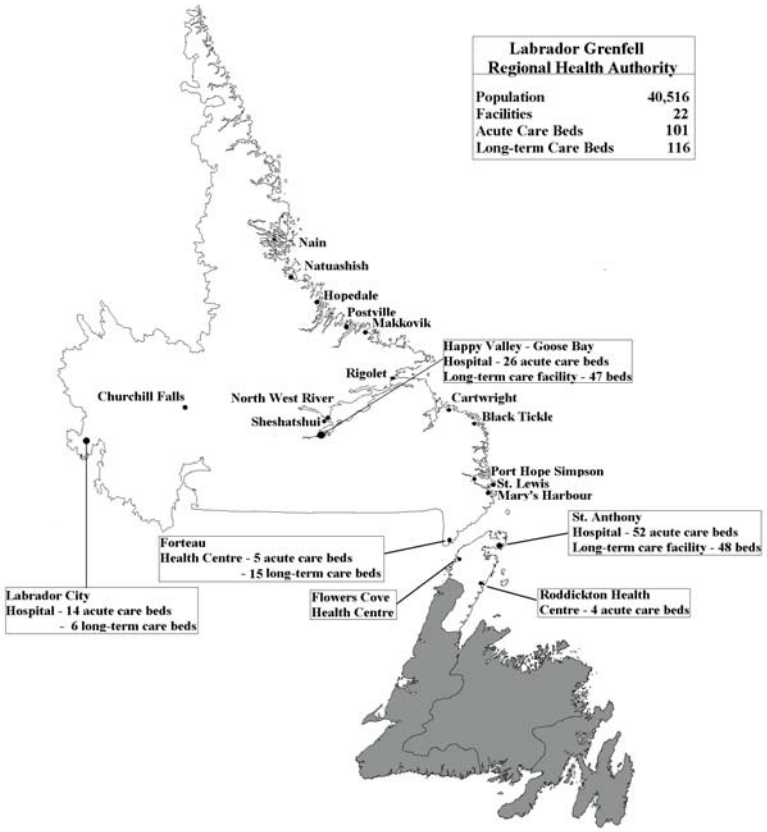
The Labrador-Grenfell Regional Integrated Health Authority (the Authority) was established on 1 April 2005 when the Authority assumed the operations of the former Health Labrador Corporation (HLC) and the former Grenfell Regional Health Services Board (GRHS). The Authority is governed by the *Hospitals Act* (a new *Regional Health Authorities Act* outlining health and community services to be provided by regional health authorities has not been proclaimed).

For 2006-07, the Authority spent $126.6 million in shareable expenditures and had $125.8 million in revenue. The $125.8 million in revenue consisted of Provincial operating grants totalling $105.0 million, Federal program revenues of $9.9 million, $8.7 million relating to user fees and recoveries, and $2.2 million in other revenue.

Figure 1 provides a map and summary information on the Authority.

Figure 1

Labrador-Grenfell Regional Integrated Health Authority Regional Map



The Authority provides primary, secondary, and long-term care, as well as continuing care and community/public health services, to approximately 41,000 residents.

The Authority's region covers the communities north of Bartlett's Harbour on the Northern Peninsula and all of Labrador. The Authority operates 22 facilities, including 3 hospitals, 2 long-term care facilities, 3 community health care centres and 14 clinics/nursing stations throughout the region. The Authority employs approximately 1,390 staff on a full or part-time basis. Its head office is located in Happy Valley-Goose Bay.

Previous reviews

Our Office conducted reviews of the two former boards as follows:

- In 1998, our review of the Health Labrador Corporation concluded there were serious financial problems regarding the Corporation's continuing operating deficits, cash flow, budget processes and financial monitoring. Our review also identified compensation to senior officials above Government policy, insufficient purchasing practices, non-compliance with the *Public Tender Act*, inadequate controls over capital assets and inventory, and documentation issues with job competitions and employee leave.

- In 2004, our review of the Grenfell Regional Health Services Board concluded the Board: did not adequately address its financial position and operating results; did not maintain adequate documentation or signed contracts to support certain business activities; failed to ensure all amounts owing were recovered; spent money contrary to Government and Board policy; and did not comply with the *Public Tender Act* and *Regulations.*

Audit Objectives and Scope

Audit Objectives

The objectives of our review were to assess whether the Authority was:

- adequately monitoring its financial position and operations;

- recruiting and compensating its employees in accordance with Authority and Government policy;

- properly approving, monitoring and controlling its expenditures;
- complying with the *Public Tender Act* and *Regulations*; and
- adequately monitoring its capital assets.

Audit scope

Our review was completed in April 2007 and covered the period 1 April 2005 to 31 December 2006. Our review included an examination of policies and procedures, Board and committee minutes, and financial reports, as well as interviews with staff and a detailed analysis and sampling of the Authority's expenditure transactions.

Overall Conclusions

Our review identified a number of concerns relating to the operations of the Labrador-Grenfell Regional Integrated Health Authority. Concerns were noted with regards to the Authority's financial position, operating results, human resources, purchasing, and capital assets. In particular, after 21 months of integration, as at 31 December 2006, the Authority's financial position continues to deteriorate, it still operated as two separate entities in many areas, continued to follow former board policies/practices and did not have an integrated financial information system. Additional details are outlined as follows:

Financial Position

At 31 March 2003, the Authority's accumulated operating deficit was $27.1 million and increased to $34.1 million as at 31 March 2007, an increase of $7.0 million (26%).

The Authority's bank indebtedness increased from $11.1 million as at 31 March 2003 to $22.1 million as at 31 March 2007, an increase of $11 million (100%). Furthermore, the increased bank indebtedness resulted in high annual interest costs for the Authority - $1.5 million over the last three fiscal years. This interest bite results in less funds for program delivery.

Patient receivables have increased from $1.9 million as at 31 March 2005 to $2.7 million as at 31 March 2007, an increase of $0.8 million (42%). The Authority could do more in monitoring and collecting its patient receivables, e.g. accounts receivable systems from the former boards should be integrated, receivables should be aged correctly, and there should be follow-up on amounts owing from the Workplace Health and Safety Compensation Commission.

Financial Operations

Expenditures have increased in each of the last 4 years, from $103.2 million in 2003-04 to $126.6 million in 2006-07, an increase of $23.4 million (23%). Furthermore, the Authority incurred annual operating deficits totalling $6.6 million over the past four fiscal years excluding non-shareable expenses such as severance and vacation pay accruals. Although the Authority, at the request of the Department, identified some revenue-generating and cost-saving measures, the Department did not authorize their implementation.

Although the Authority continues to monitor and report on its financial operations using information systems from the two former boards, the lack of integration has resulted in delays and inadequacies in the financial monitoring and reporting process. Concerns about the Authority's inadequate financial monitoring were evident at the Board level. For example, an external financial consultant cautioned the Board that there were *"...real concerns with the budget and how it was set... doesn't believe that it accurately reflects the activity we are incurring."*

Expected decreases and savings of $2.1 million in administration expenditures since the Authority was integrated on 1 April 2005 have not yet materialized. In fact, administration expenditures have increased 48% from $9 million in 2003-04 to $13.3 million in 2006-07.

Although the Department requires monthly financial information to monitor the financial operations of the Authority and the Provincial health care system in total, the Authority has not been providing this information.

Human Resources

The Authority's human resource practices were not always consistent with those established by Government, hiring and compensation practices were sometimes either inconsistent or in excess of those approved by Government, termination benefits were either not always consistently applied or were in excess of those approved by Government, available leave balances were sometimes exceeded, and overtime payments were sometimes in excess of Government policy. In addition, leave systems were not integrated and the Authority had no policy governing the use of accrued overtime hours. For example:

- The Associate Vice-President of Medical Services was paid $293,892 annually, $69,476 in excess of the compensation approved by Government. The Vice-President of Medical Affairs was paid $236,008 annually, $21,592 in excess of the compensation approved by Government.

- No competitions were held for either 12 newly created Director positions or the Associate Vice-President Medical Services. Instead, the positions were offered to existing employees.

- Treasury Board approval and classification was not obtained for 6 newly created positions. Furthermore, 2 Directors, who should have been placed on step 1, were placed on steps 32 and 33 respectively without the Department's approval.

- The Authority provided 3 employees with free or subsidized rental accommodations totalling $14,400, $3,300 and $1,140 respectively in excess of Authority policy. In 2 of the 3 instances the subsidy was not reported as a taxable benefit for the employee.

- One employee had overdrawn their paid leave by 519 hours (69 days). The employee is now repaying the overdrawn leave at 3 days per pay period.

- During the 2004 public service strike, the Authority paid 59 management employees $310,821 for 4,532 overtime hours at double-time rather than Government's policy of paying at time-and-a-half.

Purchasing

Public Tender Act

The Authority did not tender for 15 purchases (31% of 48 reviewed) totalling $1,309,761 which were over $10,000 and did not obtain quotes for 5 purchases (28% of 18 reviewed) totalling $33,997 under $10,000. The Authority has neither tendered nor evaluated its food services contracts (2006 - approximately $2 million) since being integrated in April 2005. In addition, the Authority did not keep tenders in a locked box, tender envelopes were not date-stamped, and explanations of why rejected tenders did not meet tender specifications were not always documented.

Travel and Relocation Expenditures

The Authority is not adequately controlling and monitoring its travel and relocation expenditures and is not complying with Government's travel and relocation policies. Specifically, the Authority:

- improperly provided meal and private accommodation allowances at executive rates to its non-executive senior staff;
- did not always ensure that adequate documentation was attached to support travel and relocation claims. For example: 7 employees and 1 board member submitted credit card statements, credit card receipts or debit slips to support 10 claimed expenses totalling $4,440 for accommodations, meals and gas purchases; and two payments of $22,905 and $3,213 were made to moving companies with no invoices or purchase orders on file;
- reimbursed one employee for legal fees totalling $5,213 for the sale of land; however, Government policy only allows for the reimbursement of legal fees for selling principle residences;
- incorrectly reported certain non-travel expenses approximating $55,000 as travel expenses (e.g. office supplies, postage, maintenance) or inconsistently reported them within travel expenses (locum travel costs);
- did not consistently apply the GST rebate on certain travel allowances;
- used travel claims to approve approximately $12,000 in non-travel expenses (e.g. digital camera, computer hardware and software, office supplies); and

- did not always ensure relocation return-in-services agreements were in place for applicable employees.

Cellular Telephones

The Authority is not adequately monitoring the usage and cost of its 89 cellular telephones (9 months to December 2006 the Board spent approximately $59,000). The Authority had not performed required annual analyses of cellular telephone allocations and usage, maintained an updated listing of all cellular telephones, documented supervisor reviews of monthly cellular telephone invoices prior to payment, and reported cellular telephone expenditures separately in their financial information system.

Hiring of Consultants

The Authority contravened Government's *Guidelines for the Hiring of External Consultants* for two consulting contracts over $50,000, by not obtaining 3 proposals or conducting a public call for proposals and in one of the two contracts, relating to the provision of orthodontist services, by not obtaining Cabinet approval for the contract. In this case as well, the Authority had not reviewed the service arrangement since it was first put in place in 1998, to determine whether the arrangement is still financially beneficial to the Authority or whether alternative arrangements are available.

Capital Assets

Controls over the Authority's capital assets are inadequate and could result in missing assets not being detected. The Authority does not tag all of its assets once received and does not maintain a capital asset ledger. As well, periodic inventory counts are not performed and assets are not reconciled to the Authority's financial records. In the case of the former Health Labrador Corporation, Authority staff indicated that furniture and equipment have not been inventoried since 2000.

In addition, the Authority does not monitor the costs and usage of its 77 vehicles, does not maintain vehicle log books to monitor vehicle usage, and does not record operating costs by vehicle to monitor vehicle costs. Without such controls, vehicles could be used for unauthorized purposes.

As well, the Authority sold a residential unit to the former Chief Executive Officer for $13,500 less than it should have.

Detailed Observations

This report provides detailed audit findings and recommendations in the following sections:

1. Financial Position
2. Financial Operations
3. Human Resources
4. Purchasing
5. Capital Assets

1. Financial Position

Overview

Financial position shows the state of the Authority's finances at a particular point in time. Such information is useful in evaluating the Authority's ability to finance its activities, meet its liabilities and obligations, and provide future services. Our review included an analysis of the Authority's financial position over the past five years. Key areas examined included the Authority's bank indebtedness, accounts receivable and accumulated operating deficits (and how annual operations affected the accumulated deficit).

Figure 2 summarizes financial information from the Authority's statement of financial position.

Figure 2

Labrador-Grenfell Regional Integrated Health Authority
Financial Information-Operating Fund
As at 31 March
$ Millions

Financial Information	2002-03	2003-04	2004-05	2005-06	2006-07
OPERATIONS					
Cash	2.5	4.1	3.7	3.2	3.0
Accounts receivable	5.0	4.2	5.0	5.8	12.4
Other current assets	2.6	2.5	3.1	2.9	3.2
Bank indebtedness	(11.1)	(12.4)	(14.9)	(15.3)	(22.1)
Current liabilities-net of current LTD	(11.9)	(13.6)	(13.4)	(16.5)	(17.2)
Due to Authority Fund	(2.9)	(2.9)	(1.9)	-	-
Severance/Vacation pay accrual	(11.3)	(12.5)	(12.4)	(12.7)	(13.4)
Accumulated Operating Deficit	**27.1**	**30.6**	**30.8**	**32.6**	**34.1**
CAPITAL					
Capital assets	20.0	18.4	16.9	18.2	19.4
Long-term debt (LTD)	(1.3)	(1.2)	(1.2)	(1.3)	(1.2)
Deferred capital contributions	(17.4)	(15.8)	(14.4)	(15.5)	(17.0)
Net Assets Invested in Capital Assets	**(1.3)**	**(1.4)**	**(1.3)**	**(1.4)**	**(1.2)**
Accumulated Deficit	**25.8**	**29.2**	**29.5**	**31.2**	**32.9**

Source: Audited Financial Statements

Note 1: As a result of a change in accounting policy, for 2006-07 (comparative 2005-06), Authority Fund transactions were combined with Operating Fund transactions.

As Figure 2 shows, the financial position of the Authority and its predecessor boards has declined over the past five fiscal years. As at 31 March 2007, the Authority had an accumulated deficit of $32.9 million, an increase of $7.1 million (28%) from the accumulated deficit of $25.8 million in 2003.

Our review of the Authority's financial position identified issues in the following areas:

A. Bank Indebtedness
B. Accounts Receivable
C. Accumulated Operating Deficit

1A. Bank Indebtedness

Introduction

As at 31 March 2006, the Authority maintained a $14 million and a $3 million line of credit for the former Health Labrador Corporation (HLC) and the former Grenfell Regional Health Services (GRHS) respectively. In March 2006, the Authority received approval from the Minister of Health and Community Services to increase the $3 million line of credit to $5 million effective 1 April 2006 and in April 2006 received approval to combine the two lines of credit into a $19 million line of credit with one bank.

A review of the Authority's 2007 audited financial statements indicated that the Authority's **approved** line of credit increased to $22.6 million during the 2006-07 fiscal year and reduced to $19 million on 30 April 2007.

Increasing bank indebtedness

Our review of the Authority's bank indebtedness identified the following issues:

- Although Provincial funding to the Authority has increased annually, the Authority has had to borrow additional funds each year to meet its operational expenditures. As at 31 March 2007, the Authority reported a bank indebtedness of $22.1 million, an increase of $11 million (100%) from the 2003 bank indebtedness of $11.1 million.

  The bank indebtedness increased $6.8 million (44%) from $15.3 million in 2005-06 to $22.1 million in 2006-07. A significant portion of this increase can be attributed to financing an increase of $5.5 million in the receivable from the Province, of which $3.9 million relates to deficit funding.

Increasing interest expense

- The Authority incurred approximately $1.5 million in interest charges during the past three fiscal years as follows:

  - 2004-05 $307,000
  - 2005-06 $445,000
  - 2006-07 $731,000

  The increase in the Authority's bank indebtedness since 2003 has resulted in a corresponding increase in interest expense and increase in the Authority's accumulated operating deficit. Monies paid on interest expenses (the interest bite), means that there will be less funding available for program delivery.

1B. Accounts Receivable

Introduction

For the fiscal year ending 2007, the Authority reported $12.4 million in net accounts receivable; $9.4 million for the former HLC and $3.0 million for the former GRHS. Figure 3 provides details on the accounts receivable over the past 3 fiscal years.

Figure 3

Labrador-Grenfell Regional Integrated Health Authority
Accounts Receivable
Fiscal years 2004-05 to 2006-07
$ Millions

	2004-05			2005-06			2006-07		
	HLC	**GRHS**	**Total**	**HLC**	**GRHS**	**Total**	**HLC**	**GRHS**	**Total**
Government	$ 2.4	$ 0.8	$ 3.2	$ 2.7	$ 0.6	$ 3.3	$ 8.0	$ 1.4	$ 9.4
Patient	**1.2**	**0.7**	**1.9**	**1.3**	**1.2**	**2.5**	**1.5**	**1.2**	**2.7**
Other	0.8	0.1	0.9	0.7	0.1	0.8	0.8	0.6	1.4
Gross Receivable	4.4	1.6	6.0	4.7	1.9	6.6	10.3	3.2	13.5
Allowance	(0.9)	(0.1)	(1.0)	(0.8)	(0.1)	(0.9)	(0.9)	(0.2)	(1.1)
Net Receivable	**$ 3.5**	**$ 1.5**	**$ 5.0**	**$ 3.9**	**$ 1.8**	**$ 5.7**	**$ 9.4**	**$ 3.0**	**$ 12.4**

Source: Authority financial information system

Our review of the Authority's accounts receivable identified the following issues:

- As Figure 3 indicates, accounts receivable have increased from $5.0 million in 2004-05 to $12.4 million in 2006-07, an increase of $7.4 million (148%). This increase can be attributed to the following:

  - Patient receivables increased by $0.8 million from $1.9 million at 31 March 2005 to $2.7 million at 31 March 2007. The patient receivables balance for HLC operations increased from $1.2 million to $1.5 million and for GRHS operations increased from $0.7 million to $1.2 million.

  - An increase of $6.2 million in the receivable from the Government, of which $3.9 million relates to deficit funding from the Province.

  Receivables have to financed and, as a result, bank indebtedness has also increased.

Multiple accounts receivable systems

- The Authority does not maintain an integrated system for monitoring its accounts receivable. Instead, the Authority maintains:

  - separate patient and client Meditech accounts receivable modules for both HLC and GRHS;

  - a manual ledger which records pre-2000 outstanding patients receivable not included in the Meditech systems; and

  - a separate dental and orthodontic accounts receivable system.

  The use of multiple accounts receivable systems makes it difficult for the Authority to monitor and report the Authority's accounts on a regional basis. For example, the Authority's external auditor reported one instance where a $50,000 account receivable from a doctor was removed from the system and was not transferred when the doctor transferred from the former GRHS to the former HLC.

Inadequate reporting of accounts receivable

- During our review, we identified that the Authority did not provide a breakdown in its audited financial statements of its accounts receivable. By not providing a classification of its accounts receivable in the notes to the financial statements it was not possible for financial statement users to determine the source of

the Authority's accounts receivable. This issue was heightened given the Authority's large and increasing accounts receivable. We note that for 2006-07 this information was included in the audited financial statements.

Ageing of patient receivables not readily available

- Our review indicated that receipts totalling $539,000 in the GRHS Meditech patient receivable system were not aged. As a result of not posting these receipts to the proper ageing period, the system does not provide an accurate ageing of patient receivables for monitoring purposes.

No write-off policy

- The Authority does not have a write-off policy for uncollectible accounts. As a result, many older uncollectible accounts are maintained in the receivable system. For example, the Authority has $206,000 in patient receivables which are dated 1999 or earlier, i.e. at least 7 years old, and are all considered doubtful of collection.

Numerous old and large outstanding accounts

- Discussions with Authority staff indicated that, although the Authority has collection procedures such as the provision of invoices and statements, and uses the services of a collection agency for former GRHS accounts, receivables continue to increase. A review of the 31 December 2006 accounts receivables identified numerous old and large outstanding accounts.

  For example, 4 accounts totalling $122,335 for six claims were due from the Workplace Health and Safety Compensation Commission for the years 2000 to 2006. There was no follow-up by the Authority on these receivables to determine why the full amount of the invoices was not paid.

Inappropriate employee loans

- The Authority has made interest free loans to employees although there was no policy permitting such loans. During 2006, one employee was provided $7,500 (paid out of Operating Fund) and another employee was paid $2,700 (paid out of Board Fund). The use of public money for employee loans is inappropriate and is inconsistent with Government policy.

1C. Accumulated Operating Deficit

As at 31 March 2007, the Authority reported an accumulated operating deficit of $34.1 million of which $13.4 million related to severance and vacation pay accruals. The Authority's accumulated operating deficit continues to increase as a result of annual operating deficits.

Increasing accumulated deficit

At 31 March 2003, the Authority's accumulated operating deficit was $27.1 million and increased to $34.1 million as at 31 March 2007, an increase of $7.0 million (26%).

The Authority's accumulated operating deficit will be affected by the results of future operations and the level of funding by Government. If the Authority has annual operating surpluses in the future, these surpluses could be used to fund the deficit. However, if the Authority has annual operating deficits, these deficits, along with the accumulated deficit, will have to be funded by Government.

Conclusions

The Authority's financial position continues to deteriorate. At 31 March 2003, the Authority's accumulated operating deficit was $27.1 million and increased to $34.1 million as at 31 March 2007, an increase of $7.0 million (26%).

The Authority's bank indebtedness increased from $11.1 million as at 31 March 2003 to $22.1 million as at 31 March 2007, an increase of $11 million (100%). Furthermore, the increased bank indebtedness resulted in high annual interest costs for the Authority - $1.5 million over the last three fiscal years. This interest bite results in less funds for program delivery.

Patient receivables have increased from $1.9 million as at 31 March 2005 to $2.7 million as at 31 March 2007, an increase of $0.8 million (42%). The Authority could do more in monitoring and collecting its patient receivables. Accounts receivable systems from the former boards are not integrated, receivables are not being aged correctly, and there is a lack of follow-up on amounts owing from the Workplace Health and Safety Compensation Commission.

Recommendations

The Authority should:

- address its accumulated operating deficits and increasing bank indebtedness; and
- integrate its accounts receivable systems, properly age patient receivables and ensure adequate follow-up on all receivables.

2. Financial Operations

Overview

Financial operating results show the Authority's financial changes in a particular year. Such information is useful in evaluating how the Authority used monies provided by Government and monies obtained directly from its operations. Figure 4 provides a summary of the Authority's revenue, expenditure and annual operating deficits for 2003-04 through to 2006-07.

Figure 4

Labrador-Grenfell Regional Integrated Health Authority
Revenues and Expenditures
Fiscal Years
$ Millions

	2003-04	2004-05	2005-06	2006-07
Revenue				
Provincial Program(including MCP)	$ 88.6	$ 91.8	$ 96.9	$105.0
Federal programs	4.8	6.5	7.1	9.9
User fees and recoveries	6.3	7.4	8.3	8.7
Other	1.5	1.2	2.0	2.2
Total revenue	101.2	106.9	114.3	125.8
Expenditure				
Administration	9.0	9.8	12.9	13.3
Support Services	19.7	20.3	22.2	23.1
Nursing Inpatient Services	16.7	17.0	18.3	18.8
Ambulatory Care	12.0	11.9	13.1	13.5
Diagnostic & Therapeutic	9.4	8.9	10.8	11.1
Community & Social Services	21.6	23.6	25.4	31.9
Medical Services	13.1	13.5	13.2	12.7
Education/Research	0.9	1.1	1.0	0.9
Other	0.8	0.9	1.1	1.3
Total expenditure	103.2	107.0	118.0	126.6
Deficit before non-shareable items	**(2.0)**	**(0.1)**	**(3.7)**	**(0.8)**
Non-shareable Expenses	1.4	0.1	0.5	0.9
Deficit after non-shareable items	**$ (3.4)**	**$ (0.2)**	**$ (4.2)**	**$ (1.7)**

Source: Audited Financial Statements
Note 1: 2006 and 2007 fiscal years include Authority Fund transactions

As outlined in Figure 4, the Authority incurred annual operating deficits totalling $6.6 million over the past 4 fiscal years excluding non-shareable expenses such as severance and vacation pay accruals, and amortization of capital assets and capital grants. We note that the $141,000 deficit for 2004-05, the lowest deficit in the past 4 years, occurred during the year of a public sector strike.

Expenditures have increased in each of the last four years, from $103.2 million in 2003-04 to $126.6 million in 2006-07, an increase of $23.4 million (23%). In particular, there were significant increases in administration expenditures which increased from $9.0 million to $13.3 million, an increase of $4.3 million (48%) and community and social services expenditures which increased from $21.6 million to $31.9 million, an increase of $10.3 million (48%). We found the following:

Administration Expenditures

The Authority was integrated on 1 April 2005; therefore, it would be expected that these administration expenditures (e.g. terminations and redundancy payments) would increase during a reasonable transition period and then start to decrease and realize the expected savings. The 2005-06 and 2006-07 budget documentation indicated that the savings were expected to be $0.7 million for 2005-06 and $1.4 million for 2006-07 and each year subsequently. However, the expected decreases and savings have not yet materialized. Instead, the expenditures continue to increase even in the second year after integration.

In 2005-06, redundancy, severance and leave payouts ($0.9 million) as well as new programs related to the Provincial primary health initiative ($0.5 million) caused a significant increase in administrative expenditures. In 2006-07, redundancy, severance and leave payouts decreased $0.5 million; however, increases in interest costs on the line of credit ($0.3 million) and insurance premiums ($0.2 million) caused administrative expenditures to remain high.

Community and Social Services Expenditures

We note that $5.6 million of the $10.3 million relates to changes in the Child, Youth and Family Services program. In particular, in 2006-07, $0.7 million was provided for family resource centres and $1.7 million was provided for group homes. In addition, child welfare costs in Innu communities continue to increase ($1.7 million increase in 2006-07). Most of this increase was offset by increased funding.

Our review identified significant issues in the following areas:

A. Deficit Budgeting
B. Financial Monitoring and Reporting

2A. Deficit Budgeting

Introduction

In each of the fiscal years ending 2006, 2007 and 2008, the Minister of Health and Community Services requested each of the regional health authorities to submit balanced budgets. However, our review identified that the Authority budgeted operating deficits for each of its first two fiscal years (2008 budget not submitted as of review) as follows:

2006 - $2.57 million
2007 - $2.0 million

Our review of the Authority's budget process identified the following issues:

Measures to eliminate deficit budgeting not approved

- Subsequent to the submission of their budgets, the Department requested the Authority to take appropriate measures/action plans to achieve a balanced budget or identify areas where budgetary issues exist. For each fiscal year, the Authority provided various revenue-generating and cost-savings measures to achieve a balanced budget; however, the Department did not approve these measures. As a result of not being authorized to implement these measures, the Authority was not able to realize any related savings. Examples of proposed 2006-07 revenue generating measures which were rejected by the Department included:

    - Making all drug dispensing fees throughout the Authority consistent at $7.90. At the time, drug dispensing fees at the GRHS were $2.00 while in the HLC the fee was $8.50. The Authority expected to generate additional revenue of $171,000 annually from this change.

- Making all drug sales throughout the Authority at market price. At the time, drugs were sold at the GRHS at cost plus dispensing fee ($2.00) while in the HLC drugs were sold at market price plus dispensing fee ($8.50). The Authority expected to generate additional revenue of $818,000 annually from this change.

Inadequate projections of financial operations

- In December 2005, the Department approved $2.1 million in one-time deficit funding for the Authority based upon information contained in a mid-year review made to the Department. In the December 2005 Departmental letter to the Authority it stated that $2.1 million deficit funding was expected to eliminate the 2006 projected deficit. However, just 3 months later the Authority reported a deficit of $3.1 million, even after the additional $2.1 million. The large variance in the 2006 deficit projection and the actual deficit raises concerns over the Authority's financial monitoring system and its ability to adequately monitor its financial affairs at that time.

Operating deficits continue

- As at 31 December 2006, the Authority reported an operating deficit of $2.8 million, with a projected annual deficit of $3.8 million for the year ended 31 March 2007. In March 2007, the Department informed the Authority that one-time funding of $3.9 million, to offset the expected deficit, would be provided to the Authority. However, even with this additional funding, the Authority still incurred an annual operating deficit of $850,000.

2B. Financial Monitoring and Reporting

Introduction

The Authority continues to monitor and report on its financial operations using information systems from the two former boards. The lack of integration has resulted in delays and inadequacies in the financial monitoring and reporting of the Authority's financial operations.

Our review of the Authority's financial monitoring and reporting identified the following issues:

Financial information systems not integrated

- The Authority continues to operate the two separate financial information systems that were present at the former boards. As a result, the Authority has to manually combine its financial reports to determine its overall financial operations and position. This process results in reporting delays, lack of financial transaction detail, and increases the risk of reporting errors.

  Although the Authority is developing a system which will automatically transfer financial information from the GRHS system to the HLC system, it will not provide any detailed transactions from the GRHS system. Instead, it will only provide summarized GRHS system information. As a result, management is still not being provided with sufficient detailed information necessary to adequately monitor the Authority's financial activities.

Financial information not submitted to Department of Health

- For 2006-07, the Authority did not submit the monthly financial information to the Department for its Tele-data system as required. Specifically:

  - April 2006 was not submitted until February 2007;
  - May 2006 through October 2006 was never submitted;
  - November 2006 and December 2006 were not submitted until July 2007; and
  - January 2007 to March 2007 were not submitted until August 2007.

  The Department requires this information to adequately monitor the financial operations of the Authority and the Provincial health care system in total. Without the consistent periodic submission of detailed financial information, this monitoring cannot take place.

Human resource vacancies in financial area

- During the fiscal year ending 2007, the Authority experienced vacancies in human resources for its two senior financial positions. From May 2006 to January 2007, the Regional Director of Financial Services was on extended leave and in August 2006 the Authority terminated the position of Vice-President of Corporate Affairs. These two vacancies resulted in temporary but significant resource constraints in the financial area. In addition, in September 2006, the Authority terminated the position of budget analyst as a cost-savings measure.

  The Authority, in response to these vacancies, contracted the services of a financial consultant for 4 months to assist with the 2006 fiscal year end audit preparations. However, in September 2006 the consultant's contract was extended until a permanent Vice-President of Corporate Affairs could be recruited. The permanent Vice-President of Corporate Affairs position had not been filled at the time of our review in April 2007.

  Although the Authority contracted the service of an external financial consultant, the absence of dedicated full-time senior financial positions contributed to weaknesses in the Authority's financial monitoring and reporting.

Inadequate financial reporting system

- Concerns about the Authority's inadequate financial monitoring were evident at the Board level. For example, at the 13 December 2006 Board meeting, the financial consultant presented a financial report for the period ending October 2006. The consultant cautioned the Board regarding a lack of "*...absolute confidence in the information because of the complexity and magnitude of it and the lack of human resources to do the analytical work that needs to be done.*" The consultant also stated there were *"...real concerns with the budget and how it was set... doesn't believe that it accurately reflects the activity we are incurring."*

Conclusions

The Authority incurred annual operating deficits totalling $6.6 million over the past 4 fiscal years excluding non-shareable expenses such as severance and vacation pay accruals. As well, expenditures have increased in each of the last four years, from $103.2 million in 2003-04 to $126.6 million in 2006-07, an increase of $23.4 million (23%).

Expected decreases and savings in administration expenditures since the Authority was integrated on 1 April 2005 have not yet materialized.

As a result of not being authorized by the Department to implement revenue-generating and cost-saving measures, the Authority was not able to realize planned savings.

The Authority continues to monitor and report on its financial operations using information systems from the two former boards. The lack of integration has resulted in delays and inadequacies in the financial monitoring and reporting of the Authority's financial operations.

The Authority is not providing monthly financial information required by the Department to adequately monitor the financial operations of the Authority and the Provincial health care system in total.

Concerns about the Authority's inadequate financial monitoring were evident at the Board level. For example, the financial consultant cautioned the Board that there were *"...real concerns with the budget and how it was set... doesn't believe that it accurately reflects the activity we are incurring."*

Recommendations

The Authority should:

- fully integrate its two financial information systems;
- provide the Department of Health with required monthly financial information; and
- address its annual operating deficits and inadequate financial monitoring.

3. Human Resources

Overview

Salaries are the largest expense at the Authority. As at 31 March 2007, the Authority employed approximately 1,390 staff and spent $77.0 million, or 61% of its $126.6 million in total expenditures on salaries and benefits. Our review disclosed that the Authority's compensation practices were not always consistent with Government policy with regards to:

A. Recruitment
B. Compensation practices
C. Termination benefits
D. Paid leave
E. Overtime
F. Other issues

3A. Recruitment

Introduction

The Merit Principle, championed by the Public Service Commission (PSC), requires that candidates be assessed with fairness and equity so that jobs will be awarded to the candidates most suitable for a position. The Merit Principle is the primary means to restrain or avoid political and bureaucratic influence over appointments and internal promotions.

Although the Authority is not governed by the *Public Service Commission Act,* we would expect that the Authority would have recruitment processes in place to ensure fairness and equity similar to that of the Merit principle.

Competitions not held for all senior positions

Our examination of 28 senior management appointments identified significant inconsistencies in the process followed to fill the positions. Specifically:

- 12 of the 22 newly created director positions examined did not have competitions held. Instead, the Authority offered the most senior employee holding a similar position with the former boards the choice to accept the new position or have their position declared redundant and avail of termination benefits. If the senior employee accepted the position, then the other less senior employee with the other former board would have their position declared redundant. If the senior employee did not accept the offer, the position was offered to the less-senior staff. The Authority deemed this to be the most efficient process to follow assuming eligible candidates (existing employees) offered the new position would have been qualified as they were already performing similar duties. However, by not holding competitions for these positions, the Authority limited its recruitment of qualified personnel to internal candidates only.

- 1 position, the Associate Vice-President of Medical Services, was created during 2005-06. The former Assistant Executive Director of Medical Services with the former GRHS board was appointed to the position. The Authority did not conduct a competition for the position.

- All 5 vice-president positions were appointed through public competition.

- Of the 10 director positions for which the Authority held public competitions, our review identified the following:

Inadequate documentation maintained on ranking of applicants

  - The Authority did not maintain a selection or rating sheet to document the assessment and ranking of 5 candidates. Candidates were assessed by a selection committee based upon how well they met the position criteria and answered interview questions, and on reference checks. However, without documentation of the selection committee's assessment, it is difficult to determine whether the position had been awarded to the most suitable candidate as required by the Merit Principle.

Interviews not conducted for all competitions

  - The interview process is an essential tool in assessing an applicant's merits and skills. However, the Authority filled 3 positions without conducting interviews with the successful candidate. In all 3 cases, the selection committee deemed that the successful candidate was clearly superior to the other applicants, and therefore interviews were deemed unnecessary.

3B. Compensation Practices

Introduction

Our review of compensation provided to 29 senior employees identified instances where compensation practices were inconsistent with Government policy. Government policy requires that approved salaries must be provided according to the position classification as approved by Treasury Board.

Excess salaries and bonuses paid to Senior administrative medical staff

Our review identified the following:

- The Authority was compensating the Vice-President of Medical Affairs at $236,008, comprised of a salary of $196,258 and an annual retention bonus of $39,750.

  The Authority established the $196,258 salary by taking the salary of the Assistant Executive Director of Medical Services of the former HLC who was appointed to the position and providing a 10% promotion increase. The maximum salary for this position as approved by Treasury Board is $178,416.

  The maximum annual retention bonus as approved by Treasury Board is $36,000.

  As a result, the Authority is over compensating this employee $21,592 annually ($17,842 in salary and $3,750 in retention bonus).

- The Authority is compensating the Associate Vice-President of Medical Services at $293,892, comprised of a salary of $243,702 and an annual retention bonus of $50,190.

  The $243,702 salary is based upon the doctor's specialist salary of $169,920, $51,741 (a 29% stipend of the Medical Director's salary of $178,416 for duties as medical director), a $10,000 administrative benefit, and an additional unexplained amount of $12,041. The maximum salary for administrative physicians as approved by Treasury Board is $178,416 plus the $10,000 administrative benefit.

  The $50,190 annual retention bonus consists of a retention bonus of $39,750 (maximum allowed by Treasury Board - $36,000) for the specialist position plus 29% of the $36,000 retention bonus ($10,440) for his duties as Associate Vice-President of Medical Services.

  At its 17 May 2005 meeting the Board approved the continuation of this doctor's salary arrangement as established by a former board for fear that the employee would terminate their position.

  As a result, the Authority is over compensating this employee $69,476 annually ($55,286 in salary and $14,190 in retention bonus) as shown in Figure 5.

Figure 5

Labrador-Grenfell Regional Integrated Health Authority
Associate Vice-President of Medical Affairs
Salary and Overpayment

	Amount paid by Authority	Amount per Government Policy	Overpayment
Medical directors salary	$ -	$ 178,416	
Specialist salary	169,920	-	
Medical directors stipend (29% of $178,416)	51,741	-	
Administrative bonus	10,000	10,000	
Other	12,041	-	
Salary	243,702	188,416	$55,286
Retention bonus for specialist	39,750	36,000	
Retention bonus for Associate VP of Medical Services (29% of $36,000)	10,440	-	
Retention bonus	50,190	36,000	14,190
Total compensation	**$ 293,892**	**$ 224,416**	**$69,476**

Source: Authority financial records

Inconsistent promotion of senior staff

- In 6 newly created positions, the Authority used Government promotion policies to establish new salaries without these positions being classified. Treasury Board approval is required for any change in permanent position classifications.

New employees placed at wrong step

- Two directors were placed above step 1 of their respective salary scales without the required approval of the Department of Health and Community Services. Government policy states that new managers will generally start at step 1 of the assigned salary range and any appointments above step 1 must be approved by the Department. One of the two employees was new to Government and placed on step 32 and the other was a former employee who was re-hired and placed on step 33.

Employee benefits above Treasury Board amounts

- The Authority provided employee benefits above those approved by Treasury Board. For example:
  - One director was provided with free housing at a cost of $1,200 per month during the first 3 years of employment (not reported as a taxable benefit).
  - 2 directors were provided with an annual allowance of $983 for having a Bachelor of Nursing degree. This allowance is provided to nurses as an incentive under the nurses' union collective agreement; however, the director positions are not under the union agreement and are rated under the Hay system.
  - 1 director was placed on payroll effective the day after resignation from their former employer and provided with a maximum of 10 working days for travel purposes. In addition, the Authority guaranteed that casual work would be available for the employee's spouse at one of the Authority's long-term care facilities.
  - The Authority is providing one senior employee with paid leave benefits in excess of Government policy. One senior employee, in addition to their 35 days of paid leave per year (Government policy), is provided with an additional 10 days paid leave to pursue locums with other organizations. As a result, this employee received a total of 45 days per year, 10 days above Government policy.

Subsidized rent not in accordance with policy

The Authority provided free accommodation to certain employees which were not in accordance with its accommodations policy. HLC policy provides for free accommodations for students, short-term locum physicians (less than three months) and other visitors on Authority business. Our review identified that 3 employees were being provided with free or subsidized rental accommodations in excess of Authority policy as follows:

- The Authority is paying $1,200 per month rental accommodations for one management employee hired in January 2006. As at December 2006, this had cost the Authority $14,400 and will cost an additional $28,800 over the three year period identified in the offer of employment. This rental subsidy was not reported as a taxable benefit.

- The Authority is paying $550 per month rental accommodations for one employee hired in June 2006. As at December 2006, this had cost the Authority $3,300 in subsidized accommodations.

- The Authority is paying $800 per month rental accommodations for one employee hired in August 2006. The Authority is recovering $715 per month from the employee after the initial month when there was no recovery. As a result the Authority paid subsidized accommodations totalling $1,140 as at December 2006. This rental subsidy was not reported as a taxable benefit.

3C. Termination Benefits

Introduction

During 2005-06, the Authority paid out $1.1 million in severance and redundancy payments (year to date 2006-07 at 31 December 2006 - $315,000). Our review included an examination of termination benefits of $786,000 paid to 8 management employees and 1 non-union non-bargaining level employee.

Pay in lieu of notice not consistently applied

Our review identified the following:

- For employees who are provided 20 weeks notice of the termination, the Authority follows Government's policy and provides termination benefits of a maximum of 62 weeks less the 20 weeks notification period. Of the 8 management employee reviewed, 6 were entitled to a 62 weeks notice period. Our review identified inconsistencies in the application of the Authority's policy and non-compliance with Government's policy:

    - 2 of the 6 employees were not required to work 20 of their 62 weeks in accordance with Authority policy. In both cases, the employees positions were declared redundant 31 July 2005 and they were permitted to go on extended paid leave until their termination date of 31 December 2005.

- Government policy states that the notice period begins when the employee is notified of the redundancy. The employees who worked 20 weeks of their notice period received 42 weeks upon termination. However, the 2 employees who took paid leave during their notice period received 62 weeks redundancy pay in lieu of notice upon termination. Whether an employee works their notice period or takes paid leave should not be treated differently when calculating the final termination pay. However, the Authority did not deduct the paid leave taken by the 2 employees from the 62 week notice period and paid out the full 62 weeks pay in lieu of notice.

Unused paid leave paid in advance of termination

- One employee was paid $69,444 for 1,200 hours of unused paid leave in September 2005; however, the employee was not terminated until 31 December 2005. Treasury Board policy requires the payment of unused paid leave to be paid out at the end of the notice period.

Redundancy payments based upon incorrect salaries

- One employee was paid termination benefits based on their salary set on step 17 of the HL 23 scale. Our review of the employee's personnel file indicated the employee should have been on step 21. As a result, the employee was underpaid salary while working as well as $304 in their termination benefits.

- One employee's classification was changed from HL 19 to HL 20 three months prior to their termination. As a result, the Authority paid termination benefits to the employee at the higher HL20 scale. The classification change was made to bring the lower classification of the employee's position at one of the former boards to a higher scale of a similar position with the other former board. Our review indicated that Treasury Board had not approved this reclassification.

3D. Paid Leave

Introduction

We examined paid leave reports of all senior management staff to ensure leave was properly accumulated and taken. We identified issues with overdrawn leave and a lack of integration of the Authority's leave systems.

Our review identified the following issues:

Leave systems not integrated

- The Authority still maintains 2 separate payroll systems and as such, 2 separate leave systems for its employees based upon the former board structure. The use of 2 leave systems makes it more difficult to monitor and report on employee leave.

  For example, one employee transferred from the former GRHS to the former HLC. At the time of transfer, the employee had a credit in their paid leave bank of 52.5 hours; however, the employee's new leave bank started at zero and did not take into account the credit balance. By having two leave balances it is difficult to accurately monitor an employee's leave.

Employee paid leave bank exceeded

- One employee had a significant balance of overdrawn leave. The employee's paid leave bank was in credit of 519 hours, or 69 days, at the time of our review in February 2007. Subsequently, the employee and the employer reached an agreement where 3 days of pay for each pay period would be applied against the credit until repaid. Neither the Authority's or Government's policies allow for overdrawn leave.

3E. Overtime

Introduction

During 2006-07, the Authority incurred approximately $3.6 million in overtime. ($2.3 million former HLC and $1.6 million former GRHS). Approximately 56% of this expense related to nursing services throughout the region.

The Authority maintains two systems to track overtime which were inherited from the former board systems. As at 31 March 2007, the Authority reported $1.4 million in accrued overtime time. ($0.8 million for the former HLC and $0.6 million for the former GRHS).

Our review identified issues with the integration of the overtime monitoring systems, policies governing the accrual of overtime, and the payment of double-time for management staff during strike action.

Our review of overtime identified the following:

No policy governing overtime hour balances

- The majority of the accrued overtime relates to nursing positions along coastal Labrador, where nurses are required to provide after hour services but are unable to take the time off due to work commitments. Authority staff stated that there is no policy governing the accruing of overtime in lieu of pay or the payment or use of these hours. As such, overtime continues to accrue and will have to be paid out from future operating grants at higher wage rates.

  Our review of overtime for 2005-06 identified 12 (3%) of the 427 employees who had accrued overtime accounted for $331,000 (44%) of the accrued overtime of $748,000 reported for former HLC and 6 (2%) of the 288 employees who had accrued overtime accounted for $123,000 (25%) of the $489,000 reported by the former GRHS. One employee had accrued 2,416 hours at a cost of $78,500.

- In some cases, employees recorded a significant amount of overtime. For example, since 2003 one nurse banked 4,264 hours which included 16 bi-weekly pay periods with over 100 overtime hours each and 3 bi-weekly pay periods with over 200 hours each. In addition, this employee's income for 2005 totalled $128,510 which included $50,000 in overtime paid. The extent of overtime impacts the Authority's financial position.

Manager overtime paid at double-time during strike action

- As part of our review, we examined overtime paid to management employees during the 2004 public service strike. Our review identified that both former boards paid their management employees at double-time for any overtime hours worked. A total of 59 employees were paid $310,821 for 4,532 overtime hours at double time. Government policy only provides for overtime pay at time-and-a-half, and as such, the former boards overpaid their management staff $77,705 during 2004-05.

3F. Other Issues

No written contract for contractual arrangement

Our review of human resources identified that the Authority engaged the services of a former employee without formalizing the arrangement. The former employee was engaged to perform part-time accounting duties over the past 8 years. During our review period, the individual was being paid at $30 per hour ($25 plus 20% in lieu of benefits). During the 2006 calendar year, the individual was paid $24,390 for 813 hours.

While the individual was hired on a contractual basis, they were being treated as an employee for payroll purposes with employee deductions for CPP, EI and income tax deducted and remitted from their wages. However, the individual has not enrolled in the Provincial pension plan, group insurance plans or union which would be expected from an employee.

Our review indicated that there is no written contract with this individual to establish the conditions of their work.

Conclusions

The Authority's human resource practices were not always consistent with human resource practices established by Government. We identified instances where:

- the Authority's hiring and compensation practices were inconsistent or in excess of those approved by Government;
- termination benefits were inconsistently applied or in excess of those approved by Government;
- leave systems were not integrated and available leave balances were exceeded; and
- policies governing the use of accrued overtime hours were not present and overtime payments were in excess of Government policy.

Recommendations

The Authority should :

- ensure competitions are held when recruiting all staff;
- ensure compensation practices are in line with Government policies;
- ensure Government's termination policies are consistently applied;
- integrate its leave monitoring systems and ensure credit balances are adequately addressed;
- ensure policies and procedures are in place to monitor and report on banked overtime hours, and that the payment of overtime is in accordance with Government policy; and
- ensure that employment contracts are in place to establish conditions of employment.

4. Purchasing

Overview

For the period 1 April 2005 through 31 December 2006, the Authority spent approximately $49.2 million on goods and services. Our review of purchasing identified issues in the following areas:

A. *Public Tender Act*
B. Travel and Relocation
C. Cellular Telephones
D. Hiring of Consultants
E. Other Expenditure Issues

4A. *Public Tender Act*

Overview

Whenever the Authority acquires goods and services, it must comply with the requirements of the *Public Tender Act* and the *Public Tender Regulations 1998.* Figure 6 summarizes the requirements of the *Public Tender Act*.

Figure 6

Labrador-Grenfell Regional Integrated Health Authority
Public Tender Act Requirements

When goods and services cost . . .	Or a public work costs . . .	Then the Authority must . . .
More than $10,000	More than $20,000	Invite tenders
$10,000 and less	$20,000 and less	- Obtain quotations from at least three legitimate suppliers, or - Establish for the circumstances a fair and reasonable price.

Source: *Public Tender Act*

The *Act* provides exceptions where tenders may not be required. In such cases, the Authority must inform the CEO of the Government Purchasing Agency who must submit a report to the House of Assembly.

In a sample of 48 purchases over $10,000 and a sample of 18 purchases under $10,000 we identified issues in the following areas:

- Goods and services over $10,000
- Goods and services under $10,000
- Tendering process

Goods and services over $10,000

Non-compliance with the *Public Tender Act*

Our review included a sample of 48 purchases greater than $10,000 for the period 1 April 2005 to 31 December 2006 to assess the Authority's compliance with the *Public Tender Act* and *Regulations*.

Our review of 48 purchases over $10,000 totalling $4.6 million identified 15 purchases totalling $1,309,761 which were not tendered as required by the *Act*. Figure 7 provides details of these 15 purchases.

Figure 7

Labrador-Grenfell Regional Integrated Health Authority
Items not Tendered

Invoice Date	Amount (net of HST)	Description
20 May 2005	$ 15,030	Prostheses (two purchase orders on same day)
21 July 2005	19,917	Moving expenses
12 November 2005	10,544	Computer supplies (3 quotes obtained)
11 May 2006	27,582	Moving expenses (4 quotes obtained)
June 2006	18,000	Annual rental of house in Goose Bay
June 2006	14,400	Annual rental of house in Goose Bay
12 July 2006	18,400	Rental of two apartments in St. Johns (4 months)
August 2006	10,200	Annual rental of house in North West River
20 August 2006	11,000	Medical equipment
October 2006	27,600	Annual rental of house in Goose Bay
November 2006	21,840	Annual office rental in Labrador City
November 2006	23,238	Building supplies (two purchase orders)
11 December 2006	21,180	Furniture for Nain office
2005-2006	584,730	Food services contract in Labrador
May 2006	486,100	Upgrade of Picture Archiving and Communication System in St. Anthony
Total	$ 1,309,761	

Of the 15 purchases totalling $1,309,761 which were not tendered, our review identified the following issues:

Split purchases not tendered

- Instances were noted where the Authority issued more than one purchase order for a particular purchase and as such avoided the requirements of the *Act.* In these cases, while the purchase orders were each under the limit required for a public tender, together they totalled in excess of the limit. Details are as follows:

  - On 10 May 2005, the Authority issued two separate purchase orders (in sequence) to the same vendor, both under $10,000, to purchase prostheses equipment totalling $15,030.

  - In November 2006, the Authority issued two separate purchase orders to the same vendor, both under $20,000, for building supplies to construct foundations for four buildings. The four buildings, which were to be constructed off-site and delivered, were tendered by the Authority on 23 August 2006.

    While this tender did not include the construction of the foundation, it did require the vendor to submit site plan measurements so the Authority should have been aware of the foundation requirements before the buildings were finished. However, the Authority stated that quotes were not requested because it was an emergency purchase in order to have the foundations finished before the delivery of the buildings. In our opinion, the cost of building supplies for the foundations totalling $23,238 should have been tendered.

Food services contract not reviewed

- The Authority spends approximately $2.8 million annually on food services. The Authority has two contracts for food services with the same vendor carried over from the former boards. In addition to these contracts, the Authority also provides its own food services. Figure 8 provides a summary comparison of food services for the Authority (excluding Forteau).

Figure 8

Labrador-Grenfell Regional Integrated Health Authority
Food Services Contract

	HLC operations	GRHS operations
Contract term	Dated June 1996 and extended annually	Dated April 2002 for 3 years and renewed until March 2008.
Tendered	No	Request for Proposals issued in 2001
Food Services Cost:		
Contract cost (2006)	$ 684,730	$ 1,314,510
Credit for sales	(100,000)	N/A
Net contract cost	584,730	1,314,510
In-house cost	907,357	N/A
Total Cost	**$1,492,087**	**$ 1,314,510**

Our review identified the following issues:

- Food services for the former HLC operations have not been tendered. The contract signed in June 1996 has been extended annually.

- The Authority has not evaluated its food services arrangements since being integrated to determine if efficiencies exist with service levels and costs.

- Both contracts included management and administrative fees. During 2006-07, the Authority incurred fees of $93,453 (3% increase annually) for the former HLC operations, and $95,000 for the former GRHS operations.

Upgrade of Picture Archiving and Communication System not tendered

- Our review identified one instance where the Authority requested tenders and awarded a contract for a $1.2 million purchase of a picture archiving and communication system (PACS) for its former HLC operations. The system purchased for the former HLC operations was jointly tendered in 2003 by the former HLC and two other health boards as part of a Provincial strategy. However, the Authority also awarded a contract for $486,100 for the upgrade/replacement of an existing system costing $1.1 million in the former GRHS without requesting tenders. The Authority indicated that the upgrade was necessary to make it compatible with the HLC system; however, the Authority did not inform the Government Purchasing Agency that the $486,100 upgrade was not tendered.

  Furthermore, the contract for $1.2 million and the upgrade of $486,100 was awarded to the vendor that was the highest ranked and lowest priced for the original tender for the former GRHS. However, as reported in our 2004 report, GRHS excluded this bid because the Board determined it did not meet the criteria for the tender call. We reported that documentation was not on file to support this decision. These events confirm our concerns whether the purchase of the existing PACS system in the former GRHS was adequately assessed.

Of the 33 purchases tendered by the Authority totalling $3.3 million, our review identified the following:

Contract Overpayment

- In June 2005, the Authority awarded one tender for lease accommodations for office space for 15 years at a monthly rate of $5,580 which included HST. Our review identified the following issues:

  - The vendor was charging HST on the $5,580 monthly rental which already included HST as per the tender bid. As a result, the Authority overpaid the vendor $11,607 from November 2005 to December 2006. Subsequent to our finding, an invoice to obtain reimbursement for the overpaid HST was issued. If not identified, the Authority would have overpaid the contract $141,000 over the 15 year lease term.

  - A signed lease agreement was not on file.

Bid deposits not adequately processed

- 2 instances were identified where the Authority did not deposit two certified cheques for $7,162 and $12,447 respectively received from 2 vendors as bid deposits. These cheques were found in the tender files during our review. Staff indicated that the cheques are kept in the files until the contracts are completed at which time the vendor is reimbursed. Cheques not deposited and retained for extended periods may go misplaced and the Authority may have to reimburse the deposit from its own funds. For example, one contract was for a 15 year term.

Change orders not properly approved

- The Authority is not approving extensions or change orders made to tendered prices. Five purchases examined had extensions or change orders above the tender price but they were not approved by the Chief Executive Officer as required by the *Act*.

  One expenditure for the construction of an office building in Nain, which was tendered for $247,964, had a change order for $23,000 which was above 10% or the $15,000 change order limit stipulated in the *Act;* however, it was not approved by the Board as required by the *Act*. In this case, the Authority deemed that the $23,000 in change orders were items already included in the tender and therefore the Authority knowingly overpaid this amount.

Goods and services under $10,000

Quotes are not always obtained

Our review included a sample of 18 purchases that were $10,000 and less totalling $132,757 for the period 1 April 2005 to 31 December 2006. Our review identified that the Authority did not have the required 3 quotes or documentation that a fair and reasonable price was obtained for 5 purchases totalling $33,997.

Tendering process

Weaknesses in tendering process

The *Public Tender Act* and *Regulations* provide various requirements for the tendering process. Our review identified the following weaknesses with the tendering process:

Weakness	Consequence
Tenders are not kept in a locked box until opened.	Risk that tender bids may be misplaced or altered.
Envelopes are not date-stamped.	Risk that tender bids received after tender closing date will be considered.
Explanation of why rejected tenders did not meet tender specifications was not always documented.	Insufficient information retained to demonstrate compliance with the *Public Tender Act* and *Regulations*.

4B. Travel and Relocation

Overview

For the period 1 April 2005 through 31 December 2006, the Authority spent approximately $5.4 million on travel. Figure 9 provides a summary of the Authority's travel expenditures.

Figure 9

Labrador-Grenfell Regional Integrated Health Authority
Travel Expenditures
Fiscal Year

Expenditure	2005-06	2006-07 (to 31December 2006)
Patient travel	$ 910,947	$ 617,889
Board travel	56,428	24,352
Staff travel	1,521,405	1,438,437
Relocation/recruitment	481,663	307,663
Total travel expense	**$ 2,970,443**	**$ 2,388,341**

Source: Authority financial records

Our review included an examination of 490 travel claims and expenses from 1 April 2005 to 31 December 2006. Our review identified issues in the following areas:

- Monitoring of travel expenses
- Compliance with Government policy
- Supporting documentation
- Input tax credits on allowances
- Use of travel claims
- Relocation expenses

Monitoring of travel expenses

A review of the Authority's travel expenses indicated that travel costs are not always adequately monitored and are not always recorded consistently in the correct expense account. Details are as follows:

Inconsistent travel policies

- Given the fact that the Authority has yet to integrate its two former financial information systems and is using travel policies from the two former board operations, the Authority has created inconsistencies in the way it is monitoring and reporting travel expenses. For example:
  - At the time of our review the Authority was still using 2 separate travel claim forms which were previously used by the two former boards.
  - The Authority is monitoring vehicle mileage claims inconsistently. Mileage claims are reported to and monitored by Payroll on a separate form for the former HLC operations to ensure the proper rates are claimed; however, for the former GRHS, mileage is included on travel claims and monitored by an employee's supervisor.

Inconsistent processing of travel expenses

- The Authority is inconsistently or incorrectly recording non-travel expenses as travel expenses. For example:
  - Locum travel costs are being recorded inconsistently based upon the former boards' Meditech account structure. For the former GRHS, locum travel costs are grouped with relocation and recruitment costs; however, the former HLC financial reporting system groups locum travel costs with staff travel.

- Our sample of the Authority's travel expenses identified $55,080 in non-travel expenses from 1 April 2005 to December 2006 which were incorrectly charged to various travel expense accounts in the Authority's financial information system. Examples of these expenses were wages, consulting fees, office supplies, postage, registration fees, relocation expenses, and maintenance.

Inconsistencies with Government policy

The Authority is not always reimbursing travel expenses in accordance with Government's travel policies. Our review identified the following:

Travel times not documented

- Travel claims, submitted by former HLC employees, do not require the time of departure and arrival to be recorded on the travel claims. As a result, our review could not determine if the correct meal rates were being claimed. Travel claims submitted within the former GRHS operations did require and include the time of arrival and departure.

Incorrect allowances provided

- Government policy provides for the payment of $25 per night for private accommodations for non-executive employees and $65 per night for board members and employees defined as executives ($53 for Island travel). Our review disclosed the following:

  - The Authority paid 5 board members $109 per night for a total of 14 nights of private accommodations ($65 Labrador rate plus $44 daily meal rate) in addition to their claimed meal rates. As a result, they were paid an excess amount of $44 each day for meals which resulted in a total excess payment of $616. Officials indicated that the excess payments were a result of a misinterpretation of a directive from the Department by an employee of the Authority.

- The Authority is reimbursing its Vice-presidents for private accommodations at the executive level; however, as none of the Vice-presidents would be considered as executives under Government's policy, they would be reimbursed based upon non-executive travel rates. The Authority paid 2 Vice-presidents the $53 executive Island rate per night for private accommodations instead of the $25 rate for non-executive employees. This resulted in excess payments of $840.

  The Authority also provided executive meal rates to 5 employees who did not meet Government's definition of an executive employee. As a result, excess meal claims totalling $665 were paid to 4 Vice-presidents ($515) and 1 Chief Operating Officer ($150).

Daily incidentals claimed incorrectly

- 4 employees claimed daily incidentals totalling $95 on 19 travel claims even though they were not on overnight travel status. Daily incidentals are only claimable when on overnight travel status.

Supporting documentation

In order to ensure travel expenses claimed are for legitimate business purposes, it is important that expenses are adequately supported. Supporting documentation should not only include proof of payment but the details of the expenditure claimed.

Our review identified the following instances where documentation to support the travel expenses was inadequate:

Incorrect processing of non-Authority travel

- One employee claimed $469 for a student's accommodations whom they accompanied to a youth conference; however, the only support on file was a copy of the accompanying employee's hotel bill, i.e. there was no hotel bill to support the student's charges. Although Authority staff provided us with a copy of the employee's credit card statement which showed 2 separate charges for the hotel; the travel claim should not have been approved without adequate support for the student's travel.

As a result of our inquiry, it was determined that the student's travel should have been sent to a third party for recovery; however, this was not done. In addition, a review of Government's financial information system identified that the funding Department had also paid for the hotel accommodations for both individuals.

Payment slips used to support travel expenditures

- 7 employees and 1 board member submitted credit card statements, credit card receipts or debit slips to support 10 claimed expenses totalling $4,440 for accommodations, meals and gas purchases. This is not appropriate, as original invoices or receipts are required to document the expenditures. For example:
  - 2 employees claimed $3,236 and $609 respectively for hotel accommodations which were only supported by a credit card statement, and not the hotel bill.
  - 5 employees submitted debit slips totalling $358 to support claimed expenses. A debit card slip provides proof of payment and does not provide adequate support of the expense.
  - 1 board member submitted a credit card receipt for $236 to support a dinner meeting expense. A credit card slip provides proof of payment and does not provide adequate support of the expense.

Attendees at dinner meetings not identified

- 3 employees and 1 board member claimed a total of $703 for various dinner meeting expenses; however, the supporting documentation did not identify who attended these meetings.

Documentation not always provided

- 4 board members and 1 employee did not provide documentation to support expenses claimed totalling $401. Expenses claimed related to taxi and ferry transportation services.

Input tax credits on allowances

Input tax credit not consistently claimed

The *Excise Tax Act* permits the Authority to assume that mileage and meal allowances paid to employees include the GST, which is eligible for an 83% rebate.

Our review indicated that the former GRHS was claiming the 83% rebate on the GST for mileage and meal claims; however, the former HLC was not. Based upon our analysis of travel claims examined and annual travel expenses of the Authority, we estimate that the Authority did not claim approximately $7,000 annually in rebates.

Use of travel claims

Travel claims used to process non-travel expenses

The Authority is approving significant non-travel expenses, e.g. purchases through the travel claims process. Purchases claimed through travel claims have usually been made directly by the employee, and as such, normal purchase approval processes are being circumvented. Expenses of this nature should be processed through regular purchase procedures.

Our review identified approximately $12,012 in non-travel expenses such as office supplies, postage, minor equipment, computer hardware and software, gifts, etc. which was included on employee travel claims. One employee accounted for $7,060 of the total identified. In some cases minor equipment, such as digital cameras and hand-held electronic devices, was purchased which would typically have been identified by Materials Management through the regular purchases procedures as an asset item for inventory tracking purposes.

Relocation expenses

Our review of relocation expenses related to 20 employees and doctors identified the following issues:

Return in service agreements not in place or not in compliance with Government policy

Government policy requires the relocated employee to enter into a 2 year return in service agreement with the employer in return for reimbursing relocation expenses. Our review identified:

- 7 employees did not enter into return in service agreements as required.
- 1 service agreement was for only one year and 1 was for two-and-a half years.
- 1 return in service agreement was not signed.

- One doctor who relocated in July 2005 did not have a return in service agreement and was employed for 13 months. Based upon Government policy, the Authority should have recovered 55% of relocation expenses paid by the Authority, or $6,400. The Authority had not attempted to recover the amount as of the time of our review in April 2007.

Insufficient documentation support relocation claim

Our review identified the following relocation expenses that were not adequately detailed or supported to determine if Government policy was complied with:

- one invoice for $31,720 paid to a moving company included the transportation of a vehicle. The cost of moving the vehicle was included in the total cost and as such we were unable to determine if the maximum allowable amount of $3,000 was exceeded.

- one payment of $22,905 was made to a moving company and supported by a cheque requisition and a quote from the company for only $15,576 net of taxes. There was no invoice on file or purchase order completed to support the expense.

- one payment of $3,213 was paid to an employee for 75% of moving costs totalling $4,330 paid to a moving company. The claim was supported by a copy of a money order paid to the moving company, and an e-mail of the estimated costs. There was no invoice on file or purchase order completed to support the expense.

Ineligible expenses claimed

The following relocation claims were made which were in excess of Government policy:

- Government policy provides up to 14 days for temporary living accommodations. One employee was reimbursed for 17 days of temporary accommodations, and as such was overpaid $207 for 3 additional night's accommodations in excess of Government policy.

- One employee was reimbursed for legal fees totalling $5,213 for the sale of land. Government policy allows for the reimbursement of legal fees for selling principle residences only.

- One employee was reimbursed $1,000 for a loss on selling a snowmobile prior to being relocated. Government policy does not provide for such reimbursement.

- Government policy provides a maximum reimbursement of $3,000 to transport an employee's vehicle. Our review identified one instance where the Authority paid $3,620 plus tax to transport one doctor's vehicle and as a result, overpaid $1,163.

- One employee was placed on payroll and provided with 10 days salary during relocation and prior to commencing work. During their relocation trip from the North West Territories to Happy Valley-Goose Bay, the employee and their family made a 5 day stopover in St. John's and were reimbursed for hotel, meals, rental car and gas totalling $2,306. This reimbursement appears to conflict with Government policy which does not provide for reimbursement of expenses for side trips.

- One employee was reimbursed for ineligible expenses totalling $340. The employee claimed $108 in vehicle gas receipts while also claiming the mileage allowance and claimed $232 in credit card interest.

Relocation lump sum payments not properly administered

Government policy states that where employees can demonstrate that savings will be realized by the Authority, a lump sum taxable payment of up to $5,000 may be provided for relocations within Labrador and within the island portion of the Province, and up to $10,000 for relocations between Labrador and the island portion of the Province. Employees waive all claims to moving expenses associated with the relocation to their new location. Our review identified the following:

- 2 doctors who relocated from the island portion of the Province to Labrador were paid a $5,000 lump sum payment in lieu of submitting expenses to relocate to Labrador. In addition to these lump sum payments, the Authority also paid $1,000 for 1 of the 2 doctors for transportation costs for the doctor and their family. This means that the doctor received a total of $6,000. Government policy provides for either claiming actual relocation expenses or receiving up to a $10,000 lump sum amount for relocation to Labrador. In this case, the Authority provided both a $5,000 lump sum payment and reimbursement of expenses.

No documentation was provided to support the $5,000 lump sum payments and the Authority did not include the lump sum amounts as a taxable benefit for these individuals.

- One employee was paid $4,961 (75% of new furniture purchases at the new location) in lieu of claiming relocation expenses to St. Anthony. In addition to this lump sum payment, the Authority also paid the employee $631 in additional relocation expenses.

  Government policy provides for either claiming actual relocation expenses or receiving up to a $5,000 lump sum amount for relocation within the island. In this case, the Authority provided a $4,961 lump sum payment and reimbursement of expenses.

  The Authority did not include the $4,961 lump sum amount as a taxable benefit for the employee.

Relocation expenses not calculated properly

Government relocation policy provides that, normally, 75% of relocation expenses will be reimbursed. However, in cases of hard to fill positions, 100% of relocation expenses can be reimbursed. Our review identified 2 instances where the Authority reimbursed a portion of relocation expenses at 100%, in excess of Government policy. Details are as follows:

- One employee was reimbursed 100% of the air transportation totalling $573 and 75% of moving expenses of $4,592. There was no indication that this was a hard to fill position.

- One employee was reimbursed 100% of the ground transportation of $415 and 75% of moving expenses of $4,330. There was no indication that this was a hard to fill position.

4C. Cellular Telephones

Overview

From April 2006 to December 2006 the Board spent approximately $59,000 on cellular telephones and Blackberries. This is up from the $49,000 spent in all of the previous fiscal year. The former HLC operations account for about 85% of the cellular telephone costs. A review of vendor invoice accounts identified the former HLC had 73 cellular telephones and Blackberries, while the former GRHS had 16 cellular telephones.

In June 2006, the Department of Health and Community Services provided all health authorities with a copy of Government's policy on cellular telephones for guidance.

Our review of cellular telephones at the Authority identified the following:

Analysis not completed

- The Vice-President of Finance undertook an analysis of cellular telephones for 2005; however, the analysis was not completed. No further analysis has been performed. Government's policy requires the Chief Financial Officer to undertake an annual analysis of cellular telephone allocations and usage.

Inadequate inventory of cellular telephones

- The former HLC maintains an inventory list of cellular telephones; however, it is not up to date. The former GRHS does not maintain a listing of cellular telephones. Government's policy requires an inventory record of cellular telephones to be maintained, updated when changes occur and verified annually.

Costs not adequately reported

- The Authority uses separate object codes in their financial information system to track cellular telephone expenses for the former HLC operations; however, in the former GRHS, these expenses are included with all other telephone expenses. As such, the Authority cannot readily determine the total cost of cellular telephones.

Costs exceeding telephone packages

- A number of cellular telephones exceeded their airtime packages resulting in extra costs. For example, one cellular telephone was purchased with a limited air time package for evening use only at a monthly cost of $30; however, monthly charges had consistently gone over its plan costs. A review of this account identified the following:

    - During a 6 month period costs ranged from $71 to $252 per month as the phone was being used mainly during peak day-time hours.

    - During the 6 month period, the employee made 97 calls to their home residence which cost the Authority $144.

- The phone bills were forwarded to the supervisor documented as being responsible for the telephone; however, on 3 separate monthly bills the supervisor indicated that the cellular telephone did not belong to their department and that they could not authorize the payment. Upon further enquiry, we were informed that the cellular telephone was being used by a different employee and that the phone bills had been directed to the wrong supervisor for approval.

In this case a proper review would have detected that the phone was being used by an employee other than the stated employee, that personal phones calls were being made, and that a more appropriate package should have been acquired.

Inactive cellular telephones

- A review of 23 cellular telephone accounts for the former HLC operations identified 11 cellular telephones and 2 Blackberries that the Authority had not used during a particular month. This may indicate that these units which cost $7,200 annually are surplus to the needs of the Authority.

Accounts not being reviewed by supervisor

- Of the 23 cellular telephone accounts we examined, monthly charges for 4 accounts had not been approved by the respective supervisor to indicate that a review had been conducted.

4D. Hiring of Consultants

Overview

Government's *Guidelines for the Hiring of External Consultants* provides the requirements for expenditure approvals, proposals, and selection approvals. Specifically, Government guidelines require:

- at least 3 proposals to be obtained or a public call for proposals for the hiring of external consultants when contracts exceed $50,000, and

- contracts in excess of $100,000 to be approved by Cabinet and contracts paid on a per diem basis which are in excess of 1 year to be approved by Treasury Board.

We reviewed arrangements for two consultants in excess of $50,000 from April 2005 to December 2006 to assess whether the Authority was adhering to Government's guidelines.

Our review identified the following:

Proposals not called for financial consultant contract

- The Authority hired an external consultant from the island portion of the Province for a period from 15 May 2006 to 15 March 2007. The consultant was originally engaged to assist with preparation for the Authority's annual audit in light of staff shortages at that time. After the Vice-President of Corporate Affairs was terminated in September 2006, the consultant was kept on to manage and control the Authority's financial operations.

  For the initial period from 15 May 2006 through 14 September, the consultant was paid $2,100 per week plus travel costs, with their remuneration being changed to $10,000 per month plus travel costs commencing 15 September 2006. The initial contract was negotiated with the consultant, with the contract price for the latter period based upon the salary rate of the Vice-President's position plus 20% for employee benefits. Our review of this contract identified the following:

  - The Authority contravened the consultant guidelines by not obtaining 3 proposals or conducting a public call for proposals for either of the periods the consultant was engaged; and

  - The Authority did not enter into a contract with the consultant for the initial 17 week period.

Orthodontic services contract not adequately accounted for

- The Authority (assumed from the former HLC) entered into a contract in 1998 with an orthodontist to provide orthodontic services for a one year period. The contract was for $10,000 plus travel costs for the provision of a 3-day clinic approximately every 6 weeks in Happy Valley-Goose Bay. Our review of this contract identified the following:

  - Currently, the Authority is paying $13,330 per month ($159,960 annually) for a 4-day orthodontic clinic per month plus travel costs. However, the original contract has not been amended nor has a new contract been entered into to account for the changes in the original contract.

- The Authority contravened the consultant guidelines by not obtaining 3 proposals or conducting a public call for proposals, or obtaining Cabinet approval for the contract.

- The Authority has never reviewed this service arrangement to determine if this service arrangement is financially beneficial to the Authority or if alternative arrangements are available.

4E. Other Expenditure Issues

Our review identified issues in the following areas:

- Purchasing controls
- Property rentals
- Retirement and service awards

Purchasing controls

In order to ensure expenditures are adequately accounted for, purchasing controls related to approval, processing, posting and reporting must be documented and communicated to staff.

Our review identified a number of instances where greater care and controls are needed when approving and processing expenditures for payment:

Purchase orders not completed prior to purchase

- Our review identified 4 instances where purchase orders were dated subsequent to the invoice date or the date the goods were received. In one instance, $24,145 ($21,180 plus HST) in office furniture for the Nain office was purchased directly by the requisitioning department and the purchase order was only processed and approved once the office furniture had been received. No tender was called for this purchase. The completion of purchase orders prior to the acquisition of goods and services ensures the items purchased have been properly approved and priced.

Inadequate documentation to support invoice processing

- The Authority does not use a function stamp to ensure necessary procedures such as extension/price checks, verification of goods received, and approvals for payment are documented. Invoices examined during our review did not document that these standard processing controls were performed.

Payment made twice

- 1 instance was identified where a payment was made to the wrong vendor. On 12 September 2005, a payment of $2,253 was paid to a printing services vendor in error instead of the correct vendor for patient travel. On 24 October 2005, another invoice was received from the correct vendor and paid again, this time to the correct vendor. The recovery from the vendor paid in error was received 16 March 2006. Although the amount was later recovered, this instance indicates a lack of due regard when processing and approving invoices for payment.

Inadequate documentation to support sponsorship payment

- The Authority paid $15,000 to a dental school for sponsorship of an employee. The only documentation in the vendor file to support the expense was an e-mail requesting payment. Upon request we were provided with various request letters, former GRHS board approval, a return in service agreement for the sponsorship, and a program description for another school which indicated a $15,000 tuition down payment. Upon a second request we were provided with tuition details for the correct school. An invoice or receipt from the dental school was not provided. We also note that the $15,000 sponsorship was not included as a taxable benefit for the employee.

GST rebate incorrectly applied on expenditures

- Two instances were identified where the Authority incorrectly applied the GST rebate on expenditures as follows:

  - One instance was identified where the incorrect GST rebate was calculated for 3 invoices from one vendor which resulted in $470 not being claimed.

  - Under certain arrangements, the Authority recovers expenses from partnering third parties when the Authority incurs the expense initially. Our review identified that the Authority recovers the GST rebate on the initial purchase and then invoices the third party 100% of the invoice without making the proper credit to its GST rebate already claimed. As such, the Authority is recovering more than 100% of the amount expensed.

Property rentals

For the fiscal year ended 2006, the Authority reported $415,000 in rental expenses for office and employee accommodations. Our review included an examination of 14 accommodation rentals. Our review identified the following issues:

Inadequate policies

- The Authority uses policies relating to accommodations which were developed in 1999 for the HLC. These policies are outdated and do not reflect the policy requirements for the consolidated Authority.

Rental agreements not properly completed

- 2 rentals examined did not have a rental agreement in place and 1 rental agreement could not be located.
- 3 rental agreements were not signed by an official of the Authority.
- 6 rental agreements entered into after integration were in the name of the former HLC instead of the Authority.

Retirement and service awards

The Authority provides retirement and service awards to employees. During the period from April 2005 to December 2006, the Authority spent approximately $36,000 on retirement gifts and service awards for employees of the former HLC and $5,817 for employees of the former GRHS.

Our review of the Authority's retirement and service awards identified the following:

Inconsistent policies

- The Authority has two separate policies governing the provision of employee retirement and service awards.

  The policy for former HLC employees who retire is to provide $150 towards gifts for employees with at least 9 years of service. HLC policy also provide service awards for:

  - 5 years - key chain
  - 10 years - sterling silver lapel pin
  - 20 years - gold ring
  - 25 years - watch
  - 30 years - appropriate gift up to $150

The former GRHS does not provide service awards and while it does not have a policy for retirement gifts, practice has been to provide retirement gifts of up to $350.

- Government policy does not provide for these types of expenditures.

Conclusions

Public Tender Act

The Authority did not tender for 15 purchases (31% of 48 reviewed) totalling $1,309,761 which were over $10,000 and did not obtain quotes for 5 purchases (28% of 18 reviewed) totalling $33,997 under $10,000. The Authority has not tendered or evaluated its food services contracts since being integrated. In addition, the Authority had a number of weaknesses relating to the tendering opening, evaluation, and approval.

Travel and Relocation Expenditures

The Authority is not adequately controlling and monitoring its travel and relocation expenditures and is not reimbursing these expenditures in accordance with Government's travel and relocation policies. Specifically, the Authority:

- improperly provided meal and private accommodation allowances at Executive rates to its non-Executive senior staff;
- did not always ensure that adequate documentation was attached to support travel and relocation claims;
- incorrectly reported certain non-travel expenses approximating $55,000 as travel expenses or inconsistently reported them within travel expenses;
- did not consistently apply the GST rebate on certain travel allowances;
- used travel claims to approve approximately $12,000 in non-travel expenses; and
- did not always ensure relocation return-in-services agreements were in place for applicable employees.

Cellular Telephones
The Authority is not adequately monitoring the usage and cost of cellular telephones. The Authority is not performing required annual analyses of cellular telephone allocations and usage, maintaining an updated listing of all cellular telephones, documenting supervisor reviews of monthly cellular telephone invoices prior to payment, and reporting cellular telephone expenditures separately in their financial information system.

Hiring of Consultants
The Authority contravened Government's *Guidelines for the Hiring of External Consultants* for two consulting contracts over $50,000, by not obtaining 3 proposals or conducting a public call for proposals, and in one case by not obtaining Cabinet approval for the contract.

Other Expenditure Issues
The Authority's approval and processing controls need to be improved to ensure expenditures are properly accounted for. Our review identified that the Authority's purchasing policies are not integrated and complete, purchasing processing controls are not always evident, employee rental accommodations are not adequately controlled, and retirement and service awards are in excess of Government policy.

Recommendations

The Authority should:

- comply with the *Public Tender Act* and *Regulations*;
- evaluate its food services contracts;
- ensure its travel and other expenses are consistent with Government policy;
- ensure travel and other expenses are properly approved, supported, processed and consistently reported in its financial reporting system;
- ensure it claims all GST rebates in accordance with Federal legislation;
- ensure the need, usage and cost of cellular telephones is adequately monitored;

- comply with Government's *Guidelines for the Hiring of External Consultants*;
- ensure purchasing and travel policies and procedures are integrated and communicated to staff; and
- ensure employee rental accommodations are properly monitored.

5. Capital Assets

Overview

As at 31 March 2007, the Authority reported capital assets at a cost of $63 million and a net book value of $19.4 million. In order for the Authority to adequately control and monitor its capital assets it must ensure adequate policies and procedures exist and are communicated to staff, assets are properly identified and recorded when purchased, periodically inventoried, and reconciled to financial records.

Our review identified issues in the following areas:

A. Policy and Procedures
B. Monitoring of Capital Assets
C. Monitoring of Vehicles
D. Sale of Residential Property

5A. Policy and Procedures

Inadequate policies and procedures

The Authority has not integrated its capital asset policies and procedures into one policy and procedures manual governing all Authority capital assets. The Authority continues to use the policies and procedures that were in place with the former boards; however, these policies are inconsistent, incomplete and are not detailed to ensure staff are aware of what is expected to adequately control and monitor capital assets.

5B. Monitoring of Capital Assets

Introduction

The Authority's Material Management department indicated that all assets are tagged for identification purposes once they are purchased. Authority staff indicated that the tagging and recording of computer equipment is the responsibility of the Information Technology department, bio-medical equipment is the responsibility of the Bio-Medical department, and other furniture and equipment is the responsibility of the Materials Management department.

Our review identified the following:

Computer equipment not tagged

- Discussions with staff in the Information Technology department identified that computer equipment purchased at the former HLC is not tagged when purchased because the necessary staffing is not available. In addition, the department does not maintain an inventory of computer equipment. If computer equipment is not tagged or inventoried, it is difficult to determine if all equipment is accounted for.

Capital asset ledgers not maintained or incomplete

- Discussions with Materials Management and Bio-Medical staff indicated that assets are tagged once purchased; however, all assets tagged have not been recorded in a capital asset ledger. As such any tagged assets which go missing will not be identified. Specifically:

    - Bio-Medical staff indicated they are in the process of preparing a bio-medical inventory maintenance system. Current purchases are being recorded and inventory counts at various locations are ongoing to update the listing. Staff provided asset listings which they indicated were 70% complete for Happy Valley-Goose Bay, 60% complete for Labrador City, and coastal clinics yet to be done. Bio-medical staff stated equipment at the former GRHS is yet to be inventoried.

      The bio-medical asset listings were completed for preventative maintenance purposes. Cost information is not provided for each asset.

- Authority staff indicated that furniture and equipment have not been inventoried since 2000 for the former HLC and that an inventory system was maintained for the former GRHS; however, it was reviewed 6 years ago, found to be completely inaccurate, and deleted.

Given that capital asset ledgers are not maintained, the Authority cannot reconcile its financial records to its inventory records.

5C. Monitoring of Vehicles

Introduction

The Authority reported using 77 vehicles throughout its region. (56 passenger vehicles, 13 snowmobiles/ATV's, 7 ambulances, and 1 tractor.) Of the 56 passenger vehicles, 30 were leased by the Authority. Controls should be present to ensure vehicles are only used for legitimate business purposes, costs are monitored, and vehicles are adequately safeguarded.

Our review identified the following:

Cost information not provided on vehicles

- The Authority provided a listing of vehicles; however, the listing did not provide cost information.

Vehicle operating costs not adequately monitored

- The cost to operate the Authority's vehicle fleet is not readily available. Vehicle expenditures are charged to a number of accounts and expenditures such as insurance and gasoline are included with other non-vehicle expenditures. Authority staff indicated that operational costs are not monitored by vehicle but on a global object basis.

Vehicle usage not adequately monitored

- Vehicle log books are not maintained to track who used a vehicle, the kilometres used, or dates of use. Without tracking this information, it is difficult to determine if vehicles are always used for legitimate business purposes.

Inconsistent vehicle fueling systems

- The Authority uses two systems for fueling the vehicles. For the former GRHS, gas cards are used which are maintained in the vehicles. For the former HLC, local company accounts are used by staff. Staff indicated that vehicle licence plate numbers are provided to the local company and recorded on gas slip as a control mechanism. However, given that expenses (including gas) are not captured and reported by vehicle and that logs books are not maintained, this control is limited in determining if gas purchases per vehicle are reasonable.

5D. Sale of Residential Property

Introduction

The Authority owns 32 residential units, the majority located with the former GRHS. The Authority adopted and amended a former GRHS policy for the sale of residential property to physicians and other hard-to-recruit staff at a discounted price. These units are provided initially for rental purposes to recruited staff.

If the staff member later wishes to buy the unit, the determination of the sales price would be based upon the appraised value at the time of sale less a 2% discount per year for each year of service of the staff up to a maximum of 50%.

The policy also states that the Authority will be provided with the right of first refusal to buy back the property if sold in the future with the new sales price adjusted by any discount provided when first sold to the staff.

Non-compliance with Authority policy

Our review identified that the Authority did not comply with its residential property policy. At its last meeting in March 2005, the former GRHS board approved the sale of one of its residential units appraised at $112,500 in 1998 to the former CEO of the former GRHS for $97,800 (discounted by $14,700 based on the number of years worked). However, in September 2005, the new Authority board stated that the house would have to be sold at its appraised value as the purchaser no longer worked with the Authority and would not qualify for the discount.

Current appraisal not used

In August 2006, the Authority sold the property to the former CEO for $112,500, the 1998 appraised value. Our review identified that the former GRHS received a more current appraised value performed in March 2005 for $126,000; however, it used the earlier 1998 appraisal for determining the sales price. As such, the Authority sold the unit for $13,500 less than it should have.

Conclusions

Controls over the Authority's capital assets are inadequate and could result in missing assets not being detected. The Authority does not tag all of its assets once received and does not maintain a capital asset ledger. As well, periodic inventory counts are not performed and assets are not reconciled to the Authority's financial records.

In addition, the Authority does not monitor the costs and usage of its vehicle fleet, does not maintain vehicle log books to monitor vehicle usage, and does not record operating costs by vehicle to monitor vehicle costs. Without such controls, vehicles could be used for unauthorized purposes.

As well, the Authority sold a residential unit to the former Chief Executive Officer for $13,500 less than it should have.

Recommendations

The Authority should:

- develop and implement policies and procedures governing the identification, recording, controlling, and monitoring of capital assets;
- ensure assets are tagged once received, all information is recorded in a capital asset ledger, and assets are periodically inventoried and reconciled to financial records;
- capture and monitor vehicle costs by vehicle and maintain vehicle log books; and
- comply with its policy regarding the sale of residential property.

Authority's Response

The Board of the Labrador-Grenfell Regional Health Authority has reviewed the preceding report issued by Auditor General and makes the following comments with respect to the findings.

Financial Position

The Authority is very much aware of its overall financial position. The Authority is continually working with the Department of Health and Community Services requesting additional funding and cash flow to meet its operating demands. The overall deficit is the result of many deficits that date back to 1995. The Authority maintains that it was never adequately funded from the beginning and with the increased in demands for services, short term borrowings were necessary.

The Authority is in a deficit cash flow position as result of the operating deficits. It has borrowed short term funds to meet its operating needs. The demand for services across the region has grown and although the funding from the province has increased, the cost of providing services has been higher than this funding.

The Authority has put forward revenue generating and cost saving measures to the Department of Health and Community Services to deal with its deficit. Due to the impact that these measures would have on the level of patient and client services, the Authority in consultation with the Department has not implemented these measures.

The Authority acknowledges that the projection of financial information during the fiscal year of 2005/2006 was not reliable. The lack of financial staffing in the start up phase of the Authority contributed to this situation.

With respect to the comments regarding the 2006/2007 original budget, it is noted that this budget by the Authority was a conservative budget, holding costs from the previous year. The Authority had many discussions with the Department during fiscal year of 2006/2007 regarding its projected financial deficit and the need for stabilization funding. The final audited financial position for the fiscal year of 2006/07 was a deficit of $845,000 after stabilization funding was received. The stabilization funding provided by the Department did not include funding for interest costs of $740,000 on bank indebtedness which is included in the final deficit amount.

Financial Operations

The Authority has submitted all of the required financial reports via teledata to the Department for fiscal year end March 2007 and has submitted financial reports to September 2007 for the current fiscal year. The Authority has a plan in place to ensure that this reporting is maintained up to date.

A permanent Vice-President, Financial Services was hired by the Authority in June 2007 and started work in July, 2007. Although the process took longer than expected, the Authority ensured that the financial leadership was present during the recruitment period and was a key attribute in filling the vacancy on a permanent basis.

The Authority acknowledges the comments with respect to the difficulty to monitor its accounts receivable due to two systems. The Authority has inherited two systems that are from a same vendor but have been implemented at different times and they are very much different. The Authority also faces the challenge of dealing with two time zones which the Accounts Receivable systems are dependent on. The Authority has started a process to review its Accounts Receivable systems.

There was a significant increase in patient rates charged to out-of-province and out-of-country residents during 2005/2006 which accounts for the increase in accounts receivable. The increase in receivable from Government was a year-end timing issue. The Authority has discussed the disclosure issue with its external auditor and has provided a breakdown of the receivables in its 2007 audited financial statements.

The Authority was able to combine its financial information onto one system at the end of its fiscal year for March 31, 2007. Currently, there is a plan in place to bring all of the sub-systems together to achieve one complete integrated system by end of this fiscal year, 2007/08.

Human Resources

The Authority has adopted Human Resources Policies to ensure fairness and equity similar to those used by the provincial Public Service Commission.

With respect to job competitions when the healthcare system was restructured in April, 2005, the Authority inherited organizational structures of the predecessor organizations that were quite similar. There were two regional director positions for many functional areas. For example, there were two positions functioning with Materials Management responsibilities. Only one position was approved for the

new Authority. Both employees of the predecessor boards had an exemplary performance record and the Authority would have accepted either candidate for the new position of Regional Director, Materials Management. The Authority did limit its applicants to only internal employees of the predecessor boards since they were both qualified and there was no need to conduct an external competition process. This approach was more timely and demonstrated to managers the Authority's willingness to work with former employees of the predecessor boards while at the same time, it was most cost efficient and in no way jeopardized the caliber and competency of incumbents appointed to senior positions.

The Authority did not conduct a competition for the Associate Vice-President, Medical Services because the Assistant Executive Director, Medical Services with GRHS agreed to assume this role. This was approved at an Authority Board meeting.

Compensation Practices

In consultation with the Department of Health and Community Services, the 10% increase was approved for the Vice-President of Medical Affairs. This increase was in recognition of the fact that the Vice-President was now required to direct and oversee the medical affairs for both predecessor boards and assumes increased responsibility as a result.

A thorough review of the compensation paid to the Associate Vice-President, Medical Services was completed. The Board was aware of the payments to the Associate VP of Medical Affairs and approved the amounts. The Authority has confirmed an overpayment occurred. The Authority is currently recovering the amount outstanding from the employee.

With respect to the newly created positions the Department of Health and Community Services has approved these positions. The Authority is not required to seek Treasury Board approval.

Two management employees were placed on higher steps for hard to fill positions.

A thorough review of the benefits of employees identified by the Auditor General has been completed and the following comments are made.

- *The director who was provided with free housing has been issued an amended T4.*

- *The annual allowance paid to two directors for having a Bachelor of Nursing degree has been continued. It is standard practice throughout the provincial healthcare sector that nurse managers receive these benefits similar to nurses covered by the Newfoundland and Labrador Nurses' Union Collective Agreement.*

- *The action to place a director on payroll effective the day after his resignation from his former employer was a result of an agreement with this employee who was filling a hard-to-fill position, which had been vacant for many years. The employee's spouse did not accept employment with the Authority.*

Termination Benefits

Labrador-Grenfell Health maintains that it applied government's redundancy policy. In the case of redundancy the benefit includes notice or pay in lieu of notice on the basis of the employee's years of service. Our actions were in compliance with this policy.

Paid Leave

The employee in question was off work for an unspecified time period due to illness. The Authority continued to pay this employee until it could be determined the status of the employee's return of work.

Overtime

A thorough review of the overtime balances has been completed. The highest balances have been in the acute care areas on the coast of Labrador. Generally, these are nursing positions, the incumbent of which is often the only health professional in the community. This results in excessive overtime for patient care needs. The Regional Director regularly reviews overtime balances.

With respect to management overtime, it is the practice throughout the healthcare system that management employees working during a strike situation are paid overtime at double time rates for all hours worked outside normal work hours.

Other Issues

The individual worked a part-time basis under a mutual contract arrangement but had their hours increased to full-time. This employment arrangement was necessary because of the staff shortage in the financial services area. The rate paid under this employment arrangement is considered appropriate for the responsibility of the work assigned.

Purchasing

The Authority has reviewed the purchases of prostheses of May 10, 2005 and note that the first purchase was a normal stock replacement purchase and the second purchase was done later the same day for a specific patient need. The Authority maintains only a minimum number of this prostheses type in stock at a time.

The purchases of building supplies in November, 2006 were split because two of four buildings were for the communities on the North accounting system versus the South accounting system. Therefore, in order to maintain the capital costing to the correct ledgers two purchase orders were issued.

A Request for Proposals for Dietary, Housekeeping and Laundry Services was issued in July, 2007. The Authority is currently reviewing the proposals

The Authority was limited to upgrading the PACS system in the former GRHS region in order to make it compatible to the remainder of the region. It acknowledges the government purchasing agency was not informed.

The Authority acknowledges that HST was incorrectly charged by the vendor for rent. The issue has been corrected with the vendor and the necessary accounting adjustments have been made. With respect to the signed lease, the Authority issued a purchased order to the vendor outlining all the conditions of leasing the space which it feels constitutes a legal agreement.

The Authority acknowledges and has corrected its procedures regarding holding bid deposits. These funds have been deposited to the Authority's bank accounts.

The Authority approved all the change orders for capital projects however it acknowledges that board approval was not provided. With respect to the office building for Nain, the schedule was a tight timeline in order to meet the last shipping date before winter. If the shipping date was missed then this building would be further delayed some six months.

With respect to the five purchases where quotations were not obtained the following information is provided:

- *An advertising firm was awarded an original tender in the fiscal year 1999-2000 for service awards. After a selection was made the awards were standardized from year to year and therefore no further tender or quotations were sought.*

- *Purchase of furniture in July 2006 from a local supplier used for child intervention cases. The housing unit had to be furnished immediately to accommodate the placement of child.*

- *Purchase of furniture at a Forteau housing unit. The boating season was closed and this was the only source to purchase the furniture.*

- *Funding for an item was from CSAT funds, a special purpose fund used by physicians. The Physician researched the product and found this to be the most acceptable for the department's usage.*

- *This item was chosen through a competitive process.*

The Auditor General identified weaknesses in the Authority's tendering process. The Authority notes that it does maintain tenders in a locked filing cabinet versus a lock box, it now date stamps all tenders and that although not documented it is self-evident why some tenders do not meet tender specifications.

Travel and Relocation Expenses

Since the review, the Authority has developed a regional travel policy for staff and implemented a standard travel form and now monitors travel expenses similarly across the region.

With respect to incorrect allowances paid to board members, the Authority paid $109.00 for private accommodations and $44.00 per day for meals based on the interpretation of policy provided by the Department of Health and Community Services when the regional health authorities were established. This memorandum from the Department was provided to the Auditor General.

With respect to the senior management positions being reimbursed at the Executive Level, the Authority is following the practice of other authorities who have employees on the pay for points scale. At a regular Board meeting of the Authority, the allowances paid to Senior Executives and Board members were approved.

With respect to the daily incidentals, the Authority's new travel policy clearly states that daily incidentals are for overnight stays only. Finance staff have been informed to observe for inappropriate claims for incidentals. In addition, the Authority's new travel policy clearly states that any meals provided at no cost are not eligible for the per diem and that meals charged on hotel bills will not be reimbursed. Finance staff have been informed to observe for any such charges.

The Authority acknowledges that there was a miscommunication between itself and the Department regarding the travel arrangements a student accommodation. A student who originally planned to attend the conference did not and the Authority had to find a replacement student from another region of the province on short notice contributed to the miscommunication.

The Authority has developed its travel policy and requires that employees and Board members provide adequate documentation to support their claims. In addition, the Authority notes that the dinner meeting identified by the Auditor General was attended by the Executive members and a Board member of the Authority.

The Authority acknowledges that these HST rebates were not claimed by the former Health Labrador Corporation. The Authority has claimed these rebates and has changed its accounting practices such that all rebates are claimed.

Regarding the use of travel claims to purchase non-travel items, the Authority was assured that the items noted were purchased for Authority use. The Authority has developed a policy to ensure that all purchases are made by Materials Management.

Relocation Expenditures

Relocation costs to Labrador and Northern Newfoundland are often significantly higher than elsewhere in the province. Relocation is also negotiated with the applicants for hard-to-fill positions and is always contingent on a return-in-service or repayment of relocation expenses paid if the return-in-service is not given.

The Authority acknowledges that there was inconsistent application of return-in-service agreement documentation procedures. Return-in-service agreements are now included in letters of appointment. Any collection action that may have been required has been initiated. The Authority has taken steps to ensure it improves the documentation supporting the payment of relocation expenses.

The Authority has taken steps to ensure all lump sum payments for relocation expenses are included on the employee's T4 slip as a taxable benefit.

Cellular Telephones

The Authority is aware of its responsibility with respect to cellular phones and as it continues to organize, the issues identified by the Auditor General are being dealt with. Since the review, a comprehensive listing has been prepared and policy regarding cell phone acquisitions has been implemented. The Authority has adopted a policy with respect to authorization. Cell phone packages/plans are being reviewed to ensure the most economical plans are being used. The Authority is reviewing cell phones to ensure that they are being used most economically.

In addition, the Authority has implemented policies with respect to the authorization of expenses.

Hiring of Consultants

The Authority hired a financial consultant when it was experiencing staff shortages in financial services in May 2006 for a 17 week period. During the initial 17 weeks the Authority was unsure of the length of time required from the consultant. When the vacancy of the Vice-President, Financial Services occurred, the Authority entered into a six month contract with the consultant. A call for proposals was not considered necessary due to the urgency to have a replacement for the position, the availability of the financial consultant and the negotiated cost was based on the salaried position.

Other Expenditure Issues

Although some purchase orders was issued after the invoice date for goods, the purchasing department initiated the purchasing process in these instances. The vendor proceeded based on a requisition. There was a breakdown in the communication regarding the shipment and receiving of goods. The Authority has taken action to ensure that purchase orders are issued on a timely basis.

With respect the application of GST rebates, the Authority makes every attempt to pay invoices correctly. With regards to the recovery of expenses from third parties, the GST rebate portion is no longer submitted for reimbursement.

Property rentals

The Authority has reviewed its policies and procedures regarding property rentals to ensure that employee rental agreements are properly entered into and monitored.

Retirement and service awards

A new Authority Employee Recognition/Service Awards policy has been developed and implemented.

Capital Assets

The Authority is currently reviewing and developing capital assets policy with respect to monitoring and safeguarding assets. In addition, the Authority has reviewed its deferred capital funding and has updated its equipment and capital renovation listing.

Monitoring of Vehicles

The Authority has entered into an agreement with a local vendor for vehicle repairs through the Public Tender process. The vendor is tracking repair costs for each vehicle. Many of the coastal vehicles will be shipped into the same vendor for repairs during the marine shipping season.

Sale of Residential Property

With respect to the sale of a residential property, the Authority would like to note that it was not established until April 2005 and was not aware of the March, 2005 appraisal until after the sale of the property had closed.

Highlights

Highlights of a review of the MCP Physicians Fee for Service Audit Process within the Department of Health and Community Services' Newfoundland and Labrador Medical Care Plan as at 31 March 2007.

Why our Office did this Review

The objectives of our review were to determine whether: policies and procedures used to audit payments to Fee For Service physicians were adequate to ensure that only legitimate and accurate claims have been paid; and any overpayments identified through audits have been recovered.

What our Office Recommends

The Department should continue its efforts in auditing payments to FFS physicians to ensure that only legitimate and accurate payments have been made.

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.11

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

MCP Physician Fee for Service Audit Process

The Newfoundland and Labrador Medical Care Plan (MCP) was introduced on 1 April 1969. It is a comprehensive plan of medical care insurance designed to cover the cost of physician services for bona fide residents of the Province. Prior to 1 April 2000, the MCP was administered by the Newfoundland Medical Care Commission. On 1 April 2000, Government dissolved the Newfoundland Medical Care Commission and merged its activities with the Department of Health and Community Services (the Department) and in July 2001 transferred the claims assessing and processing section to Grand Falls-Windsor. MCP headquarters, including the Audit Services Division (the Division), remained in St. John's. The Division's main function is to investigate potential over-billings by Fee For Service (FFS) physicians.

What We Found

In 2006-07, payments to physicians from the MCP amounted to $289.0 million. Of this amount, approximately $206.1 million or 71.3% was paid to physicians who submitted claims on a FFS basis. The focus of this review was the audits of FFS payments conducted by the Division. These payments are made on the basis of claims submitted by physicians for insurable services and are paid through a computerized payment system operated by MCP.

We concluded that since the transfer of the MCP to the Department on 1 April 2000, the Division has not been able to carry out its mandate to ensure that only legitimate and accurate claims are paid to FFS physicians. During the 10 years ending 1 April 2000, there were approximately 438 audits (average of 44 audits per year) of FFS physicians started; however, from 1 April 2000 to 31 March 2007 only 48 audits (average of 7 audits per year) in total were started. The reduction in audit activity came at a time when FFS payments were increasing significantly i.e. from $127.8 million in 2000-01 to $206.1 million in 2006-07 (for a total of $1.2 billion over the seven year period). We would have expected that as FFS payments increased, audit activity would increase rather than decrease. The extent of the reduction is of concern and was attributed by officials to such things as staffing issues resulting from Government regionalization which transferred MCP claims processing to Grand Falls-Windsor 1 July 2001, and audits placed "on hold" during the Joint MCP Audit Review Committee (Report January 2003).

Review of Audit Files: Of the 48 audits which were started since 1 April 2000, 31 were closed and 17 were in progress as at 31 March 2007. Of the 31 closed files, 11 had satisfactory claims documentation, 7 were closed without being completed due to lack of audit resources and 13 were closed for other reasons. It was noted that the 7 files which were closed for lack of resources were flagged for another review after one year; however, this was not done.

Time Frames for Audits: We found that audits took a significant amount of time to complete. For example, some audits took almost 9 years to complete. These delays have resulted in significant issues in recovering FFS overpayments.

Varying Recovery Rates: Although audits conducted by the Division result in significant potential to recover monies owed to the Department, in 2003 the Department implemented an Alternate Dispute Resolution (ADR) negotiation process to settle on an amount to be repaid, rather than require the repayment in full. Prior to 2003, there was no ADR process. Instead, any overpayments were fully recovered unless there was a legitimate misinterpretation of the rate schedule or if legal action resulted in a change in the amount recovered. Since the ADR process was implemented in 2003, the recovery of overpayments has been reduced. The recovery of overpayments through the ADR process for a sample of five audits closed in 2006 resulted in an average recovery of 57.2% of the overpaid amounts. The rate recovered varies on a case by case basis as indicated by the negotiated recovery on a $662,487 overpayment where the recovery was only $175,000 or 26.4%.

Background

The Newfoundland and Labrador Medical Care Plan (MCP) was introduced on 1 April 1969. It is a comprehensive plan of medical care insurance designed to cover the cost of physician services for bona fide residents of the Province. Prior to 1 April 2000, MCP was administered by the Newfoundland Medical Care Commission. On 1 April 2000, Government dissolved the Newfoundland Medical Care Commission and merged its activities with the Department of Health and Community Services (the Department) and in July 2001 transferred the claims assessing and processing section to Grand Falls-Windsor. MCP headquarters, including the Audit Services Division (the Division), remained in St. John's.

The Division has five employees dedicated to conducting audits: two audit analysts, two medical claims auditors and one audit manager. The Division's main function is to investigate potential over-billings by Fee For Service (FFS) physicians.

The Division is part of the Audit and Claims Integrity Division which reports to the Assistant Deputy Minister, Support Services, at the Department.

How physicians are paid

Physicians are reimbursed as salaried employees of the Regional Integrated Health Authorities or on a FFS basis. The salaries and FFS rates are established through periodic negotiations between Government and the Newfoundland and Labrador Medical Association (NLMA), with the latest Agreement covering the period 1 October 2005 to 30 September 2009.

Figure 1 shows the expenditures for the MCP for seven years ended 31 March 2007.

Figure 1

MCP Physician Services Payments
Fiscal Years 2000-01 to 2006-07
$ Millions

Payment Category	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	Total
Fee for Service Payments	$127.8	$131.3	$133.5	$182.4	$189.9	$201.7	$206.1	$1,172.7
Out of Province Services	5.8	4.8	5.6	5.9	6.5	7.2	8.2	44.0
Salaries and Insurance Subsidies	49.2	55.4	62.2	70.5	72.9	71.5	74.7	456.4
Total:	**$182.8**	**$191.5**	**$201.3**	**$258.8**	**$269.3**	**$280.4**	**$289.0**	**$1,673.1**

Source: Public Accounts

Figure 1 shows that payments to physicians have increased by $106.2 million (58.1%) over the past seven years from $182.8 million in 2000-01 to $289.0 million in 2006-07. A Canadian Institute for Health Information (CIHI) report in June 2007 indicated that FFS payments to Canadian physicians rose by 12.4% during the four years from 2001-02 to 2004-05. As noted in Figure 1, during the same four year in this Province, the FFS payments to physicians increased by $58.6 million or 44.6% from $131.3 million in 2001-02 to $189.9 million in 2004-05. This difference is attributed to increases in negotiated rates and in particular the October 2003 agreement between the Province and the NLMA which Department officials indicated brought rates in this Province more in line with the other Atlantic Provinces.

Physicians

Figure 2 shows the number of physicians who received payments from MCP between 1 April 2005 and 31 March 2007.

Figure 2

Physicians Receiving Payments
Fiscal Years 2005-06 to 2006-07

Physician Payment Type	2005-06		2006-07	
	#	%	#	%
FFS	780	.650	785	.653
Salaried	420	.350	417	.347
Total Physicians	**1,200**	**100.00**	**1,202**	**100.00**

Source: MCP Databases

Legislation

MCP payments made to physicians are governed by the:

- *Medical Care Insurance Act, 1999* and it's *Regulations;*
- Memorandums of Agreement negotiated by Government and the NLMA on a periodic basis; and
- the MCP rate schedule which shows allowable rates physicians can be reimbursed by MCP for each type of service provided as well as guidance as to how to claim for a service.

Audit Objectives and Scope

Audit objectives

The objectives of our review were to determine whether:

- policies and procedures used to audit payments to FFS physicians were adequate to ensure that only legitimate and accurate claims have been paid; and
- any overpayments identified through audits have been recovered.

Audit scope

Our review of the MCP Audit Services Division included:

- discussions with Audit Services Division officials and a review of documentation;
- a review of three reports prepared since 1992 that reviewed the FFS physician payments audit process;
- an assessment of the impact of the various policy changes occurring as a result of the reviews carried out;
- a detailed review of the audits carried out since the Newfoundland Medical Care Commission was merged with the Department; and
- a review and comparison of audit activity before and after the merger with the Department in 2000.

We completed our review in December 2007.

Overall Conclusions

In fiscal 2006-07, payments to physicians from the Medical Care Plan (MCP) amounted to $289.0 million. Of this amount, approximately $206.1 million or 71.3% was paid to physicians who submitted claims on a Fee For Service (FFS) basis.

The focus of this review was the audits of FFS payments conducted by the Audit Services Division (the Division) of the Department of Health and Community Services (the Department). These payments are made on the basis of claims submitted by physicians for insurable services and are paid through a computerized payment system operated by MCP.

We concluded that since the transfer of the MCP to the Department on 1 April 2000, the Audit Services Division has not been able to carry out its mandate to ensure that only legitimate and accurate claims are paid to FFS physicians. During the 10 years ending 1 April 2000 there were approximately 438 audits (average of 44 audits per year) of FFS physicians started; however, from 1 April 2000 to 31 March 2007 only 48 audits (average of 7 audits per year) in total were started.

The reduction in audit activity came at a time when FFS payments were increasing significantly i.e. from $127.8 million in 2000-01 to $206.1 million in 2006-07 (for a total of $1.2 billion over the seven year period). We would have expected that as FFS payments increased, audit activity would increase rather than decrease. The extent of the reduction is of concern and was attributed by officials to such things as staffing issues resulting from Government regionalization which transferred MCP claims processing to Grand Falls-Windsor 1 July 2001, and audits placed "on hold" during the Joint MCP Audit Review Committee (Report January 2003).

Review of Audit Files

Of the 48 audits which were started since 1 April 2000, 31 were closed and 17 were in progress as at 31 March 2007.

Of the 31 closed files, 11 had satisfactory claims documentation, 7 were closed without being completed due to lack of audit resources and 13 were closed for other reasons. It was noted that the 7 files which were closed for lack of resources were flagged for another review after one year; however, this was not done.

Of the 13 audit files closed for other reasons, following are examples of the issues noted:

- there was a general practitioner who was the subject of an audit in 2000-01 which resulted in the identification of overpayments totalling $51,263. In April 2001 the physician advised audit officials that they would be leaving the Province in August of the same year and wanted the audit resolved. The audit was ready for management review in late 2002; however, there was no further action on the audit in 2003 and in August 2004 the audit was closed with no recovery. The reason cited for closure was the unreasonable delay;

- there were three significant ongoing audits (one general practitioner and two psychiatrists) which were closed as a result of a change in audit policy providing that audits would be restricted to two years, rather than five as had been done in the past. These audits were closed without further recovery action even though the audit work completed to date indicated that these physicians were overpaid an estimated $2.0 million. Had the audits been completed for the additional three year period, based on the recovery rate achieved in the initial two year audit, the Department could have recovered an additional $725,500. For the general practitioner, the

Medical Consultants Committee (MCC) directed the *"MCP audit department to consult with legal counsel regarding the appropriateness of referring the question of fraud in the audit to the RCMP."* Police determined that there was inadequate evidence to proceed with a fraud charge; and

- there was one physician who claimed an amount for referred consultations, based on incorrect advice from a MCP official. Upon being advised by audit staff that the amount being claimed was incorrect, the physician referred the audit staff to the advice received from the MCP official. This physician was subsequently instructed in the correct procedure and, given that the claim was based on incorrect advice from a MCP official, the audit was closed and the overpayment was not investigated further.

Of the 17 audit files in progress, following are examples of the issues noted:

- there was one general practitioner who had an estimated recovery of $169,367. With respect to this audit, officials were trying to do an "on-site" visit but this was unlikely since the general practitioner is no longer practicing and has been convicted of other criminal offences. Officials indicated that it is probable that the audit will close without any recovery; and

- there was one psychiatrist who had billed an unusual amount for office psychotherapy for 2004-05. Records indicated that the physician billed 7,294 units compared to 2,793 units for the next highest psychiatrist.

  The status of this audit at 31 March 2007 was that the estimated recovery of $997,206 was being negotiated under the Alternate Dispute Resolution (ADR) process with the physician's legal counsel, who indicated that their client was willing to pay $550,000 over three or four years. The Department has made a counter proposal in the amount of $600,000 plus interest over an approximate five year period.

  In addition, for this psychiatrist, it was noted that the MCC also had concerns related to the clinical appropriateness of the patient files and *"...wished to obtain a legal opinion if audit findings can be passed on to the College of Physicians and Surgeons of Newfoundland and Labrador in the form of a complaint."* Officials advised that this matter was referred to the College of Physicians and Surgeons of Newfoundland and Labrador.

Time Frames for Audits

We found that audits took a significant amount of time to complete. For example, some audits took almost 9 years to complete. These delays have resulted in significant issues in recovering FFS overpayments.

Varying Recovery Rates

Although audits conducted by the Audit Services Division result in significant potential to recover monies owed to the Department, in 2003 the Department implemented an Alternate Dispute Resolution (ADR) negotiation process to settle on an amount to be repaid, rather than require the repayment in full. Prior to 2003, there was no ADR process. Instead, any overpayments were fully recovered unless there was a legitimate misinterpretation of the rate schedule or if legal action resulted in a change in the amount recovered.

Since the ADR process was implemented in 2003, the recovery of overpayments has been reduced. The recovery of overpayments through the ADR negotiation process for a sample of five audits closed in 2006 resulted in an average recovery of 57.2% of the overpaid amounts. The rate recovered varies on a case by case basis as indicated by the negotiated recovery on a $662,487 overpayment where the recovery was only $175,000 or 26.4%.

It is difficult to understand why recoveries from physicians with a history of overpayments and unacceptable clinical and possibly fraudulent behavior are not aggressively pursued.

Detailed Observations

Background

The Audit Services Division (the Division) was established at the inception of the MCP in 1969. Located in St. John's, its current mandate, as noted in the Audit Policies and Procedures manual, is to ensure that funds paid to Fee For Service physicians "have been properly paid."

Fee For Service (FFS) claims submitted by physicians for insurable services they provide are paid through a computerized payment system operated by the MCP. These transactions are audited by the Division.

Our findings and observations are contained in the following sections:

1. Audit Process
2. Audit Activity

1. Audit Process

Physicians paid on a FFS basis submit claims using the approved rate schedule and based on periodic communication with the MCP.

The audit policies and procedures are designed to be progressive in nature whereby the physician selected for audit is required to provide a preliminary representative sample of documents selected by the Division to support claims submitted and paid. If the supporting documentation for this sample is not adequate, the audit progresses to a more comprehensive stage where a larger sample of supporting documents is examined. In this case, the percentage of errors in the sample files is used to estimate (extrapolate) errors in all of the other claims or for the fee code being audited. The result of the process is that the documentation supporting the claims are either satisfactory and the audit is closed, or the physician is required to negotiate repayment of the estimated overpayment.

Although the process of estimating the amount of the overpayment is based upon statistical methods, physicians have for a long time complained that the process of extrapolating was unfair.

The various steps in the audit process are as follows:

Figure 3

MCP Claims Audit Process

Step	Procedure	Detail
1	Audit initiation	Physician audits may be initiated based upon information from: - beneficiary utilization audits; - complaints or voluntary information; - physician practice profiles; and - targeted fee code audits.
2	Preliminary audit stage	Involves a review of a small sample of claims and if these claims are satisfactory the audit is closed, if not, the review proceeds to a more comprehensive stage.
3	Comprehensive audit stage	As a result of any one of the occurrences noted in Step 1, a comprehensive audit is initiated that: - uses a larger statistical sample of physician claims; - involves a two year audit period; - is closed if the number of over-billings is small; and - is moved to the notification, appeal and negotiation phase if the estimated total value of over-billings is significant.
4	Physician Claims Intervention Program (PCIP)	The PCIP is a control mechanism where physicians who have been identified with potential billing problems must provide adequate support for all of their claims in order to get paid.
5	Physician interview	Physician advised of audit issues and asked to respond.
6	Medical Consultants Committee (MCC)	A professional, peer dominated, review committee comprised of: - three physicians nominated by the NLMA; - the Medical Consultant to audit; - the Medical Director; - the Dental Director; and - a private industry Chartered Accountant. The mandate of the MCC is to assess and make recommendations with regard to cases of physician and beneficiary over-utilization, inappropriate billing and/or abuse.

Figure 3 (cont.)

Step	Procedure	Detail
7	Alternate Dispute Resolution (ADR) process	A 90 day negotiation process between Department officials and the physician to arrive at a settlement as to the amount to be recovered. The process involves legal counsel for both parties.
8	Audit Review Board	The Board consists of three members including, one member appointed by the Minister, one member appointed by the physician under audit and a third member who is appointed jointly by the Minister and the physician.
9	Ministerial Order	After considering the results of the previous audit, negotiation and appeal phases the Minister makes a decision on the case that may include an order for the physician to repay the estimated overpayment and any penalties.
10	Appeal to Supreme Court Trial Division	The physician can appeal the Minister's decisions to the Supreme Court Trial Division and ultimately to the Supreme Court of Canada.

New Claims Monitoring System being piloted

In November 2006, the Audit Services Division piloted an "on line" Claims Monitoring System (CMS). This program starts with the random selection of one claim for each physician for every cycle (currently quarterly) for review. For these claims the physician is required to supply support from patient files and the service is confirmed with the patient. If the supporting documentation is unsatisfactory, or it is found that the service was not supplied, the claim is adjusted and the physician is notified of the reason for the failure. If a claim fails, the next cycle the number of claims selected for review will increase progressively to 4-6-10 and eventually all claims until they are either satisfactory or a comprehensive audit is initiated. As the CMS is still in a pilot phase, it was not included in this review.

2. Audit Activity

Introduction

Department officials indicated that the MCP audit process has been a contentious issue with physicians for a long time.

Officials indicated that issues raised by physicians, through the NLMA, have included:

- amount of time taken by the Division to complete an audit;
- detriment to the recruitment and retention of physicians;
- the process of extrapolating as being unfair; and
- targeting of certain groups of physicians and/or fee codes.

As a result of these issues, since 1989 there were three formal reviews occurring in 1992, 2001 and 2003. During the process involving the 2001 and 2003 reviews, some audit activities were put on hold. The main result of the 1992 review was to limit a comprehensive audit from five to two years, unless, in the opinion of the Medical Consultants Committee (MCC), there was a gross and obvious deviation from practice norms or if outright fraud was suspected. In this case, the audit scope would be expanded to five years.

The 2001 review resulted in the striking of a Joint MCP Audit Review Committee in 2002 consisting of representatives of the Department and the NLMA as follows:

- Assistant Deputy Minister, (Support Services), the Department;
- Medical Consultant to MCP, the Department;
- Coordinator, the Department;
- Director, Health Policy and Economics, NLMA;
- Chief Executive Officer, NLMA;
- Physician representative, NLMA; and
- Physician observer, NLMA.

The mandate of the Joint MCP Audit Review Committee was to review the MCP audit program. The review concluded in 2003 and included recommendations such as:

- new physicians should be reviewed within two years;
- all physicians should have a review every five years;
- all comprehensive audits should cover a maximum of two years i.e. the five year comprehensive audit should be abolished;

- the MCC should be reorganized to make it more efficient;
- a new Alternate Dispute Resolution system should be introduced to negotiate a settlement amount to be paid by physicians on overpaid claims identified; and
- all new physicians should undergo mandatory orientation of the claims process.

In light of the current staff complement, the recommendations related to reviewing new physicians within two years and other physicians every five years were deemed by the Audit Services Division as impractical and were not implemented. However, recommendations relating to reducing comprehensive audits to two years, reorganizing the MCC and instituting an Alternate Dispute Resolution process were implemented. While there is no mandatory orientation, Division officials indicated that some training is provided to new physicians relating to the claims process and guidance is also provided where services are incorrectly claimed.

Significant reduction in audit activity

Our review of the MCP audit file archives indicated that there were approximately 438 routine audits of physician claims started during the ten years prior to the transfer of the MCP to the Department on 1 April 2000 (an average of 44 audits per year). Of the 438, approximately 57 were still in progress as of 1 April 2000. In addition, there were special audits carried out for the psychiatry specialty and for specific fee codes such as psychotherapy.

In seven years since the MCP was transferred to the Department on 1 April 2000, to 31 March 2007, there have been only 48 physician audits started (average of 7 audits per year).

Officials attributed the reduction in activity to:

- complaints by physicians through the NLMA about the audit process;
- concern by the Department and the NLMA over the impact of audit activity on recruitment and retention of physicians;
- delays resulting from the merger of the Newfoundland Medical Care Commission into the Department;
- staffing issues resulting from Government regionalization which transferred MCP claims processing to Grand Falls-Windsor 1 July 2001;
- audits placed "on hold" during the Joint MCP Audit Review Committee (Report January 2003); and
- difficulties in arranging meetings of the Medical Consultants Committee (MCC) to review audit files.

It is noted that the reduction in audit activity came at a time when FFS payments were increasing significantly i.e. $127.8 million in 2000-01 to $206.1 million in 2006-07 (for a total of $1.2 billion over the seven year period). We would have expected that as FFS payments increased, audit activity would increase rather than decrease. Officials indicated that part of the reason for the reduction in audit activity was the fact that the entire audit process was under review from 2000 until 2003. During the review process, some audit activities were put on hold. In addition, two staff were permanently transferred from the Division to another division in the Department. This has resulted in the audit staff complement for the Division being reduced from seven to five at a time when FFS expenditures were increasing. Despite these contributing factors, the significant extent of the reduction is of concern.

Of the 48 physician audits started in the past seven years between 1 April 2000 and 31 March 2007, 31 had been closed and 17 were still in progress. Findings are presented as follows:

2A. closed audits
2B. audits in progress
2C. time frames for audits
2D. varying recovery rates

2A. Closed Audits

Of the 31 audits that were closed, 11 had satisfactory claims documentation. For 7 of the remaining 20, officials indicated that they were closed due to *"current staffing and workload levels."* These files were closed during May and June 2001, near the time officials were involved in the transfer of MCP processing to Grand Falls-Windsor. These files were flagged to be reviewed again in one year; however, at the time of our review, this had not been done.

In 13 of the 20 files, the audits were closed for other reasons as noted in Figure 4.

Figure 4

Reasons for Closing Physician Audit Files
1 April 2000 to 31 March 2007

Reason for Closure	Number of Files
Closed as a result of change in policy	3
Assessed overpayment or ADR amount paid in full	3
Physicians left the Province	3
Insignificant claims errors	2
Physician audited previously	1
Difference in interpretation of dental policy	1
Total	**13**

Source: Department audit files

Our review of the 13 closed files indicated the following:

Closed as a result of change in policy (3 files)

One of the recommendations of the Joint MCP Audit Review Committee was that *"all comprehensive audits should span a two-year time frame,"* and that *"the five-year comprehensive audit should be abolished."*

At the time of this change, three significant ongoing audits were closed as a result of the policy change. The audits involved a general practitioner and two psychiatrists and covered an additional three year review as a result of significant findings in the initial two year review. Had the audits been completed for the additional three year period, based on the recovery rate achieved in the initial two year audit, the Department could have recovered an additional $725,500.

Figure 5 shows the estimated recoveries and settlements in the three audits.

Figure 5

Estimated Recoveries and Settlements
Details on Audits Closed as a Result of Change in Policy

Audit Summary	General Practitioner	Psychiatrist #1	Psychiatrist #2	Totals
Initial two year audit				
Estimated Overpayment	$ 662,487	$ 393,385	$ 144,112	$ 1,199,984
Actual Recovery	175,000	175,000	61,400	411,400
Percentage	26.4%	44.0%	42.6%	34.3%
Additional three year audit				
Estimated Overpayment	752,035	510,134	703,243	1,965,412
Estimated Recovery	199,000	226,500	300,000	725,500
Percentage	26.4%	44.0%	42.6%	36.9%
Total Estimated Overpayment	**$ 1,414,522**	**$ 903,519**	**$ 847,355**	**$ 3,165,396**
Total Actually Recovered	**$ 175,000**	**$ 175,000**	**$ 61,400**	**$ 411,400**
Overall Percentage	**12.4%**	**19.4%**	**7.2%**	**13.0%**

Source: MCP

Audits closed even though there were significant findings

As Figure 5 shows, out of a potential $3.2 million in overpaid claims over a five year period ($1.2 million plus $2.0 million), the Department recovered only $411,400 or 13% from the physicians. Results from the three audits that were closed at the time of the policy change indicated that, in addition to $1.2 million of overpaid claims identified in an initial two year audit, an additional $2.0 million of overpaid claims had been identified in an additional three year audit of claims. As a result of closing this audit, the Department abandoned the potential to recover an estimated $725,500 in overpaid claims based on the recovery rate during the initial two year audit.

We noted that in the case of the general practitioner, based on the audit results reviewed by the MCC, they had recommended:

- *"the matter concerning the physician be referred to the Newfoundland Medical Board (NMB) for activities unbecoming a physician;"* Officials advised that this matter was referred to the NMB.

- *"we request that the NMB investigate the potential danger to the public occurring based on the documentation which the MCC reviewed today."* The MCC further stated, *"we urge the NMB to do so at as closely a time as possible."* This referred to inadequate clinical file documentation including a situation where the physician had rubber stamps made to document the results of such procedures as blood pressure checks. These stamps had a predetermined result (eg. normal) designed into them; and

- *"the MCC direct the MCP audit department to consult with legal counsel regarding the appropriateness of referring the question of fraud in the audit to the RCMP."* Police determined that there was inadequate evidence to proceed with a fraud charge.

Assessed overpayment or ADR amount paid in full (3 files)

One file related to the audit of a general practitioner for claims covering the period 6 March 2001 to 5 March 2003. The amount of the assessment was $21,826 and the amount recovered was $15,576 or 71.4 %.

One file also involved the audit of a general practitioner and covered claims for the period 26 February 2002 to 25 February 2004. The assessed amount of $10,305 was paid in full.

One file involved the audit of a urologist and covered claims for the period 27 November 2001 to 26 November 2002. The amount assessed was $20,290 and the amount recovered was $17,000 or 83.8%.

Delay resulted in $51,263 overpayment not recovered

Physicians left the Province (3 files)

One file involved an audit of a urologist who was included on the MCP system for only eight of the twenty-six pay periods for a year but had billed a total of $183,672 which when annualized would have been a considerably higher wage than their predecessor. However, management closed the audit because the physician had left the Province.

One file involved a general practitioner about whom the Assistant Director of Medical Services had noted in November 2000 that the physician was billing excessive numbers under a particular fee code. The audit resulted in an estimated overpayment of $51,263. In April 2001 the physician advised audit officials that they would be leaving the Province in August of

the same year and wished to have the audit settled prior to their leaving. There was some difficulty in obtaining support documents from the hospital involved; however, the audit was completed and ready for management review in late 2002.

There was no further action on the audit during 2003 and on 16 August 2004 the audit was closed. The fact that the physician had moved their practice to Ontario was cited as the reason; however, correspondence from the physician's legal counsel stating, *"the periodic letters to the physician informing him that his audit is ongoing has been appreciated, however, we would suggest that they also emphasize an unreasonable delay is continuing,"* implied delay was the problem. Officials indicated that due to the physician leaving the Province and the time passing since the audit was completed, there was no attempt to recover the estimated overpayment.

One file involved a second general practitioner who was randomly selected for an educational audit; however, the physician left the Province before the audit was started.

Insignificant claims errors (2 files)

These two files related to the audit of a general practitioner and an ophthalmologist both of whom were audited for the period 26 February 2003 to the 25 February 2004. The errors in the claims involved amounts of $1,838 and $4,719 respectively. In these cases an adjustment to future claim payments was processed to correct the errors.

Physician audited previously (1 file)

This file was closed in October 2004 before the audit was completed because a previous audit covering the period 26 December 1996 to 25 December 1998 had only been completed 12 May 2004. It was likely that the closed audit may have identified overpayments, given that the prior audit resulted in an assessment of $42,085 of which $37,000 or 87.9% was recovered.

Difference in interpretation of dental policy (1 file)

The physician in this case was claiming an amount for referred consultations, based on incorrect advice from a MCP official. Upon being advised by audit staff that the amount being claimed was incorrect, the physician referred the audit staff to the advice received from the MCP official. This physician was subsequently instructed in the correct procedure and, given that the claim was based on incorrect advice from a MCP official, the audit was closed and the overpayment was not investigated further.

2B. Audits in Progress

Audit files still in progress

Figure 6 shows the status of the physician audits that were started since the Medical Care Commission was merged with the Department that are still in progress.

Figure 6

Details of Physician Audit Files in Progress
1 April 2000 to 31 March 2007

Status	Number of Files
In various stages of completion	7
Ready for review by Medical Consultants Committee	6
In collection activity	1
Clinical and legal issues	1
In Alternate Dispute Resolution (ADR) and clinical issues	1
Pending management review	1
Total Audits in Progress	**17**

Source: Department audit files

Our review of the 17 audit files in progress indicated the following:

In various stages of completion (7 files)

All 7 files were started in 2006. These audits had not reached an advanced stage of completion; therefore, there was no estimate of any recoveries.

Ready for review by the Medical Consultants Committee (6 files)

The audit completion dates for these audits ranged from 25 September 2006 to 17 February 2007. The audit findings are waiting for review by the MCC. The recovery for these 6 files is estimated to be $376,520.

In collection activity (1 file)

This file relates to an audit of a physician randomly selected under the pilot educational audit program. The audit commenced in 2003. The total amount of the assessment was $7,140 and is in the process of being collected.

Clinical and legal issues (1 file)

The Review Board process is still in place for this initial audit with an estimated recovery of $169,367. With respect to this audit, officials were trying to do an "on-site" visit but this was unlikely since the general practitioner is no longer practicing and has since been convicted of other criminal offences. It is probable that the audit will close without any recovery.

In Alternate Dispute Resolution (1 file)

This audit commenced after the Manager, Claims Assessing, noticed that this psychiatrist had billed an unusual amount for office psychotherapy for 2004-05. Records indicated that the physician billed 7,294 units compared to 2,793 units for the next highest psychiatrist.

Psychiatrist does not keep records on patients

From the comprehensive audit sample of 99 claims (covering the period 15 November 2003 to 15 November 2004), 98 were deemed to be unacceptable because there was no documentation in the patients' file other than a copy of the prescription form. Documentation from the audit file indicated that the physician stated that they completed *"...records approximately 80 days after service"* and stated that *"...personal problems has affected* [their] *record keeping for the past several years."* The MCC also had concerns related to the clinical appropriateness of the patient files and *"...wished to obtain a legal opinion if audit findings can*

be passed on to the College of Physicians and Surgeons of Newfoundland and Labrador in the form of a complaint." Officials advised that this matter was referred to the College of Physicians and Surgeons of Newfoundland and Labrador.

Over-billing of $997,206

The status of this audit at 31 March 2007 was that the amount of the recovery in the amount of $997,206 is being negotiated under the ADR process with the physician's legal counsel indicating a willingness to pay $550,000 over three or four years. The Department has made a counter proposal in the amount of $600,000 plus interest over an approximate five year period.

Pending management review (1 file)

The last note in the audit file dated 12 December 2006 indicated that this audit was in progress, pending discussion of audit findings with MCP management. The recovery estimate has not been calculated as yet.

2C. Time Frames for Audits

We found that audits took a significant amount of time to complete. These delays have resulted in significant issues in recovering FFS overpayments. For example, as shown in Figure 7, some audits took almost 9 years to complete:

Figure 7

Length of time to complete audits

	Start date	Closing date	Duration	Amount Assessed	Amount Recovered
1	November 1998	May 2005	6 years, 5 months	$ 662, 487	$ 175,000
2	June 1995	August 2001	6 years, 2 months	453,044	0
3	March 1997	November 2005	8 years, 7 months	377,697	175,000
4	March 1997	October 2005	8 years, 9 months	315,332	200,000
5	March 1997	December 2004	7 years, 9 months	144,112	61,400
6	November 1998	February 2004	5 years, 3 months	42,085	37,800

Source: MCP Records

Officials indicated that factors affecting the time it takes to complete an audit include:

- time frame inherent in the lengthy audit process;
- difficulty in scheduling meetings with physicians;
- some audits prior to 2003 covered a five year time frame;
- MCC did not meet frequently enough;
- difficulty obtaining information from physicians; and
- complexity of claims to be reviewed affected the number of claims that could be reviewed by the MCC.

Delayed audit costs $453,000 plus court costs

With respect to audit #2 in Figure 7, the restructuring of the MCP contributed to the delay. In this case, the audit started in June 1995, covered the period April 1993 to October 1996 and resulted in a potential recovery amount of $453,044. In November 1998, a hearing was being arranged with the Review Board. At the same time, because the Department was being restructured, eight of the ten voting members of the Board became inactive during the 1998-99 fiscal year. The appointment of new members was deferred pending a comprehensive review of the organizational structure of the Department. According to Audit Services Division officials, this prevented the Audit Review Boards from being established until the restructuring was completed.

By May 2001, the Review Board had still not met at which time the physician's lawyer sought a judge's order to prohibit the hearing because of the unacceptable “state-caused” delay which had resulted in a clear abuse of the process. Prohibiting the hearing would eliminate the possibility of recovery of the overpayment.

The case proceeded to court and resulted in a ruling in August 2001 which was in favour of the physician. The ruling prohibited the Minister from establishing a Review Board and awarded court costs to the physician. There was no recovery of the amount owed by this physician.

2D. Varying Recovery Rates

In 2003, the Department implemented an Alternate Dispute Resolution (ADR) process which results in the negotiation of a settlement amount to be paid by physicians on overpaid claims identified. This change resulted from recommendations by the Joint MCP Audit Review which was

initiated to respond to issues raised by physicians. Prior to 2003, there was no ADR process. Instead, any overpayments were fully recovered unless there was an agreed upon misinterpretation of the rate schedule or if legal action resulted in a change in the amount recovered.

Since the ADR process was implemented, the recovery of overpayments has been reduced. For example, the recovery of overpayments for a sample of five audits closed in 2006 resulted in an average recovery of 57.2% of the overpaid amounts. The rate recovered varies on a case by case basis as indicated by the recovery on a $662,487 overpayment where the recovery was only $175,000 or 26.4%.

As a result, although audits conducted by the Audit Services Division result in significant potential to recover monies owed to the Department, the Department uses an ADR negotiation process to settle on an amount to be repaid, rather than require the repayment in full.

Recommendation

The Department should continue its efforts in auditing payments to FFS physicians to ensure that only legitimate and accurate payments have been made.

Department's Response

The MCP audit function has undergone considerable changes in the past 20 years as it continues to evolve and adapt to environmental changes, changing demographics (both physicians and beneficiaries of the plan) and technological advances. This trend will continue as the Division continually scans the horizon for changing trends or events that may impact or improve the audit process. The Audit Division was instrumental in establishing an Annual Medical Audit Workshop where Provincial/Territorial representatives meet to discuss medical audit issues. These workshops are held in a different host province each year and have proven a valuable resource to all concerned.

The more significant environmental changes have been mentioned in your report and include; (1) The Newfoundland Medical Care Commission was dissolved and its' activities merged with the Department of Health & Community Service on April 1, 2000, (2) The transfer of MCP claims processing activities to Grand Falls-Windsor in July 2001, and (3) Two reviews of the Audit process in 2001 and 2003. These three events had considerable negative impact on the audit process during the period from 1999 (when the merger was announced) to the conclusion of the second audit review. Examples of these negative influences are; staff turnover resulting from the merger, the use of audit staff to train the new staff in the Grand Falls-Windsor office and a curtailment of audit activities while the review was being carried out.

The reviews caused considerable re-evaluation of the audit process and the intervening years were somewhat of a rebuilding period. All of the Review Committee recommendations were considered over the course of the 3-4 years leading up to your review and several were implemented or implemented with some modification. As a result of the Review Committee recommendations an Educational Audit was implemented in May 2003. The Educational Audit was designed to audit all new physicians within 2 years of starting practice and all physicians were to be audited every 5 years. This process proved to be impractical within the existing staff compliment, since it would have required a significant increase in the number of auditors required to carry out over 100 audits per year. However, reflection on the goals and merits of the Educational Audits, subsequent to determining the impracticality of this type of auditing, resulted in the development of the Claims Monitoring System.

The Claims Monitoring System (CMS), as noted in your report, was introduced in November 2006. This system has been in operation for 15 months to date and the results are very positive. This system samples the documentation of every fee for service physician (approximately 600) on a quarterly basis. It is proactive and educational. The Department believes this system is working well and appears to be well received by the physician community. This approach is broader in coverage and timelier than the traditional audit process since it samples current records and has the ability to correct billing errors before they develop into significant amounts.

The Alternate Dispute Resolution (ADR) process was in part modeled after a similar process in British Columbia and is intended to encourage a cooperative climate, achieve fair and appropriate settlements, and avoid the excessive financial and procedural costs associated with formal court proceedings. Recovery rates have varied since ADR was implemented, due to the complexities and merits of individual cases. The unique circumstances surrounding each audit can and often does have a direct effect on the amount recovered through ADR or appeal.

Payments to Fee for Service physicians represent a significant portion of the overall Departmental budget. The Audit Division is committed to educating physicians and monitoring billing activities with the aim of preventing and recovering inaccurate and inappropriate claims.

Highlights

Highlights of a monitoring review of regional integrated health authorities from 1 April 2006 to 31 March 3007.

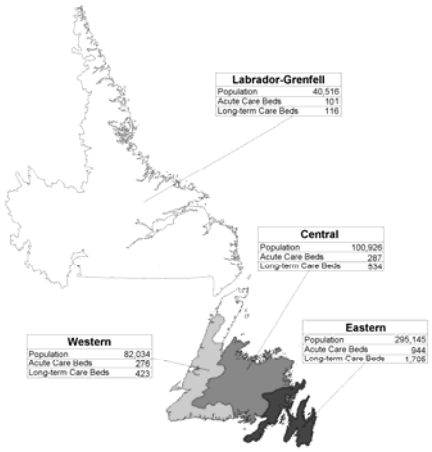
Why our Office did this Review

As part of our work we continue to monitor the financial position and annual operating results of the regional integrated health authorities.

Our review of the Authorities' financial position in 2006-07 included an assessment of the annual operating results and the financial position of the four Authorities for each of the five years to 31 March 2007.

Figure 1 shows information on the four regional integrated health authorities.

Figure 1
Department of Health and Community Services
Regional Integrated Health Authorities



What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.12
DEPARTMENT OF HEALTH AND COMMUNITY SERVICES
Monitoring of Regional Integrated Health Authorities

Effective 1 April 2005, Government established four regional integrated health authorities (the Authorities) throughout the Province by combining the eight health care institutions and integrated boards with the four health and community services boards. In addition, the Eastern Regional Integrated Health Authority assumed the operations of the St. John's Nursing Home Board and the Newfoundland and Labrador Cancer Treatment and Research Foundation.

The financial position of the Authorities has been deteriorating over the past several years. In an effort to control operating deficits, the Authorities have implemented changes to reduce costs and Government has provided additional funding. As in the past, our Office monitors the financial position and annual operating results of the regional integrated health authorities.

What We Found

Financial Position

The overall financial position of the Authorities improved slightly in the fiscal year 2006-07 with unfunded liabilities declining $7.7 million (1.5%) from $525.3 million in the fiscal year 2005-06 to $517.6 million in the fiscal year 2006-07. All four Authorities had unfunded liabilities at 31 March 2007. The combined unfunded liabilities of the four Authorities for the fiscal year 2006-07 of $517.6 million is a 5.6% increase from the $490.3 million reported in the fiscal year 2002-03. The unfunded liabilities will eventually have to be funded by Government.

The Eastern Regional Integrated Health Authority accounted for $349.2 million or 67% of the total $517.6 million in unfunded liabilities. Two of the four Authorities, the Central Regional Integrated Health Authority and the Labrador-Grenfell Regional Integrated Health Authority, reported increases in the total unfunded liabilities for 2006-07 over 2005-06.

Operating Deficits

During the year, all four Authorities reported operating deficits totalling $19.2 million. Operating deficits ranged from $400,000 for the Western Regional Integrated Health Authority to $14.8 million for the Eastern Regional Integrated Health Authority. Two Authorities, the Eastern Regional Integrated Health Authority and the Central Regional Integrated Health Authority, reported annual operating deficits higher than that reported for the fiscal year 2005-06.

Upon integration in the fiscal year 2005-06, the Department imposed funding reductions totalling $7 million on the newly integrated Authorities in expectation of administrative/integration cost savings. However, targeted savings did not materialize in fiscal year 2005-06, and administration and support expenditures continued to increase, even in the second year after integration. Since integration, administration and support expenditures for the four Authorities increased from $319.2 million in the fiscal year 2004-05 to $371.0 million in the fiscal year 2006-07, an increase of $51.8 million or 16%.

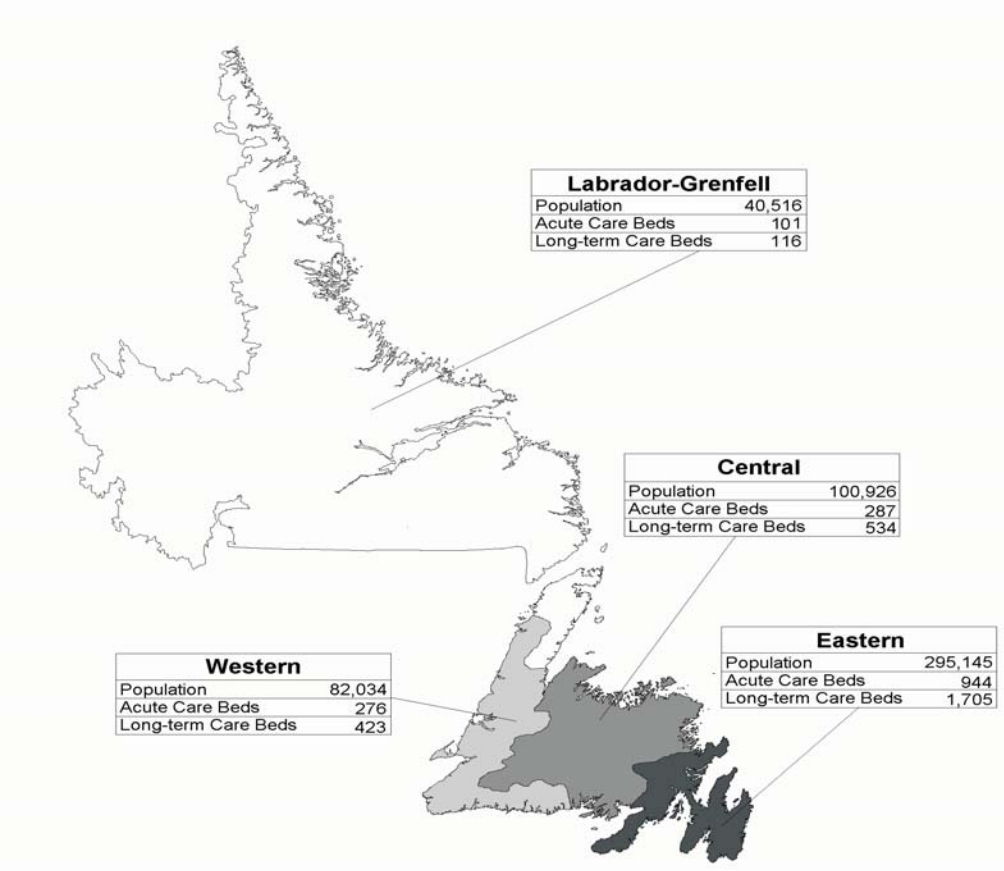
Background

Effective 1 April 2005, Government established four regional integrated health authorities (the Authorities) throughout the Province by combining the eight health care institutions and integrated boards with the four health and community services boards. In addition, the Eastern Regional Integrated Health Authority assumed the operations of the St. John's Nursing Home Board and the Newfoundland and Labrador Cancer Treatment and Research Foundation.

Figure 1 shows information on the four Authorities.

Figure 1

Department of Health and Community Services
Regional Integrated Health Authorities



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Overall Conclusions

Financial Position

The overall financial position of the Authorities improved slightly in the fiscal year 2006-07 with unfunded liabilities declining $7.7 million (1.5%) from $525.3 million in the fiscal year 2005-06 to $517.6 million in the fiscal year 2006-07. All four Authorities had unfunded liabilities at 31 March 2007. The combined unfunded liabilities of the four Authorities for the fiscal year 2006-07 of $517.6 million is a 5.6% increase from the $490.3 million reported in the fiscal year 2002-03. The unfunded liabilities will eventually have to be funded by Government.

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Upon integration in the fiscal year 2005-06, the Department imposed funding reductions totalling $7 million on the newly integrated Authorities in expectation of administrative/integration cost savings. However, targeted savings did not materialize in fiscal year 2005-06, and administration and support expenditures continued to increase, even in the second year after integration. Since integration, administration and support expenditures for the four Authorities increased from $319.2 million in the fiscal year 2004-05 to $371.0 million in the fiscal year 2006-07, an increase of $51.8 million or 16%.

Detailed Observations

1. Financial Position

Overview

Our review of the Authorities' financial position in 2006-07 included an assessment of the annual operating results and the financial position of the four Authorities for each of the five years to 31 March 2007. Information on the financial position of the four Authorities is contained in Figure 2.

Figure 2

Regional Integrated Health Authorities
Summary of Financial Position
As at 31 March
($ Millions)

	2006-07				Totals				
	Eastern	Central	Western	Labrador-Grenfell	2006-07	2005-06	2004-05	2003-04	2002-03
Cash (Bank Indebtedness)	$ 2.8	$ (9.8)	$ (16.1)	$ (19.1)	$ (42.2)	$ (67.8)	$ (73.0)	$ (69.4)	$ (59.4)
Accounts Payable	(81.8)	(21.6)	(22.7)	(10.0)	(136.1)	(112.3)	(108.4)	(106.2)	(107.2)
Current LTD	(3.3)	(1.0)	(0.8)	-	(5.1)	(6.1)	(5.7)	(5.9)	(5.5)
Less: A/R	30.9	10.7	8.8	12.4	62.8	44.3	43.6	54.7	61.9
Net Liability	**(51.4)**	**(21.7)**	**(30.8)**	**(16.7)**	**(120.6)**	**(141.9)**	**(143.5)**	**(126.8)**	**(110.2)**
Long-term Debt	(159.7)	(17.2)	(6.0)	(1.2)	(184.1)	(190.5)	(198.6)	(204.9)	(208.5)
Severance Pay	(107.3)	(22.0)	(23.6)	(8.6)	(161.5)	(145.5)	(143.2)	(139.4)	(129.8)
Vacation Pay	(30.8)	(9.0)	(6.8)	(4.8)	(51.4)	(47.4)	(47.3)	(46.1)	(41.8)
Total Unfunded Liabilities	**$(349.2)**	**$ (69.9)**	**$ (67.2)**	**$ (31.3)**	**$(517.6)**	**$(525.3)**	**$(532.6)**	**$(517.2)**	**$(490.3)**

Source:Audited Operating Fund Financial Statements.

Financial position

Our review identified the following regarding the financial position of the Authorities:

- The overall financial position of the Authorities improved slightly in 2007 with unfunded liabilities declining $7.7 million (1.5%) from $525.3 million for the fiscal year 2005-06 to $517.6 million for the fiscal year 2006-07.

- The total unfunded liabilities of the four Authorities increased $27.3 million (5.6%) from $490.3 million for the fiscal year 2002-03 to $517.6 million for the fiscal year 2006-07.

- For the fiscal year 2006-07, the Authorities reported bank overdrafts (indebtedness) totalling $42.2 million. The cash positions ranged from cash of $2.8 million for the Eastern Regional Integrated Health Authority to an overdraft of $19.1 million for the Labrador-Grenfell Regional Integrated Health Authority.

- The Authorities reported a combined net liability of $120.6 million for the fiscal year 2006-07, which represents the amount by which suppliers' credit and current portion of long-term debt exceed the liquid (cash convertible) assets.

- Of the $184.1 million in long-term debt, $159.7 million, or 87%, related to the Eastern Regional Integrated Health Authority.

The $517.6 million in total unfunded liabilities for the fiscal year 2006-07 will be affected by the results of current operations and the level of funding by Government. If the Authorities have annual operating surpluses in the future, these surpluses could be used to fund the liabilities. On the other hand, if the Authorities have annual operating deficits, then the deficits, along with the liabilities, will eventually have to be funded by Government.

2. Operating Results

Overview

Figure 3 outlines the annual operating results for the four Authorities for the five years to 31 March 2007.

Figure 3

Regional Integrated Health Authorities
Summary of Annual Operating Results
Years Ended 31 March
($ Millions)

	2006-07				Totals				
	Eastern	Central	Western	Labrador-Grenfell	2006-07	2005-06	2004-05	2003-04	2002-03
Revenue									
Province	$846.5	$215.3	$209.2	$107.2	$1,378.2	$1,301.1	$1,201.9	$1,169.0	$1,132.9
Other	74.3	20.9	21.6	18.7	135.5	129.7	113.1	125.0	113.8
Total Revenue	920.8	236.2	230.8	125.9	1,513.7	1,430.8	1,315.0	1,294.0	1,246.7
Expenses									
Admin. and Support	207.8	67.6	59.4	36.2	371.0	356.5	319.2	318.3	304.9
Programs	684.5	166.3	167.0	89.0	1,106.8	1,048.2	980.8	964.7	913.6
Interest on LTD	10.6	1.0	0.4	0.1	12.1	12.5	13.1	13.3	13.3
Other	6.9	-	2.1	1.4	10.4	9.4	8.5	6.5	6.0
Total Expenses	909.8	234.9	228.9	126.7	1,500.3	1,426.6	1,321.6	1,302.8	1,237.8
Surplus (Deficit) before non-shareable expenses	11.0	1.3	1.9	(0.8)	13.4	4.2	(6.6)	(8.8)	8.9
Non-shareable expenses	25.8	3.6	2.3	0.9	32.6	16.1	17.7	24.7	29.8
Deficit after non-shareable expenses	**$(14.8)**	**$ (2.3)**	**$ (0.4)**	**$ (1.7)**	**$ (19.2)**	**$ (11.9)**	**$ (24.3)**	**$ (33.5)**	**$ (20.9)**

Source:Audited Operating Fund Financial Statements.

Operating deficits

As Figure 3 shows, total revenue of the Authorities has increased by $267 million or 21% from $1.247 billion in fiscal year 2002-03 to $1.514 billion in fiscal year 2006-07. For the fiscal year 2006-07, revenue from the Province accounted for approximately 28% of the Provincial budget.

Figure 3 also shows that all four Authorities reported annual operating deficits for fiscal year 2006-07 totalling $19.2 million. Operating deficits ranged from $400,000 for the Western Regional Integrated Health Authority to $14.8 million for the Eastern Regional Integrated Health Authority.

Overall, the annual operating deficits reflected in Figure 3 peaked in fiscal year 2003-04 at $33.5 million and totalled $19.2 million in fiscal year 2006-07. Two Authorities (Eastern Regional Integrated Health Authority and Central Regional Integrated Health Authority) had operating deficits which were higher than that reported in fiscal year 2005-06.

Administration expenditures

In September 2004, the Minister of Heath and Community Services stated that "*creating fewer, more accountable health authorities is a necessary step in renewing our health and community services system and meeting client needs. Fewer regions mean less administration and more opportunity for collaboration*."

Upon integration in 2005, the Department imposed funding reductions totalling $7 million on the newly integrated Authorities in expectation of administrative/integration cost savings as follows:

- Eastern - $3.9 million
- Central - $1.3 million
- Western - $1.1 million
- Labrador-Grenfell - $0.7 million

However, due to concerns expressed by the Authorities over the magnitude of the savings target, and their inability to achieve the targeted savings, no further budget reductions were imposed in subsequent years.

Our review indicated that the targeted savings did not materialize in fiscal year 2005-06, and that administration and support expenditures continued to increase, even in the second year after integration. Since integration, administration and support expenditures for the Authorities increased from $319.2 million in fiscal year 2004-05 to $371.0 million in fiscal year 2006-07, an increase of $51.8 million or 16%.

Department's Response

Financial Position and Operating Results

The Department shares the concerns of the Auditor General regarding the financial position of the Regional Integrated Health Authorities (RHAs) in this province. Many other provinces and territories have been struggling with significant increases in health care operating costs in recent years, while the Federal Government has provided insufficient increases in funding to offset this growth.

It should be noted that the health care delivery system was restructured from fourteen (14) health boards to four (4) regional health authorities effective April 2005. The new health authorities assumed the financial assets, liabilities, revenue base, and accumulated deficits of the merging entities at that time. The fiscal year 2006-07 represents the second year of operations under these new governance structures and management teams. It should be noted to varying degrees, RHAs were still engaged in integration activities including recruitment of positions, consolidation of bargaining units, merger of information and reporting systems, and establishment of common policies and procedures. Integration remains a work in progress for the authorities. Despite these operational challenges and constraints, RHAs were able to achieve a combined operating surplus of $7.2 million for 2006-07 (before non-shareable expenses such as the increase in severance pay due to employees upon retirement).

Despite the improvement in financial position of the health authorities of late, the Department remains concerned about the magnitude of the accumulated deficits being carried by the health authorities. Combined operating shareable deficits are approximately $113 million. When adjusted for non-shareable liabilities, such as severance and unused vacation pay to be paid to employees upon retirement, the combined deficits of the health authorities is in excess of $300 million.

One of the Department's four Strategic Directions is to "Improve Accountability and Stability" of the health care system. The Department continues to work with RHAs and other stakeholders to improve financial results and improve accountability of health authorities. Some initiatives being undertaken are as follows:

- *Health Authorities are expected to take all reasonable measures to balance their budgets at the beginning of the fiscal year. RHAs are required to present a re-cast balanced budget plan against which they measure fiscal results throughout the year.*

- *Health Authorities have been implementing various measures towards improving their fiscal positions which include: restructuring administrative functions; implementation of "best practises" in various programs and services; improved management reporting and monitoring; maximization of revenue opportunities; effective cash management; and improved focus on evidence informed decision making.*

- *Health Authorities are required to report monthly financial operating results relative to budget to the Department throughout the fiscal year. Health Authorities are also required to submit relevant statistical information relative to operations. This information allows the Department to perform detailed analysis on operations as necessary.*

- *The Department continues to monitor the fiscal position of RHAs throughout the fiscal year to ensure RHAs are taking appropriate and reasonable measures to improve their overall financial position without compromising the quality of health care services and programs.*

- *In Budget 2007 Government approved approximately $82 million in incremental funding for RHAs for key budget pressures and new program initiatives. The significant investments in health care made by the Province in Budget 2006 and Budget 2007 are expected to improve the overall financial position of the Health Authorities in the future.*

- *Finally, each C.E.O. of the four (4) RHAs must meet annual performance criteria on which their annual performance bonuses are based. A key element of this criteria is achieving balanced budgets on an annual basis based on a agreed set of indicators.*

Your report comments on the increase in the cost of administration and support services since the integration of the health boards in April 2005. The Department would first like to point out that support services in health authorities include housekeeping, food/meals, and laundry/linen services, the cost of which would not be expected to decrease with the consolidation of health boards and are in the range of $235 million. One of the reasons for the increase in administration expenses, however is negotiated salary increases, which were effectively 3% for each of the two years since amalgamation. It should be further noted that RHAs have achieved some administrative savings arising from integration (such as an overall reduction in the number of executive positions). In addition, RHAs made some reinvestments of administration savings to support the implementation and monitoring of the significant investments made in programs and services in the last two years by Government. Despite these increases in administration costs, NL health authorities are considered to have lower administrative regimes than others in the country. According to a report by the Canadian Institute for Health Information, NL health authorities spend only 5% on administration expenses, while the national average is almost 6%.

Highlights

Highlights of a review of Newfoundland and Labrador Housing Corporation's Rental Housing Program from January 2007 to December 2007.

Why our Office did this Review

The objectives of our review were to assess the adequacy of the Corporation's rental property portfolio to meet the demand of its clientele and review the progress of the implementation of recommendations from the Housing Administration Study of March 2006.

What our Office Recommends

The Corporation should:

- develop a long-term housing accommodation plan;
- continue with their efforts to address the recommendations from the Housing Administration Study;
- ensure that Corporation staff comply with the policies resulting from the recommendations; and
- ensure all information in the Rental Management System is accurate.

What the Corporation Said

To provide balance to this report and to ensure full disclosure, the Corporation was asked to formulate a response to our findings and conclusions. The Corporation's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Corporation's comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.13
NEWFOUNDLAND AND LABRADOR HOUSING CORPORATION
Rental Housing Program

The Rental Housing Program (the Program) is the oldest and largest housing assistance program administered by the Newfoundland and Labrador Housing Corporation (the Corporation). The purpose of the Program is to provide affordable housing to low-income individuals and families.

Housing Administration Officers (HAO) are responsible for delivery of the Program in four regions and are located at seven offices across the Province. The HAOs report to the applicable Regional Director in Eastern and Western regions and Managers in Labrador and Central regions. The Corporation's headquarters is located in St. John's. At the time of our review there were 26 HAOs employed by the Corporation. Figure 1 shows the rental unit portfolio by region.

Figure 1
Newfoundland and Labrador Housing Corporation
Rental Unit Portfolio by Region
As at 8 November 2007

Region	Type of Rental Unit						Total
	Bachelor	One Bedroom	Two Bedroom	Three Bedroom	Four Bedroom	Five Bedroom	
Eastern	80	678	659	2,006	492	19	3,934
Central	1	155	160	841	94	-	1,251
Western	4	159	202	745	100	14	1,224
Labrador	1	16	54	169	27	-	267
Total	**86**	**1,008**	**1,075**	**3,761**	**713**	**33**	**6,676**
Occupied	**83**	**986**	**1,020**	**3,394**	**650**	**30**	**6,163**

Source: Newfoundland and Labrador Housing Corporation Rental Management System

What We Found

The Corporation is unable to match the client demographics to its rental unit portfolio and as a result has an excess bedroom capacity in many of its units i.e. "over-housed." The Corporation has 14,077 tenants occupying 6,163 rental units with a total of 16,041 available bedrooms. Therefore, even assuming that each tenant will occupy a separate bedroom, there is still an excess of 1,964 bedrooms. In fact, since 2002, the percentage of units with more bedrooms than occupants has increased from 35% to 40%.

In March 2006 the Corporation completed a Housing Administration Study (the Study) of its Rental Housing Program and identified 48 recommendations in 9 areas of the Program. The purpose of the Study was to identify and recommend efficient and effective use of the Corporation's rental housing resources and improvements to client service. The Corporation identified 32 recommendations as priority to be implemented by 1 April 2007.

The Corporation did not fully meet its goal of maximizing the efficiency and effectiveness of its rental housing resources as evidenced by the fact that the Corporation did not comply with all of the 32 recommendations by 1 April 2007. Recommendations which were not complied with covered such areas as: inspections prior to a tenant vacating, inaccurate waitlists, no certified tax returns obtained from new tenants, delayed collection efforts, no agreements to pay arrears, termination notices not always issued after 45 days of arrears, the need for improved contact with tenants and inconsistent applicant assessment among regions.

Background

Rental Housing Program overview

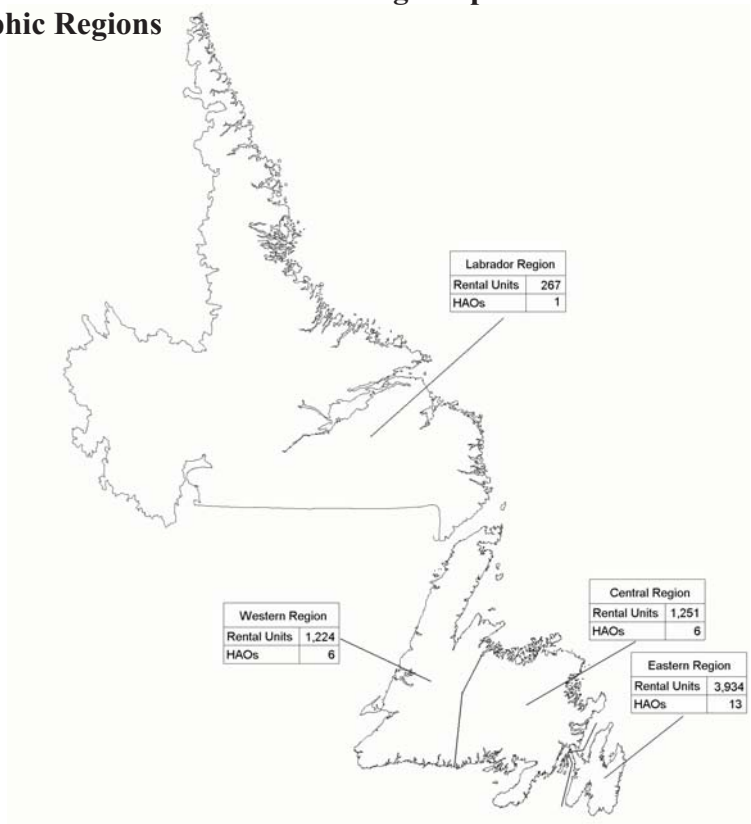
The Rental Housing Program (the Program) is the oldest and largest housing assistance program administered by the Newfoundland and Labrador Housing Corporation (the Corporation). The purpose of the program is to provide affordable housing to low-income individuals and families.

Housing Administration Officers (HAO) are responsible for delivery of the Program in four regions and are located at seven offices across the Province. The HAOs report to the applicable Regional Director in Eastern and Western regions and Managers in Labrador and Central regions. The Corporation's headquarters is located in St. John's. At the time of our review there were 26 HAOs employed by the Corporation.

Figure 1 shows the four geographic regions, the number of HAOs and the number of rental units in each region.

Figure 1

Newfoundland and Labrador Housing Corporation Geographic Regions



Revenues and expenditures

In 2006-07, rental revenue totalled $18.7 million ($19.3 million in 2005-06) and expenditures on rental housing totalled $53.5 million ($52.9 million in 2005-06).

Rental units by region

The Corporation has a total of 6,676 units available for rental. Figure 2 identifies the type of rental units and occupancy within each of the Corporation's four regions.

Figure 2

Newfoundland and Labrador Housing Corporation
Rental Unit Portfolio by Region
As at 8 November 2007

Region	Type of Rental Unit						Total
	Bachelor	One Bedroom	Two Bedroom	Three Bedroom	Four Bedroom	Five Bedroom	
Eastern	80	678	659	2,006	492	19	3,934
Central	1	155	160	841	94	-	1,251
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Total	**86**	**1,008**	**1,075**	**3,761**	**713**	**33**	**6,676**
Occupied	**83**	**986**	**1,020**	**3,394**	**650**	**30**	**6,163**

Source: Newfoundland and Labrador Housing Corporation Rental Management System

Housing Administration Study

In December 2005, the Corporation appointed an internal committee to study the administration of the Rental Housing Program. The process examined existing policies and procedures and included consultation with employees involved in the Program and an analysis of Program statistics from the computerized Rental Management System.

In March 2006, the committee issued a report titled “Housing Administration Study” (the Study). The report included 48 recommendations focusing on the following 9 aspects of the Rental Housing Program:

- rental housing structure (2);
- applications (10);
- income determination (6);
- lease administration(9);
- tenant transfer (2);
- rental arrears (8);
- tenant damages (5);
- termination of tenancy (1); and
- rental housing policy and program monitoring (5).

Audit Objectives and Scope

Audit objectives

The objectives of our review were to:

- assess the adequacy of the Corporation's rental property portfolio to meet the demand of its clientele; and
- review the progress of the implementation of recommendations from the Housing Administration Study of March 2006.

Audit scope

Our review covered the period January 2007 to December 2007 and included discussions with officials of the Corporation as well as an examination of files related to administration and delivery of the Corporation's Rental Housing Program. We completed our review in December 2007.

Overall Conclusions

The Corporation is unable to match the client demographics to its rental unit portfolio and as a result has an excess bedroom capacity in many of its units i.e. "over-housed." The Corporation has 14,077 tenants occupying 6,163 rental units with a total of 16,041 available bedrooms. Therefore, even assuming that each tenant will occupy a separate bedroom, there is still an excess of 1,964 bedrooms. In fact, since 2002, the percentage of units with more bedrooms than occupants has increased from 35% to 40%.

In March 2006 the Corporation completed a Housing Administration Study (the Study) of its Rental Housing Program and identified 48 recommendations in 9 areas of the Program. The purpose of the Study was to identify and recommend efficient and effective use of the Corporation's rental housing resources and improvements to client service. The Corporation identified 32 recommendations as priority to be implemented by 1 April 2007.

The Corporation did not fully meet its goal of maximizing the efficiency and effectiveness of its rental housing resources as evidenced by the fact that the Corporation did not comply with all of the 32 recommendations by 1 April 2007. Recommendations which were not complied with covered such areas as: inspections prior to a tenant vacating, inaccurate waitlists, no certified tax returns obtained from new tenants, delayed collection efforts, no agreements to pay arrears, termination notices not always issued after 45 days of arrears, the need for improved contact with tenants and inconsistent applicant assessment among regions.

Detailed Observations

Our review included an examination of:

1. The Corporation's Rental Housing Portfolio
2. Progress on Recommendations from the Housing Administration Study

1. The Corporation's Rental Housing Portfolio

Rental housing portfolio

Many of the rental units managed by the Corporation were built over 25 years ago. At that time, the focus was to provide housing for families, which consisted primarily of two parents and multiple children. As a result, the homes constructed typically contained three or four bedrooms. In addition, there was little emphasis placed on housing for those with special needs. As a result, the Corporation was unprepared for the significant change that has occurred in the demographics of its clientele. The client base has changed from mainly families to single individuals, single parents and elderly couples.

As at 8 November 2007, the Corporation had 6,676 rental units, 6,163 of which were occupied. Figure 3 shows the composition of occupants in the rental units.

Figure 3

Newfoundland and Labrador Housing Corporation
Composition of Occupants in Rental Units
As at 8 November 2007

Type of rental unit	Number of rental units	Number of occupied rental units	Number of bedrooms	Number of occupants	Number of vacant bedrooms	Average number of occupants
Bachelor	86	83	83	83	-	1.00
One bedroom	1,008	986	986	1,040	(54)	1.05
Two bedroom	1,075	1,020	2,040	1,707	333	1.67
Three bedroom	3,761	3,394	10,182	9,029	1,153	2.66
Four bedroom	713	650	2,600	2,112	488	3.25
Five bedroom	33	30	150	106	44	3.53
Total	**6,676**	**6,163**	**16,041**	**14,077**	**1,964**	**2.28**

Source: Newfoundland and Labrador Housing Corporation Rental Management System

As Figure 3 shows, the Corporation has 14,077 tenants occupying 6,163 rental units with a total of 16,041 available bedrooms. Therefore, even assuming that each tenant will occupy a separate bedroom, there is still an excess of 1,964 bedrooms.

As Figure 3 also shows, again even with the assumption that every tenant will occupy a separate bedroom, most of the rental units have an average occupancy rate that is lower than the number of bedrooms in the rental unit. As a result, there are vacant bedrooms in many of the occupied rental units. For example, the average occupancy rate for four bedroom units is 3.25 occupants. There are 2,600 bedrooms in the 650 occupied four bedroom rental units; however there are only 2,112 occupants. Therefore at least 488 bedrooms in the four bedroom units are unoccupied.

Figure 4 shows the family size to bedroom count within the 6,163 occupied rental units.

Figure 4

Newfoundland and Labrador Housing Corporation
Rental Unit Portfolio Composition
As at 8 November 2007

Family Size	Number of Bedrooms						Total rental units	Number of rental units with more bedrooms than occupants
	0	1	2	3	4	5		
1	83	933	446	547	92	4	2,105	1,089
2		52	477	1,048	131	4	1,712	1,183
3		1	82	1,045	155	12	1,295	167
4			14	558	131	3	706	3
5			1	163	91	3	258	
6				27	38	1	66	
7				6	10	2	18	
8					2		2	
>8						1	1	
Total	**83**	**986**	**1,020**	**3,394**	**650**	**30**	**6,163**	**2,442**

Source: Newfoundland and Labrador Housing Corporation Rental Management System

As Figure 4 shows, there were 2,442 (40%) rental units which had more bedrooms than the number of occupants, even with the assumption that every tenant will occupy a separate bedroom. As a result, rental units were occupied by a smaller number of occupants than the rental unit's capacity. In fact, since 2002, the percentage of units with more bedrooms than occupants has increased from 35% to 40%.

Conclusion

The Corporation is unable to match the client demographics to its rental unit portfolio and as a result has an excess bedroom capacity in many of its units i.e. "over-housed." Therefore, even assuming that each tenant will occupy a separate bedroom, there is still an excess of 1,964 bedrooms.

Recommendation

The Corporation should develop a long-term housing accommodation plan.

2. Progress on Recommendations from the Housing Administration Study

In March 2006 the Corporation completed a Housing Administration Study (the Study) of its Rental Housing Program and identified 48 recommendations in 9 areas of the Program. The purpose of the Study was to identify and recommend efficient and effective use of the Corporation's rental housing resources and improvements to client service.

On 22 January 2007, a Senior Executive Director issued an interoffice memo that identified 32 recommendations as priority to be implemented by 1 April 2007 as outlined in Figure 5.

Figure 5

Newfoundland and Labrador Housing Corporation
Housing Administration Study
Recommendations to be Implemented in 2007

Program aspect	Recommendations			
	Number	Not adopted	On hold pending new computer system	To be implemented by 1 April 2007
Rental housing portfolio	2	1	-	1
Applications	10	1	4	5
Income determination	6	-	1	5
Lease administration	9	1	1	7
Tenant transfer	2	-	1	1
Rental arrears	8	-	-	8
Tenant damages	5	-	4	1
Termination of tenancy	1	-	1	-
Rental housing policy and program monitoring	5	-	1	4
Total	**48**	**3**	**13**	**32**

Source: The Corporation's Update on Housing Administration Study

The 3 recommendations which the Corporation did not adopt addressed planning relating to the types of rental accommodations, advertising relating to types of tenants, and splitting HAO duties.

Our review indicated that the Corporation did not comply with all of the 32 recommendations by 1 April 2007. Details on the recommendations are outlined in the following sections:

A. Applications
B. Wait List
C. Rental Unit Administration
D. Rental Housing Policy and Program Monitoring

2A. Applications (7 Recommendations)

Application process

Applications for rental units are processed at the regional offices where they are assigned a unique identifier and entered into the Rental Management System. An HAO assesses the application in relation to an established set of criteria including income and expenses. Once approved, the application is reviewed by a regional selection committee which recommends a rental unit for the applicant.

As a result of the Study, the following recommendations were to be implemented by 1 April 2007:

- the regional selection committees were to use their best efforts to consider client mix in the demographic areas of Department of Human Resources, Labour and Employment clients, seniors, working poor families, and non-elderly singles. Client mix is to be considered in the placement of new tenants and the transfer of existing tenants;

- for eligibility purposes, a household income threshold of $30,000, $32,000 and $40,000 is to be applied to the Island portion of the Province, Goose Bay and the North Coast of Labrador respectively. Certified income tax returns were to be used to verify income for all household members;

- total household net income should be used for eligibility purposes and for the calculation of affordability;

- any applicant within the low income thresholds and with a rental affordability problem should be considered eligible. (i.e. paying 25% or more of income as rent);

- the Point Score system used to rank applicants for eligibility was to be discontinued to be replaced with income eligibility only. As well, the requirement for home visit and credit reporting on the applicant was to cease;

- the actual hours of work over a month were to be used to calculate monthly income from employment. Where actual hours could not be verified, the employer should provide independent verification; and

- a net pay approach should be used for working poor clients with income from employment.

Detailed findings

Our review indicated that, while HAOs were informed of the need to implement the recommendations by 1 April 2007, the recommendations were not always complied with.

We reviewed 86 of 810 applications that had been approved since 1 April 2007. We identified 87 issues with 54 approved applications as follows:

- essentially all applications (53 of 54) were approved without the provision of certified copies of income tax returns, as required;
- 12 applications were approved, but there was insufficient documentation to determine whether net income was adequately assessed;
- 9 applications were approved, but there was insufficient documentation to determine whether the applicant's current rent payments were compared to the applicant's income, as required;
- 3 applications were assessed based on the Point Score system that had been abolished as of January 2007;
- 2 applications were approved without a calculation of hours of work to determine the monthly income, as required; and
- 8 applications were approved, but there was insufficient documentation to determine whether the client was eligible.

2B. Wait List (1 Recommendation)

Wait list policy

The Study recommended that effective January 2007 the wait list should be renewed every six months and be purged of applicants who no longer indicated an interest in housing assistance. The recommendation was subsequently revised to renew the wait list every 12 months.

Wait list as of 6 November 2007

The Corporation provided a list of applicants who, as at 6 November 2007, had been approved for residence in a rental unit but were waiting for a rental unit to become available. The list indicated a total of 951 applicants on the wait list. In 2003, a similar list indicated that a total of 771 applicants were on a wait list.

Figure 6 identifies the number of applicants by region and the time on the wait list.

Figure 6

Newfoundland and Labrador Housing Corporation
Wait List by Region
As at 6 November 2007

Time on Wait List	Regions				
	Eastern	Central	Western	Labrador	Total
1 to 6 months	195	83	97	44	419
7 to 12 months	119	60	42	16	237
More than 12 months	33	102	91	22	248
Sub-total	**347**	**245**	**230**	**82**	**904**
% of Sub-total	**38%**	**27%**	**26%**	**9%**	**100%**
Unable to determine	-	45	1	1	47
Total	**347**	**290**	**231**	**83**	**951**

Source: Newfoundland and Labrador Housing Corporation Rental Management System

As Figure 6 shows, 248 of the 951 applicants (26%) have been on the wait list for more than one year. There are 47 applicants for which the Corporation could not demonstrate how long they were on the wait list because the application date occurred after the approved date in the Rental Management System (the System), these applications may have been incomplete, the information may have been recorded incorrectly or an HAO may not have entered data in certain fields in the System. Of these 47 applicants, 45 were from the Central region.

Figure 7 provides similar information as Figure 6 on a demographic basis.

Figure 7

Newfoundland and Labrador Housing Corporation
Demographics of the Wait List
As at 6 November 2007

Time on Wait List	Demographics of Wait List						
	Single	Senior Single	Single Parents	Senior Couples	Sub-totals	Other	Total
1 to 6 months	78	65	161	20	324	95	419
7 to 12 months	60	46	67	13	186	51	237
More than 12 months	52	51	55	25	183	65	248
Sub-total	**190**	**162**	**283**	**58**	**693**	**211**	**904**
%of Sub-total	**21%**	**18%**	**32%**	**6%**	**77%**	**23%**	**100%**
Unable to determine	3	4	21	1	29	18	47
Total	**193**	**166**	**304**	**59**	**722**	**229**	**951**

Source: Newfoundland and Labrador Housing Corporation Rental Management System

As Figure 7 shows, 77% of the applicants on the wait lists are singles, senior singles, single parents and senior couples. This would indicate that the Corporation has a greater demand for smaller rental units. Officials indicated that they do not have a long-term accommodation plan in place to address the effect of the demographic changes.

Wait lists may not be accurate

Applicants on wait lists longer than 12 months were to be issued a letter requesting that they confirm that they still required a rental unit. Applicants not requiring a rental unit would be purged from the wait list.

Our review indicated that the Corporation has not contacted all applicants on the wait list over 12 months as required. As a result, the wait list can not be purged and therefore may not be accurate.

We reviewed files for 24 of the 248 applicants that have been on the wait list for 12 months or longer to determine if the Corporation had contacted the applicant to ensure the need for housing still existed. Our review identified the following:

- 8 files had letters issued requesting that the applicant respond to indicate they still needed a rental unit. Of these 8:
  - 4 applicants responded that they still required a rental unit; and
  - 4 applicants did not respond.
- 11 files contained no documentation that letters had been issued or any notation indicating that the applicants were still in need of housing; and
- 5 files contained notes that contact had been made with the applicant within the last 12 months confirming that they were still in need of a rental unit.

2C. Rental Unit Administration (17 Recommendations)

Rental leases renewed without required documentation

Rental Lease Renewals

Approved applicants are required to sign a lease which outlines the terms and conditions that the tenant must meet when renting the unit from the Corporation (e.g. monthly rent amount). The lease must be renewed every three years.

The Study recommended that in order to renew a rental lease, tenants must provide copies of certified income tax returns to the Corporation (exception: long-term clients of the Department of Human Resources, Labour and Employment (DHRLE). In addition:

- lease renewals were to continue on a project renewal basis for all "working poor", seniors and clients of DHRLE; and
- lease renewal notices need only be issued and executed where there is an actual change in the monthly rent.

Our review indicated that the Corporation did not always comply with the new requirement that files for lease renewals contain a copy of a certified income tax return.

We reviewed 98 of 983 files relating to renewed leases on rental units with the Corporation since 1 April 2007. We found that 76 of the 98 files had the leases renewed without a certified income tax return on file.

Inspections

The Study recommended that:

- move-in inspections should occur for new tenants. Where possible, inspectors should perform this task in rural areas during their regular scheduled visits;
- home inspections and project and ground inspections should be conducted;
- move-out inspection should occur with the tenant before the unit is vacated; and
- move-in, move-out and annual inspections should be documented using the standard corporate forms.

To determine which units have been inspected, head office staff must request this information from each regional office.

Inspections not being carried out

Our review indicated that these requirements were not always complied with. Furthermore, we found that the Corporation does not maintain a comprehensive listing of completed inspections.

We reviewed 49 of 484 tenants who had been placed in units from 1 April 2007 to 19 November 2007. We found that in 4 instances there was no evidence that a move-in inspection had been conducted.

We reviewed 60 of 593 tenants who had vacated their rental units from 1 April 2007 to 19 November 2007. We found issues with 33 as follows:

- 25 had no evidence a move-out inspection was completed;
- 6 had the move-out inspection done after the tenant had vacated;
- 1 file was unable to be located by the Corporation; and
- 1 file was incomplete.

Corporation not complying with requirement

Tenant Damages

The Study recommended that only damages awarded by the Residential Tenancies Division (RTD) of the Department of Government Services should be applied to a rental account. This direction was also provided in the interoffice memo issued to all regional offices by a Senior Executive Director.

The Corporation was unable to provide a listing of tenant damages that had been applied to tenant accounts. Officials indicated that historically they were not subject to the *Residential Tenancies Act* and did not obtain an award of damages from the RTD when applying tenant damages to tenants' accounts. Although the Corporation became subject to the *Act* in 2000, officials indicated that the Corporation has continued to apply tenant damages to tenant accounts without these damages being awarded by the RTD. As a result, the Corporation is not complying with the new requirement.

Refurbishing Rebate Program not developed

Refurbishing Rebate Program

The Study recommended that a Refurbishing Rebate Incentive Initiative was to be piloted in Grand Falls-Windsor. The purpose of the initiative was to motivate tenants to maintain rental units in a good state of repair during tenancy and when vacating by providing a rebate in cases where the rental unit was well maintained.

At the time of our review, the policy for this initiative had neither been developed nor implemented.

Rental Arrears

The Study recommended the following requirements related to administration of rental arrears be implemented by 1 April 2007:

- rental collections were to be given priority;
- collection procedures should commence immediately after an account is 10 days in arrears;
- personal contact should be made and maintained on a persistent basis with the client to collect the full balance owing. All collection contacts should be documented in the Corporations rental management system;
- within 45 days of rental arrears, a formal written arrangement should be negotiated with the client to resolve the arrears and keep rental payments current;
- clients should be advised that if an arrangement cannot be reached in 45 days, or an internal arrangement is broken, the Corporation would issue a termination notice. An "Order of Eviction" should simultaneously be filed with the RTD. The Corporation should always seek to mediate to resolve arrears;
- when tenants provide a notice to terminate tenancy while in arrears, the Corporation should immediately file for a hearing at the RTD for an order for arrears;
- arrears accounts should not be sent to a collection agency until all reasonable internal efforts are made to collect or legally secure the rental arrears; and
- management should meet, at a minimum of once a month, with the HAO responsible, to review each and every account in arrears and discuss collection efforts.

Our review indicated that the Corporation did not always comply with the new requirements. This is evidenced from the following findings:

Collection efforts not applied to arrears as required

As of 5 November 2007, there were 1,911 tenants who owed the Corporation rental payments totalling $658,637. There were 79 tenants who had not made a rental payment in 45 days or longer. We reviewed 8 of these files with arrears totalling $4,337 and identified the following 21 issues:

- 6 had no evidence that collection efforts started when the account was 10 days in arrears;
- 4 had no evidence of personal contact being maintained throughout the collection process;
- 6 had no evidence of an agreement to pay on file; and
- 5 had no evidence that a notice of eviction was filed after 45 days.

We reviewed 6 of 60 accounts that had been sent for collection from 1 April 2007 to 6 October 2007 and identified the following 9 issues relating to 3 files:

- 3 had no evidence that collection efforts had started when the account was 10 days in arrears;
- 1 had no evidence of personal contact being maintained throughout the collection process;
- 2 had no evidence of an agreement to pay on file;
- 1 had no evidence that a notice of eviction was filed after 45 days;
- 1 had no evidence that a hearing with Residential Tenancies Division was filed for; and
- 1 did not have a hearing with Residential Tenancies Division immediately upon the tenant vacating the rental unit, instead it did not file a hearing until 60 days after the tenant vacated.

D. Rental Housing Policy and Program Monitoring (7 Recommendations)

Policy and procedures manual not updated

The Study recommended that:

- higher mileage rates should be available to HAOs required to travel where fleet vehicle is unavailable and the HAO accepts the conditions for the higher rate designation;
- for the Eastern regional office, small fuel efficient fleet cars should be made available to HAOs. These should be marked to indicate a corporate vehicle;
- continued vigilance and adherence to corporate transfer policy should occur. Transfers and their reasons should be available for review/reporting in any new rental management system;
- regions must strictly adhere to corporate policy and procedures, including approved forms;
- requests for policy and procedure changes/amendments should be routed through the Policy and Procedure Coordinator;
- teleconference calls between the Programs Division and regions should occur at least once a quarter. Minutes of these discussions should be retained; and
- at least once every two years, HAOs and their managers from all regions should meet to review policies, practices and relevant concerns regarding the delivery of the Rental Housing Program. The first HAO conference should be held in Gander in 2007 to coincide with the Annual Tenants Conference.

Our review indicated that not all requirements were always complied with as evidenced by the fact that:

- several policies are still in draft form e.g. tenant damages, inspections, lease renewals and the arrears policy;
- none of the new policies are included in the Corporation's policy and procedures manual; and

- file maintenance varies between staff and from region to region, i.e. some files contain letters stating they were approved for housing, some files have a note written on the file, and some files have nothing indicating they were approved.

Conclusions

The Corporation did not comply with all of the 32 recommendations by 1 April 2007. Recommendations which were not complied with covered such areas as: inspections prior to a tenant vacating, inaccurate waitlists, no certified tax returns obtained from new tenants, delayed collection efforts, no agreements to pay arrears, termination notices not always issued after 45 days of arrears, the need for improved contact with tenants and inconsistent applicant assessment among regions.

Recommendations

The Corporation should:

- continue with their efforts to address the recommendations from the Housing Administration Study;
- ensure that Corporation staff comply with the policies resulting from the recommendations; and
- ensure all information in the Rental Management System is accurate.

Corporation's Response

Recommendation:

NL Housing should develop a long-term housing accommodation plan.

Corporate Response:

- *NL Housing has recognized for some time, the issue of over housing in its portfolio, especially as it relates to three bedroom homes. This issue has arisen over time due to factors beyond NL Housing's control. Our housing stock was developed during a time when family size dictated the need for larger homes. Over the past two decades, the birth rate has declined rapidly and, with an aging population, many of our clients are living alone as their children have moved out to other accommodations.*

- *NL Housing is presently working on a Provincial Housing Strategy to be completed in the fall of 2008. This Strategy will look at all aspects of housing in the Province, with a view to identifying specific actions to be taken to address issues such as demographic changes and housing demand. In the interim, NL Housing is pursuing other avenues including seeking an increase in its rent supplement program and other initiatives which would give the flexibility to better meet the changing demographics of our clientele.*

- *Your report indicates that NL Housing has a number of vacant homes. It should be noted that in excess of 50 percent of these vacant homes were unavailable for rent for various reasons, such as no client demand and homes that require major repairs. The vacant homes which are available for occupancy, once they have been refurbished, are adequate in numbers to manage the needs of families who require three bedroom homes.*

  The challenge for housing is that 77 percent of clients on our wait list require one and two bedroom homes and as is pointed out in your report, these clients should not be placed in three bedroom homes because they would be overhoused.

Recommendation:

NL Housing should:

- *Continue with efforts to address recommendations from the Housing Administration Study.*
- *Ensure that NL Housing staff comply with the policies resulting from the recommendations.*
- *Ensure that all information in the Rental Management System is accurate.*

Corporate Response:

- *As indicated in your report, NL Housing initiated a comprehensive joint review of its Rental Housing Program between NL Housing and CUPE Local 1860. The report was completed in March 2006. All recommendations were to be implemented on April 1, 2007, with the exception of those tied to the new computer system. During the period after the report was released until implementation, all staff, in particular the HAO's, were continually consulted for input on results of the study in order to ensure validity of the study's findings.*

  In January 2007, a directive was sent to all staff indicating which recommendations were to be implemented by April 1, 2007. This was subsequently followed up by an In-House newsletter released in February 2007. During the months of June and July 2007, senior management met with regional office staff to follow up on the implementation of the study.

  During the September 2007 Tenant Conference held in Gander, there was a seminar held with all HAO's and regional office management to review the progress of implementation of the recommendations. This was also followed up in October 2007 with a memorandum from senior management to all regional offices.

  NL Housing is very diligently following up on the implementation of the study and will continue to monitor the progress. A number of recommendations cannot be implemented until the new computer system is activated on April 1, 2008, but we are pleased to report that the remaining 32 recommendations have been actioned.

You indicated in your report that as of November 5, 2007 there were 1,911 tenants that owed NL Housing rental payments totalling $658,637. This is factually true as of that date, however, it should be noted that many of our clients do not pay their rent on the first of the month. We review outstanding arrears as of month end and action at that time, as necessary. In the case of the November 2007 month end, rental arrears were $190,840 for 560 accounts.

- *NL Housing has worked diligently towards updating existing policy and drafting new policies as related to the recommendations arising from the HAO study. NL Housing will continue to monitor the Rental Housing Program to ensure compliance with all policies.*

- *NL Housing considers the issue of data integrity very important and has set up an internal senior management committee led by the Senior Executive Director to review and make recommendations to ensure that the data is accurate and reliable. NL Housing is in the process of implementing a new fully integrated computer system, which should also aid in providing more accurate and reliable data.*

Highlights

Highlights of a review of small business funding programs for the period 1 April 2005 to 31 March 2006 as well as other projects funded directly by the Department for the year ended 31 March 2006.

Why our Office did this Review

The objectives of our review were to determine whether the Department: adequately assessed and approved project applications; ensured payments were adequately supported and approved; and monitored approved projects.

What our Office Recommends

Following are the highlights of recommendations included in the report. The Department should ensure:

- funding is only provided to eligible businesses;
- applications for funding are supported with all required documentation;
- applications are approved in accordance with Department policy;
- adequate security is obtained prior to funds being disbursed;
- requests for funding payments are adequately supported, verified and approved;
- applicant's investments are supported and verified; and
- projects are appropriately monitored.

Furthermore, the Department should consider whether the *Financial Administration Act* permits the Department to make direct investments and ensure annual audited financial statements are received after funding has been provided.

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.14

DEPARTMENT OF INNOVATION, TRADE AND RURAL DEVELOPMENT

Small Business Funding Programs

The Department of Innovation, Trade and Rural Development (the Department) provides programs and services to assist small and medium-sized businesses. Funding programs are intended to support new growth opportunities in the economy such as value-added manufacturing and export activities. Until 2005-06, funding had been provided through the Small Business Seed Capital Equity (SEED) Fund and the Small Business and Market Development (SBMD) Program.

In 2005-06, the Province established a $10 million Small and Medium-sized Enterprise (SME) Fund that combined new funding of $7.9 million dollars with the previous $2.1 million in funding from the SEED Fund. The new fund is used to provide term loans of up to $250,000 and equity investments of up to $50,000 per year with a maximum of $100,000 in aggregate to small and medium-sized businesses. The funding targets specific growth sectors with particular emphasis on businesses that have export potential and need assistance to enter or expand into external markets. For the year ended 31 March 2007, 33 projects totalling $3.5 million were approved from the $10.0 million budget for the SME and 112 grants totalling $1.1 million were approved from the $1.0 million budget for the SBMD.

What We Found

Our review indicated that there were weaknesses in the Department's assessing, approving, disbursing and monitoring of loans and investments under the SME Fund and the SBMD Program. For example:

- we identified 2 instances where loans were provided to businesses which appeared to be non-financially viable;
- in 1 instance a loan was provided to a business which appeared to be in a financial position to access private sector financing;
- complete application information was not always obtained;
- funding was not always approved in accordance with Department policy;
- security was either not always obtained or not always registered;
- adequate documentation was not always provided to support expenses claimed;
- the required applicant investment was not always verified;
- companies provided with funding were not always adequately monitored; and
- companies which had not complied with conditions in previous Offers of Financing were provided additional funding.

We are of the opinion that there is no explicit authority under the *Financial Administration Act* for the Department to make direct investments in companies. During 2005-06, the Department made three such investments totalling $1.05 million to three companies. Furthermore, there are no documented due diligence procedures for approving, disbursing and monitoring such investments. We found inconsistencies between the requirements under the SME Fund and for the three investments. For example:

- none of the three companies were required to repay the investment contingent on either income earned or a maximum seven year period;
- one company was not required to submit documentation to support specific expenditures;
- shareholders for one company who received $500,000 were not required to make new equity investments as part of their contribution to the project; instead, previous investments were accepted;
- shareholders for one company who received $500,000 were not required to provide personal net worth statements; and
- Department officials were not entitled to attend any company meetings for one company even though the company was provided with funding totalling $500,000.

Background

Overview

The Department of Innovation, Trade and Rural Development (the Department) provides programs and services to assist small and medium-sized businesses. Funding programs are intended to support new growth opportunities in the economy such as value-added manufacturing and export activities. Until 2005-06, funding had been provided through the Small Business Seed Capital Equity (SEED) Fund and the Small Business and Market Development (SBMD) Program. Details are as follows:

- The SEED Fund had a $2.1 million budget prior to 2005-06 and was used to provide only equity investments of up to $50,000 on a matching basis with the applicant. The program was discontinued in 2005-06; however, funds were still paid out under this program for projects approved prior to the termination of the program.

- The SBMD Program had a $1 million budget in 2005-06 and was used to provide grant contributions of up to $25,000 on a matching basis to new entrepreneurs and expanding small businesses to help them pursue new business ideas and markets in new growth areas of the economy.

In 2005-06, the Province established a $10 million Small and Medium-sized Enterprise (SME) Fund that combined new funding of $7.9 million dollars with the previous $2.1 million in funding from the SEED Fund. The new fund is used to provide term loans of up to $250,000 and equity investments of up to $50,000 per year with a maximum of $100,000 in aggregate to small and medium-sized businesses. The funding targets specific growth sectors with particular emphasis on businesses that have export potential and need assistance to enter or expand into external markets.

Figure 1 provides a summary of funding program information for the last four fiscal years.

Figure 1

Department of Innovation, Trade and Rural Development
SME Fund and SBMD Program Information
Fiscal years ending 2003-04 to 2006-07

	2003-04	2004-05	2005-06	2006-07
SME Fund				
Program budget	$2,096,000	$2,678,900	$10,000,000	$0 (Note)
Projects approved	58	61	41	33
Funding approved	$2,269,695	$2,539,000	$ 3,537,082	$3,470,000
SBMD Program				
Program budget	$ 525,000	$ 500,000	$1,000,000	$1,000,000
Projects approved	54	64	76	112
Funding approved	$ 457,795	$ 455,280	$ 788,794	$1,080,000

Source: Department of Innovation, Trade and Rural Development's Annual Report
Note: The original budget for 2006-2007 was $8 million; however, this was amended as there were sufficient funds remaining from the previous 2005-2006 budget of $10 million.

Business Investment Corporation role

The program budgets for both the SME Fund and the SBMD Program are provided annually to the Business Investment Corporation (BIC). The mandate of the BIC is to manage the Department's investment portfolio and to administer new investments of the SME Fund and the SBMD Program.

For the year ended 31 March 2007, 33 projects totalling $3.5 million were approved from the $10.0 million budget for the SME Fund and 112 grants totalling $1.1 million were approved from the $1.0 million budget for the SBMD Program. At 31 March 2007, the BIC had undisbursed funds of $14.6 million (2006 - $13.3 million).

Program descriptions

Figure 2 provides an overview of the Department's funding programs for small business for the year ended 31 March 2007.

Figure 2

Department of Innovation, Trade and Rural Development
Funding Programs
Year Ended 31 March 2007

	SEED Program	SME Fund	SBMD Program
Description	Established in 2000 to provide equity investments to small and medium-sized businesses seeking expansion opportunities in areas of the economy that offer significant growth potential.	Established in 2005-06 to provide funding investments to small and medium-sized businesses. Eligible applicants include all types of business and sectors, except real estate services, retail services, wholesale operations, beverage rooms and taverns.	Provides new entrepreneurs and expanding small businesses with funding to assist them in acquiring the necessary expertise to pursue new business ideas and new markets for their products or services. Eligible applicants are small businesses with less than 50 employees and less than $5 million in annual sales, located and operating in Newfoundland and Labrador.
Equity Investments	Up to $50,000 on a matching basis	Up to $50,000 per year; with a maximum of $100,000 in aggregate per applicant and affiliated/associated companies, on a matching basis with "new" capital investment in the form of cash or equivalent equity.	No
Term Loans	No	Up to $250,000 per applicant and affiliated/associated companies with a minimum applicant investment of 20% of project costs after application date.	No
Grants	No	No	Up to $25,000 on a matching basis.
Restrictions	Funds cannot be used: - to retire existing applicants'/shareholders'/ investment; - for debt consolidation, refinancing or purchase of existing operations; or - to assist a business to gain market share from other local companies; and/or result in a local market becoming further fragmented.	Funds cannot be used: - to retire existing applicants'/ shareholders' investment; - for debt consolidation, refinancing or purchase of existing operations; or - to assist a business to gain market share from other local companies; and/or result in a local market becoming further fragmented.	Funds cannot be used to fund: - pre-commercial industrial research and development activity; or - generic business plans for new business start-ups or expansions unless extenuating circumstances exist.
2006-07 budget	Replaced by the SME Fund.	$10,000,000	$1,000,000

Source: Department program descriptions

Other Department investments

In addition to funds approved for the SME Fund and the SBMD Program, the Department also invested $1.09 million in three projects that exceeded the funding limits established for the SME Fund. These investments are identified in Figure 3.

Figure 3

Department of Innovation, Trade and Rural Development
Other Investments
31 March 2006/31 March 2007

Company	Investment
Knowledge-based IT Company A	$ 500,000
Knowledge-based IT Company B	500,000
High-technology R&D Company	90,000
Total	**$ 1,090,000**

Source: Government's financial management system

Audit Objectives and Scope

Audit objectives

The objectives of our review were to determine whether the Department:

- adequately assessed and approved project applications;
- ensured payments were adequately supported and approved; and
- monitored approved projects.

Audit scope

Our review was completed in November 2007. It included an examination of projects approved and funds disbursed under the SME Fund and the SBMD Program for the period 1 April 2005 to 31 March 2006, as well as other projects funded directly by the Department for the year ended 31 March 2006. Our review included an examination of policies and procedures, monitoring reports, committee minutes, interviews with staff, and a sample of project files.

Sample selected

Our sample included an examination of 25 loans under the SME Fund totalling $1,849,377 and 6 grants under the SBMD Program totalling $41,388 paid to 18 companies, as well as 3 investments totalling $1,050,000 paid by the Department to 3 companies.

Overall Conclusion

Our review indicated that there were weaknesses in the Department's assessing, approving, disbursing and monitoring of loans and investments under the SME Fund and the SBMD Program. For example:

- we identified 2 instances where loans were provided to businesses which appeared to be non-financially viable;
- in 1 instance a loan was provided to a business which appeared to be in a financial position to access private sector financing;
- complete application information was not always obtained;
- funding was not always approved in accordance with Department policy;
- security was either not always obtained or not always registered;
- adequate documentation was not always provided to support expenses claimed;
- the required applicant investment was not always verified;
- companies provided with funding were not always adequately monitored; and
- companies which had not complied with conditions in previous Offers of Financing were provided additional funding.

We are of the opinion that there is no explicit authority under the *Financial Administration Act* for the Department to make direct investments in companies. During 2005-06, the Department made three such investments totalling $1,050,000 to three companies. Furthermore, there are no documented due diligence procedures for approving, disbursing and monitoring such investments. We found inconsistencies between the requirements under the SME Fund and for the three investments. For example:

- none of the three companies were required to repay the investment contingent on either income earned or a maximum seven year period;
- one company was not required to submit documentation to support specific expenditures;
- shareholders for one company (Knowledge-based IT Company A) who received $500,000 were not required to make new equity investments as part of their contribution to the project; instead, previous investments were accepted;
- shareholders for one company (Knowledge-based IT Company B) who received $500,000 were not required to provide personal net worth statements; and
- Department officials were not entitled to attend any company meetings for one company (Knowledge-based IT Company B) even though the company was provided with funding totalling $500,000.

Detailed Observations

Findings

Findings from our review are outlined in the following sections:

1. Projects funded by the SME Fund and the SBMD Program
    - Assessment and Approval of Applications
    - Processing of Payments
    - Monitoring of Approved Projects

2. Other Investments by the Department

- Knowledge-based IT Company A
- Knowledge-based IT Company B
- High-technology R&D Company

1. Projects funded by the SME Fund and the SBMD Program

Findings

The detailed findings to support our conclusions are contained in the following sections:

A. Assessment and Approval of Applications;
B. Processing of Payments; and
C. Monitoring of Approved Projects.

1A. Assessment and Approval of Applications

Introduction

All types of business and sectors except for real estate services, retail, service and wholesale operations, and beverage rooms and taverns, are eligible to apply for funds from the SME Fund and SBMD Program. Funding may be used for the start-up, modernization or expansion of a business.

Application process

Applications for funding must be accompanied by:

- a business plan;
- supporting documentation of major purchases/constructions;
- market data;
- resumés of key personnel;
- short history of shareholders;
- personal net worth statements for all key shareholders;
- the current and previous 2 years' financial statements (new businesses would provide projected statements for 2 years); and
- a signed environmental contamination warranty form if the proposal includes the purchase or use of land or buildings.

Assessment and approval process

Department policy requires the application be assessed either at the regional level by an Economic Development Officer or at the Department level by a designated project officer. If eligible, a detailed project evaluation must be completed and a Presentation for Funding Report presented for approval to one of the Department's five Regional Directors, the Corporate Transaction Committee consisting of four Department employees and a representative of the Board of Directors of the BIC, the Board of Directors of the BIC or Cabinet, depending on the aggregate amount of funding requested in the current application and the outstanding balances from existing loans.

Furthermore, in cases where there is an existing facility or when the project involves purchase or construction of property, the Economic Development Officer must conduct a site visit.

Approval limits

The following table outlines the approval limits:

Approval By	Aggregate amount
Regional Director	Up to $100,000
Corporate Transaction Committee	$100,001 to $500,000
Board of Directors	$500,001 to $1,000,000
Cabinet	in excess of $1,000,000 annually

Once approved, an Offer of Financing is required to be prepared to detail the conditions under which the funding is provided to the applicant. Once signed by the applicant, the Offer of Financing acts as the contract between the Department and the applicant.

Detailed Findings

Our review of the assessment and approval of applications identified issues in the following areas:

- project eligibility;
- required application information;
- approval of funding; and
- adequacy of security.

Figure 4 shows a summary of the findings under each of these areas related to funding for the 18 companies in our sample.

Figure 4

Department of Innovation, Trade and Rural Development
Assessment and Approval of Applications
Summary of Findings

Companies	Funding	Eligibility	Application Information								Approval		Security	
			Business Plan	Site Visits	Credit Reports	Personal Net Worth	Financial Statements	Clearance of Debt	Contamination Warranties	Environmental Approvals	By Offer Deadline	Funding Limits	Security Documentation	Landlord's Waiver
1	$100,000			**N**			**N**	**N**	N/A	N/A	**N**		**N**	**N**/A
2	$50,000				**N**	**N**			N/A	N/A				N/A
3	$24,735 $20,000				**N**	**N**			**N**	N/A N/A				N/A N/A
4	$200,000 $50,000 $50,000							 **N**	N/A	N/A N/A N/A			**N**	N/A N/A N/A
5	$250,000			**N**						N/A				N/A
6	$55,000	**N**					**N**		N/A	N/A				N/A
7	$90,000		**N**					**N**	N/A	N/A				N/A
8	$200,000 $50,000			 **N**					 **N**	N/A N/A				N/A N/A
9	$32,000							**N**		N/A				N/A
10	$44,892			N/A	**N**				N/A	**N**	**N**		**N**	N/A
11	$75,000 $38,200		**N**		**N**	**N**	**N**	**N**	**N**	N/A N/A				N/A N/A
12	$82,500	**N**							N/A	N/A				N/A
13	$50,000 $50,000					**N**		 **N**		N/A N/A				N/A N/A
14	$30,000	**N**		**N**				**N**		N/A				**N**
15	$75,000									N/A				N/A
16	$74,550 $50,000								**N**	N/A N/A				N/A N/A
17	$87,500									N/A			**N**	N/A
18	$20,000			N/A					N/A	N/A				
Total issues 39		3	2	4	4	4	3	7	4	1	2	0	4	1
Total applicable population - 268		25	25	23	25	25	25	25	17	1	25	25	25	2

As Figure 4 shows, 39 issues (15%) were found in a population of 268 applicable items in the assessment and approval of applications process.

Ineligible projects approved for funding

Project Eligibility

Department public information and Department policy for the period of our review on the SME Fund states that eligible applicants "*must demonstrate potential for viability, sustainability and growth. The applicant must also demonstrate that it is unable to obtain sufficient funding under reasonable terms and conditions from conventional sources ...*". Based on our review and analysis of documentation on file, the Department provided loans to businesses which appeared not to be financially viable or which were in a financial position to access private sector financing, and as such, should not have been eligible for funding. Our review of 25 approved loan applications identified issues with 3 applications as follows:

- 1 company **(Company 6)** was approved for a $55,000 term loan and it was not required to provide documentation to indicate that private funding had been sought and declined. Information on file indicated that the company was profitable and had no significant debt, and therefore, should have been able to obtain financing from a private lending institution.

  As a result, the Department contravened its program guidelines and provided funding to a company that did not demonstrate that it was unable to obtain sufficient funding under reasonable terms and conditions from conventional sources.

- 1 company **(Company 14)** was approved for a $30,000 term loan. Our review identified that the Department provided previous funding to 2 related companies which had produced similar products and that the previous operations had been dissolved. Transactions with these 2 related companies are as follows:

  - In 2003 and 2004, $1.3 million in principal and interest was written off for one dissolved related company. As at 31 March 2006, this company owed $183,658 which had been outstanding since 1999.

- In 2003, $84,600 owed by the second dissolved related company was assumed by another company currently owned by the applicants. In addition, in 2003, this other company had been provided with a $31,600 equity investment.

In its application for funding for $30,000, the company provided incorrect shareholder information and did not indicate that shareholders for the 2 dissolved related companies were involved with the new venture. However, upon registration of security documents it was identified by the Department's legal advisors that 48% of the applicant company was owned by the previous clients of the Department. The son-in-law and daughter of the previous clients own the remaining 52%.

In addition, one of the contingent conditions of the loan was to provide externally prepared financial statements of a current related company that provides raw materials. These statements were not provided to the Department; therefore, the Department was not able to confirm the viability of the related company.

As a result, the Department contravened its program guidelines by providing funding to an applicant that had not provided all the required information and, in our opinion, had not demonstrated its financial viability, sustainability and growth potential.

- 1 company **(Company 12)** was approved a $100,000 term loan even though it had not demonstrated its potential for viability and sustainability as required by Department policy. Our review of documentation on file indicated that the company had been dependent on Federal and Provincial funding for the past 5 years, with little sales revenue. In addition, the company had an accumulated deficit of approximately $500,000 and outstanding payroll and remittances owing to its employees and the Federal government totalling $58,000.

  As a result, the Department contravened its program guidelines by providing funding to an applicant that, in our opinion, had not demonstrated its financial viability, sustainability and growth potential.

Inadequate assessment of applications

Required Application Information

The Department did not always obtain the necessary and required information from applicants to conduct a proper assessment of loan applications. Our review of 25 approved loan applications identified 29 issues with 15 applications as follows:

- 1 application **(Company 11)** was not supported with a current business plan;
- 1 application **(Company 7)** was not supported with any business plan;
- 4 applications **(Company 1, Company 5, Company 8, Company 14)** did not include documentation that any required site visits had been made by Department staff;
- 4 applications **(Company 2, Company 3, Company 10, Company 11)** were not supported with credit reports on the company or owners;
- 4 applications **(Company 2, Company 3, Company 11, Company 13)** did not include statements of personal net worth of all of the proponents;
- 3 applications **(Company 1, Company 6, Company 11)** did not have either the required 2 year projected financial statements, the actual financial statements for the previous 2 years or current year statements;
- 7 applications **(Company 1, Company 4, Company 7, Company 9, Company 11, Company 13, Company 14)** did not have the required clearance of debt notification from the Workplace Health and Safety Compensation Commission or the Canada Customs and Revenue Agency on file;
- 4 of 17 applicable applications **(Company 3, Company 8, Company 11, Company 16)** did not provide the required contamination warranty forms; and
- 1 applicable application **(Company 10)** did not have an environmental approval on file.

Inadequate approval of funding

Approval of Funding

The Department did not always approve funding in accordance with Departmental policy. In 2 of 25 companies **(Company 1, Company 10)** funding was provided although the Offers of Financing had expired and had not been extended in accordance with Department policy.

Inadequate security documents

Adequacy of Security

The Department did not always obtain adequate security or register security documents to ensure it had protected its loan or investment positions. In order to secure its loans and investments, the Department requires that security be put in place on all financing. Our review of 25 approved loan applications identified 5 issues as follows:

- 4 companies' **(Company 1, Company 4, Company 10, Company 17)** files did not have evidence that the required security documentation was in place. For example, the Department registered 1 company's General Security Agreement nine months after it was signed and only after our request to review the file; and the Department did not have documentation in 1 instance of the required assignment of insurance in case of loss.

- 1 company **(Company 14)** where the applicant uses leased premises, files did not have the required landlord's waiver of distraint and consent form that would allow the Department to access and carry on business if required.

1B. Processing of Payments

Detailed Findings

The Department did not always ensure that either the legitimacy and sufficiency of expenses claimed, or the applicant's investment as reported by the applicant, was adequately verified. Our review of the processing of payments to applicants identified issues in the following areas:

- sufficiency of applicant's expenses;
- verification of applicant's investment; and
- approval of payments.

Figure 5 shows a summary of the findings under each of these areas related to funding for the 18 companies in our sample.

Figure 5

Department of Innovation, Trade and Rural Development
Processing of Payments
Summary of Findings

Companies	Funding	Claimed Expenses			Applicant Investment			Payments properly approved
		Supplier Invoices	Sufficient Invoices	Eligible expenses	Applicant Investment Adequate	Assets appraised	Support for cash invested	
1	$100,000	**N**			**N**	N/A	**N**	
2	$50,000		**N**			N/A		
3	$24,735 $20,000				**N**	N/A **N**	**N** **N**	
4	$200,000 $50,000 $50,000		**N**			N/A N/A N/A	**N** **N**	**N**
5	$250,000		**N**			**N**		
6	$55,000	**N**			**N**	N/A	**N**	
7	$90,000				**N**	N/A	N/A	
8	$200,000 * $50,000	N/A	N/A	N/A	N/A	N/A N/A	N/A	N/A
9	$32,000	**N**	**N**			N/A	**N**	
10	$44,892					N/A	**N**	**N**
11	$75,000 $38,200	**N**		**N**	**N**	N/A N/A		
12	$82,500				**N**	N/A	N/A	
13	$50,000 $50,000	**N**		**N**		N/A N/A	N/A N/A	**N**
14	$30,000					**N**	N/A	
15	$75,000		**N**				N/A	
16	$74,550 $50,000	**N**				N/A N/A	**N** **N**	
17	$87,500					N/A	**N**	
18	$20,000			**N**	**N**	N/A	**N**	
Total issues - 39		**6**	**5**	**3**	**7**	**3**	**12**	**3**
Total applicable population - 142		**24**	**24**	**24**	**24**	**4**	**18**	**24**

* Funds not disbursed at time of review

As Figure 5 shows, 39 issues (27%) were found in a population of 142 applicable items in the processing of payments.

Insufficient support of applicant's expenses

Sufficiency of Applicant's Expenses

Our review of 25 approved loan and 6 approved grant applications identified 16 files containing 18 instances in where there was insufficient support for expenses claimed by the applicant as follows:

- 6 companies (9 instances) were identified where there was not adequate support, such as supplier invoices, for expenses claimed.
    - 4 companies **(Company 6, Company 11, Company 13, Company 16)** only supported their claims with copies of quotes totalling $271,557; and
    - 5 instances where 4 companies **(Company 1, Company 9, Company 11, Company 13 - 2 accounts)** supported their claims with vendor statements or client listings totalling $158,824 which did not identify specific items purchased.
- 5 companies **(Company 2, Company 4, Company 5, Company 9, Company 15)** did not provide sufficient invoices and other support to account for total project expenses. For example, $50,000 was paid in trust to one applicant's solicitor, to be released upon completion of security documents and verification of project expenses totalling $671,027. There was no support on file to indicate that the expenses had been verified prior to the release of funds.
- 3 companies were provided funding based on invoices submitted for expenses that were not eligible for funding as follows:
    - 2 companies **(Company 11, Company 13)** were funded based on invoices which included HST totalling $29,317 as part of the total project cost. HST is not an eligible expense since the applicant can receive reimbursement from the Federal Government in the form of an input tax credit.

1 of these 2 companies **(Company 13)** was also provided funding for financing service charges totalling $2,965 that is not an eligible expense.

- 1 company **(Company 18)** was provided funding for insurance costs totalling $6,000 that was not an eligible expense for the grant. It was only after the payment was made that additional invoices were provided to support the $6,000.

Insufficient verification of applicant's investment

Verification of Applicant's Investment

Our review of 25 approved loan and 6 approved grant applications identified 22 issues in 19 files where the applicant's required investment was either not adequately verified or supported as follows:

- 7 companies were not required to have the applicant contribute the amounts required under Department guidelines as follows:

  - 3 companies **(Company 7, Company 11, Company 12)** were either not required to invest any new monies into the project, or the amount of their required investment was significantly reduced because the Department determined that the company had invested sufficient funds prior to the application. Department policy requires the applicant to invest a certain amount towards the total cost of each new project regardless of past investment in the company. As such, these 3 applications were not in compliance with Department policy.

  - 2 companies invested less than the required 20% of total project costs for term loans. One applicant **(Company 6)** invested only 19% while the other **(Company 1)** invested only 17%.

- 2 companies **(Company 3, Company 18)** were not required to invest the matching cost for grants totalling $11,490. The applications for the grants were part of a term loan application. The clients were only required by the Department to invest 20% of the project cost (the required amount for term loans), rather than requiring the applicants to also invest the additional $11,490 matching portion. According to Department policy, the loan and grant applications should have been considered separately.

- 3 companies **(Company 3, Company 5, Company 14.)** did not have the required appraisal completed on equipment/assets transferred from the owners as part of the shareholders' investment. Transfers of assets included a building valued at $20,000, equipment valued at $222,297 and equipment valued at $16,000 respectively. Without an appraisal of transferred assets, the Department was not able to determine if the applicant's investment was sufficient to meet the requirements of the funding agreement.

- 12 instances where 9 companies were not required to provide adequate support for the applicant's investment as follows:

  - 10 instances where 9 companies **(Company 1, Company 2, Company 4 - 2 accounts, Company 6, Company 9, Company 10, Company 16, Company 17, Company 18)** were not required to provide either the required confirmation by an accountant or lawyer or paid receipts to support cash invested by the applicant. As a result, the Department was not able to determine if the applicant's cash investment was sufficient to meet the requirements of the funding agreement.

- 2 companies **(Company 16, Company 17)** did not provide adequate support for the applicant's investment into the project. For example, 1 company's investment **(Company 16)** included $14,802 paid by the company towards its building and equipment rather than any funds paid directly by the applicant into the company. The other company's investment **(Company 17)** for $10,000 was supported by a company cheque provided to an external vendor for licenses. Support of this nature only verified the use of newly invested funds (or existing funds) and not the source of these funds. As a result, the Department was not able to determine if the applicant's investment was sufficient to meet the requirements of the funding agreement.

Approval of payments not consistent with policy

Approval of Payments

Our review of 25 approved loan and 6 approved grant applications identified 3 issues with approval of payments as follows:

- 1 company **(Company 10)** was provided with a loan of $44,892 even though the cheque requisition had not been approved by the Regional Director as required by Department policy.

- 1 loan advance for $18,757 was issued in the name of the company owner instead of in the name of the company **(Company 13)**.

- 1 grant payment for $7,500 was issued in the name of the company owner instead of in the name of the company **(Company 4)**.

1C. Monitoring of Approved Projects

Introduction

In order for the Department to ensure the approved project and funding meet its intended purpose, the Department must monitor each client account to determine whether:

- the project was completed in accordance with the proposal;
- the shareholder's investment remained in the company until the loan or investment had been repaid or redeemed;
- funds were not used to retire the existing applicant's investment;
- the company continued to be financially viable;
- its security position had not been subordinated; and
- loans and investments were adequately collected.

The Department's monitoring processes include the:

- maintenance of a client monitoring system;
- maintenance of a loans administration system;
- contact with clients through site visit or telephone; and
- requirement that financial statements reviewed by a professional accountant be submitted within 90 days of the applicant's fiscal year end.

Detailed findings

Our review of the Department's monitoring of approved projects identified issues in the following areas:

- required financial statements;
- additional debt; and
- repayment of loans and investments.

Figure 6 shows a summary of the findings under each of these areas related to funding for the 18 companies in our sample.

Figure 6

Department of Innovation, Trade and Rural Development
Monitoring of Approved Projects
Summary of Findings

Companies	Funding	Financial Statements	Additional debt approved	Adequate Repayment Terms
1	$100,000	**N**	N/A	
2	$50,000		N/A	
3	$24,735 $20,000		N/A **N**	**N**
4	$200,000 $50,000 $50,000		N/A N/A N/A	
5	$250,000		N/A	
6	$55,000		N/A	
7	$90,000		N/A	
8	$200,000* $50,000	N/A N/A	N/A N/A	N/A
9	$32,000	**N**	**N**	**N**
10	$44,892		N/A	
11	$75,000 $38,200	**N**	N/A N/A	
12	$82,500	**N**	N/A	**N**
13	$50,000 $50,000	**N** **N**	N/A N/A	
14	$30,000	**N**	N/A	
15	$75,000		N/A	
16	$74,550 $50,000		N/A **N**	
17	$87,500	**N**	N/A	
18	$20,000		N/A	
Total issues - 14		**8**	**3**	**3**
Total applicable population - 50		**23**	**3**	**24**

* Funds not disbursed at time of review

As Figure 6 shows, 14 issues (28%) were found in a population of 50 applicable items in the monitoring of approved projects.

Required financial statements not submitted

Required Financial Statements

The Department was not able to adequately monitor the financial position and operating results of companies that have been provided with financing since financial statements were either not always being provided or were not provided on a timely basis. Our review of 25 approved loan applications identified 9 issues with 7 companies as follows:

- 5 companies **(Company 1, Company 12, Company 13, Company 14, Company 17)** had not submitted the required externally reviewed financial statements.

- 2 of the 5 companies **(Company 12, Company 13)** and 2 other companies **(Company 9, Company 11)** received additional funding totalling $239,500 even though financial statements had not been received for previous funding.

Additional debt without approval

Additional Debt

The Offer of Financing requires the prior written consent of the Department before the applicant can incur any additional debt. Our review of the 25 approved loan applications identified issues with 3 companies as follows:

- 3 companies **(Company 3, Company 9, Company 16)** were provided funding even though they incurred additional debt without first obtaining the required approval from the Department. Furthermore, each of these companies was also provided with term loans since incurring this additional undisclosed debt. As a result, the Department provided subsequent loans and grants to companies which had not complied with conditions stipulated in previous Offers of Financing. Figure 7 shows these companies and the amounts.

Figure 7

Department of Innovation, Trade and Rural Development
Companies Incurring Additional Debt

Company	Initial Provincial Loan		External Debt		Subsequent provincial Loan	
	Date	Amount	Date	Amount	Date	Amount
3	Jan. 2003	$20,000	May 2005 May 2004	$ 11,025 6,716	Oct. 2005	$24,735
16	Aug. 2003	50,000	Dec. 2003	23,788	Sept. 2005	74,550
9	July 2004	50,000	June 2005 Aug. 2005	102,338 56,692	Dec. 2005	32,000

Inadequate repayment terms

Repayment of Loans and Investments

The Department did not always ensure that the repayment of loans and equity investments was in accordance with Department policy and that all requirements were documented. The Department requests the applicant to repay loans through pre-authorized payments over an established repayment period depending upon the type of funding (e.g. working capital, equipment). Of the 25 loan applications examined, we identified 5 issues with 3 companies as follows:

- 2 companies **(Company 9, Company 12**) were provided with repayment periods of 5 years instead of the maximum 3 years for working capital funding; and

- 1 of the 2 companies **(Company 9 - 2 accounts)** and 1 other company **(Company 3)** were provided funds without having the repayment due date recorded on the cheque requisition or Offer of Financing as required by Department policy. Without the due date, the Department may have difficulty enforcing repayment terms.

Summary of Findings

An overall summary of all findings related to funding for the 18 companies in our sample is provided at the end of this report item. The summary provides findings relating to:

- project eligibility;
- required application information;
- approval of funding;
- adequacy of security;

- sufficiency of applicant's expenses;
- verification of applicant's investment;
- approval of payments;
- required financial statements;
- additional debt; and
- repayment of loans and investments.

Conclusions

As a result of our review, we have concluded that the Department:

- provided loans to businesses which appeared not to be financially viable or were in a financial position to access private sector financing, and as such, should not have been eligible for funding;

- did not always obtain the required information to support the application for funding. Documentation such as current business plans, required financial statements, credit reports, personal net worth statements, clearance reports, environmental forms and evidence of site visits was not always on file;

- did not always approve funding in accordance with Department policy. Extensions of Offer of Financing were not always approved before funding was provided;

- did not always obtain adequate security or register security documents to ensure it has protected its loan or investment positions;

- did not always ensure the legitimacy and sufficiency of expenses claimed;

- did not always adequately verify the applicant's investment in the approved project by ensuring new funds were actually invested in the company by the applicant or transferred assets into the company were adequately appraised; and

- did not always adequately monitor the financial position and operating results of companies which had been provided funding because financial statements were either not being provided or were not provided to the Department on a timely basis. In addition, the Department provided subsequent loans and grants to companies which had not complied with conditions stipulated in previous Offers of Financing.

Recommendations

The Department should ensure:

- funding is only provided to eligible businesses;
- applications for funding are supported with all required documentation;
- applications are approved in accordance with Department policy;
- adequate security is obtained prior to funds being disbursed;
- requests for funding payments are adequately supported, verified and approved;
- applicant's investments are supported and verified; and
- projects are appropriately monitored.

2. Other Investments by the Department

Overview

During 2005-06, the Department directly invested a total of $1,050,000 in three companies. The funding was used for investments in situations where the type and/or amount of funding to be approved were not within the guidelines for the SME Fund and the SBMD Program.

In order to provide the necessary funds for these investments, $1 million was transferred (pursuant to the *Supply Act*) from one of the Department of Finance's financial assistance activities to the Department of Innovation, Trade and Rural Development's Strategic Enterprise Development Fund (SEDF) - Loans, Advances and Investments activity. In addition, $100,000 was transferred from one of the Department of Innovation, Trade and Rural Development's grant activities into the SEDF activity.

The investments in the three companies are outlined as follows:

Company	Investment
Knowledge-based IT Company A	$ 500,000
Knowledge-based IT Company B	500,000
High-technology R&D Company	50,000
Total	**$ 1,050,000**

Source: Government's financial management system

Findings

The Department does not have any documented procedures for reviewing, assessing, approving and disbursing loans other than the procedures established for the SME Fund. As a result, we compared the procedures followed for the three loans totaling $1,050,000 to those established for the SME Fund. Our findings for each of the three companies are outlined in the following sections.

2A. Knowledge-based IT Company A

Introduction

In October 2005, Cabinet directed the Department to invest $500,000 in Knowledge-based IT Company A and also directed the Department of Finance (pursuant to the *Supply Act*) to transfer $500,000 from its financial assistance activity (Grants) to the Department of Innovation, Trade and Rural Development's SEDF activity (Loans, Advances and Investments) to cover the expenditure.

As a result of this directive, the Department purchased 5,000 non-voting, Class B preference shares in the company at a cost of $500,000. The investment was part of a $1.1 million project to develop, produce and market household energy monitors that would allow consumers to view energy consumption from display units within their homes.

Detailed findings

Our review of the investment in the Company identified the following issues:

- We are of the opinion that there was no explicit authority under the *Financial Administration Act* for the Department to invest $500,000 in shares of the company. Therefore, there was no clear legislative authority to make this investment.

- Our review of the applicant's business plan and the financial statements for the year ended 31 March 2006 identified that the company's financial projections were not met, and reported actual results were well below the projected amount.

  For example, the company's updated business plan in June 2005 stated that by the Fall of 2005, the company was expecting an order of 20,000 to 40,000 units with expected revenues of $2.9 million for the 2006 fiscal year. Our review of the company's financial statements identified that revenues for the fiscal year 2006 were only $251,000, down from revenues of $386,000 in 2005.

- The Department does not have a policy dealing with application, approval and monitoring of this sort of investment. Therefore, we looked at the requirements under the SME Fund and identified the following inconsistencies:

  - Contrary to the Department's policy on applicant investment under the SME Fund which provides that only funds made after the application date specified in the acknowledgment letter are eligible to meet the required applicant investment, the Department allowed investments of $144,939 which were made by the shareholders before the proposal date. This amount was reflected in the "Due to shareholders" on the company's financial statements as of 31 March 2005, i.e. before the $500,000 was requested in October 2005.

  - Furthermore, the applicant was required to invest $112,735 as part of the $1.1 million application (10% of projects costs). However, although the shareholders investment was $144,939, $50,000 of this was provided to match a contribution made by the Department in 2004. Therefore, the shareholders provided only $94,939 of the required $112,735 investment.

- Although the Offer of Financing dated 21 October 2005 required that 100% of legal fees would be paid by the applicant, the Department, in a letter dated June 2006, required the applicant to pay only 50% of the legal fees incurred relating to some changes in the initial Offer of Financing.

- The company contravened the Shareholders' Agreement it had with the Department which required the prior written consent of the Department before the company could offer additional common shares. On 17 February 2006, the company issued shares which were not approved by the Department until 8 May 2006.

- The company contravened the Offer of Financing, Shareholders' Subordination Agreement and Unanimous Shareholders Agreement it had with the Department which subordinated any amounts owing to shareholders to the Department's investment. The company's financial statements for the year ended 31 March 2006 indicated that shareholders had been repaid $118,007 in shareholder loans without the Department's approval.

In June 2006 the Department required the shareholders to either reinvest the $118,007 or repay the Department the $118,007. However, the Department subsequently decided to accept an issuance of $2 million in common shares to 18 investors as sufficient funds to deal with the non-compliance.

- The Department requires the submission of financial statements, reviewed by a professional accountant, 90 days after the company's fiscal year end. However, given the level of financing for this investment, audited financial statements would provide more assurance.

2B. Knowledge-based IT Company B

Introduction

In June 2005, Cabinet directed the Department to invest $500,000 in Knowledge-based IT Company B and also directed the Department of Finance (pursuant to the *Supply Act*) to transfer $500,000 from its financial assistance activity (Grants) to the Department of Innovation, Trade and Rural Development's SEDF activity (Loans, Advances and Investments) to cover the expenditure.

As a result of this directive, the Department subsequently purchased 562,182 non-voting, Class B common shares in the company at a cost of $500,000. The investment was part of a $3.35 million project to assist in the development and commercialization of the company's wireless e-mail solutions system.

Detailed findings

Our review of the investment in the Company identified the following issues:

- We are of the opinion that there was no explicit authority under the *Financial Administration Act* for the Department to invest $500,000 in shares of the company. Therefore, there was no clear legislative authority to make this investment.

- There was no documentation on file to indicate that the Offer of Financing which expired on 23 September 2005 had been extended to 30 September 2005 i.e. the date the $500,000 was paid.

- The company contravened the Subordination Agreement it had with the Department which subordinated any amounts owing to shareholders to the Department's investment. Prior to the release of the $500,000 by the Department, two additional investors invested an additional $2.5 million in the company without a Subordination Agreement. Furthermore, one of the investments for $2 million did not receive the required Department approval prior to the shares being issued.

- The Department does not have a policy dealing with application, approval and monitoring of this sort of investment. Therefore, we looked at the requirements under the SME Fund and identified the following inconsistencies:

    - Unlike the SME Fund which requires that the repayment of Government's investment be contingent on either income earned or a maximum seven year period, in this case, Government's $500,000 investment would be fully repayable when the company raised a minimum of $5 million in excess of the $3.35 million project. As a result, the company's future earnings growth will not have any bearing on the repayment of the investment.

    - Unlike the SME Fund which requires a company to demonstrate its financial viability, sustainability and growth potential, the Department provided a $500,000 investment in a company which had poor financial results. Information on file indicated that the project was a high risk financially and that there were no tangible assets available for security. The company's 31 December 2005 financial statements indicated a net loss of $2.8 million for 2005 (a net loss $1.7 million for 2004).

    - Unlike the SME Fund which requires a Unanimous Shareholders Agreement before the Department will provide an investment, the Department did not require such an agreement.

    - Unlike the SME Fund which requires personal net worth statements on shareholders and company credit checks, the Department required neither.

    - Unlike the SME Fund which requires a professional opinion on the technical aspects of a company's business plan, the Department did not require such an opinion.

- Unlike the requirements of the SME Fund and the Department's arrangement with Knowledge-based IT Company A, the Department was not "entitled" to attend any of the company's meetings.

2C. High-technology R&D Company

Introduction

In March 2005, the Department approved a $100,000 investment in High-technology R&D Company. In order to facilitate this expenditure, Treasury Board approved the transfer of $100,000 from countervailing savings in another grant activity within the Department to the SEDF activity.

In September 2005, the Department purchased 10,000 non-voting, non-interest bearing Class B common shares in the company at a cost of $50,000. In November 2006, the Department purchased another 4,000 common shares for $40,000. The remaining $10,000 investment was to be made when the project was completed.

The $100,000 approved investment was part of a $1.45 million project to assist the company in developing a natural gas transportation containment system.

Detailed findings

Our review of the investment in the Company identified the following issues:

- We are of the opinion that there was no explicit authority under the *Financial Administration Act* for the Department to invest $100,000 in shares of the company. Therefore, there was no clear legislative authority to make this investment.

- There was no evidence on file to show that all concerns identified by another funding agency were dealt with by the Department prior to the project being approved in March 2005. Two assessment reports commissioned by that agency in November 2004 identified concerns with the development of the containment systems, misleading technical information, patent concerns, understated costs of the project, and optimistic time lines for development and commercialization.

- The Department does not have a policy dealing with application, approval and monitoring of this sort of investment. Therefore, we looked at the requirements under the SME Fund and identified the following inconsistencies:

  - Unlike the SME Fund which requires confirmation on the clearance of debt, the Department did not require confirmation on the clearance of debt from the Department of Finance, the Workplace Health, Safety and Compensation Commission or the Canada Customs and Revenue Agency.

  - Unlike the SME Fund which requires personal net worth statements on shareholders and company credit checks, the Department required neither.

  - Unlike the SME Fund which requires a contamination warranty form, the Department did not complete a contamination warranty form.

  - Unlike the SME Fund which requires that the repayment of Government's investment be contingent on either income earned or a maximum seven year period, in this case, the repayment of the approved $100,000 is to commence six months after the month in which "Project Success" occurs i.e. *"...when the technology [is] developed, Fiber Reinforced Plastic Pressure Vessels are ready for commercial application or any other event the Department... deems to be sufficient evidence of successful technical development."* Repayment is then to be made in 10 equal quarterly installments.

  - Unlike the SME Fund which requires the submission of supporting documentation for expenditures, the company was not required to submit documentation to support expenditures related to the $50,000 investment.

  - Unlike the SME Fund which requires a Unanimous Shareholders Agreement and a Shareholders' Subordinate Agreement before the Department will provide an investment, the Department did not require such agreements.

- The Department required the shareholders of the company to invest $58,000 in the project; however, this investment was not verified by the Department.

- Although the Offer of Financing required the submission of audited financial statements, as of November 2006 the company had not provided any type of financial statements to the Department even though the funds were provided in September 2005 i.e. prior to the company's year end of 30 September.

Conclusions

We are of the opinion that there is no explicit authority under the *Financial Administration Act* for the Department to make direct investments in companies. During 2005-06, the Department made three such investments totalling $1,050,000 to three companies. Furthermore, there are no documented procedures for approving, disbursing and monitoring such unique investments and, as a result, these investments were not subject to the same due diligence required for investments under the SME Fund. As a result, there were deficiencies. For example:

- none of the three companies were required to repay the investment contingent on either income earned or a maximum seven year period;

- one company was not required to submit documentation to support specific expenditures;

- shareholders for one company (Knowledge-based IT Company A) who received $500,000 were not required to make new equity investments as part of their contribution to the project; instead, previous investments were accepted;

- shareholders for one company (Knowledge-based IT Company B) who received $500,000 were not required to provide personal net worth statements; and

- Department officials were not entitled to attend any company meetings for one company (Knowledge-based IT Company B) even though the company was provided with funding totalling $500,000.

Recommendations

The Department should:

- consider whether the *Financial Administration Act* permits the Department to make direct investments;
- ensure applicants' investments are supported and verified;
- ensure adequate security is maintained to support funds being disbursed;
- ensure documentation is submitted by companies to support expenditures made; and
- ensure annual audited financial statements are received after funding has been provided.

Department's Response

The Department appreciates the constructive recommendations which are outlined in the report. However, we do not concur with some of the findings based on your office's interpretation of certain sections of our policy and procedures manual, comments made as it relates to acceptable level of risk and your contention that the Department did not have authority under the Financial Administration Act to make direct investments in companies.

The Department's mandate is to foster and promote economic development. The objective of the SME Fund (Fund) is to support the growth of small-to-medium sized businesses, in strategic growth sectors where competitive impact is not a concern and where it is determined that business financing needs cannot be met from other sources, or met under reasonable terms and conditions.

When the SME Revolving Fund was established in 2005, a comprehensive manual of policies and procedures was developed and approved by the Board of Directors of the Business Investment Corporation, which oversees the Fund. A training module and sessions were developed and implemented with ongoing training as identified. This manual sets basic policy pertaining to the processing of applications, evaluation, funding decisions, security, account management, reporting and accountability.

The manual remains a fluid document and a standing cross departmental committee reviews the manual on an on-going basis; taking into consideration feedback from staff balanced with analyses of portfolio performance and client service needs. The Board has the authority to override and/or alter these policies and procedures to achieve the overall mandate and objectives of the program. Since the manual was first approved, several amendments have since been approved by the Board mainly to provide staff with greater flexibility in certain circumstances based on the merits of the business proposal. Additional training has been undertaken as well.

Given the Department's mandate, we often lend to clients at the higher end of the risk spectrum. As part of our evaluation, we consider the future earnings potential of a business and not just the historical performance or the assessment of the financial statements at a point in time. We consider the ability of the businesses to achieve viability/sustainability based on future market potential for its product or service. While we ensure sufficient security to protect the Department's investments, this is balanced to the opportunity for employment growth and wealth generation. Along with security, we also consider access to an identified market, technical feasibility of the operation, the caliber of the management team and the ability to demonstrate the long term viability of the operation. In all cases, approvals are made based on full knowledge of the potential risk, available security, development objectives and the appropriate decision making process was followed.

We concur that in some cases all the documentation outlined in the manual was not obtained in a timely manner and placed on file. In situations where there are deficiencies, in future we will ensure that the documentation is on file where necessary and practical. ***However, in none of these cases was the lack of documentation sufficient to alter the decision that was rendered or place the Department's investment at risk.***

There are a number of instances, however, where the Department does not concur or has concerns with the findings, some of which are based on your office's interpretation of our policy and procedures. These include:

Written confirmation that funding is not available from other sources *- while we indicated "where the business financing needs cannot be met from other sources under reasonable terms and conditions", the policy does not require the client to provide written confirmation that funding is not available from other sources. It must be noted that "reasonable terms and conditions" is subjective and based on the circumstances in question, including our review of the financial position of the company, the geographic location, industry sector and eligibility/desirability of the*

initiative. We have positioned ourselves as a complimentary developmental lender rather than a "lender of last resort".

Externally prepared financial statements *in most cases, it is not practical or reasonable to have externally prepared financial statements for new start ups or operations less than one year old.*

Site visits *- in today's environment, many of the companies are sub-contracting work or we are dealing with technology based companies where there is no traditional "brick and mortar lending". In many cases, a site visit is not a critical step in the assessment process and thus is not explicitly required; only that it is to be noted if one is completed. Our CIS system provides tracking records which provides information on site visits.*

Business plans *while in a couple of cases the Department did not have a formal business plan, the Department did have all the information deemed necessary to make an informed decision.*

Law firm "In Trust" *- in the interest of timely client service, we often send funds to our law firm "In Trust" as do many financial institutions. However, before any funds are disbursed to the client, legal counsel and ourselves ensure all contingent and other conditions have been satisfied and the required security is in place. A final letter to such effect is received from the law firm.*

Résumés *- while résumés are sometimes not attached, the information on the shareholders and key management staff are included in the main text of the submitted business plan and are noted, as necessary, in presentations for funding decisions.*

Security not registered *it was noted in 4 approvals that security was registered incorrectly by our law firms in the name of the Department rather than BIC. They have since rectified the matter and provided written confirmation that at no time was our security or our priority, in event of default, at risk.*

Working capital *- in these situations it is not always practical or possible to have the paid invoices submitted at the front end. Often the business will require the funding to finance the purchases and it is sometimes difficult to ensure the receipts are provided in a timely manner.*

Required financial statements not submitted *- the Department has taken a number of steps to ensure that the requirement for clients to provide financial statements is satisfied. On all repayable investments, prior to the disbursement of funds, we require the client to sign and return a form authorizing and directing the company's Accountant to provide annual Review Engagement Financial Statements. Also, we consistently use our Client Information System (CIS) to track compliance of the terms and conditions of the Letter of Offer. While there are investments where the required financial statements have not been received, the CIS clearly documents our efforts towards achieving compliance. Given our mandate, it would not be prudent or practical to automatically commence recovery/legal action against a client for not submitting financial statements.*

Matching cost for BMDP *clients often borrow the funds to meet their matching share under BMD and the latitude exists to match such other funding sources, such as commercial banks, the federal government or provincial government through the SME Fund.*

Maximum repayment term for working capital *- While the policy indicates a maximum repayment term of three years, the Authorizing Committee has the authority to amend this requirement. In the two cases referenced, our assessment of the business plan and the projected cash flows demonstrated the need for the additional two years.*

HST *- A reference was made that HST was not an eligible expense. The SME policy does not make any reference to HST. From a practical stand point when it comes to working capital, the payment of HST could be considered a reasonable disbursement as it has to be paid up front. However, when our funding is in the form of a non-repayable contribution such as BMDP, it would normally be excluded as the business is eventually reimbursed by the Federal Government.*

Clearance letters *- clearance of debt notification from Workplace Health and Safety Compensation Commission (WHSCC) or the Canada Revenue Agency (CRA) is not required, however, the status of the account is required and in a number of situations where there may not have been a clearance letter, there were acceptable arrangements in place to address the debt or the amount outstanding was paid from the investment proceeds.*

Additional debt without approval *this is a reflection of the client disclosure. In all three cases outside borrowings became evident when additional borrowings were sought. As first charge lenders, options with respect to calling the loan were not believed to be an effective course of action.*

Incorrect shareholder information *- in some cases, clients will inadvertently or, in rare cases, intentionally provide incorrect information. The fact that legal counsel verified ownership before disbursement is confirmation that the necessary checks and balances were in place.*

With respect to other investments outside our normal programs, we do not concur with your interpretation that there is no explicit authority under the Financial Administration Act for the Department to make direct investments in companies. We understand that there is a separate section in the Report on the Financial Administration Act to which the Department of Finance has responded.

Government, as has always been the case, receives proposals from companies seeking financial assistance of various types and levels that do not fit our normal business programs. Government reviews each case based on its own merit, including full due diligence, and, when considered appropriate, has provided assistance to some of these companies. The process that is followed in these cases is the Cabinet process. Economic development and business growth, especially new growth sectors, are priorities. Access to capital is an important issue for these SMEs in this Province. These investments levered additional funding for these companies and involved young entrepreneurs, leading edge technology, the potential to increase export sales and to increase quality employment opportunities in new growth sectors for our post-secondary graduates.

As noted, these investments were approved, with the required analysis and due diligence outside the SME program and therefore were not subject to the same requirements for auditing purposes. At the time of the approval, the Department did not have a program to support commercial research and development, and/or invest in businesses at the pre-commercial stage of operation. Since then, the Department has established a Commercialization Program that accommodates projects of this nature.

Company	Funding	Eligibility	Application information							Approval		Security		Expenses			Investment			Payment approval	Monitoring		
			Business Plan	Site Visits	Credit Reports	Personal Net Worth	Financial Statements	Clearance of Debt	Contamination Warranties	Environmental Approvals	By Offer Deadline	Funding Limits	Security Documentation	Landlord's Waiver	Supplier Invoices	Sufficient Invoices	Eligible expenses	Applicant Investment Adequate	Assets appraised	Support for cash invested		Financial statements	Additional Debt	Adequate Repayment
1	$100,000			N			N	N	N/A	N/A	N		N	N/A	N			N	N/A	N		N	N/A	
2	$50,000				N	N			N/A	N/A				N/A		N			N/A				N/A	
3	$24,735				N	N			N	N/A				N/A				N	N	N			N	N
	$20,000									N/A				N/A				N	N	N			N	
4	$200,000								N/A	N/A			N	N/A					N/A	N	N		N/A	
	$50,000							N		N/A				N/A		N			N/A	N			N/A	
	$50,000									N/A				N/A					N/A				N/A	
5	$250,000			N						N/A				N/A		N		N	N/A				N/A	
6	$55,000	N					N		N/A	N/A				N/A	N			N	N/A	N			N/A	
7	$90,000		N					N	N/A	N/A				N/A				N	N/A	N			N/A	
8	$200,000								N/A	N/A				N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	$50,000			N					N	N/A				N/A				N/A	N/A	N			N/A	
9	$32,000							N		N/A			N	N/A	N	N		N	N/A	N		N	N	N
10	$44,892			N/A	N				N/A	N/A	N		N	N/A				N	N/A	N	N		N/A	
11	$75,000		N		N	N	N	N	N	N/A			N	N/A	N		N	N	N/A		N	N	N/A	N/A
	$38,200				N	N	N	N	N	N/A				N/A		N			N/A			N	N/A	
12	$82,500	N							N/A	N/A				N/A				N	N/A	N	N	N	N/A	N
13	$50,000					N		N		N/A				N/A	N		N		N/A	N	N	N	N/A	
	$50,000							N		N/A				N/A					N/A		N	N	N/A	
14	$30,000	N		N				N		N/A				N					N		N	N	N/A	
15	$75,000							N		N/A				N/A		N			N/A				N/A	
16	$74,550						N		N	N/A				N/A	N				N/A	N		N	N/A	
	$50,000									N/A				N/A					N/A				N/A	
17	$87,500									N/A			N	N/A				N	N/A	N	N	N	N/A	
18	$20,000			N/A					N/A	N/A				N/A			N	N	N/A	N			N/A	
Total issues - 92 (20%)		3	2	4	4	4	3	7	4	1	2	0	4	1	6	5	3	7	3	12	3	8	3	3
Total applicable population - 460		25	25	23	25	25	25	25	17	1	25	25	25	2	24	24	24	24	4	18	24	23	3	24

Office of the Auditor General
Newfoundland and Labrador

Highlights

Highlights of a review of the Adult Custody Program in the Department of Justice covering the period 1 April 2005 to 31 March 2007.

Why our Office did this Review

The objectives of our review were to assess whether the Department's management practices and controls were adequate in the following areas of adult custody services: planning and reporting; human resource management; purchasing and tendering; inventory and capital assets; information management and technology; and legislation.

What our Office Recommends

Following are highlights of recommendations included in the Report that the Department should address:

- develop long-term goals and objectives, and operational plans relating to the provision of adult custody services;
- monitor and control and report quarterly information on all areas of operations including callback, overtime and sick leave;
- develop a procedures manual for the Resource Utilization System and distribute it to all centres;
- adhere to its policies in relation to food service contracts;
- consider using the computer inventory system for recording, tracking stores supplies, pepper spray and movable capital assets;
- develop a comprehensive preventative capital asset maintenance program and inspection schedule;
- strengthen its information technology (IT) and physical security controls over adult custody services' files; and
- comply with relevant legislation.

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

♦ ♦ ♦ ♦ ♦ ♦

To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.15
DEPARTMENT OF JUSTICE
Adult Custody Program

The Department of Justice (the Department) through the Adult Custody section of the Corrections and Community Services is responsible for accommodating and managing: offenders sentenced to provincial terms of imprisonment (two years less a day); accused persons remanded in custody by the courts; and low risk offenders sentenced to federal terms of imprisonment (two or more years). Services are provided through seven centres comprised of five correctional centres and two detention centres which have a total capacity for 281 inmates, employ 214 permanent staff, 54 temporary staff (full-time equivalent) and are overseen by a Superintendent. For 2006-07, average expenditures per inmate totalled approximately $66,000.

What We Found

Our review of the Adult Custody Program identified a number of concerns as follows:

Planning and Reporting: Our review indicated there are no long-term goals and objectives relating specifically to adult custody services; there are no operational plans relating to the provision of adult custody services; and centres are not reporting (e.g. overtime, sick leave, training and food services) quarterly to the Superintendent as required by policy. As well, some of the centres do not report semi-annually, and others which do report semi-annually do not include all of the required information; required contingency plans were not in place for all identified critical situations such as natural disaster, loss of utilities, noxious/toxic substance threats and suspicious letter/parcel; and none of the centres have an Emergency Planning Committee in place and, as a result, a statement of training requirements specific to each critical situation has not been developed.

Human Resource Management: As salary costs account for 82% of total expenditures, we would expect adequate controls over staffing, callback and overtime, and sick leave. Our review indicated that callback and overtime, and sick leave are not being adequately monitored and controlled and has increased in the last three years. For example callback and overtime increased by 158% in the last three years, from $455,000 in 2004-05 to $1.17 million in 2006-07 (HMP increased by 291% from $153,000 to $597,000). Sick leave increased by an estimated 33% in the last three years, from $918,000 in 2004-05 to $1.23 million in 2006-07 (HMP increased by 54% from $553,000 to $659,000). In addition, no procedures manual has been developed outlining the objectives, administration procedures and controls related to tracking leave and overtime, centres are not reporting quarterly information to the Superintendent and annual staff performance appraisals are not being performed.

Purchasing and Tendering: Our review indicated that the Department did not comply with the *Public Tender Act* (six purchases totalling $94,473 were not publicly tendered) and the *Financial Administration Act* (18 instances totalling $87,000 where goods and services were ordered and received without the prior issuance of a purchase order). In addition, issues with the on-site food service contracts at four centres were identified, the on-site food service operator is not complying with the food services contracts and the centres are not complying with policies in relation to food service contracts e.g. providing written reports to the Superintendent on nutritional adequacy of meals and menu planning effectiveness.

Inventory and Capital Assets: Our review indicated that there is inadequate control over inventory and capital assets and not all cost information is provided to the Comptroller General as required by Government's financial management policy and procedures.

Information Management and Technology: The Department's IT practices are inadequate in that backups are not tested regularly for data integrity, network passwords are not changed on a regular basis and there is no documented disaster recovery plan. In addition, physical security over adult custody services' files is inadequate in that in some cases inmate records are kept in unlocked file cabinets.

Legislation: The Department is not in compliance with the *Adult Corrections Act* in that the Departmental Board of Corrections has never been established. In addition, the Department is not in compliance with the *Prisons Act* in that the Superintendent does not submit any reports to the Minister containing information pertaining to prisoners released.

Background

Overview

The Department of Justice (the Department) through the Adult Custody section of the Corrections and Community Services is responsible for accommodating and managing:

- offenders sentenced to provincial terms of imprisonment (two years less a day);
- accused persons remanded in custody by the courts; and
- low risk offenders sentenced to federal terms of imprisonment (two or more years);

The Department is also responsible for providing programs and services, including academic/vocational, personal/social and forestry/agriculture to assist offenders in reintegrating into the community after release from custody.

Composition of adult custody services

Adult Custody services are the responsibility of the Director of Corrections and Community Services. Services are provided through seven centres comprised of five correctional centres and two detention centres (lock-ups), which provide services and programs for sentenced, remanded and detained offenders. The seven centres are as follows:

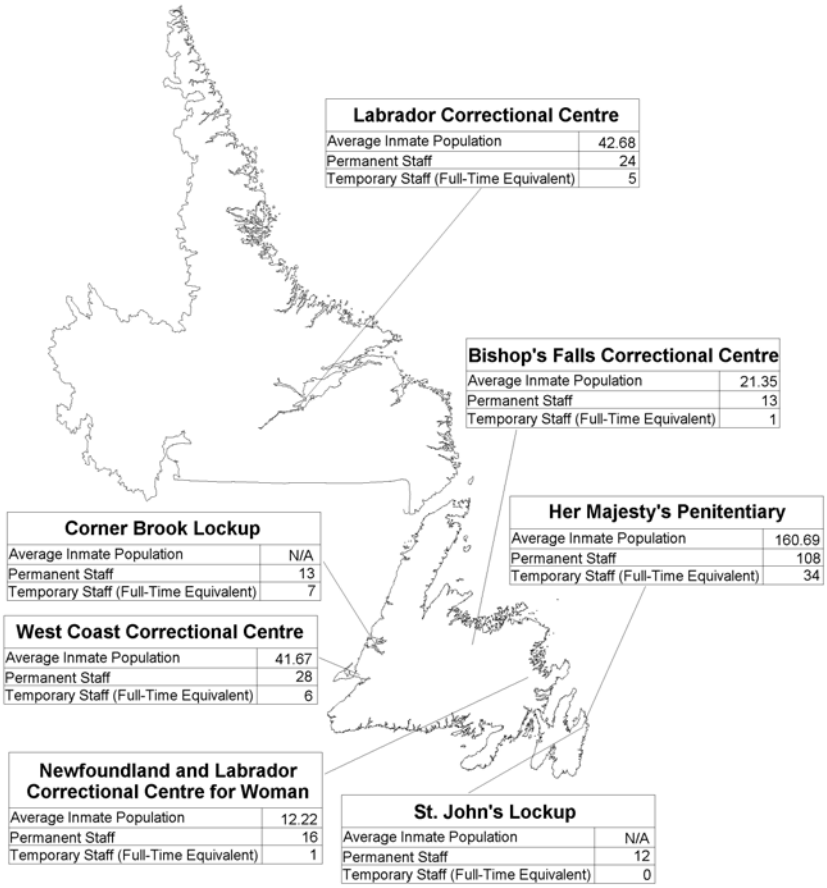
- Bishop's Falls Correctional Centre (BFCC);
- Corner Brook City Lock-up (CBLU)
- Her Majesty's Penitentiary (HMP);
- Labrador Correctional Centre (LCC);
- Newfoundland and Labrador Correctional Centre for Women (NLCCW);
- St. John's Lock-up (SJLU); and
- West Coast Correctional Centre (WCCC);

These centres have a total capacity for 281 inmates, employ 214 permanent staff, 54 temporary staff (full-time equivalent) and are overseen by a Superintendent.

Figure 1 shows the location of these centres throughout the Province, the average number of inmates during 2006-07, the number of permanent staff and the number of temporary (full-time equivalent) staff in each centre.

Figure 1

Adult Custody
Location of Correctional Facilities



Expenditure

Figure 2 provides a summary of the expenditure relating to Adult Custody services for the last three fiscal years. As the Figure shows, salaries are the major cost in providing adult custody services.

Figure 2

Department of Justice
Adult Custody Expenditure
Fiscal Years 2004-05 to 2006-07

Expenditure	2004-05	2005-06	2006-07
Salaries	$15,123,699	$14,888,297	$15,225,669
Employee Benefits	1,990	9,631	12,355
Transportation & Communications	200,508	245,835	266,416
Supplies	526,971	713,399	843,269
Professional Services	358,922	452,960	672,290
Purchased Services	1,330,372	1,327,209	1,353,920
Property, Furnishings & Equipment	40,542	100,460	105,780
Grants & Subsidies	17,950	-	-
Information Technology	135,946	-	-
Total Expenditure	**$17,736,900**	**$17,737,791**	**$18,479,699**
Average # of Inmates	**258.6**	**279.5**	**278.6**
Average Cost Per Inmate	**$68,588**	**$63,463**	**$66,331**
Number of Employees	**261**	**264**	**269**

Source: Public Accounts of Newfoundland and Labrador and the Department of Justice

Audit Objectives and Scope

Audit objectives

The objectives of our review were to access whether the Department's management practices and controls were adequate in the following areas of adult custody services:

- planning and reporting;
- human resource management;
- purchasing and tendering;
- inventory and capital assets;
- information management and technology; and
- legislation.

Audit scope

Our review was completed in December 2007. It included an examination of Adult custody services within the Adult Corrections Program administered by the Department of Justice. Our review covered the period 1 April 2005 to 31 March 2007.

The review included interviews with key personnel in the Department of Justice and also included compliance testing in the areas of planning, reporting, human resource management, purchasing, inventory, information management and technology, and legislation.

Overall Conclusion

For 2006-07, Adult Custody Services had approximately 279 inmates and incurred total expenditures of $18.5 million, representing an average cost per inmate of approximately $66,000. Our review identified a number of concerns regarding administrative practices in the areas of planning and reporting, human resource management, purchasing and tendering, inventory, information management and technology, and legislation as follows:

Planning and Reporting

Strategic and operational plans help ensure an organization is focused and deploys resources to meet desired outcomes. Our review indicated the following**:**

- there are no long-term goals and objectives relating specifically to adult custody services;
- there are no operational plans relating to the provision of adult custody services;
- centres are not reporting specific information (e.g. overtime, sick leave, training and food services) quarterly to the Superintendent as required by policy. As well, some of the centres do not report semi-annually and others which do report semi-annually do not include all of the required information;
- required contingency plans were not in place for all identified critical situations such as natural disaster, loss of utilities, noxious/toxic substance threats and suspicious letter/parcel; and

- none of the centres have an Emergency Planning Committee in place and, as a result, a statement of training requirements specific to each critical situation has not been developed.

Human Resource Management

As salary costs account for 82% of total expenditures, we would expect adequate controls over staffing, callback and overtime, and sick leave. Our review indicated the following**:**

- callback and overtime is not being adequately monitored and controlled and has increased by 158% in the last three years, from $455,000 in 2004-05 to $1.17 million in 2006-07. The largest increase in callback and overtime cost was at HMP where it increased by 291% from $153,000 in 2004-05 to $597,000 in 2006-07;

- sick leave is not being adequately monitored and controlled and has increased by an estimated 33% in the last three years, from $918,000 in 2004-05 to $1.23 million in 2006-07. The largest increase in sick leave cost was at HMP where it increased by 54% from $553,000 in 2004-05 to $659,000 in 2006-07;

- although the Resource Utilization System (a leave management and scheduling system implemented to track leave and overtime for adult custody staff) is in place, no procedures manual has been developed outlining the objectives, administration procedures and controls, and centres are not reporting quarterly information on callback, overtime and sick leave to the Superintendent as required by policy; and

- contrary to policy, annual staff performance appraisals are not being performed.

Purchasing and Tendering

For the year ended 31 March 2007, approximately $3.2 million was spent on the purchase of goods and services for adult custody services. Our review indicated the following**:**

- the Department did not comply with the *Public Tender Act* in that six purchases totalling $94,473 were not publicly tendered;

- the Department did not comply with the *Financial Administration Act* in that there were 18 instances totalling $87,000 where goods and services were ordered and received without the prior issuance of a purchase order and a recording of the commitment in Government's financial management system;

- the following are issues with the on-site food service contract at the HMP and SJLU:

  - a three year contract with an estimated cost of $1.96 million was not awarded to the lowest bidder in that food costs were not factored in the bid evaluation; and

  - the on-site food service operator is not complying with the food services contract in that they did not provide an audit report on food service operations, medical certificates for the food service operator's staff, certificates of insurance and suitable documentation verifying registration and good standing with the Workplace Health and Safety Compensation Commission.

- the following are instances where the Department is not complying with its policies in relation to food service contracts:

  - centre staff are not providing the required annual written report to the Superintendent regarding nutritional adequacy of meals, menu planning effectiveness and meal service procedures;

  - the contract with the food service provider did not include a requirement to provide a quarterly report to the Superintendent evaluating such areas as equipment needs, costs, sanitation, safety and storage procedures;

  - the contract with the food service provider did not include a requirement to provide information to the Director and Superintendent on offsite food service relating to the number of meals provided to inmates, staff, guests or visitors, total cost for meals and average food cost per person per day; and

  - meals for staff are being subsidized. e.g. LCC staff paid $2.50 per meal while the total average cost per meal to that centre is $5.33. WCCC staff paid an average of $2.00 per meal while the total average cost per meal to that centre is $4.10. Policy provides that staff shall pay the average cost i.e. not subsidized.

Inventory and Capital Assets

Inventory is comprised mainly of materials and supplies that will subsequently be expended or consumed directly to carry out their internal operations. Capital assets include such things as equipment, motor vehicles and furniture. Our review indicated the following**:**

- Adult Custody has a computer system to record and track stores supplies at all centres, however the system is not used;
- although the Department has a computer system for movable capital assets, the system is not used;
- monthly inventory reports on pepper spray are not being submitted by each centre to the officer responsible at the HMP as required;
- the Department does not have a comprehensive preventative capital asset maintenance program or preventative maintenance inspection schedule;
- there are no reports on capital asset maintenance costs or maintenance history; and
- other than computer equipment monitored by the Office of the Chief Information Officer, the Department does not conduct any annual inventory counts or account for capital assets. As a result, there is inadequate control over inventory and capital assets and not all cost information is provided to the Comptroller General as required by Government's financial management policy and procedures.

Information Management and Technology

The Department's IT practices are inadequate in that backups are not tested regularly for data integrity, network passwords are not changed on a regular basis and there is no documented disaster recovery plan. In addition, physical security over adult custody services' files is inadequate in that inmate records are kept in unlocked file cabinets within HMP.

Legislation

The Department is not in compliance with the *Adult Corrections Act* in that the Departmental Board of Corrections has never been established. In addition, the Department is not in compliance with the *Prisons Act* in that the Superintendent does not submit any reports to the Minister containing information pertaining to prisoners released.

Detailed Observations

Findings

Findings from our review are reported in the following sections:

1. Planning and Reporting
2. Human Resource Management
3. Purchasing and Tendering
4. Inventory and Capital Assets
5. Information Management and Technology
6. Legislation

1. Planning and Reporting

Findings

The detailed findings to support our conclusions in this area are contained in the following sections:

A. Strategic and Divisional Operational Plans;
B. Contingency Plans;
C. Training Plans; and
D. Reporting

1A. Strategic and Divisional Operational Plans

Long-term objectives not well defined

In January 2007, the Department of Justice Strategic Plan 2006-2008 was released, identifying the Department's goals and objectives. Our review indicated that there are no long-term goals and objectives relating specifically to adult custody services.

Operational plans not in place

Although we would have expected operational plans to be in place for the seven centres, our review indicated that there were no operating plans for the centres or for the Adult Custody section covering the seven centres, which would enable the Department to focus its activities towards achieving its strategic goals and objectives.

Department officials advised that divisional and work plans were in the process of being developed by the Department.

1B. Contingency Plans

Adult Custody has policies and procedures in place to ensure appropriate crisis interventions are in effect when needed. We reviewed each of these requirements to determine compliance.

Emergency planning committees not established

Each centre is required to establish an Emergency Planning Committee to develop contingency plans for specific potential critical situations.

Our review indicated that Emergency Planning Committees have not been set up for any of the centres.

Each centre is required to have a contingency plan in place for 13 critical situations as specified by Adult Custody. Figure 3 outlines the plans required and whether they were in place for each centre.

Figure 3

Adult Custody
Contingency Plans

		Centre						
	Plan	**BFCC**	**CBLU**	**HMP**	**LCC**	**NLCCW**	**SJLU**	**WCCC**
1	Inmate escape	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2	Riot control	Yes	Yes	Yes	Yes	Yes	No	Yes
3	Hostage incident	Yes	Yes	Yes	Yes	Yes	No	Yes
4	Adverse job action	Yes	No	Yes	Yes	Yes	No	Yes
5	Medical emergency	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6	Fire emergency	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7	Death of a person	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8	Epidemics	Yes	Yes	Yes	Yes	Yes	Yes	No
9	Bomb threat	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10	Natural disaster	No	No	No	No	No	No	No
11	Loss of utilities	No	No	No	No	No	No	No
12	Noxious/toxic substance threats	No	No	No	No	No	No	Yes
13	Suspicious letter/parcel	No	No	No	No	Yes	No	No

Source: Department of Justice

All contingency plans not developed and none submitted to the Superintendent

As Figure 3 shows, contingency plans have not been developed for all critical situations as required. None of the centres had contingency plans in place to cover all 13 critical situations. Most centres had no contingency plans for the following conditions:

- natural disaster;
- loss of utilities;
- noxious/toxic substances threats; and
- suspicious letter/parcel.

Contingency plans that have been developed are required to be submitted to the Superintendent and updated annually thereafter. Our review indicated that none of the plans have been submitted to the Superintendent, as required.

Statements of training not developed as required

Each contingency plan is required to include a statement of training requirements specific to each critical situation. This would be developed through an Emergency Planning Committee. However, there were no Emergency Planning Committees in place at any of the centres. As a result, no training requirements have been developed for critical situations.

1C. Training Plans

Training not being monitored to ensure compliance with policies and procedures

The policy and procedures of Adult Custody require that each centre develop and provide training as follows:

- every prospective correctional officer recruit have a minimum of 240 hours of pre-employment training;
- all permanent employees complete a minimum of 40 hours in service training, annually;
- emergency response training be provided annually to designated correctional officers;
- staff training to ensure fire protection services are maintained;
- staff who use or may use pepper spray in the course of their duties should be re-qualified every three years and instructors re-certified every three years; and
- staff training requirements be developed for each critical situation and training performed.

During our review we confirmed that while some training is being carried out at each of the centres, these requirements have not been incorporated into a multi-year training plan. In addition, the Department does not monitor compliance to ensure that the training is being carried out in accordance with the policies and procedures.

1D. Reporting

No system for reporting on long-term plans

Department officials indicated that the strategic plan was intended to reflect a new planning process throughout Government. Status updates and accomplishment reports on the strategic directions of the Department are expected to be in annual performance reports. However, at the time of our review, there was no system was in place for reporting on long-term plans.

No system for reporting on Adult Custody objectives

Because there are no operational plans for Adult Custody, there is no system in place to report on annual objectives.

No quarterly reporting on operational activities

In accordance with policy and procedures, each institutional officer in charge is required to submit a quarterly report to the Superintendent (within 30 days of the close of the quarter) on operational activities. The Superintendent is required to submit the reports to the Director within 15 days who in turn circulates to senior management at the Department. During our review Department officials indicated that:

- reports are not prepared quarterly as required, but are prepared semi-annually;
- the semi-annual reports are submitted to the Director, who acknowledges and responds to them;
- the Director compiles the reports into one package and circulates to all centres so that each centre can see the other centre's report; and
- the reports are not circulated to the Executive of the Department.

Semi-annual reports

We reviewed the semi-annual reports to determine if the reports were received by the Director of Correctional Services as required. Figure 4 outlines our findings.

Figure 4

Adult Custody
Review of Semi-Annual Reports
Summary of Findings
Fiscal years 2005-06 to 2006-07

Centre	1 April 2005 to September 2005	1 Oct. 2005 to March 31 2006	1 April 2006 to 30 Sept. 2006	1 October to 31 March 2007
BFCC	Yes	Yes	Yes	Yes
CBLU	Late	Late	No	No
HMP	Late	No	No	No
LCC	Late	No	No	No
NLCCW	Yes	Yes	Yes	Yes
SJLU	Yes	Late	Yes	Yes
WCCC	Late	Late	Late	Not indicated

Source: Department of Justice

Semi-annual reporting inadequate

As Figure 4 shows, all semi-annual reports have not been submitted by the centres. Our review of these reports indicated the following:

- for the period 1 April 2005 to September 2005 four centres submitted reports to the Director late;
- for the period 1 October to 31 March 2006, 2 centres, HMP and LCC, did not submit the required report, while 3 of the remaining 5 centres submitted the report late. The SJLU report was received in March 2007;
- for the period 1 April 2006 to 30 September 2006, 3 centres, HMP, LCC and CBLU, did not submit reports. One report, from WCCC, was received after February 2007 but was not date stamped;
- for the period 1 October to 31 March 2007, 3 centres, HMP, LCC and CBLU, had not submitted the required reports. One report, WCCC, was not date stamped so we were unable to determine when it was received; and
- HMP and LCC have not submitted the last three semi-annual reports as required.

Furthermore, the reports were required to include information on operations and activities such as overtime, sick leave, training, food services, equipment and vehicles, supplies and maintenance. However, we found that in general, reports contained very limited or no information on these operational activities.

Conclusions

As a result of our review, we have concluded that:

- there are no long-term goals and objectives relating specifically to adult custody services;
- there are no operational plans relating to the provision of adult custody services;
- centres are not reporting specific information quarterly to the Superintendent as required by policy;
- required contingency plans were not in place for all identified critical situations; and
- none of the centres have an Emergency Planning Committee in place.

Recommendations

The Department should:

- develop long-term goals and objectives relating to adult custody services;
- develop operational plans relating to the provision of adult custody services;
- require that centres report specific information as outlined in the policy;
- develop the required contingency plans for all critical situations; and
- require that centres have an Emergency Planning Committee in place.

2. Human Resource Management

Findings

Although human resource management is centralized in the Department, each centre has administrative personnel to coordinate payroll and maintain the computerized database. The centres have 214 permanent staff and 54 temporary staff (full-time equivalent), overseen by a Superintendent.

The detailed findings to support our conclusions in this area are contained in the following sections:

A. Staffing;
B. Callback and Overtime; and
C. Sick Leave

2A. Staffing

Figure 5 shows the staffing costs by centre for the fiscal years 2004-05 to 2006-07.

Figure 5

Adult Custody
Salary Costs by Centre
Fiscal Years 2004-05 to 2006-07

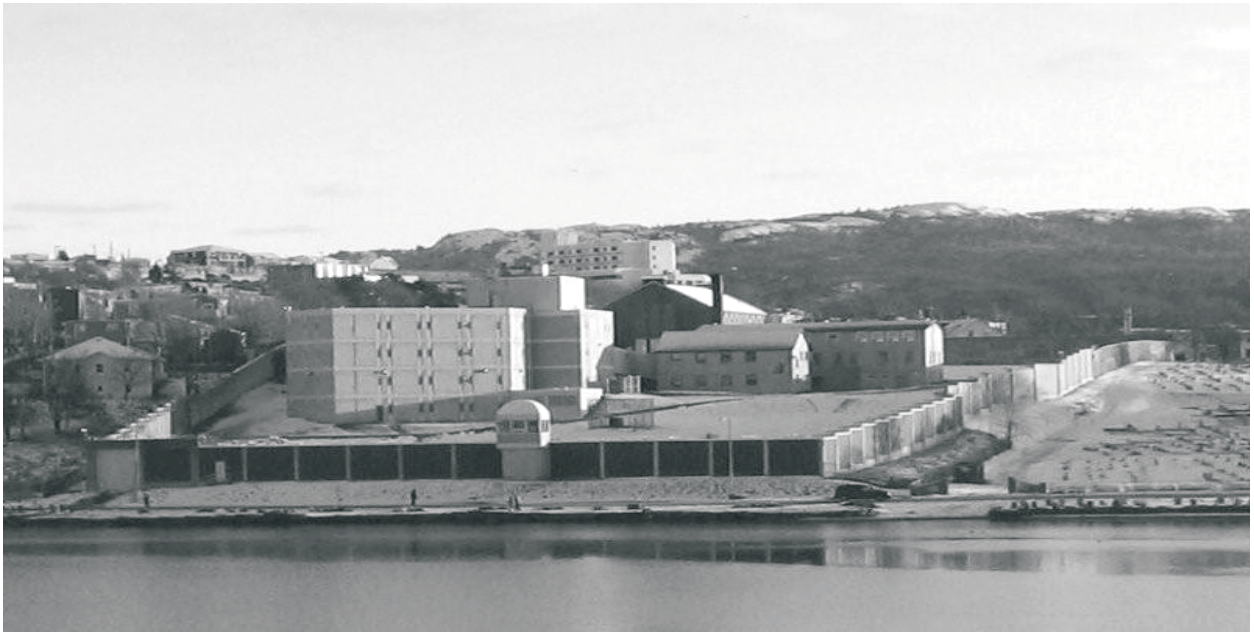
Centre	2004-05*	2005-06	2006-07	Total # of Employees 2006-07	Average Salary Cost per Employee 2006-07
BFCC	$ 793,669	$ 873,885	$ 807,400	14	$ 57,671
HMP	7,664,861	7,402,976	7,681,961	142	54,098
LCC	1,867,288	1,951,693	1,965,197	29	67,765
NLCCW	968,726	979,752	1,054,947	17	62,056
WCCC	1,839,437	1,865,794	1,856,575	34	54,605
Sub-total	**13,133,981**	**13,074,100**	**13,366,080**	**236**	**56,636**
CBLU	766,212	830,768	916,014	20	45,801
SJLU	636,196	763,971	812,451	12	67,704
Sub-total	**1,402,408**	**1,594,739**	**1,728,465**	**32**	**54,015**
Administration	223,859	219,459	131,123	-	131,123
Total	**$14,760,247**	**$14,888,298**	**$15,225,668**	**268**	**$ 56,812**

Source: FMS data
*Expenditure for Salmonier Correctional Centre ($363,452) was removed to normalize data.

As Figure 5 shows, as of 31 March 2007, the Department spent over $15.2 million on staff salaries in total at its five correctional and two detention centres. Salaries at the five correctional centres account for over $13.3 million (88%) of total salary costs with the HMP, the largest correctional centre in the Province, accounting for over $7.6 million (50%).

Figure 6

Her Majesty's Penitentiary, St. John's



Adult custody correctional centres have a capacity for incarceration of 281 adults. Figure 7 provides information on the number of inmates in relation to capacity by correctional centre for the last three fiscal years.

Figure 7

Adult Custody
Correctional Centre Usage Ratio
Fiscal years 2004-05 to 2006-07

		2004-05		2005-06		2006-07	
Correctional Centre	Capacity	Average # of Inmates	% of Capacity	Average # of Inmates	% of Capacity	Average # of Inmates	% of Capacity
BFCC	26	16	62%	21	81%	21	81%
HMP	145	160	110%	166	114%	161	111%
LCC	38	38	100%	43	113%	43	113%
NLCCW	22	10	45%	9	41%	12	55%
WCCC	50	35	70%	41	82%	42	84%
Total	**281**	**259**	**92%**	**280**	**99%**	**279**	**99%**

Source: Department of Justice

NLCCW operating below 50% capacity

As Figure 7 shows, two facilities (HMP and LCC) are operating at or above capacity, while BFCC, NLCCW and WCCC are operating at below capacity. Of particular note is that the NLCCW has operated, on average, below 50% capacity for the last three years.

Figure 8 shows an analysis of the number of average inmates compared to the number of staff by correctional centre.

Figure 8

Adult Custody
Inmate to Staff Ratio by Centre
Fiscal years 2005 to 2007

	2004-05	2005-06	2006-07	3 Year Average
Correctional Facility	Inmate to Staff Ratio	Inmate to Staff Ratio	Inmate to Staff Ratio	Inmate to Staff Ratio
BFCC	1.16	1.48	1.49	1.38
HMP	1.16	1.21	1.13	1.17
LCC	1.36	1.50	1.48	1.45
NLCCW	0.63	0.49	0.72	0.61
WCCC	1.02	1.18	1.22	1.14
Average	**1.06**	**1.17**	**1.21**	**1.15**

Source: Department of Justice and FMS data
Note: Staff includes permanent and temporary full time equivalents.

The inmate to staff ratio varies significantly among centres

As Figure 8 shows, four of the centres had inmate to staff ratio ranging from 1.14 to 1.45. However, as indicated in Figure 8, the NLCCW has an inmate to staff ratio 0.61. Department officials indicated that the low occupancy rate at the centre was the main reason for this low inmate to staff ratio.

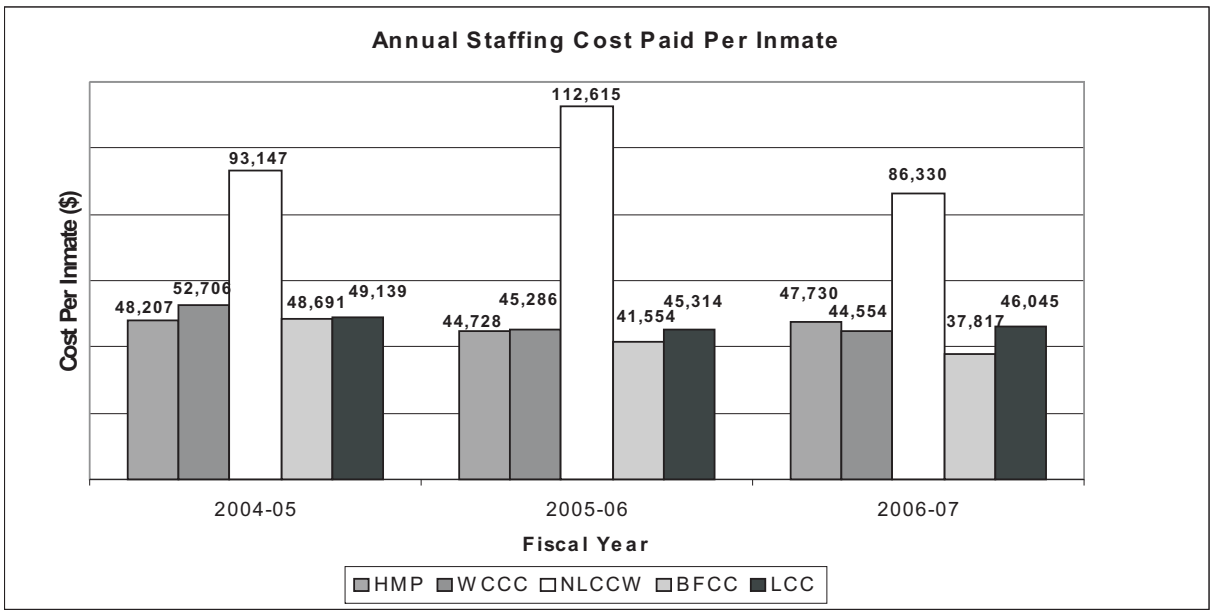
Average daily inmate costs

The most recent Statistics Canada report covering the year 2004 indicated that the average daily inmate costs for all provinces in Canada ranged from a low of $103 in Alberta to a high of $193 in Newfoundland and Labrador.

Figure 9 shows the average annual cost per inmate for each correctional centre for the last three years.

Figure 9

Adult Custody
Annual Staffing Cost per Inmate
Fiscal years 2005 to 2007



Source: Department of Justice and FMS data

Average staffing cost per inmate almost double for NLWCC

As Figure 9 shows, the average cost per inmate for the Newfoundland and Labrador Correctional Centre for Women in 2006-07 was $86,330. This was almost double that of any of the other correctional centres. Department officials indicated that the low occupancy rate at the facility was the main reason for this high average cost.

Annual staff performance appraisals not performed

All staff are required to have their work performance appraised on an annual basis. A performance evaluation system helps to establish individual goals and objectives, and provide any necessary feedback and coaching.

Our review indicated that annual performance appraisals of staff are not being performed.

2B. Callback and Overtime

Callback is defined as when an employee is called back to work after he has left his place of work and reports back.

Overtime represents the continuation of a shift or overtime that is scheduled in advance. It also includes when employees are required to work their lunch hours.

Figure 10 shows the breakdown of overtime expenditures by centre, and the callback and overtime paid as a percentage of total salary cost for the last three fiscal years.

Figure 10

Adult Custody Services
Callback and Overtime Paid by Centre
Fiscal Years 2004-05 to 2006-07

Correctional Centre	2004-05*	2005-06	2006-07	Total
Callback and Overtime				
BFCC	$ 39,094	$ 33,250	$ 42,746	$ 115,090
CBLU	27,956	48,292	94,440	170,688
HMP	152,826	266,123	597,028	1,015,977
LCC	120,470	156,273	171,051	447,794
NLCCW	48,767	57,747	103,356	209,870
SJLU	12,128	33,929	74,696	120,753
WCCC	53,586	61,108	89,059	203,753
Total	**$ 454,827**	**$ 656,722**	**$ 1,172,376**	**$ 2,283,925**
Total Salaries	$ 14,536,388	$ 14,668,838	$ 15,094,544	$ 44,299,770
% of Total Staffing Costs	3.13%	4.48%	7.77%	5.16%

Source: FMS data
*Payments to employees at the Salmonier Correctional Centre were removed for normalization of data

Callback and overtime costs increasing

As Figure 10 shows, since 2004-05, total overtime and callback costs have increased from $454,827 to $1,172,376, an increase of 158%. HMP overtime costs increased by almost 291%.

Callback and overtime costs continue to increase and represent a significant cost in providing adult custody services. As Figure 10 shows, callback and overtime paid increased from $454,827, or 3.13% of total salary costs for 2004-05, to $1,172,376, or 7.77% of total salary costs for 2006-07.

Reason for increase in overtime and callback costs

Each correctional facility has a standard number of employees for each shift. When it becomes apparent that the standard staff compliment has not been achieved for a given shift, the lieutenant on duty calls a correctional officer or officers back to cover the shift. Temporary employees, who have not worked their 36 hours per week, are contacted first since this will result in only straight time. However, we were informed that the correctional centres have limited success in contacting these casuals. This forces them to call back at overtime rates, either full time staff or temporary employees who have worked their allowable hours.

The need for callback may occur when scheduled staff are on sick leave, annual leave or when hospital escort duty is required. It may also be necessary when female staff are required to work at the SJLU or staff are needed to supervise intermittent inmates (e.g. inmates serving time on weekends).

Officials indicated that the increase in overtime costs at the correctional centres was due to:

- unavailability / shortage of casuals / temporary staff;
- sick leave usage; and
- granting annual / paid leave to an employee when a casual is not available to work in his place.

Figure 11 shows the incidents of callback by centre for 2006-07.

Figure 11

Adult Custody
Incidents of Callback by Centre
For the year ended 31 March 2007

Month	HMP	WCCC	NLCCW	BFCC	LCC	SJLU	CBLU	Total
April	76	22	10	7	14	13	1	**143**
May	63	29	8	8	18	9	12	**147**
June	62	18	15	5	34	10	9	**153**
July	111	15	10	9	31	20	26	**222**
August	168	38	24	5	19	15	19	**288**
September	94	15	3	13	37	18	9	**189**
October	91	18	7	7	34	12	9	**178**
November	97	6	7	14	28	6	25	**183**
December	89	22	15	8	4	11	6	**155**
January	84	25	9	20	47	14	6	**205**
February	134	13	26	12	30	18	10	**243**
March	208	50	13	5	20	36	10	**342**
Total	**1,277**	**271**	**147**	**113**	**316**	**182**	**142**	**2,448**

Source: Department of Justice

Highest incidents of callback

As Figure 11 shows, the highest incidents of callback took place during the summer period (July and August) and near year end (February and March). There were 288 incidents of callback for August 2007 with the HMP accounting for 168 (58.3%) of these callbacks. There were 342 incidents of callback in March with the HMP accounting for 208 (61%).

2C. Sick Leave

Sick leave costs increasing

Sick leave represents a significant cost in providing adult custody services. Sick leave costs for last three years totalled approximately $3.1 million, as follows:

- 2004-05 - $ 917,508
- 2005-06 - $ 952,730
- 2006-07 - $1,225,526

Figure 12 shows sick leave costs, by centre, for the last three years.

Figure 12

Adult Custody
Cost of Sick Leave by Centre
Fiscal Years 2004-05 to 2006-07

Centre	2004-05*	2005-06*	2006-07*	Total
BFCC	$ 13,950	$ 21,673	$ 29,195	**$ 64,818**
CBLU	38,703	55,733	73,489	**167,925**
HMP	553,034	495,973	659,140	**1,708,147**
LCC	51,548	113,017	134,679	**299,244**
NLCCW	45,332	83,577	120,160	**249,069**
SJLU	85,073	86,200	111,198	**282,471**
WCCC	129,869	96,556	97,667	**324,092**
Total	**$ 917,509**	**$ 952,729**	**$ 1,225,528**	**$ 3,095,766**

Source: Department of Justice and FMS data
* The average hourly salary rate for 2006-07 of $22.32 was applied in costing hours of sick leave used.

As Figure 12 indicates, the cost of sick leave has increased over 33% since 2004-05. HMP accounts for over $1.7 million (54%) of the total cost in 2006-07.

The incidence of sick leave is closely linked with the incidence of callback. Figure 13 shows the incidence of callback due to sick leave by centre during 2006-07.

Figure 13

Adult Custody
Incidents of Callbacks Due to Sick Leave by Centre
For the year ended 31 March 2007

Month	HMP	WCCC	NLCCW	BFCC	LCC	SJLU	CBLU	Total
April	10	4	2	1	3	2	1	**23**
May	15	2	1	1	12	1	0	**32**
June	17	3	8	1	3	3	4	**39**
July	36	6	5	6	11	3	8	**75**
August	59	10	17	2	10	6	6	**110**
September	32	5	1	6	12	7	2	**65**
October	41	5	0	2	15	3	2	**68**
November	28	0	5	1	7	1	1	**43**
December	22	14	7	1	1	2	2	**49**
January	30	5	3	3	4	7	3	**55**
February	45	4	4	3	6	5	2	**69**
March	55	8	2	2	8	6	3	**84**
Total	**390**	**66**	**55**	**29**	**92**	**46**	**34**	**712**

Source: Department of Justice

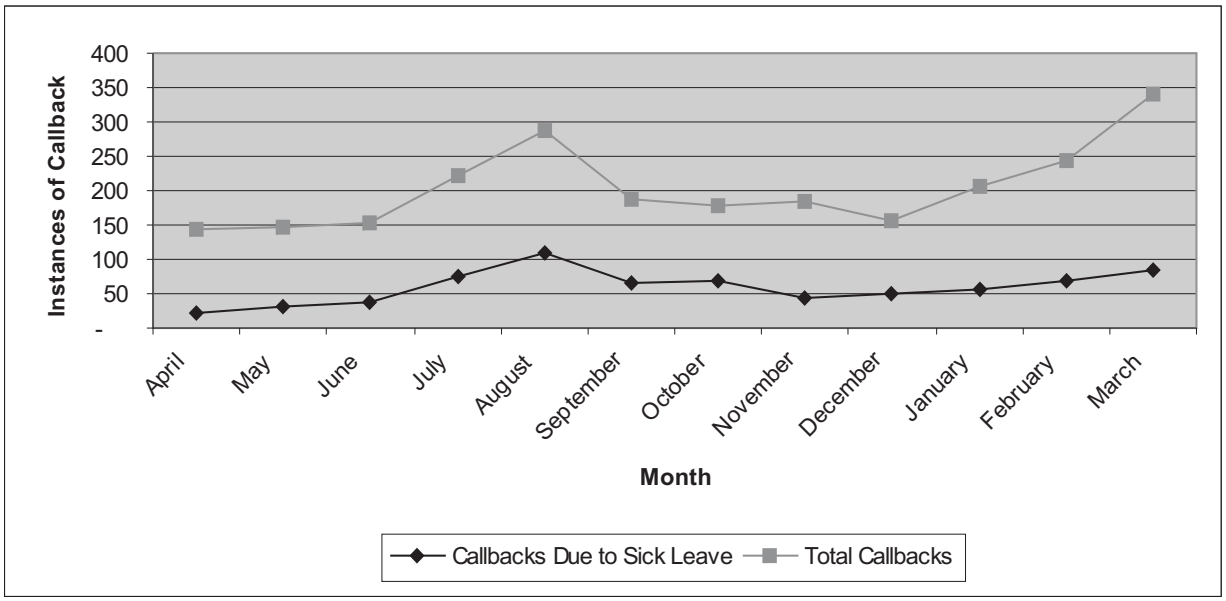
Highest incidents of sick leave

As Figure 13 shows, the HMP accounted for 390 (55%) incidents for the year with the highest incidents of sick leave occurring in the summer months and near year end.

Figure 14 compares the incidents of callbacks and sick leave, by month, for 2006-07.

Figure 14

Adult Custody Services
Incidents of Callbacks Due to Sick Leave
For the year ended 31 March 2007



Source: Department of Justice

Link between callbacks and sick leave usage

Figure 14 indicates that there was a higher incident of callback and sick leave during the months of July, August, February and March. Of 288 callbacks in August 2006, 110 (38%) were due to sick leave.

Overtime and sick leave not adequately monitored

The Resource Utilization System (RUS) is the leave management and scheduling system implemented to track leave and overtime for adult custody staff. This system was intended to provide all the necessary information to monitor leave and overtime.

Institutional heads can monitor leave and overtime by reviewing, analyzing and reporting on information obtained from the system. The system can identify details such as name of employee, date, duration of shift, reason for callback, and status of casuals.

All centres use the RUS, however, there is no procedures manual outlining the objectives, administration procedures and controls.

In addition, as indicated earlier, the system for regular reporting on all areas of adult custody operations is inadequate. Reports on leave and overtime are not being prepared by all centres and submitted to superintendent, director, and senior management quarterly, as required.

The seven centres were to provide semi-annual reports for the periods ending 30 September 2006 and 31 March 2007. Our review indicated that three centres (HMP, LCC and CBLU) did not submit these reports. The report from WCCC for the period 1 April 2006 to 30 September 2006 was received after February 2007 but was not date stamped, and the report for the period 1 October to 31 March 2007 was also not date stamped so we were unable to determine when it was received. Furthermore, we found for the reports that were received, that they contained very limited or no information on sick leave and overtime.

Conclusions

As a result of our review, we have concluded that:

- callback and overtime is not being adequately monitored and controlled and has increased by 158% in the last three years, from $455,000 in 2004-05 to $1.17 million in 2006-07;
- sick leave is not being adequately monitored and controlled and has increased by an estimated 33% in the last three years, from $918,000 in 2004-05 to $1.23 million in 2006-07;
- although the Resource Utilization System (RUS) is in place, no procedures manual has been developed outlining the objectives, administration procedures and controls, and centres are not reporting quarterly information on callback, overtime and sick leave to the Superintendent as required by policy; and
- contrary to policy, annual staff performance appraisals are not being performed.

Recommendations

The Department should:

- monitor and control callback, overtime and sick leave;
- develop a procedures manual for RUS and distributed to all centres;
- ensure centres report quarterly information on callback, overtime and sick leave; and
- conduct annual performance appraisals of all adult custody staff.

3. Purchasing and Tendering

Findings

The detailed findings to support our conclusions in this area are contained in the following sections:

A. Public Tendering
B. Food Services

3A. Public Tendering

Whenever goods and services are to be purchased for the operation of adult custody services, the Department must comply with the requirements of the:

- *Public Tender Act*; and
- *Public Tender Regulations*.

The *Public Tender Act* requires that, when goods or services cost more than $10,000, or a public work costs more than $20,000, then the Department must invite tenders.

When the values are less than those amounts, the Department must obtain quotes from at least three legitimate sources or establish a fair and reasonable price for the circumstances.

The *Act* does provide exceptions where tenders may not be required. In cases where a public tender is not called, the Department must inform the Chief Operating Officer of the Government Purchasing Agency who in turn informs the House of Assembly.

For the year ended 31 March 2007, approximately $3.2 million was spent on the purchase of goods and services for adult custody services. We reviewed transactions for the period 1 April 2005 to 31 March 2007, focusing on:

- items that were required to go to tender;
- items that were considered by the Department to be exceptions requiring a completed Form B; and
- items that were $10,000 and less.

To determine compliance with the *Act* we examined 39 purchases that were in excess of $10,000 and 32 purchases for $10,000 or less.

Issues with public tendering

Of the 39 purchases in excess of $10,000:

- 10 were through Government's standing offer agreements;
- 22 were through public tenders;
- 6 with a total value of $94,473 were not publicly tendered; and
- 1 was publicly tendered, but the lowest bidder was not selected.

Public tender not invited

The area of greatest concern was the 6 purchases that did not go to public tender and one purchase for which the lowest bidder was not accepted. Details are as follows:

- 3 of the purchases relate to payments to two different vendors for prescription drugs. While the individual transactions tested were less than $10,000, both vendors received total payments in excess of $10,000. In such a case the requirement for purchases totalling in excess of $10,000 should have been anticipated and the purchases tendered.

  One vendor received a total of $38,160 over the two year period for 366 purchases while the second vendor received $11,066 in 2005-06 for 107 purchases. We were informed that the purchases were for emergencies, however, no Form B to cover such purchases, was completed.

- 2 of the purchases relate to payments to two different vendors for the purchase of mattresses. While the individual transactions tested were less than $10,000, both vendors received total payments in excess of $10,000. In such a case the requirement for purchases totalling in excess of $10,000 should have been anticipated and the purchases tendered.

  One vendor received a total of $13,809 in 2005-06 for 5 purchases while the second vendor received a total of $16,404 in 2006-07 for 17 purchases.

- In 2005-06, an auto body repair shop received a total of $15,034 for specialized body work on vehicles used to provide adult custody services. The Department informed us that this was from a sole source. However, the required Form B was not completed.

Lowest bid not accepted

The food services contract for HMP and SJLU went to tender in June 2006. There were two bids received. Figure 15 outlines the details of the two bids that were submitted.

Figure 15

Comparison of Tenders for Catering Contract for HMP and SJLU

	Total 3 Year Estimate Accepted Bidder	Total 3 Year Estimate Bidder B
Food Costs	$1,590,000	$ 883,429
Firm Labour Costs	255,000	275,070
Firm Management and Administration Fee	17,200	19,500
Other Costs	103,000	38,750
Total Cost	**$ 1,965,200**	**$ 1,216,749**

Source: Department of Justice

As Figure 15 shows, the bid covers a three year term with the unsuccessful bidder quoting over $748,000 less than the company that was awarded the contract.

Although information on food and other costs were requested and received, our review indicated that the contract was awarded based on labour cost and administration and management fees only. As a result, the tender was not awarded to the lowest bidder.

Three quotes not obtained

Of the 32 purchases we reviewed, we found that neither three quotes were obtained nor a fair and reasonable price established for 9 purchases totalling $16,138. This is in contravention the *Public Tender Act.*

Contravention of the Financial Administration Act

Our review identified 18 instances totalling approximately $87,000 where goods and services were ordered without encumbering funds as required under the *Financial Administration Act.*

In addition, contrary to sound financial management practices, purchase orders, which are designed to document the required authorization, were either prepared after the receipt of goods and services and related invoices or not at all.

3B. Food Services

In 2006-07, the Department spent $1.26 million on the purchase of food services for its adult custody operation. This included $983,000 for its on-site operations and $277,000 for its off-site operations.

The Department currently has one on-site food service operator who caters to the following four facilities:

- Her Majesty's Penitentiary;
- Labrador Correctional Centre;
- St. John's Lock-up; and
- West Coast Correctional Centre;

Off-site catering services are provided by three different caterers for the remaining three facilities:

- Bishop Falls Correctional Centre;
- Corner Brook Lock-up; and
- Newfoundland & Labrador Correctional Centre for Women.

Food service contract

In August 2006 the Department entered into a three year contract with the on-site food service operator to provide food service for HMP and delivered meals to the SJLU.

Figure 16 shows the contract cost for the three years.

Figure 16

Adult Custody
On-Site Service Operator Costs for HMP and SJLU
Fiscal Years 2006-07 to 2008-09

	2006-07*	2007-08	2008-09	Total
Food Costs	$375,000	$605,000	$610,000	$1,590,000
Labour Costs	58,000	97,500	99,500	255,000
Management and Administration Fee	4,200	6,500	6,500	17,200
Other Costs (cleaning, paper, food license etc.)	24,500	39,000	39,500	103,000
Total Operating Costs	**$461,700**	**$748,000**	**$755,500**	**$1,965,200**

*includes portion of year covered by contract

As Figure 16 shows, food costs will account for $1.6 million or 81% of the operating cost of providing food services over the term of the contract.

The labour costs are for one fulltime cook/manager, two full-time cooks and one part-time canteen employee.

Requirements of the food service contract

The food service contract includes several provisions which aid in the Department's control over adult custody food service operations. The food service operator is responsible to:

- ensure an independent audit is completed and forwarded to the Manager of Corporate Services at HMP within 60 days of the end of the fiscal year. The audit is to report on:
  - labour costs;
  - management fee;
  - inventory control system;
  - verification of billing procedures; and
  - other related issues.
- supply medical certificates for each cook/employee on an annual basis to the Manager of Corporate Services;
- keep in force at all times a general public liability insurance policy with an inclusive limit of liability of at least $1 million for bodily injury, death or property damage. In addition, there should be at least $1 million liability insurance for products legal liability. The food service operator is required to furnish the Manager of Corporate Services with a certificate of insurance prior to the commencement of the contract and annually, thereafter; and
- provide suitable documentation verifying registration and good standing with the Workplace Health and Safety Compensation Commission.

Non - compliance with food service contract

Our review indicated that the food service operator has not provided to the Manager of Corporate Services, nor has the Department followed-up with the food service operator to obtain the following:

- the audit report on food service operations;
- medical certificates for the food service operator's staff;
- the required certificates of insurance; and
- suitable documentation verifying registration and good standing with the Workplace Health and Safety Compensation Commission.

There are two other on-site food service contracts in place for WCCC and LCC containing similar provisions. Officials indicated that the food service operator has also not complied with these provisions in those contracts.

Requirements of the Adult Corrections Policy and Procedure Manual

In addition to the food services contracts, we examined the Adult Corrections Policy and Procedures Manual related to food services and identified the following areas of non-compliance with those requirements:

- food services assessment not completed;
- quarterly reports not prepared;
- off-site food service operators not reporting information; and
- staff meal rates subsidized.

Food services assessment not completed

The food service system of each centre is required to be reviewed at regular intervals.

The officer-in-charge is to ensure that the food service operation is assessed at least annually by a qualified dietitian and a written report is submitted to the Superintendent regarding:

- nutritional adequacy of meals;
- menu planning effectiveness; and
- meal service procedures.

Our review indicated that this report is not being prepared and submitted, as required.

Quarterly reports not prepared

If the food service operation is managed on-site by a private enterprise, the Food Service Manager is to complete a quarterly report and submit it to the Manager of Corporate Services. The report should evaluate the following areas:

- standard ratio compliance;
- menu plans;
- equipment needs;
- staffing model;
- costs;
- special problems;
- sanitation;
- safety;
- storage procedures; and
- physical plant.

Our review indicated that these reports were not being prepared and submitted as required.

Staff meal rates subsidized

Policy provides that meal rates charged to staff should reflect the actual cost incurred by the food service operator i.e. not subsidized.

Our review indicated that WCCC staff paid $2.00 per meal while the average total cost per meal for WCCC for 2006-07 was $4.10. LCC staff paid $2.50 per meal while the total average cost per meal to that centre is $5.33. In both centres, staff pay the food service operator directly for the meals and the caterer credits the monthly invoice for the staff meals purchased. As a result, WCCC subsidized staff meals by $2.10 and LCC subsidized staff meals an average of $2.83 per meal.

Off-site food service operators not reporting information

Where the food service is not on-site and the contract is based on a pre-established price for each meal served, the food service operator is to provide information on monthly basis, calculated for the current month as well as the cumulative total for the fiscal year, to the Director and the Superintendent. The information to be provided includes the following:

- number of breakfasts, dinners and suppers provided to inmates;
- number of meals provided to staff;
- number of meals provided to guests or visitors;
- total cost for meals;

- average daily food cost (total); and
- average food cost per person per day.

Our review indicated that this information was not being provided as required.

Conclusion

As a result of our review, we concluded that:

- the Department did not comply with the *Public Tender Act* in that six purchases totalling $94,473 were not publicly tendered;
- the Department did not comply with the *Financial Administration Act* in that there were 18 instances totalling $87,000 where goods and services were ordered and received without the prior issuance of a purchase order and a recording of the commitment in Government's financial management system;
- there were several issues identified with the on-site food service contract at the HMP and SJLU;
- there were several instances identified where the Department did not comply with its policies in relation to food service contracts; and
- although policy provides that staff shall pay the average cost, in some cases meals for staff were being subsidized.

Recommendation

The Department should:

- comply with the *Public Tender Act* and the *Financial Administration Act*;
- address issues identified with the on-site food service contracts;
- adhere to its policies in relation to food service contracts; and
- comply with their policy in determining staff meal rates.

4. Inventory and Capital Assets

Requirements of the Financial Management Policy Manual

All Government departments are required to adhere to Government's policy and procedures on financial management.

The Financial Management Policy Manual indicates that inventory consists mainly of materials and supplies that will subsequently be expended or consumed directly by the departments as they carry out their internal operations.

For the purposes of inventory management, capital assets which are valued below specified dollar thresholds and are not capitalized, must be inventoried and accounted for in the same manner as materials and supplies. Thresholds vary from $15,000 (vehicles) to $100,000 (computer software) depending on their category.

An inventory system and procedures that provide for accounting and control of items should be place in all government departments.

Departments are responsible to ensure that:

- the inventory system provides accurate information for financial reporting and forecasting of inventory;
- periodic comparisons of physical quantities on hand to inventory records to detect inventory losses are conducted; and
- the value of inventory (which includes capital assets) on hand as of 31 March of the fiscal year is reported to the Comptroller General for Public Accounts purposes.

Non-compliance with the Financial Management Policy

Our review indicated that:

- the inventory system for stores supplies, such as correctional officers' uniforms and inmates' clothing, is a manual system, which does not provide information for financial reporting and forecasting of inventory. Adult Custody does have a computer system to record and track stores inventory at all centres, however this system is not in use.

- periodic comparisons of physical quantities on hand to inventory records to detect inventory losses are not conducted; and
- the value of inventory on hand (including capital assets) as of 31 March of the fiscal year is not reported to the Comptroller General, as required.
- the Department has a computer system for reporting on movable capital assets, however officials indicated that the system does not function properly, and is not currently being used.

Inventory control over pepper spray not adequate

The main inventory of pepper spray is stored at HMP and issued to each centre when requested. The officer responsible for inventory at HMP is required to keep a record of all canisters issued to other centres by recording the manufacturer's number and expiry date. All satellite centres are required to keep their own inventory.

A complete inventory is to be conducted every 30 days at each centre and the reports forwarded to the officer in charge of inventory at HMP. A standard report on each canister used is to be included. Used or outdated canisters are to be returned to HMP inventory officer for proper disposal.

Our review indicated that these inventory reports are not being submitted by any of the seven centres as required.

No preventative maintenance plan in place

Capital assets are non-financial assets having physical substance that are acquired, constructed or developed and have a useful life normally in excess of one year.

A comprehensive preventative maintenance program is required to be in place for all capital assets including buildings, equipment and vehicles. The officer in charge of each facility is required to conduct an annual audit of the preventive maintenance inspection schedule to ensure proper maintenance and service checks have been conducted.

Our review indicated:

- there is no preventative maintenance plan for capital assets;
- there is no annual audit of the preventative maintenance inspection schedule; and
- there is no system in effect to report on capital asset maintenance cost and maintenance history.

Conclusions

As a result of our review, we concluded that:

- Adult Custody has a computer system to record and track stores supplies at all centres, however the system is not used;
- although the Department has a computer system for movable capital assets, the system is not used;
- monthly inventory reports on pepper spray are not being submitted by each centre to the officer responsible at the HMP as required;
- the Department does not have a comprehensive preventative capital asset maintenance program or preventative maintenance inspection schedule;
- there are no reports on capital asset maintenance costs or maintenance history; and
- other than computer equipment monitored by the Office of the Chief Information Officer, the Department does not conduct any annual inventory counts or account for capital assets.

Recommendations

The Department should:

- consider using the computer inventory system for recording and tracking stores supplies;
- consider adapting or replacing the existing computer system for tracking movable capital assets;
- ensure monthly inventory reports on pepper spray are submitted by each centre as required;
- develop a comprehensive preventative capital asset maintenance program and inspection schedule;
- provide reports on capital asset maintenance costs or maintenance history; and
- conduct annual inventory counts and account for capital assets.

5. Information Management

Records management

Adult Custody is responsible for maintaining an accurate, confidential and secure system for recording and management of inmate's records

An accurate and complete record of inmate information is required to be kept at each correctional facility. The Provincial Corrections Offenders Management System (PCOMS) is the system used by adult custody services to process and store information regarding individuals who are in the correctional system.

IT security controls not in place

There are several major computer system applications that are used in the operation of adult custody services. These include PCOMS and RUS.

System security includes protecting infrastructure, confidentiality and data. Preserving data is critical in the adult custody environment. We would expect to see IT security controls in place to ensure security over all adult custody's automated systems.

Our review indicated the following:

- policy and procedures for IT security controls are not well defined and communicated;
- there is no documented disaster recovery plan for adult custody computer systems including no planned recovery site should a disaster occur;
- backups are not tested regularly for data integrity;
- a chart of authorities had not been approved for all adult custody computer applications;
- each workstation is not password protected after a period of inactivity;
- adult custody network passwords are not changed on a regular basis;
- there was no regular review and clean up of all accounts on the servers; and
- there is no process in place to modify access privileges to adult custody computer applications by staff after the employment status of employee's changes, i.e. termination or leave of absence.

Physical security over records not adequate

Our review indicated that inmate records for the HMP are kept in unlocked file cabinets. The room and filing cabinets are not fire proof and access to the area is not restricted. The area is also prone to flooding.

Conclusion

The Department's IT practices are inadequate and physical security over adult custody services' files is inadequate.

Recommendation

The Department should strengthen its IT and physical security controls over adult custody services' files.

6. Legislation

Non-compliance with *Adult Corrections Act*

The *Adult Corrections Act* allows for the establishment of the Adult Correction Division in the Department of Justice. A Director of Adult Corrections is appointed by the Lieutenant-Governor in Council to administer the affairs of the division.

"*The minister shall appoint a board of advisors to be known as the Departmental Board of Corrections....*" The Director is to be the chairperson of the board of advisors. The Board *"shall comprise at least 1 provincial court judge, 1 member of a police force operating in the province, 1 official from every department of government having responsibility to administer juvenile corrections, together with other persons having the qualifications or being the holders of offices that may be prescribed in the regulations."*

Our review indicated that the Board has not been established since this *Act* was proclaimed in 1975.

Non-compliance with *Prisons Act*

The *Prisons Act* allows for the appointment of a superintendent and assistant superintendent. The Superintendent is required to report monthly to the minister, on or before the 10th day of each month, information relating to each prisoner released from the penitentiary during the preceding month.

Our review indicated that the Superintendent does not submit any reports to the Minister containing information pertaining to prisoners released.

Conclusion

The Department is not in compliance with the *Adult Corrections Act* in that the Departmental Board of Corrections has never been established. In addition, the Department is not in compliance with the *Prisons Act* in that the Superintendent does not submit any reports to the Minister containing information pertaining to prisoners released.

Recommendation

The Department should comply with the *Adult Corrections Act* and the *Prisons Act*.

Department's Response

Planning and Reporting

The Department will develop long-term goals and objectives for Adult Custody and incorporate them into the Departmental plan. The first meeting to develop a strategic plan for the Department is the end of January 2008.

The Department will develop operational plans for Adult Custody and incorporate them into the Departmental plan. Meetings with facility management are scheduled for early February 2008.

The Department will review the policy with respect to the frequency of quarterly reports from the various centers - to either change or incorporate bi-annual reporting into policy.

The Department is now in the process of re-establishing Emergency Planning Committees and completing all institutional contingency plans.

Human Resource Management

These costs [callback, overtime and sick leave] are currently monitored but the Department's ability to control such expenditures is challenged constantly. The Department does have a Leave Management Committee in each institution and all sick leave data is reported and consolidated. The Attendance Management protocol will be renewed and alternative strategies explored for reducing reliance on callback and overtime.

A resource will be engaged to complete a procedures manual [for RUS].

Effective immediately, the Department will incorporate this information in Semi-Annual Reports.

Discussions with the Public Service Secretariat to develop performance appraisals will be initiated.

Purchasing and Tendering

The Department will comply with the Public Tender Act *and the* Financial Administration Act.

The Department will comply with the requirements of the on-site tendered food contracts.

The Department will comply with the policies in the tendered food contracts.

The Department has already complied with relation to staff meal rates.

Inventory and Capital Assets

The Department will consider present computerized inventory system for recording supplies inventory.

The Department will ensure inventory counts for pepper spray are completed monthly for each center.

The Department will work with the Department of Transportation and Works in developing a capital asset maintenance program and inspection schedule.

Once a capital asset maintenance program is developed, and in place, the Department will provide reports.

The Department is working with OCIO to develop and implement an inventory system to capture and report on all assets at year end.

Information Management and Technology

This reply comes directly from the OCIO

Security and Information Protection is a key focus for the OCIO.

Currently, through the Manager of Networks/Security, in conjunction with EWA, a leading Canadian Security Company, the IS Branch has developed a Security Framework which will focus security and information protection priorities over the next number of years.

There is currently a Disaster Recovery planning project underway within the OCIO to help prioritize areas where DR plans are required for critical systems within government. In addition, all applications and data pertinent to Adult Custody Division are either being housed in locations external to the sites that use them, being backed up external to those locations, and in many cases, both situations apply. Until a formal DR Plan is implemented, the OCIO is confident that emergency computers and access to required applications can be recovered in a timely manner at any other location within the Government of Newfoundland and Labrador.

The OCIO has just recently formed an 'Enterprise Storage and Recovery' section of Infrastructure Services consisting of four (4) staff dedicated to back-ups. In addition, the OCIO has invested in a sweeping overhaul of its back-up and recovery infrastructure, along with enterprise-grade monitoring and management tools. These initiatives are intended to enhance and improve the reliability, validity and security of Government's back-up environment,and will address the need for regularly scheduled tests for data integrity.

Charts of Authorities for PCOMS have been approved and meetings have been scheduled to for sign off on Charts of Authorities for RUS.

As part of the Infrastructure Renewal project, which is deploying Active Directory (AD) to all GNL employees, the OCIO will be able to more effectively manage and secure GNL computers. In addition, the policies of the AD environment require users to change their passwords at least once every 30 days. The Adult Corrections Division of the Department of Justice is scheduled to be migrated to this new environment by June, 2008.

Legislation

A comprehensive review is being conducted with the objective of repealing Adult Corrections Act *and the* Prisons Act *to consolidate the law governing Corrections into one statute and drafting legislation which is more contemporary and progressive.*

Highlights

Highlights of a review of employment support programs in the Department of Municipal Affairs for the fiscal years 2005-06 and 2006-07.

Why our Office did this Review

The objectives of our review were to determine: how the CEP and other employment support programs were funded; whether the Department adequately and consistently evaluated project applications; and whether the Department monitored the effectiveness of the CEP and other employment support programs.

What our Office Recommends

Following are highlights of recommendations included in the Report that the Department should address. The Department should:

- ensure that the basis for funding allocations to electoral districts is documented by the Department for all programs;
- decisions relating to the approval and rationale for funding of projects, including funding to those sponsor groups who were non-compliant in prior programs, are formally documented;
- the receipt date of program related information from sponsor groups is documented and the date is within program deadlines;
- all applications for funding have sufficient support in the file regarding eligibility of the sponsor group, individuals and project;
- sufficient documentation is submitted by project sponsors, and that missing information is followed up on as part of the review process; and
- final report reconciliations for all project files, including an indication as to who performed the final report review and when, are formally documented.

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.16
DEPARTMENT OF MUNICIPAL AFFAIRS
Employment Support Programs

The Department of Municipal Affairs (the Department) provides services and assistance to municipalities throughout Newfoundland and Labrador. The Employment Support Division administered employment support programs during 2005-06 and 2006-07 ranging from short-term employment programs to community enhancement projects. The main program is the Community Enhancement Program (CEP), an ongoing employment support program, which was known as the Job Creation Program prior to 2005-06. In 2006-07, $4.3 million was used to fund 287 projects under the CEP (2005-06 - $6.0 million to fund 375 projects). Other programs were specifically created in response to employment needs in communities. During 2006-07, the Department spent a total of $10.2 million on all employment support programs, including the CEP ($13.2 million for 2005-06).

What We Found

Our review focused on the main program, the CEP; however, we also reviewed the other employment support programs. Our findings are as follows:

Community Enhancement Program

Overall, the Department did not adequately administer the CEP. Significant concerns were noted with regard to how funding was allocated to electoral districts in the Province, how projects were selected and how projects were monitored. In particular:

District Funding Allocation: While Department officials indicated that funding allocations were made by electoral district, this allocation process was never documented. As a result, the Department could not demonstrate the basis for allocating the extent of funding by district. Furthermore, there was not always documentation in project files to demonstrate that MHAs were advised as to the level of funding approved under the CEP for their district. In addition, due to the allocation being by electoral district, the merit of a project was not evaluated on a Province-wide basis.

Project and Applicant Selection: Our review of the project and applicant selection criteria indicated that the Department could not demonstrate: whether the criteria of "relatively short-term" and "small scale" were met; that the funded projects were approved based on recommendations from MHAs; the basis on which additional funding was approved; whether all applications were received before the deadline date; that all approved applicants met the eligibility criteria for the CEP; justification for continuing to provide project funding to sponsor groups who showed non-compliance in prior years; justification for not approving the funding or official notification to the sponsor group that the funding request was not approved.

Project Monitoring: We found that the Department issued contradictory guidelines for 2005-06, did not always follow-up on non-compliance by sponsor groups, did not adequately review the final reports submitted by sponsor groups, released final funding for projects even when required information was not provided or there were documented instances of non-compliance, and released portions of the final payment either before projects were completed or before final reports were received and reviewed.

Other Employment Support Programs
We also identified similar issues with the following employment programs:

- Crab Workers' Support Program
- Fish Plant Workers' Employment Support Program
- Harbour Breton FPI Workers' Employment Support Program
- Community Enhancement Program - Fish
- Fortune Support Program

Background

The Department of Municipal Affairs (the Department) provides services and assistance to municipalities throughout Newfoundland and Labrador. The Employment Support Division administered seven employment support programs during 2005-06 and 2006-07 ranging from short-term employment programs to community enhancement projects. The main program is the Community Enhancement Program (CEP), an ongoing employment support program, which was known as the Job Creation Program prior to 2005-06. Other programs are specifically created in response to employment needs in communities.

Figure 1 shows the number of projects funded under each program and the expenditures for fiscal years 2005-06 and 2006-07.

Figure 1

Department of Municipal Affairs
Expenditures and Projects Funded
Fiscal Years 2005-06 and 2006-07

Program	2005-06		2006-07	
	No. of Projects	Total	No. of Projects	Total
Community Enhancement Program (CEP): an ongoing employment initiative that replaced the Job Creation Program. The goal of the CEP is to provide funding to community and other groups for community enhancement and other projects.	375	$ 5,977,364	287	$ 4,245,576
Crab Workers' Support Program (CWSP): an employment initiative specifically created to provide assistance to those negatively impacted by the delay in the opening of the crab fishery in 2005.	272	$ 3,685,281	n/a	-

Figure 1 (cont.)

Program	2005-06 No. of Projects	2005-06 Total	2006-07 No. of Projects	2006-07 Total
Fish Plant Workers' Employment Support Program (FPWESP): an employment initiative specifically created in 2006-07 focused on creating short-term employment for fish plant workers who are unemployed as a result of a permanent closure of a fish plant and have not been successful in securing a sufficient number of insurable hours to qualify for Employment Insurance (EI). Funding was directed to fish plant workers in Marystown and Fortune.	n/a	-	55	$ 3,277,238
Harbour Breton FPI Workers' Employment Support Program (HBWESP): an income and employment support program specifically created in 2005-06 for the displaced Fishery Products International (FPI) plant workers in Harbour Breton.	314 individuals	$ 2,691,440	n/a	-
Brush Cutting Program (BCP): an employment initiative to aid individuals in securing a sufficient number of insurable hours to quality for EI. (The BCP was funded through the Department of Transportation and Works, with the Department of Municipal Affairs administering portions of the program.)	n/a	-	51	$ 1,548,643
Community Enhancement Program - Fish (CEP-Fish): an employment initiative specifically created for 2006-07 to help fish plant workers who may not have been successful in securing a sufficient number of insurable hours to quality for EI.	n/a	-	36	$ 1,113,199
Fortune Support Program (FSP): an employment initiative specifically created in 2005-06 to provide assistance to fish plant workers in Fortune who were displaced while FPI enhanced its plant processing capabilities.	27	$ 741,197	n/a	-
Total:		**$ 13,095,282**		**$10,184,656**

Source: Department of Municipal Affairs

All programs are applicant driven and administered by the Department. In the case of the CEP and CEP-Fish, Department officials advised the applicable Member of the House of Assembly (MHA) of eligible projects indicating the ranking for each project. The MHA then recommends to the Department which applications are to be approved, with final approval resting with the Minister of Municipal Affairs. For all other programs, successful projects are approved by Department officials. Successful projects are monitored by the Department, for the most part, through a review of final reports submitted by sponsor groups. Initial project payments of 75% are to be made to sponsor groups for approved projects with the final 25% payment being made upon receipt and review of a final report.

Sponsor groups include organizations such as non-profit groups, municipal councils, and service groups. These organizations may apply for funding for more than one project in any given year.

Audit Objectives and Scope

Audit objectives

The objectives of our review were to determine:

- how the CEP and other employment support programs were funded;
- whether the Department adequately and consistently evaluated project applications; and
- whether the Department monitored the effectiveness of the CEP and other employment support programs.

Audit scope

We reviewed the CEP and other employment support programs for the fiscal years 2005-06 and 2006-07. The review included discussions with Department officials and an examination of project files. We completed our review in December 2007.

Figure 2 shows the number of files reviewed.

Figure 2

Department of Municipal Affairs
Number of Files Reviewed

Program	No. of Files Reviewed		
	2005-06	2006-07	Total
CEP	52	42	94
CWSP	28	n/a	28
FPWESP	n/a	20	20
CEP-Fish	n/a	5	5
HBWESP	35	n/a	35
BCP	n/a	-*	-
FSP	10	n/a	10

*Note: Funding was provided through the Department of Transportation and Works. Therefore, no project files were reviewed.

Overall Conclusions

The Employment Support Division of the Department of Municipal Affairs (the Department) administered employment support programs during 2005-06 and 2006-07 ranging from short-term employment programs to community enhancement projects.

Our review focused on the main program, the Community Enhancement Program (CEP), an ongoing employment support program, which was known as the Job Creation Program prior to 2005-06. We also reviewed other programs which were specifically created in response to employment needs in communities. Our findings are as follows:

1. Community Enhancement Program

Overall, the Department did not adequately administer the Community Enhancement Program. Significant concerns were noted with regard to how funding was allocated in the Province, how projects were selected and how projects were monitored. In particular:

District Funding Allocation

While Department officials indicated that funding allocations were made by electoral district, this allocation process was never documented. As a result, the Department could not demonstrate the basis for allocating the extent of funding by district. Furthermore, there was not always documentation in project files to demonstrate that MHAs were advised as to the level of funding approved under the CEP for their district.

In addition, due to the allocation being by electoral district, the merit of a project was not evaluated on a Province-wide basis.

Project and Applicant Selection

Our review of the project and applicant selection criteria indicated that:

- The Department did not establish definitions for two of the five selection criteria, i.e. the terms "relatively short-term" and "small scale" criteria. As a result, the Department could not demonstrate whether these criteria were met. These criteria were in place only for 2005-06.

- Project files did not always contain copies of recommendations from the district MHA regarding project approvals. As a result, the Department could not demonstrate that the funded projects were approved based on recommendations from MHAs.

  In addition, prior to 2006-07, because projects were approved on a first come, first served basis, they were not evaluated relative to other potential projects to maximize the effectiveness of the Program for the district.

- Numerous sponsor groups were approved for funding amounts that were more than the funding amount requested. For example, we found that of the 42 CEP projects we reviewed that were funded from 36 different sponsor groups in the 2006-07 year, 4 sponsor groups were granted a total of $3,414 in additional funding over the $58,210 which was originally requested.

- In 2005-06 there was no established application process for additional funding requests which would provide details from the sponsor group on either the work to be completed or the rationale for requesting the additional amount. As well, there was no documentation indicating on what basis the Department had approved the additional funds. As a result, the Department could not demonstrate the basis on which the additional funding was approved.

- The Department could not demonstrate whether all applications were received before the deadline date because applications were not always date stamped.

- The Department did not require individuals to provide documentation to support whether they were eligible for employment under the CEP. We note that for 2006-07, although the Department developed a form whereby potential applicants were to indicate their eligibility, the form was never used. As a result, the Department was not able to demonstrate that all approved applicants met the eligibility criteria for the CEP.

- Sponsor groups received funding for 2005-06 and 2006-07 even though they did not comply with program guidelines in prior years. As a result, the Department could not demonstrate justification for continuing to provide project funding to sponsor groups who showed non-compliance in prior years.

- Project files did not contain documentation outlining the justification for not approving the funding or official notification to the sponsor group that the funding request was not approved.

Project Monitoring

We found that the Department issued contradictory guidelines for 2005-06, did not always follow-up on non-compliance by sponsor groups, did not adequately review the final reports submitted by sponsor groups, released final funding for projects even when required information was not provided or there were documented instances of non-compliance, and released portions of the final payment either before projects were completed or before final reports were received and reviewed.

2. Other Employment Support Programs

Crab Workers' Support Program

We found that the Department issued contradicting guidelines for 2005-06, demonstrated non-compliance in applicant selection, did not always follow-up on non-compliance by sponsor groups, did not adequately review the final reports submitted by sponsor groups, and released final funding for projects even when required information was not provided.

Fish Plant Workers' Employment Support Program

We found that the Department demonstrated non-compliance in applicant and project selection, did not always follow-up on non-compliance by sponsor groups, did not adequately review the final reports submitted by sponsor groups, released final funding for projects even when required information was not provided, and released portions of the final payment either before projects were completed or before final reports were received and reviewed.

Harbour Breton FPI Workers' Employment Support Program

This program was reviewed by an external auditor. Their audit report indicated that the Department did not adequately administer and define program payment options to individuals, did not always follow-up on non-compliance by sponsor groups, and released final funding for projects even when required information was not provided.

CEP-Fish

We found that the Department demonstrated non-compliance in project selection, did not release separate program guidelines, did not always follow-up on non-compliance by sponsor groups, released final funding for projects even when required information was not provided, and released portions of the final payment before projects were completed.

Fortune Support Program

We found that the Department demonstrated non-compliance in applicant and project selection, did not release separate program guidelines and administered the FSP using inconsistent guidelines for 2005-06 which were based on the CEP guidelines, did not always follow-up on non-compliance by sponsor groups, did not adequately review the final reports submitted by sponsor groups, and released final funding for projects even when required information was not provided.

Detailed Observations

Overview

Projects funded under the employment support programs included activities such as:

- brush cutting, landscaping;
- painting, repairs and maintenance of community buildings;
- clean up and maintenance of community and beaches;
- relocation of community building;
- cemetery and church maintenance;
- compilation of town history;
- artifacts preservation and cataloguing;
- fence and wharf construction;
- development and enhancement of trail systems;
- seniors' care;
- snow removal;
- developing parking spaces;
- water systems maintenance;
- general arena operations;
- playground and recreation facility upgrades;
- staffing of SPCA facility;
- ski park improvements;
- office administration duties;
- wetland nature trail extension and maintenance;
- repairs and construction of fishing shed/stage; and
- extension of landfill site.

Who could receive funding

The following sponsor groups are eligible for funding under all of the employment support programs:

- non-profit organizations;
- community-based agencies;
- service groups;
- churches;
- municipal councils and local service district committees;
- development agencies; and
- women's institutes and heritage groups (as of 2006-07).

Application process

All programs are applicant driven and administered by the Department. In the case of the CEP and CEP-Fish, Department officials advised the applicable Member of the House of Assembly (MHA) of eligible projects indicating the ranking for each project. The MHA then recommends to the Department which applications are to be approved, with final approval resting with the Minister of Municipal Affairs. For all other programs, successful projects are approved by Department officials.

Project applications for all programs must be submitted to the Department by the deadline stated in the applicable Program guidelines.

The CEP guidelines for 2005-06 indicated that applications would be processed on a first come, first served basis until all electoral district funding had been allocated.

Processing applications on a first come, first served basis meant that applications were evaluated and awarded before the deadline when all applications had to be submitted. By not waiting for the application deadline to close before evaluation of proposed projects, some applications may not have been considered because the funding allocated to that electoral district had already been committed.

For 2006-07, the CEP guidelines were modified to indicate that all project proposals would be evaluated by an inter-departmental committee after the application deadline. The selection was based on regional allocation and focused on primary objectives. This provided an opportunity for the merit of a project to be evaluated on an electoral district basis.

The CEP is the main employment support program administered by the Department. As such, our review focused on this program; however, other programs were reviewed. Our findings are contained in the following sections:

1. Community Enhancement Program (CEP)
2. Other Employment Support Programs

1. Community Enhancement Program

Program objectives

The overall specific objectives of the CEP were to:

- provide a short-term employment initiative;
- support projects with an enduring benefit to the communities and which have an economic development or community infrastructure focus; and

- act as leverage to combine with other government programs and community-based fundraising initiatives to supply materials, specialized labour, and other non-labour related project components.

For 2006-07, the Department modified the objectives to note that the resulting projects should focus on four key areas, namely, public health and safety; economic development; community infrastructure; and beautification.

Eligible applicants

Sponsor groups apply for funding to employ eligible applicants who were unemployed and have not been successful in securing sufficient hours of insurable employment to apply for EI benefits.

CEP expenditures

The actual expenditures for the CEP were $5.98 million for 2005-06 and $4.25 million for 2006-07. Figure 3 shows CEP expenditures by electoral district for each fiscal year.

Figure 3

Department of Municipal Affairs
Community Enhancement Program
Expenditures by Electoral District
Fiscal Years 2005-06 and 2006-07

Electoral District	Actual 2005-06	Actual 2006-07
Baie Verte	$ 323,805	$ 210,628
Bay of Islands	90,554	54,980
Bellevue	165,400	115,412
Bonavista North	282,900	224,483
Bonavista South	352,100	239,385
Burgeo and La Poile	242,794	161,205
Burin - Placentia West	184,980	123,915
Cape St. Francis	24,464	12,166
Carbonear - Harbour Grace	130,000	89,085
Cartwright - L'Anse Au Clair	184,392	122,102
Conception Bay East and Bell Island	30,799	20,120
Conception Bay South	10,500	6,922
Exploits	100,000	72,472

Figure 3 (cont.)

Electoral District	Actual 2005-06	Actual 2006-07
Ferryland	271,485	169,478
Fortune Bay - Cape La Hune	249,196	166,736
Gander	19,649	-
Grand Bank	164,700	107,686
Grand Falls - Buchans	117,300	73,749
Harbour Main - Whitbourne	116,702	91,953
Humber East	38,843	11,445
Humber Valley	74,000	39,371
Kilbride	12,000	-
Lake Melville	28,000	15,770
Lewisporte	164,972	116,069
Placentia and St. Mary's	210,300	140,942
Port au Port	190,900	163,433
Port de Grave	75,361	52,315
St. Barbe	278,900	217,315
St. George's - Stephenville East	130,000	88,023
St. John's Centre	23,600	-
St. John's South	10,500	10,708
Terra Nova	193,494	127,604
The Straits and White Bay North	531,204	241,952
Torngat Mountains	120,000	74,586
Trinity - Bay de Verde	133,750	105,379
Trinity North	127,000	80,347
Twillingate and Fogo	171,320	111,699
Windsor - Springdale	251,500	174,219
Administration	150,000	411,922
Total	**$ 5,977,364**	**$ 4,245,576**
Number of projects	**375**	**287**

Source: Department of Municipal Affairs

As Figure 3 shows, during 2005-06 funding valued at $5,977,364 was provided to 38 districts with total funding per district ranging from $10,500 to $531,204. During 2006-07, funding valued at $4,245,576 was provided to 35 districts with total funding per district ranging from $6,922 to $241,952.

The detailed audit findings for the CEP are contained in the following sections:

A. District Funding Allocation
B. Project and Applicant Selection
C. Project Monitoring

1A. District Funding Allocation

Funding allocations for the CEP were made by electoral district. Therefore, we would expect that there would be criteria and/or documentation available to support the amount of funding provided to each district. Department officials indicated that historical funding levels were considered during the allocation process and that funding was allocated to districts after discussions among the Minister of Municipal Affairs, the Manager of Employment Support Programs (the Manager) and applicable MHAs.

Our review indicated that:

- the funding allocation process as described by Department officials was never documented. As a result, the Department could not demonstrate the basis for allocating the extent of funding by district. For example, there was no documented evidence to support why the district of The Straits and White Bay North received the largest allocation of funding in both 2005-06 and 2006-07.

- there was not always documentation in project files to demonstrate that MHAs were advised as to the level of funding approved under the CEP for their district. For example, there was no documentation in 40 files for 2005-06 and 2 files for 2006-07 to advise the MHA regarding funding allocations. In the files which did contain documentation, the documentation present was in the form of e-mails. Department officials advise that MHAs are informed of their districts' allocation in a letter provided to them each year. However, this letter is normally not placed in individual project files but is instead retained in overall program files by district. We would have expected all approvals to be included in the project files.

In addition, due to the allocation being by electoral district, the merit of a project was not evaluated on a Province-wide basis.

1B. Project and Applicant Selection

CEP projects

We reviewed a total of 94 CEP projects covering the two year period 2005-06 and 2006-07. Details by year follow.

CEP projects reviewed for 2005-06

For fiscal year 2005-06, we reviewed 52 CEP projects in 23 districts represented by 30 sponsor groups. Details of these samples are outlined in Figure 4.

Figure 4

Department of Municipal Affairs
Community Enhancement Program
Summary of Sponsor Groups Reviewed
For the Year Ended 31 March 2006

	Sponsor Group	Electoral District	No of Projects	Total Funding
1	Town of Englee	The Straits and White Bay North	4	$ 251,204
2	Port au Port Economic Development Association	Port aux Port	6	152,514
3	Lewisporte Area Development Association	Lewisporte	12	116,890
4	Regional Joint Council - Hawkes Bay	St. Barbe	1	101,634
5	St. Barbe Development Association	St. Barbe	1	98,385
6	Bonavista Historic Townscape Foundation	Bonavista South	2	71,300
7	Matthew Legacy	Bonavista South	2	68,814
8	Central Development Association	St. Barbe	1	63,775
9	Town of Harbour Breton	Fortune Bay - Cape la Hune	2	63,000
10	St. Marys Bay North Development Association	Placentia and St. Mary's	1	50,800
11	Town of Marystown	Burin - Placentia West	1	40,980
12	Fermeuse Hall Committee	Ferryland	1	39,000
13	Burgeo Recreation Committee	Burgeo and La Poile	1	30,000
14	Royal Canadian Legion Branch 7	Bonavista South	1	29,003

Figure 4 (cont.)

	Sponsor Group	Electoral District	No of Projects	Total Funding
15	Codroy Valley Development Association	St. Georges - Stephenville East	1	25,000
16	Labrador Friendship Committee	Lake Melville	1	23,222
17	Indian Bay Snowmobile and ATV Club	Bonavista North	1	23,000
18	MIRA Incorporated	Bonavista North	1	20,000
19	Local Service District of Georges Brook & Miltown	Trinity North	1	20,000
20	Town of LAnse au Loup	Cartwright - Lanse au Clair	1	17,507
21	Airport Nordic Ski Club	Gander	1	15,649
22	Get Active Committee	Bonavista South	1	14,949
23	Fortune Harbour Development Committee	Exploits	1	14,000
24	St. Annes Parish Board of Administration	Harbour Main - Whitbourne	1	11,152
25	Bay of Islands SPCA	Bay of Islands	1	7,000
26	Shea Heights Development Association	St. Johns South	1	6,000
27	Your Strength is Our Strength Club	Exploits	1	5,000
28	Local Service District of Shoe Cove	Baie Verte	1	5,000
29	Flatrock Heritage Committee	Cape St. Francis	1	4,584
30	Humber Valley United Church	Humber East	1	3,000
	Total Projects Examined		**52**	**$ 1,392,362**
	Program Total		**375**	**$ 5,977,364**

Source: Department of Municipal Affairs

CEP projects reviewed for 2006-07

For fiscal year 2006-07, we reviewed 42 CEP projects in 25 districts represented by 36 sponsor groups. Details of these samples are outlined in Figure 5.

Figure 5

Department of Municipal Affairs
Community Enhancement Program
Summary of Sponsor Groups Reviewed
For the Year Ended 31 March 2007

	Sponsor Group	Electoral District	No of Projects	Total Funding
1	Port au Port Economic Development Association	Port au Port	1	$ 163,660
2	St. Barbe Development Association	St. Barbe	1	98,683
3	Lewisporte Area Development Association	Lewisporte	7	91,057
4	Town of Roddickton	The Straits and White Bay North	1	85,302
5	Bonavista Historic Townscape Foundation	Bonavista South	1	70,564
6	Regional Council of Port Saunders, Port au Choix, Hawkes Bay, etc.	St. Barbe	1	55,000
7	Town of Harbour Breton	Fortune Bay - Cape la Hune	1	52,157
8	White Bay Central Development Association	The Straits and White Bay North	1	50,888
9	Central Development Association	St. Barbe	1	47,766
10	Greater Lamaline Area Development Association	Grand Bank	1	45,452
11	Grand Bank Heritage Society	Grand Bank	1	42,196
12	Placentia Area Development Association	Placentia and St. Mary's	1	38,000
13	St. Mary's Bay North Rural Development Association	Placentia and St. Mary's	1	36,000
14	Msgr. McCarthy Council #5902, K of C	Carbonear - Harbour Grace	1	35,421
15	Southern Avalon Development Association	Ferryland	1	34,905
16	Bonaventure English Harbour Dev. Assoc	Trinity North	1	32,474
17	Town of Belleoram	Fortune Bay - Cape la Hune	1	31,745
18	Englee United Church Board of Management	The Straits and White Bay North	1	30,889
19	Burin Heritage Tourism Association	Burin - Placentia West	1	29,950

Figure 5 (cont.)

	Sponsor Group	Electoral District	No of Projects	Total Funding
20	Town of Triton	Windsor - Springdale	1	29,503
21	Isthmus Development Association	Bellevue	1	28,214
22	Placentia West Development Association	Burin - Placentia West	1	28,000
23	Town of Channel-Port aux Basques	Burgeo and La Poile	1	28,000
24	Town of New-Wes-Valley	Bonavista North	1	25,000
25	Bay St. George South Area Development Association	St. Georges - Stephenville East	1	24,000
26	Sir William Ford Coaker Heritage Foundation	Bonavista South	1	23,853
27	Town of Nippers Harbour	Baie Verte	1	23,000
28	Fermeuse Town Council	Ferryland	1	22,255
29	Mary's Harbour Town Council	Cartwright - Lanse au Clair	1	20,871
30	Town of Wabana	Conception Bay East and Bell Island	1	20,120
31	Windmill Bight Park Inc.	Bonavista North	1	19,803
32	Main River Academy Naturalization Committee	Humber Valley	1	19,534
33	Town of Peterview	Exploits	1	19,500
34	Town of Twillingate	Twillingate - Fogo	1	18,911
35	Rigolet Inuit Community Government	Torngat Mountains	1	17,738
36	Bonavista Bay Search and Rescue Team	Terra Nova	1	4,949
	Total Projects Examined		**42**	**$ 1,445,360**
	Program Total		**287**	**$ 4,245,576**

Source: Department of Municipal Affairs

We reviewed the following aspects of the project selection process:

(i.) Project eligibility criteria
(ii.) Approval process
(iii.) Amended applications
(iv.) Applicant eligibility criteria
(v.) Adherence to program guidelines
(vi.) Funding requests not approved

Specific eligibility criteria not documented and not complied with

(i.) Project Eligibility Criteria

The Department established project eligibility criteria in order to optimize the number and nature of projects offered to communities across the Province. Projects submitted by sponsor groups for the 2005-06 fiscal year had to meet specific criteria to demonstrate that the project was:

- relatively short-term;
- labour intensive;
- available for immediate start-up;
- small scale; and
- administered by the sponsor group.

We found that the Department did not establish definitions for the "relatively short-term" and "small scale" criteria. As a result, the Department could not demonstrate whether these criteria were met. For example, our review indicated that for 12 of the 52 project files reviewed in 2005-06, the number of people employed was 18 or greater with one project having in excess of 40 employed. This does not appear small scale in comparison to other approved projects.

The guidelines used for programs offered in 2006-07 did not include either the short-term or small scale criteria.

Rationale for approvals not documented

(ii.) Approval Process

We were advised by Department officials that an inter-departmental committee was in place to review and approve projects based on the CEP guidelines. This committee consisted of the Director of Employment Support Programs, the Manager of Employment Support Programs and, as appropriate, a representative from other departments. The committee meets once a year, after the application deadline, to review all applications received. The review is based on a project summary prepared by project coordinators.

Commencing in 2006-07 the committee used the summaries and the project files to rank projects by priority. The ranking criteria in order of priority for each project are:

1. public health and safety;
2. economic development;
3. community infrastructure; and
4. beautification.

The ranking is then added to the project summary in a database. Department officials advise the applicable MHA of eligible projects indicating the committee's ranking for each project. The MHA then recommends to the Department which applications are to be approved, with final approval resting with the Minister of Municipal Affairs.

Our review of the CEP project files indicated that copies of recommendations from the district MHA regarding project approvals were not in project files for 29 of the 52 files for 2005-06 and 13 of the 42 files for 2006-07.

As a result, the Department could not demonstrate that projects were approved based on recommendations from MHAs.

In addition, prior to 2006-07, because projects were approved on a first come, first served basis, they were not evaluated relative to other potential projects to maximize the effectiveness of the Program for the district.

Funding approvals exceed funding requests

Numerous sponsor groups were approved for funding amounts that were more than the funding amount requested. For example, we found that of the 42 CEP projects we reviewed that were funded from 36 different sponsor groups in the 2006-07 year, 4 sponsor groups were granted a total of $3,414 in additional funding over the $58,210 which was originally requested.

Additional funding issued without an application

We would expect a process whereby requests for additional funds would have to be documented, reviewed and approved. Additional funding should be supported by documented rationale. Department officials indicated that commencing in 2006-07 additional funding was to be requested through submission of an amended application form.

Our review indicated the following:

- For 2005-06 there was no established application process for additional funding requests which would provide details from the sponsor group on either the work to be completed or the rationale for requesting the additional amount. As well, there was no documentation indicating on what basis the Department had approved the additional funds. As a result, the Department could not demonstrate the basis on which the additional funding was approved.

- For 2005-06, we reviewed 52 project files and found that 11 of the 14 projects that received additional funding did not submit a separate application. With regard to these 11 projects, we found that:

    - 1 sponsor group used the original funding application to process the request. The original application was copied and the funding amount updated for the current request;

    - 3 sponsor groups requested additional funding through letters;

    - 1 sponsor group requested additional funding through e-mail; and

    - 6 project files had no documentation indicating sponsor group requests.

- For 2006-07, we reviewed 42 project files and found that 2 of the 16 projects that received additional funding did not submit an amended application. With regard to these 2 projects, we found that 1 sponsor group requested additional funding through e-mail, while for the other project, there was no documentation indicating the sponsor group's request.

Figure 6 shows the total additional funding approved for the sponsor groups for 2005-06 and 2006-07.

Figure 6

Department of Municipal Affairs
Community Enhancement Program
Additional Funding Issued Without Application
For the Years Ended 31 March

Sponsor Group	Electoral District	Original Funding	Additional Funding
CEP, 2005-06			
Port au Port Economic Development Association	Port au Port	$29,500	$ 900
Regional Joint Council - Hawkes Bay	St. Barbe	70,000	31,634
St. Barbe Development Association	St. Barbe	80,000	18,385
Town of Marystown	Burin - Placentia West	40,000	980
Town of Harbour Breton	Fortune Bay - Cape la Hune	40,000	20,000
Matthew Legacy	Bonavista South	20,000	45,000
Bonavista Historic Townscape Foundation	Bonavista South	25,000	1,300
Central Development Association	St. Barbe	55,000	8,775
Labrador Friendship Centre	Lake Melville	22,883	339
St. Mary's Bay North Development Association	Placentia and St. Marys	35,800	15,000
Town of Lanse au Loup	Cartwright - Lanse au Clair	13,069	4,438
Total		**$ 431,252**	**$ 146,751**
CEP, 2006-07			
Bonavista Historic Townscape Foundation	Bonavista South	30,000	40,650
St. Barbe Development Association	St. Barbe	90,000	8,587
Total		**$ 120,000**	**$ 49,237**

Source: Department of Municipal Affairs

As Figure 6 shows, during 2005-06, 11 sponsor groups were approved for additional funding totalling $146,751, even though no application for additional funding was submitted. During 2006-07, 2 sponsor groups were approved for additional funding under the CEP totalling $49,237 even though no application for additional funding was submitted.

Projects approved after the application deadline

Under the CEP program guidelines, applications were to be submitted by the deadline date of 31 August. We would expect there to be documentation indicating that all applications were received by the deadline date.

Our review indicated that the following projects were approved:

- for 2005-06, 8 applications of the 52 project files reviewed were date stamped after the deadline while 2 of the applications were not date stamped; and

- for 2006-07, 18 applications of the 42 project files reviewed were date stamped after the deadline while 1 of the applications was not date stamped.

As a result, the Department could not demonstrate whether 3 of the applications were received before the deadline date while the acceptance of the 26 applications subsequent to the deadline date, without a published extension of the deadline date, did not provide all potential applicants with equal opportunity to apply for funding.

Amended applications not received

(iii.) Amended Applications

In 2006-07, the revised guidelines included a requirement that if a project is approved for a lesser amount than originally requested or the project description changes, an amendment will be required to reflect any adjustments before the initial advance of 75% of funding is released.

We found that in 2006-07, numerous sponsor groups either did not submit an amended application for funding approvals that were lower than the original amount requested, or did not submit accurate amended applications (they do not reconcile with the Department's approved funding amount).

Of the 42 project files reviewed 5 sponsor groups did not submit an amended application even though they were approved for funding which was for a lesser amount than requested. In addition, 6 sponsor groups submitted amended applications as required; however, the amended application was not accurate in that it did not agree to the amount of funding approved.

Applicant eligibility not documented

(iv.) Applicant Eligibility Criteria

According to the guidelines, sponsor groups could only hire individuals who were eligible under the program guidelines. Applicants were eligible if they were within the last nine weeks of their current EI benefits claim or they were in receipt of survivor benefits and this was their only source of income.

Our review indicated that the Department did not require sponsor groups to provide documentation to support whether individuals hired were eligible for employment under the CEP. We note that for 2006-07, although the Department developed a form whereby potential applicants were to indicate their eligibility, the form was never used. As a result, the Department was not able to demonstrate that all approved applicants met the eligibility criteria for the CEP.

Commencing in 2006-07, the Department added specific criterion that the project should also support gender equity.

Funding approved despite prior non-compliance

(v.) Adherence to Program Guidelines

The CEP guidelines indicated that the sponsor groups may not be eligible for future project funding if they did not comply with guidelines in prior projects. We would expect to see documentation supporting the rationale for continuing to provide project funding to specific non-compliant sponsor groups.

Our review indicated that:

- 11 of the 27 sponsor groups we examined for 2004-05 received funding for 2005-06 even though they did not comply with program guidelines for projects approved under the Job Creation Program in 2004-05. For example, a sponsor group received $152,930 in 2005-06 even though they had not complied with the guidelines for an approved project in 2004-05; however, there was no documentation to support the rationale for providing continued funding for that sponsor group.

- 17 of the 30 sponsor groups we examined for 2005-06 received funding for 2006-07, even though they did not comply with the program guidelines for 2005-06. For example, a sponsor group received $163,433 in 2006-07 even though they had not complied with the guidelines for an approved project in 2005-06; however, there was no documentation to support the rationale for providing continued funding for that sponsor group.

As a result, the Department did not demonstrate justification for continuing to provide project funding to sponsor groups who showed non-compliance in prior years.

Funding requests not approved were not well documented

(vi.) Funding Requests Not Approved

Applications are reviewed by an inter-departmental committee and/or the respective MHAs for the region. Approval of eligible projects is at the discretion of the MHA. Eligible projects may not be approved because:

- funding has already been allocated to other projects in the region;
- the application was received after the deadline; and/or
- the project does not meet program objectives.

We would expect that sponsor groups would be notified as to the reason their funding request was not approved.

Our review indicated the following:

- We examined 30 project applications received by the Department in 2005-06 to determine on what basis the funding was not approved. We found that 28 project files did not contain documentation outlining the justification for not approving the funding or official notification to the sponsor group that the funding request was not approved.

- We examined 32 project applications received by the Department in 2006-07 to determine on what basis the funding was not approved. We found that 1 project file did not contain documentation outlining justification for not approving the funding or official notification to the sponsor group that the funding request was not approved.

1C. Project Monitoring

Overview

The Department monitored projects by reviewing final reports which were required to be submitted by sponsor groups at the conclusion of each project. Final reports were due by 31 March for the projects in 2005-06. For projects undertaken in 2006-07, reports were due 30 days after the project end date.

The final report is intended to demonstrate whether the project funding was used for the purposes intended and whether the sponsor groups met the requirements. The content requirements of the final report are outlined in the program guidelines and include employment cost details, copies of invoices to support numbers in the final report, and copies of records of employment and payroll information. The final 25% payment was to occur after the Department received the final report. The initial 75% payment was issued when the project was approved.

Guidelines for 2005-06

The published set of guidelines for the CEP provided that the sponsor groups should meet the following requirements for 2005-06:

- individuals employed were screened to establish if they were qualified for employment;
- labour costs were a minimum of 65% of the total costs of the project;
- costs of materials were a maximum of 25% of the total costs of the project;
- administration costs were a maximum of 10% of the total costs of the project;
- individuals were employed for a maximum of 420 hours;
- wages paid in excess of the Provincial minimum wage received prior approval from the Department;

- projects were completed by established deadlines; and
- project extensions received prior written approval from the Department.

Guidelines for 2006-07

There were significant changes to the requirements for sponsor groups participating in the CEP offered by the Department in 2006-07. In addition to the guidelines required for the 2005-06 year, the following items were added:

- special measures were taken to support the participation of women on the project;
- project selection is based on four key criteria - public health and safety, economic development, community infrastructure, and beautification;
- amendments to original submissions will be required if the project funding amount or description changes;
- an authorization to Collect and Disclose Information form must be signed by each employee to permit sponsor groups to disclose personal information to the Department contained on the Record of Employment;
- documentation is required to support administration costs;
- the deadline for submission of final reports is 30 days after project completion;
- costs of materials were revised to a maximum of 25% of the total labour costs of the project; and
- administration costs were revised to a maximum of 10% of the total labour costs of the project.

In our review of final reports for all project files, we found the following issues:

(i.) Contradicting guidelines
(ii.) Non-compliance with guidelines
(iii.) Inadequate review
(iv.) Final payment issuance not consistent with guidelines

Department provided contradictory guidelines to sponsor groups

(i.) Contradicting Guidelines

There were conflicting versions of CEP program guidelines available to sponsor groups for the 2005-06 fiscal year.

The CEP program guidelines provided on the Department's Internet site stated that material and administration costs were calculated as a percentage of total labour costs. However, the application guidelines which were provided via the Internet stated that material and administration costs were calculated as a percentage of total project costs.

The Minister's approval letters and the blank copies of final reports which were sent to the sponsor groups also included calculations which were based on total project costs.

These contradictory guidelines resulted in sponsor groups providing inconsistent final reports in that some were based on total labour costs while others were based on total project costs. These inconsistencies also resulted in difficulties for the Department when reviewing final project reports. Department officials indicated that the CEP guidelines for 2005-06 were intended to allocate monies based on percentages of total labour costs. However, due to contradictory guidelines, the Department decided to monitor projects based on total project costs, which was the basis on which the vast majority of sponsor groups reported.

The Department had a focus on total labour costs in order to ensure maximum benefits for people seeking employment. However, as a result of the contradictory guidelines, the Department was forced to accept total project costs (i.e. with less focus on the labour component). Furthermore, it also resulted in increased work at the Department in adjusting final reports, e.g. in 2005-06, 34 of the 52 final reports we reviewed were adjusted by the Department.

(ii.) Non-Compliance with Guidelines

We reviewed final reports to determine whether sponsor groups complied with the CEP guidelines. We reviewed 52 project files for 2005-06 and 42 project files for 2006-07. Details of our review are as follows:

Non-compliance for 2005-06

We reviewed 52 project files for 2005-06 representing 30 sponsor groups and identified the following instances of non-compliance:

- none of the sponsor groups provided sufficient documentation to support hiring decisions and to establish if employees were qualified for employment;
- 4 sponsor groups, representing 4 project files, paid labour amounts that constituted less than the minimum 65% of total project costs;
- 9 sponsor groups, representing 13 project files, paid amounts for materials in excess of the maximum 25% of total project costs; however, 1 sponsor group received prior approval from the Department;
- 4 sponsor groups, representing 4 project files, paid administration amounts in excess of the maximum 10% of total project costs;
- 13 sponsor groups, representing 19 project files, had employees who worked for more than the maximum 420 hours over the life of the projects; and
- 18 sponsor groups, representing 36 project files, paid employees at a rate higher than the Provincial minimum wage, and of these, 13 sponsor groups representing 31 project files had not received the required prior approval from the Department to pay at the higher rate.

In addition, we found other areas where reports lacked supporting documentation. In particular:

- 4 files did not include invoices for materials purchased;
- 2 files did not include support for mileage claims paid;
- 1 file did not include payroll information, in particular, information relating to Receiver General Remittances; and
- 18 files did not include individual details for worker compensation calculations which were calculated under total labour costs.

Non-compliance for 2006-07

We reviewed 42 project files for 2006-07 representing 36 sponsor groups and identified the following instances of non-compliance:

- none of the sponsor groups provided sufficient documentation to support hiring decisions and to establish if employees were qualified for employment;

- 17 sponsor groups, representing 22 project files, paid employees at a rate higher than the Provincial minimum wage, and of these, 7 sponsor groups representing 12 project files had not received the required prior approval from the Department to pay at the higher rate. The Department indicated that in situations where a carpenter or a supervisor is required, approval for payment is sometimes at the final cost stage as the Department considered the payment of the special skill rate to be reasonable. However, there was no documentation in the project files to support this assessment;
- 13 sponsor groups did not submit the final report by the established deadline; and
- 12 sponsor groups did not submit sufficient Authorization to Collect and Disclose Information forms. For one project, one person selected "no" to the disclosure.

In addition, we found other areas where reports lacked supporting documentation. In particular:

- 1 file did not include invoices for materials purchased;
- 6 files contained reimbursements for travel/gas claims; however, no mileage details were provided;
- 3 files contained a general invoice for administration; however, no detail of the expense was outlined on the invoice;
- 7 files contained significantly high costs for bookkeeping expenses in the administration costs; and
- 9 files did not contain evidence in the final report that gender composition of employees was considered.

Insufficient follow-up by Department

We would expect the Department to follow-up with sponsor groups on any instances where required information was not provided in the final report. Our review indicated that Department officials did not always take any action to obtain information not provided by the sponsor groups. In addition, when the sponsor group did provide information, the Department did not always take further action with the identified non-compliance.

Funding holdbacks released even though non-compliance

The Department has a policy which provides that the final 25% payment may not be issued and future funding may not be approved if the sponsor group is in non-compliance with the guidelines.

Our review indicated that final funding was released for projects even when required information was not provided or there were documented instances of non-compliance. For example:

- in 2005-06, for all 21 of the 52 project files reviewed where the Department issued a letter to sponsor groups advising of non-compliance, the final 25% funding holdback was released. The Department did not take any action on issues of non-compliance and the non-compliance did not lead to rejection of funding in the next year.

- in 2006-07, for all 8 of the 42 project files reviewed where the Department issued a letter to sponsor groups advising of non-compliance, the final 25% funding holdback was released. The Department did not take any action on issues of non-compliance.

(iii.) Inadequate Review

Department officials indicated that project coordinators reviewed the final reports. The final report review is intended to identify whether sponsor groups complied with program guidelines before release of the final payment. We would expect to see the result of this review along with a proper sign-off to signify who conducted the review and when the review was completed.

Inadequate review for 2005-06

We reviewed 52 final reports for 2005-06 and found the following:

- 4 reports contained no evidence of any review, i.e. no signature, no notation;
- 35 reports had no signature to indicate who performed the review even though there were notations on the final report; and
- none of the final reports indicated the date when the review was completed.

Inadequate review for 2006-07

In 2006-07, the Department introduced a formal final report reconciliation form which was to be completed and signed by the project coordinator who reviewed the final report. This form was then to be approved by the Manager before release of the final payment.

We reviewed 42 final reports for 2006-07 and found that in 5 project files, while the final reports included notations to indicate review by project coordinators, they did not contain a final report reconciliation form.

(iv.) Final Payment Issuance not Consistent with Guidelines

Final payments made before project completed

Program guidelines indicated that projects for 2005-06 had to be completed by 31 March 2006 and that final payment could not be made until the final report was received and reviewed. For 2006-07, the final report was due 30 days after the project was completed. If the sponsor group was not in compliance with the guidelines, they may be denied access to the final payment.

Our review indicated that although the Department received all 94 reports, we were unable to determine when 7 of the 52 reports for 2005-06, and 3 of the 42 reports for 2006-07 were received since they were not date stamped. Therefore, the Department could not demonstrate whether the final reports were received prior to the final payment being released to the sponsor group.

Portion of final payment made before project completed

Although there is no provision in the guidelines for the Department to release a portion of the final payment prior to completion of the project or receipt of the final report, our review indicated that a portion of the final payment was released as follows:

- for 26 of 52 project files reviewed for 2005-06:
  - 23 of the 26 project files contained evidence that the sponsor group requested early release of the payment; and
  - 3 of the 26 project files did not contain documentation to indicate why a portion of the final payment was issued before the project was complete.

- for 18 of 42 project files reviewed for 2006-07:
  - 14 of the 18 project files contained evidence that the sponsor group requested early release of the payment; and
  - 4 of the 18 project files did not contain documentation to indicate why a portion of the final payment was issued before the project was complete.

2. Other Employment Support Programs

While the CEP is the main employment support program offered by the Department, other programs were administered during the period 2005-06 and 2006-07 as follows:

- Crab Workers' Support Program
- Fish Plant Workers' Employment Support Program
- Harbour Breton FPI Workers' Employment Support Program
- Community Enhancement Program-Fish
- Fortune Support Program

In addition, the Brush Cutting Program was funded through the Department of Transportation and Works, with the Department of Municipal Affairs only administering portions of the program. Therefore, no detailed review of this program was conducted. Findings related to our review of five programs are as follows:

2A. Crab Workers' Support Program

The Crab Workers' Support Program (CWSP) was an employment initiative specifically created to provide assistance to those negatively impacted by the delay in the opening of the crab fishery in 2005. It was to provide up to $18 million in funding to cover the approximately 8,500 potentially affected workers.

Eligible applicants

In the case of the CWSP, the following applicants were eligible for funding:

- workers who demonstrated attachment to the Crab Industry in 2004 and 2005;
  - core and casual plant workers, graders, monitors, off loaders, and truck drivers directly impacted by the delay in the opening of the crab season;
  - workers who were employed for less weeks in 2005 than in 2004; and
  - workers who were employed for less than 14 weeks or less than 560 hours in the 2005 season.

Extent of review

In total, 272 projects were funded in 2005-06 with expenditures totalling $3,685,281. We reviewed 28 of these project files and the related 124 applicant files with expenditures totalling $1,193,420. Our findings are contained in Figure 7.

Figure 7

Crab Workers' Support Program
Audit Findings
2005-06

Applicant Selection	Of the 124 applicants tested , we found the following issues with 48 of 124 applicant files: - 24 received more assistance than they were qualified for; - 11 had worked more than 560 hours in 2005 and were still provided assistance; - 4 applicant files could not be located; - 4 worked more than 14 weeks in 2005 and were still provided assistance; - 2 received less assistance than for which they qualified; - 2 worked more hours and weeks in 2005 than in 2004 and still received assistance; and - 1 where the Department could not demonstrate the number of hours/weeks worked.

Figure 7 (cont.)

Project Monitoring	There were conflicting versions of CWSP program guidelines available to sponsor groups for the 2005-06 fiscal year. The CWSP program guidelines provided on the Department's Internet site stated that materials and administration costs were calculated as a percentage of total labour costs. However, the program guidelines sent to the sponsor groups, and included in the final report form stated that materials and administration costs were calculated as a percentage of total project costs. These contradictory guidelines resulted in sponsor groups providing inconsistent final reports, in that, for the most part, these reports were based on total project costs. We found that the Department revised final reports for 20 of 28 files examined so that the materials and administration costs were calculated based on a percentage of total labour costs. As a result, the Department increased the total project costs for 15 projects and released more funding than originally approved to the sponsor groups. We reviewed final reports to determine whether sponsor groups complied with the CWSP guidelines. Of the 28 project files for 20 sponsor groups reviewed, we identified the following instances of non-compliance: - 2 sponsor groups, representing 2 project files, paid employees more than the maximum $8.50 per hour wage rate; and - 8 sponsor groups, representing 8 project files, paid amounts for materials in excess of the maximum 25% of total labour costs. In addition, we found reports which lacked supporting documentation as follows: - all 28 files did not contain details of worker compensation calculations; - 8 files did not contain support for travel expenses claimed; - 2 files had instances of employees who were reimbursed for use of personal vehicles and tools; - 1 file contained no support for vehicle allowances paid; and - 1 file was missing a Record of Employment.

Figure 7 (cont.)

	Of the 28 final reports which we reviewed, we found the following: - 8 reports contained no evidence of any review, i.e. no signature, no notation; - 15 reports had no signature to indicate who performed the review even though there were notations on the final report; and - none of the final reports indicated the date when the review was completed. Our review indicated that although the Department received all 28 reports, we were unable to determine when 2 of the 28 reports were received since they were not date stamped. Therefore, the Department could not demonstrate whether the final reports were received prior to the final payment being released to the sponsor group. In addition, as there were no dates provided in final reports, the Department could not demonstrate whether projects commenced immediately at the end of the crab season as was required by the CWSP guidelines.

2B. Fish Plant Workers' Employment Support Program

The Fish Plant Workers' Employment Support Program (FPWESP) was an employment initiative specifically created in 2006-07 focused on creating short-term employment for fish plant workers who are unemployed as a result of a permanent closure of a fish plant and have not been successful in securing a sufficient number of insurable hours to qualify for Employment Insurance (EI). Funding was directed to fish plant workers in Marystown and Fortune.

Eligible applicants

In the case of the FPWESP, to qualify for employment, unemployed fish plant workers must demonstrate an attachment to the fish plant designated closed. Eligible individuals must be identified from either a seniority list provided by a union or from a company list of employees.

Extent of review

In total, 55 projects were funded in 2006-07 with expenditures totalling $3,277,238. We reviewed 20 of these project files with expenditures totalling $2,198,345. Our findings are contained in Figure 8.

Figure 8

Fish Plant Workers' Employment Support Program
Audit Findings
2006-07

Project/Applicant Selection	During our review of 20 project files representing 15 different sponsor groups, we found: - 3 sponsor groups were approved for more funding than was requested; and - 2 sponsor groups were required to submit amended applications which were not submitted.
Project Monitoring	During our review of the FPWESP final reports for 20 project files, we identified the following instances of non-compliance with program guidelines: - 3 project files did not contain evidence that gender composition was considered; - 4 sponsor groups, representing 4 project files, had individuals who were approved for a certain number of weeks at a higher wage rate but sponsor groups actually paid out even more to the workers; and - 3 sponsor groups, representing 7 project files, did not submit final reports within 30 days after completion of the project as required. In addition, of the 20 project files reviewed, 2 final report reconciliation forms were not signed off by the Manager. Although there is no provision in the guidelines for the Department to release a portion of the final payment prior to completion of the project or receipt of the final report, our review indicated that for 5 of the 20 project files reviewed, a portion of the final payment was released. Of those 5 files, - 1 of the project files contained evidence that the sponsor group requested early release of the payment; and - 4 of the project files (administered by 1 sponsor group) did not contain documentation to indicate why a portion of the final payment was issued before the project was complete.

2C. Harbour Breton FPI Workers' Employment Support Program

The Harbour Breton FPI Workers' Employment Support Program (HBWESP) was an income and employment support program specifically created in 2005-06 for the displaced FPI plant workers in Harbour Breton.

The Provincial Government initially committed $1.25 million in funding. A further $1.5 million was subsequently provided by FPI. The total funding for the program was $2.75 million.

It is estimated that 314 people were provided assistance under this program. Total expenditures on employment projects were approximately $1.8 million, and approximately $900,000 was expended on lump sum payments to former employees of FPI.

Lump Sum Payment options

There were two payment options available to former FPI employees under the HBWESP.

Option 1: Lump Sum Tax-Free Payment of $5,000.

- Eligible former FPI workers who were already working on Federal or Provincial projects on 24 October 2005, or were hired on projects after 24 October 2005 and were subsequently laid off, were only entitled to a lump sum, tax-free payment of $5,000.

- Eligible former FPI workers who were employed on a Federal program and received an hourly wage rate of less than $14.50 per hour (normally $8.75 per hour) were entitled to a lump sum, tax-free payment of $5,000 in lieu of a retroactive wage adjustment.

- Eligible former FPI workers could opt to receive a lump sum, tax-free $5,000 payment provided they waived their right to a rotation on an employment project.

Option 2: Employment with a wage rate of $14.50 per hour.

- Eligible former FPI workers who were not already hired on Federal or Provincial projects after 24 October 2005 and who had not opted for a lump sum payment were entitled to a 14-week rotation on an employment project at a wage rate of $14.50 per hour.

- Eligible former FPI workers who were hired on Federal or Provincial projects before 24 October 2005 and had received an hourly wage rate of less than $14.50 per hour, and who had not opted for a lump sum payment, could have their wage retroactively adjusted to $14.50 per hour.

Extent of review

The HBWESP has been audited by an external accounting firm to determine if program guidelines were followed - specifically whether persons who received assistance were on the eligibility list, and the financial records relating to projects were in compliance with criteria relating to labour, administration, and cost of materials. A summary of their findings are contained in Figure 9.

Figure 9

Harbour Breton FPI Workers' Employment Support Program
Audit Findings
2005-06

Applicant Selection	The external audit report noted items on non-compliance with the project as follows: - individuals were paid in accordance with Option #1 (Lump sum payment of $5,000) whose file indicates that only Option #2 was available to that individual. - individuals who did not work the full 560 hours did not receive a reduction of the $5,000 for finishing work early; however, individuals who opted out of employment project part way through their rotation received a pro-rata lump sum, tax-free payment calculated on the basis of the number of weeks/hours worked.

Figure 9 (cont.)

Applicant Selection	- individuals were paid above the specified wage rate of $8.75 per hour. $2.00 per hour more can be paid for a special skill according to the external audit Request for Proposals; however, there is nothing to indicate this in any program information. Additionally there is no support in the project files for any individuals who received higher wages to substantiate that they do indeed have a special skill. - individuals were paid above the specified wage rate of $14.50 per hour under Option #2. $2.00 per hour more can be paid for a special skill according to the external audit Request for Proposals; however, there is nothing to indicate this in any program information. Additionally, there is no support in the project files for any individuals who received higher wages to substantiate that they do indeed have a special skill. - One individual's hours exceeded the 560 maximum, and they were paid $15.75 per hour (maximum $14.50 per hour) under Option #2. According to the external audit report, the worker was a supervisor and was kept on until project completion, as no replacement was available. Without the supervisor the project would have been cancelled before completion.
Project Monitoring	The external audit report noted items on non-compliance with the project as follows: - there were instances when invoices were not approved by sponsor groups, and there was no indication the invoice had been paid; - materials were delivered to individuals instead of to the sponsor group; and - travel costs were not supported sufficiently (mileage details, etc.).

2D. Community Enhancement Program-Fish

The Community Enhancement Program-Fish (CEP-Fish) was an employment initiative specifically created for 2006-07 to help fish plant workers who may not have been successful in securing a sufficient number of insurable hours to qualify for EI.

Eligible applicants

The CEP-Fish was focused on fish plant workers who were unemployed as a result of a permanent closure of a fish plant. Eligible applicants for the CEP-Fish were fish plant workers who were either:

- a member of the plant's core work force for 2006, 2005, or 2004 if the plant was not open in the immediately proceeding year(s). Core status was determined as follows:
  - in a unionized plant, via a seniority list; or
  - in a non-unionized plant, via confirmation from the employer.
- a casual employee who qualified for employment insurance in 2005 based on plant employment alone.

Extent of review

In total, 36 projects were funded in 2006-07 with expenditures totalling $1,113,119. We reviewed 5 of these project files with expenditures totalling $591,934. Our findings are contained in Figure 10.

Figure 10

Community Enhancement Program-Fish
Audit Findings
2006-07

Project Selection	During our review of 5 project files, we found: - 2 sponsor groups were approved for funding amounts that were more than the funding amount requested; - 1 sponsor group received additional funding and did not submit an amended application as required by the guidelines; and - 3 sponsor groups did not submit an amended application for additional funding amounts which were lower than the original amount requested.
Project Monitoring	We found that the Department did not release separate program guidelines for the CEP-Fish. Department officials indicated that the guidelines used for the CEP were applied to this program. During our review of the CEP-Fish final reports for 5 project files, we identified the following instances of non-compliance with the guidelines: - 1 project file did not contain evidence that gender composition was considered; - 2 sponsor groups, representing 2 project files, paid employees at a wage rate higher than Provincial minimum wage, and of these, 1 sponsor group had not received the required prior approval from the Department to pay the higher rate. The Department indicated that in situations where a carpenter or a supervisor is required, approval for payment is sometimes at the final cost stage as the Department considered the payment of the special skill rate to be reasonable. However, there was no documentation in the project file to support this assessment; - 2 sponsor groups, representing 2 project files, did not submit final reports to the Department within 30 days of the completion of the project; and - 2 sponsor groups, representing 2 project files, had a signed privacy form on file for all of the workers; however, some of the workers did not select the option on the form to permit the disclosure of their personal information to the Department. Although there is no provision in the guidelines for the Department to release a portion of the final payment prior to completion of the project or receipt of the final report, our review indicated that for 4 out of 5 projects reviewed, a portion of the final payment was released and the file contained evidence that the sponsor group requested early release of the payment.

2E. Fortune Support Program

The Fortune Support Program (FSP) was an employment initiative specifically created in 2005-06 to provide assistance to fish plant workers in Fortune who were displaced while FPI enhanced its plant processing capabilities.

Eligible applicants

In the case of the FSP, a list of eligible applicants and their required work weeks was provided to the sponsor groups by a local committee of concerned citizens. Sponsor groups were responsible for clearing the names of intended employees with FPI to ensure there were no current employment opportunities available through FPI. They were also responsible for hiring people in accordance with the provided list and in the required order to maximize the benefit from existing accumulated hours of employment.

Extent of review

In total, 27 projects were funded in 2005-06 with expenditures totalling $741,197. We reviewed 10 of these project files with expenditures totalling $347,980. Our findings are contained in Figure 11.

Figure 11

Fortune Support Program
Audit Findings
2005-06

Project/Applicant Selection	We found that the Department did not establish definitions for the relatively short-term and small scale criteria. As a result, the Department could not demonstrate whether these criteria were met. During our review of 10 project files, representing 10 sponsor groups, we found that 5 employees from 5 different projects were hired, who were not on the approved employee eligibility list.
Project Monitoring	We found that the Department did not release separate program guidelines for the FSP. Department officials indicated that the guidelines used for the CEP were applied to this program. As there were conflicting versions of CEP program guidelines available to sponsor groups for the 2005-06 fiscal year, the Department was forced to accept total project costs as the basis of review of the final reports since this was the basis on which sponsor groups reported. Furthermore, these contradictory guidelines resulted in increased work at the Department in adjusting final reports, e.g. in 2005-06, in cases where the sponsor group claimed less than 10% of administration costs, and the Department increased administration costs to equal 10%. During our review of the FSP final reports, we identified the following instances of non-compliance with the guidelines: - 1 sponsor group paid administration amounts in excess of maximum 10% of total labour costs; however, this amount was approved by the Department; and - 3 sponsor groups had employees who worked for more than the maximum 420 hours over the life of the project.

Figure 11 (cont.)

Project Monitoring	We also found instances where final reports lacked supporting documentation. In particular: - 1 report was missing invoices for materials purchased; - 2 reports were missing support for mileage claims paid; and - 10 reports did not have individual details for workers compensation calculations. Our review indicated that Department officials did not always take any action to obtain information not provided by the sponsor groups. We reviewed 10 final reports for 2005-06 and found that 2 reports had no signature to indicate who performed the review even though there were notations on the final report, and none of the final reports indicated the date when the review was completed. Our review indicated that although the Department received all 10 reports, we were unable to determine when 7 of the 10 reports were received since they were not date stamped. Therefore, the Department could not demonstrate whether the final reports were received prior to the final payment being released to the sponsor group.

Recommendations

District Funding Allocation

The Department should ensure that the basis for funding allocations to electoral districts, including budget details and correspondence with the MHAs regarding funding for their district, is documented by the Department for all programs.

Project and Applicant Selection

The Department should ensure:

- decisions relating to the approval and rationale for funding of projects are formally documented;

- the process of approving applications before the deadline has been reached is reviewed to ensure that all projects have an equal opportunity for approval selection process;
- all additional funding requests are made by separate application;
- amended applications are provided where required;
- funding approved for sponsor groups does not exceed funding requested for the project;
- the receipt date of program related information from sponsor groups is documented and the date is within program deadlines;
- all applications for funding have sufficient support in the file regarding eligibility of the sponsor group, individuals, and project; and
- decisions relating to the approval and rationale for funding to sponsor groups who were non-compliant in prior programs are formally documented.

Project Monitoring

The Department should ensure:

- guidelines for all programs offered are implemented, and contradictory or inadequate guidelines are restated;
- sufficient documentation is submitted by project sponsors, and that missing information is followed up on as part of the review process;
- final report reconciliations for all project files, including an indication as to who performed the final report review and when, are formally documented;
- decisions relating to the rationale for partial final funding releases to sponsor groups before final reports are received and reviewed are formally documented; and
- decisions relating to the rationale for final funding releases to non-compliant project sponsors are formally documented.

Department's Response

District Funding

Recommendation:
The Department should ensure that the basis for funding allocations to electoral districts, including the budget details and correspondence with MHAs regarding funding for their districts, is documented by the Department for all programs.

Response:
For the Community Enhancement Employment Program, funding was and continues to be allocated by electoral district based on prior year allocations. Effective fiscal year 2005-06, the actual allocation by district and the basis for the allocation was clearly articulated to each MHA in a letter from the Minister.

The Department, with assistance from the Newfoundland and Labrador Statistics Agency, is developing an evidenced-based allocation model that includes a number of employment and income indicators. Most of the relevant statistical information is not available at the level of provincial electoral districts, but it can be aggregated to standard geographies such as Economic Zones and Rural Secretariat Regions. The Department plans to test a pilot allocation model during the 2008-09 program delivery year.

Project and Applicant Selection

Recommendation:
Decisions relating to the approval and rationale for funding of projects are formally documented.

Response:
An interdepartmental committee reviews and ranks all projects within each electoral district based on established priorities now entrenched in the program guidelines. Completed ranking sheets, while not found on all project files, are found in district files.

Recommendation:
The process of approving applications before the deadline has been reached is reviewed to ensure that all projects have an equal opportunity for approval selection process.

Response:
This is an infrequent occurrence, but the Department will review the process.

Recommendation:
All additional funding requests are made by separate application.

Response:
Effective 2006-07, an amended application form is secured as a condition for increased funding. No funds are advanced until the amendment form is received.

Recommendation:
Amended applications are provided where required.

Response:
Effective 2006-07, an amended application form was required for funding changes, including a decrease in funding, to reflect the change in scope of work and funding particulars. Normally, no funds are advanced until the amendment form is received. However, sometimes the amount approved is marginally smaller than the amount requested due to minor mathematical errors in an application or a decision to approve an amount slightly smaller than requested. The Department uses discretion not to request an amended application where the approved funding is marginally less than the requested amount and the difference is not sufficient to affect the scope of work.

Recommendation:
Funding approved for sponsor groups does not exceed funding requested for the project.

Response:
On some occasions, the Department becomes aware of an employment need in an area that is greater than the number of workers proposed in an application, and sponsors may be offered additional funding to meet that need. As a condition of increased funding, an amended application form, outlining changes to the scope of work resulting from the increase, is required to be submitted by the sponsor before funding is advanced. However, the department will review the existing approval process for projects that exceed the original requested funding.

Recommendation:
The receipt date of program related information from sponsor groups is documented and the date is within program deadlines.

Response:
The Department will ensure that all information it receives is date stamped.

Recommendation:
All applications for funding have sufficient support in the file regarding eligibility of the sponsor group, individuals, and project.

Response:
The Department adheres to the eligibility criteria for sponsor groups which are clearly defined in the program guidelines. With respect to eligibility of individual workers, effective 2007-08 sponsors are required to submit with their final project reports affidavits executed by each worker that reflect the required hours needed to qualify for EI benefits. For the past several years, project applications have been assessed by an inter-departmental committee (which includes identification of any ineligible projects or sponsors), and these assessments are stored in district files.

Recommendation:
Decisions relating to the approval and rationale for funding to sponsor groups who were non-compliant in prior programs are formally documented.

At the end of the 2005-06 program cycle, the Department's own review of project reports indicated significant concerns over compliance with the Program Guidelines. In response, the Department adopted the approach of issuing letters to sponsors advising them of the non-compliance issue identified with their project and serving notice that similar occurrences the following year could jeopardize their eligibility for funding in subsequent years. Furthermore, any such sponsors who were approved in 2006-07, received a second letter along with their project approval notice; that second letter reminded them of the previous year's finding of non-compliance and repeated the caution that further issues could jeopardize future eligibility.

Response:
The Department will ensure files are properly documented if funding is approved for sponsors that were in non-compliance in the previous year.

Project Monitoring

Recommendation:
Guidelines for all programs offered are implemented, and contradictory or inadequate guidelines are restated.

Response:
The observation on contradictory guidelines related only to one element of the 2005-06 program guidelines which was rectified effective with the 2006-07 guidelines.

Recommendation:
Sufficient documentation is submitted by project sponsors, and that missing information is followed up on as part of the review process.

Response:
The Department will ensure follow-up is maintained on all files missing documentation required as part of the final report process.

Recommendation:
Final report reconciliations for all project files, including an indication as to who performed the final report review and when, are formally documented.

Response:
In 2006-07, the Department introduced a formal final report reconciliation form with appropriate signature blocks. The Department will ensure all such reports are properly executed and on file in the future.

Recommendation:
Decisions relating to the rationale for partial final funding releases to sponsor groups before final reports are received and reviewed are formally documented.

Response:
In a limited number of cases and with an appropriate rationale, the Department has paid partial final funding releases to sponsors. The Department will ensure that the rationale for decisions related to partial final advances will be documented on file.

Recommendation:
Decisions relating to the rationale for final funding releases to non-compliant project sponsors are formally documented.

Response:
The Department will ensure that the rationale for decisions on final funding releases to non-compliant project sponsors are formally documented.

Response to Comments on Harbour Breton FPI Workers' Employment Support Program

(Comments in Auditor General's report were based on a report to the Department from an External Auditor)

Based on a comment in the external auditor's report, the report item indicates that some individuals were paid in accordance with Option 1 when only Option 2 was available for them. The external auditors had noted that two workers received lump sum payments under Option 1 even though an internal Department of Municipal Affairs reference sheet in each of their files indicated that only Option 2 was available to them.

In early March 2006, the Department's staff planned to travel to Harbour Breton to explain the program options and then meet individually with each worker. Departmental staff expected to meet with several hundred individuals during the March visit, and, in advance of the trip, they prepared individual reference sheets on each Harbour Breton worker to avoid confusion and ensure that staff gave correct information to each individual. The internal reference sheet indicated each person's available options (1, 2 or either) under the program. The available options varied from one person to the next based on whether the person had already finished working on an employment project (only Option 1 available), was still employed on a project (only Option 2 available), or had not yet started work on a project (either Option 1 or 2 available). These internal reference sheets were prepared early in March, but the visit to Harbour Breton was delayed for several weeks while the department waited for a decision from the federal government on whether the lump sum payments would be tax free. During that delay, two people who had been working on a project in early March (and therefore only had Option 2 available at that time) finished work (and therefore only had Option 1 available by the time departmental staff went to Harbour Breton to provide final details of the program).

As noted above, the inconsistency between the internal reference sheets in these workers' files and the actual option they were permitted to exercise is explained by a delay in holding worker information sessions. Both these individuals were provided with the correct option for which they were eligible at the time that they entered the program.

Based on a comment in the external auditor's report, the report item indicates that some workers who did not work a full 560 hours on an employment project did not receive a reduction in their lump sum payment, while other workers who opted out of an employment project part way through the project received a pro-rata lump sum payment.

When Government approved the Harbour Breton program, workers were eligible for a wage of $14.50 per hour and no lump sum payment, a wage of $8.75 per hour plus a lump sum payment of $5,000, or, if the individual did not want to work on a project, a lump sum payment of $5,000 with no other benefits. The approved program design also provided for workers earning $14.50 per hour who left the employment project early to receive a pro rata payment based on the $5,000 lump sum. The program design did not indicate a requirement to claw back a pro rata portion of the lump sum if workers earning $8.75 per hour left the project early. Such a claw back was not logical as the workers would have been entitled to the full $5,000 even if they had chosen not to work on a project.

Based on a comment in the external auditor's report, the report item indicates that some workers were paid an additional $2.00 per hour for special skills, but there was nothing in the program information to support this practice.

A total of 26 individuals received the additional wage during the life of the Harbour Breton program. The Harbour Breton program, even though it had a very different wage structure, was patterned after the Department's Community Enhancement Program which provides a $2.00 wage premium for staff in supervisory roles and staff using specialized skills on the project. In these situations, the department permits the project sponsor to determine whether an individual uses specialized skills on a project. While the wage premium for special skills was not described in the Harbour Breton program materials, the Department is satisfied that payment of the premium was consistent with past and current practices on employment support programs, and a refusal to pay the additional wage for special skills would have created difficulty.

Based on a comment in the external auditor's report, the report item indicates that materials were delivered to individuals rather than to the sponsor group.

When the above observation was made by the external auditors, the department requested and received clarification from the town (which was the project sponsor) on this item. The town indicated that, on a very small number of occasions, delivery instructions that hardware store employees wrote on invoices referenced a town employee. The town provided documentation detailing the project site as well as the name and job title of the employees who took delivery of supplies. These individuals picked up materials on behalf of the town and delivered them to the work site. Additionally, the town indicated that, prior to processing payments, the project's clerk reviewed each invoice with the project foreperson to confirm details on where each order of materials was delivered and used. Based on this information, the Department is satisfied that effective procedures were in place to control ordering, receipt and payments for materials and there was no evidence of inappropriate payments.

Highlights

Highlights of a review of the Department of Natural Resources' Firearms Program as at 31 March 2007.

Why our Office did this Review

The objectives of this review were to determine whether the Department has adequate systems to record, monitor and secure its firearms inventory; whether the Firearms Policy covered all relevant issues pertaining to the use and control of firearms; whether the Department has adequate procedures to monitor compliance by Conservation Officers with the Firearms Policy and, where appropriate, test compliance with this Policy; and whether use of force training is provided to Conservation Officers.

What our Office Recommends

Following are highlights of recommendations included in the Report. The Department should:

- ensure its firearms inventory system is accurate;
- appoint a Firearms Control Officer to provide overall responsibility for the recording and control of the Department's firearms;
- ensure that reports are prepared to document missing and/or damaged firearms;
- ensure all issued or reissued firearms are inspected by a gunsmith and that gunsmith inspection reports are provided as required;
- maintain a database to track the required annual firearms recertification training; and
- review the use of force policy and update where necessary.

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

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To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.17
DEPARTMENT OF NATURAL RESOURCES
Firearms Program

The Department of Natural Resources (the Department) is responsible for enforcement activities of the Province's *Forestry Act*, *Animal Protection Act*, *Motorized Snow Vehicle and All-Terrain Vehicle Act, Provincial Offences Act, Wilderness and Ecological Reserves Act*, *Wildlife Act* and *Endangered Species Act*. In addition, it collaborates with other government departments and agencies in enforcement activities of the *Federal Fisheries Act* (Inland Fish), *Species at Risk Act*, *Wild Animal and Plant Protection and Regulation of International and Inter-provincial Trade Act*, and the *Migratory Bird Convention Act*.

Conservation Officers conduct patrols, carry out investigations and interact with resource users and the general public on a day-to-day basis. All Conservation Officers in the field are equipped with sidearms (effective June 2006), ammunition, pepper spray, hand cuffs, protective vests and batons. Conservation Officers responsible for destroying nuisance animals are also equipped with rifles, shotguns, tranquilizer guns and starter pistols (for noise) where applicable.

What We Found

Our review identified weaknesses relating to how the Department records, monitors and secures its firearms, ammunition, pepper spray, hand cuffs, protective vests and batons. We also found noncompliance with the Department's Firearms Policy. Our conclusion is based on the following:

- Although the Department has a firearms inventory system, it is not used to control sidearms (controlled separately), ammunition or pepper spray. Furthermore, the system was not accurate in that: 16 rifles and shotguns which had either been transferred or returned to the owner were still recorded in the system, 45 rifles and shotguns were either located at a different district office or assigned to a different Conservation Officer, 125 rifles and shotguns had incomplete information as to the firearm make, model, caliber and serial number, and 19 seized rifles and shotguns as well as 5 tranquilizer guns were not recorded in the system.
- The Department has a Firearms Policy; however, it does not address a number of significant areas relating to firearms usage. It does not: address how ammunition and pepper spray should be accounted for; provide guidance for conducting semi-annual firearms policy audits; require periodic reports; require the reporting of damage to rifles and shotguns; and require rifles and shotguns to be returned during periods of leave.
- We identified instances of noncompliance with the Firearms Policy which included: only one of the three regional offices indicated that semi-annual firearms policy audits were conducted and in that case no documentation was retained; no written report had been prepared nor had the police been informed about a missing rifle; instances where Conservation Officers had not reported damaged sidearms to the Regional Compliance Manager; rifles and shotguns were transferred to police agencies without obtaining a receipt; violation reports were not fully completed and not all issued or reissued firearms were inspected by a gunsmith.
- Information on the annual sidearms recertification and use of force training is not maintained in a database and, as a result, the Department does not readily know either when officers are due for recertification or whether officers are currently certified.
- Safety issues were identified where outdated pepper spray was still in use by Conservation Officers.
- Although there has been funding approved since March 2005 for a Firearms Control Officer, the position has not been filled. As a result, it is not clear who has overall responsibility for the recording and control of the Department's firearms and this may have contributed to the issues identified during our review.

Background

Legislation

The Department of Natural Resources (the Department) is responsible for enforcement activities of the Province's *Forestry Act*, *Animal Protection Act*, *Motorized Snow Vehicle and All-Terrain Vehicle Act*, *Provincial Offences Act*, *Wilderness and Ecological Reserves Act*, *Wildlife Act* and *Endangered Species Act*. In addition, it collaborates with other government departments and agencies in enforcement activities of the Federal *Fisheries Act* (Inland Fish), *Species at Risk Act*, *Wild Animal and Plant Protection and Regulation of International and Inter-provincial Trade Act*, and the *Migratory Bird Convention Act*.

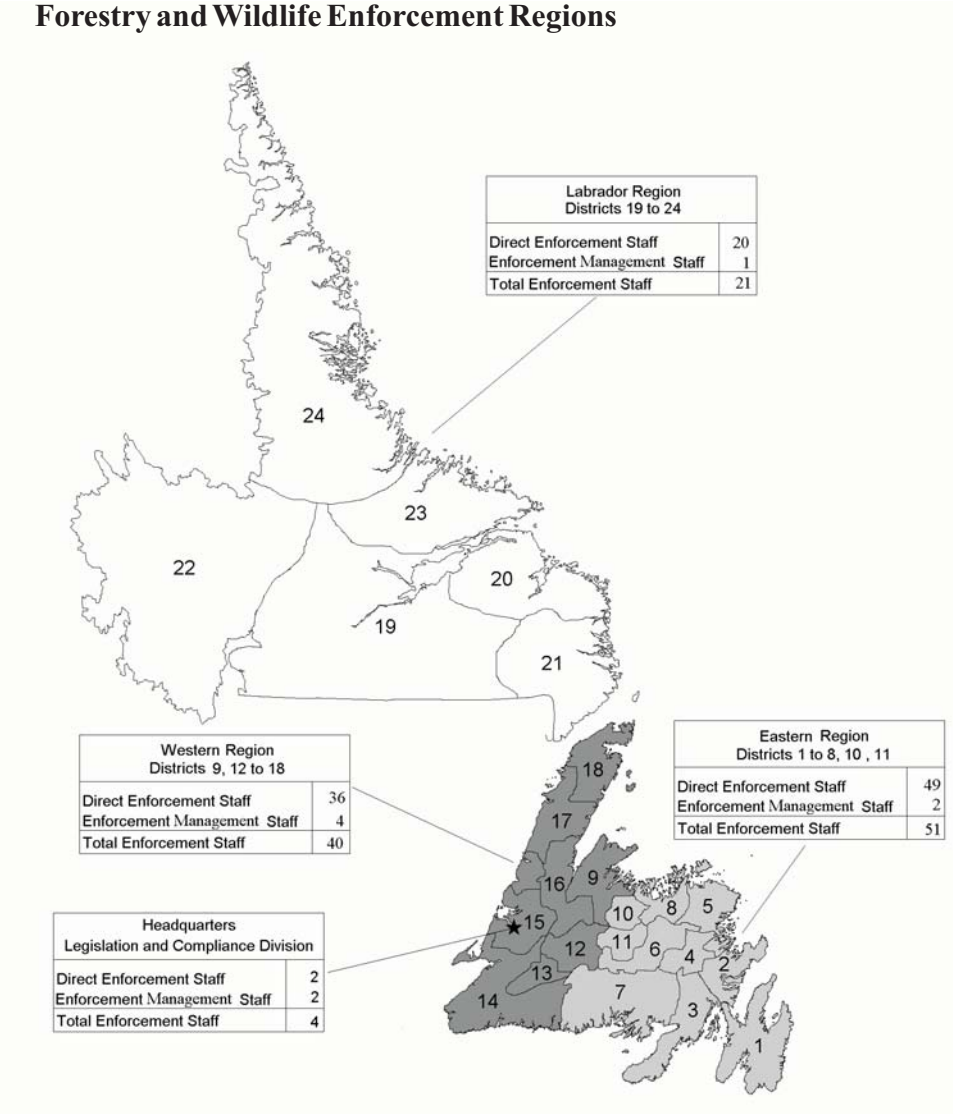
Locations

The Department's headquarters for enforcement activities is located in Corner Brook, with 3 regional offices located in Massey Drive (outside Corner Brook), Gander and Happy Valley-Goose Bay, and 15 district and 17 satellite offices located throughout 24 districts in the Province. As at June 2007, there was a total of 116 staff, including 9 management and 107 Conservation Officers involved in enforcement activities. In addition, there were 3 enforcement employees working with the Department of Justice. Conservation Officers conduct patrols, carry out investigations and interact with resource users and the general public on a day-to-day basis.

Figure 1 shows the Headquarters, 3 enforcement regions, 24 districts and enforcement staffing allocation.

Figure 1

Department of Natural Resources
Forestry and Wildlife Enforcement Regions



Firearms and equipment

All Conservation Officers in the field are equipped with sidearms (effective June 2006), ammunition, pepper spray, hand cuffs, protective vests and batons. Conservation Officers responsible for destroying nuisance animals are also equipped with rifles, shotguns, tranquilizer guns and starter pistols (for noise) where applicable.

The Department also maintains an inventory of unassigned firearms (sidearms, rifles and shotguns), firearms seized from the general public during enforcement activities, and firearms forfeited by the Courts to the Crown.

Figure 2 shows the number of firearms at the Department as of October 2006.

Figure 2

Department of Natural Resources
Number of Firearms
As of October 2006

Firearms	Head-quarters	Eastern Region	Western Region	Labrador Region	Total
Seized from Public	0	38	47	22	107
Department-Owned					
- Tranquilizer guns	0	19	0	0	19
- Starter pistols(for noise)	0	5	0	0	5
- Sidearms	4	55	37	15	111
- Shotguns	17	55	33	23	128
- Rifles	25	51	47	28	151
Total	**46**	**223**	**164**	**88**	**521**

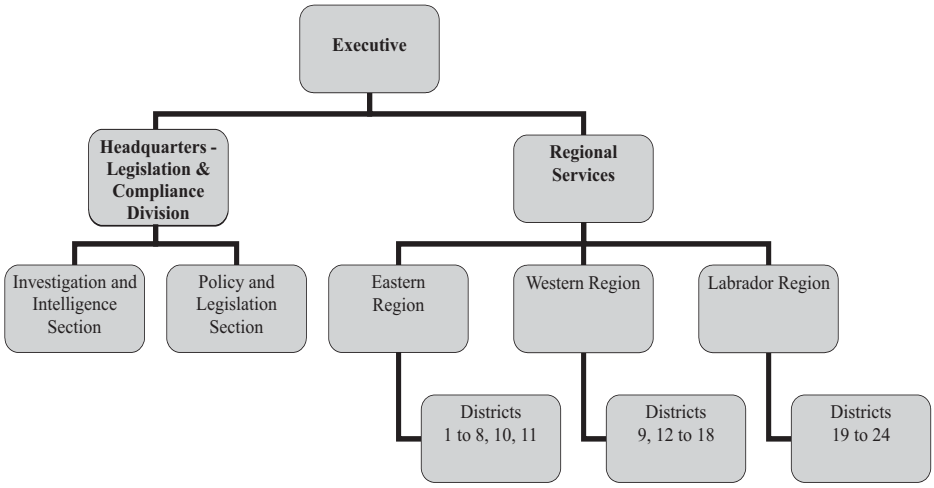
Source: Department of Natural Resources

Organization

Figure 3 shows the Department's organizational structure involved in enforcement.

Figure 3

Department of Natural Resources - Forestry Branch Organization Structure



Responsibility for firearms inventory control rests primarily with the Department's Legislation and Compliance Division at the Headquarters in Corner Brook. Regional Compliance Managers are responsible for managing firearms in their respective regions.

Audit Objectives and Scope

Audit objectives

The objectives of this review were to determine:

- whether the Department has adequate systems to record, monitor and secure its firearms inventory;
- whether the Firearms Policy covered all relevant issues pertaining to the use and control of firearms;
- whether the Department has adequate procedures to monitor compliance by Conservation Officers with the Firearms Policy and, where appropriate, test compliance with this Policy; and
- whether use of force training is provided to Conservation Officers.

Audit scope

We completed our review in June 2007. Our review included an examination of various Government reports and documents, and discussions with officials through visits to Headquarters, all three regional offices and eight district offices.

Overall Conclusions

Conservation Officers in the field are equipped with sidearms (effective June 2006), ammunition, pepper spray, hand cuffs, protective vests and batons. Conservation Officers responsible for destroying nuisance animals are also equipped with rifles and shotguns. Our review identified weaknesses relating to how the Department records, monitors and secures these items. We also found noncompliance with the Department's Firearms Policy. Our conclusion is based on the following:

- Although the Department has a firearms inventory system, it is not used to control sidearms (controlled separately), ammunition or pepper spray. Furthermore, the system was not accurate in that: 16 rifles and shotguns which had either been transferred or returned to the owner were still recorded in the system, 45 rifles and shotguns were either located at a different district office or assigned to a different Conservation Officer, 125 rifles and shotguns had incomplete information as to the firearm make, model, caliber and serial number, and 19 seized rifles and shotguns as well as 5 tranquilizer guns were not recorded in the system.

- The Department has a Firearms Policy; however, it does not address a number of significant areas relating to firearms usage. It does not: address how ammunition and pepper spray should be accounted for; provide guidance for conducting semi-annual firearms policy audits; require periodic reports; require the reporting of damage to rifles and shotguns; and require rifles and shotguns to be returned during periods of leave.

- We identified instances of noncompliance with the Firearms Policy. Such instances included: only one of the three regional offices indicated that semi-annual firearms policy audits were conducted and in that case no documentation was retained; no written report had been prepared nor had the police been informed about a missing rifle; instances where Conservation Officers had not reported damaged sidearms to the Regional Compliance Manager; rifles and shotguns were transferred to police agencies

without obtaining a receipt; violation reports were not fully completed; not all issued or reissued firearms were inspected by a gunsmith; for firearms that were inspected by a gunsmith, the required gunsmith inspection reports were not provided to the Legislation and Compliance Division at Headquarters; firearms maintenance history files were not maintained for either rifles and shotguns in use or for forfeited firearms; forfeited rifles and shotguns were not returned to Headquarters; and sidearms were not returned during periods of extended leave.

- Information on the annual sidearms recertification and use of force training is not maintained in a database and, as a result, the Department does not readily know either when officers are due for recertification or whether officers are currently certified.

- Safety issues were identified where outdated pepper spray was still in use by Conservation Officers.

- Although there has been funding approved since March 2005 for a Firearms Control Officer, the position has not been filled. As a result, it is not clear who has overall responsibility for the recording and control of the Department's firearms and this may have contributed to the issues identified during our review.

Detailed Observations

Findings

This report provides detailed audit findings and recommendations in the following sections:

1. Firearms Inventory Management
2. Adequacy of Firearms Policy
3. Compliance with Firearms Policy
4. Use of Force Training

1. Firearms Inventory Management

Overview

Inventory management controls are the organization, policies, and procedures designed to provide reasonable protection of firearms. This is especially important for equipment such as firearms where any unauthorized use could cause safety issues for the public. Therefore, controls over firearms covering acquisition, assignment, safekeeping, and disposal must be well designed, in place, understood, and complied with by all personnel.

The Department has developed a computerized firearms inventory system. The system is designed to capture information on the make and model of the firearm, its location, assignment information such as the name of the Conservation Officer and date signed out, and, for firearms which have been seized, the date of the violation and, where applicable, the date a firearm is destroyed or returned to its owner.

The Department has also developed inventory control policies and procedures to manage its firearms which include:

- assignment of responsibility for the control of firearms;
- maintenance of an inventory system;
- requirement for an internal semi-annual audit of firearms; and
- a system for requesting, issuing, transferring and disposing of firearms.

Stored Firearms at Headquarters

Inventory control findings

During the period October 2006 to February 2007, we reviewed the firearms inventory system. We identified issues in the following areas:

A. accuracy of the firearms inventory
B. control over ammunition and pepper spray
C. safety and security of firearms

1A. Accuracy of the Firearms Inventory

Computerized inventory of firearms not accurate

A review of the firearms inventory system and firearms located at the three regions indicated that not all firearms were recorded in the system. Figure 4 shows the number of firearms that were recorded in the firearms inventory system and those that were not recorded in the system.

Figure 4

Department of Natural Resources
Number of Firearms
As of October 2006

Firearm	Head-quarters	Eastern Region	Western Region	Labrador Region	Total	%
Recorded						
Seized from public	0	38	47	22	107	
Department-Owned						
- Tranquilizer guns	0	14	0	0	14	
- Starter pistols (for noise)	0	5	0	0	5	
- Shotguns	17	53	32	21	123	
- Rifles	25	48	39	25	137	
Sub-total	**42**	**158**	**118**	**68**	**386**	**74%**
Not Recorded						
- Sidearms	4	55	37	15	111	
- Shotguns	0	2	1	2	5	
- Rifles	0	3	8	3	14	
- Tranquilizer guns	0	5	0	0	5	
Sub-total	**4**	**65**	**46**	**20**	**135**	**26%**
Total	**46**	**223**	**164**	**88**	**521**	**100%**

Source: Department of Natural Resources

As Figure 4 shows, 135 or 26% of the firearms were not recorded in the firearms inventory system.

Of the 135 firearms not recorded, 111 were sidearms. Our review indicated that 110 of the sidearms were purchased by the Department in November 2005 while 1 sidearm had been transferred from the Royal Newfoundland Constabulary. While sidearms are not recorded in the system, a separate listing is maintained of all assigned sidearms. However, the listing provided during the review was not accurate in that one Conservation Officer was using a sidearm that was recorded as returned to Headquarters while another Conservation Officer was indicated as having a sidearm when in fact they had no sidearm.

Our review also indicated that:

- 19 rifles and shotguns were seized but not recorded in the firearms inventory system - 5 of these were seized in 2005.

- 5 of 19 tranquilizer guns were not recorded in the firearms inventory. All 5 of these tranquilizer guns were in the possession of one Conservation Officer. At the time of our review, 2 of these guns were at the Conservation Officer's work location and 3 were stored at the Conservation Officer's home. It should be noted that the tranquilizer drug is kept at the District Office.

- Of the 386 rifles and shotguns listed in the inventory system, 186 were not recorded accurately as follows:

    - 6 were no longer in the Department's possession and had been transferred to other law enforcement agencies - 4 to the RCMP and 2 to the RNC. These transfers were not recorded;

    - 45 were either located at a different district office or with a different Conservation Officer than was recorded in the inventory system;

    - 125 had incomplete or inaccurate information related to the make, model, calibre or serial number of the firearm; and

    - 10 were listed in the inventory system as seized firearms even though they had been returned to their owners.

As a result, the Department does not have adequate control over its rifles and shotguns.

1B. Control Over Ammunition and Pepper Spray

No inventory of ammunition or pepper spray

Ammunition is purchased for the Department's sidearms, rifles and shotguns and is also seized during enforcement activities. Ammunition is used by officers in enforcement activities and for training purposes. Pepper spray is also purchased for use by Conservation Officers. Our review of the inventory of ammunition and pepper spray indicated that:

- The Department is not tracking either ammunition or pepper spray even though it has a firearms inventory system which could be utilized for this purpose.

- When the Department purchased ammunition, it was charged to several different codes in the accounting system making it more difficult to determine cost and quantity.

- The Department could not readily demonstrate how much ammunition had been purchased, seized, forfeited, used or destroyed. In addition, the Department could not demonstrate that the orders of the courts relating to the required destruction of forfeited ammunition were being complied with.

- Information such as serial numbers and expiry dates of pepper spray canisters was not recorded and reviewed. Our examination of 39 pepper spray canisters identified that five Conservation Officers had outdated pepper spray canisters which may have been defective. While the manufacturer recommended replacement after 4 years, the 5 canisters were still in use after 12 years (1), 9 years (1), 7 years (2) and 6 years (1). Furthermore, there was no policy for destruction of these expired canisters.

- The Firearms Policy requires that pepper spray be issued to all Conservation Officers who are issued a sidearm. We found that one Conservation Officer was issued a sidearm but had not been issued pepper spray.

As a result, the Department could not determine the amount of ammunition and pepper spray on hand or assigned, and could not demonstrate that all ammunition and pepper spray was properly controlled, accounted for and used only for appropriate purposes. It also did not maintain information to determine the appropriate replacement requirement for pepper spray canisters.

1C. Safety and Security of Firearms

Overview

The Department's firearms are stored at either Headquarters, regional offices, district and satellite offices or at a Conservation Officer's home. The Headquarters office is mainly used to store forfeited firearms. Firearms are stored as follows:

Headquarters

The firearms inventory (mainly forfeited firearms) is secured in a separate locked room. Access to the room is restricted by a key which is assigned to one individual.

Regional Offices and District Offices

Rifles and Shotguns
Conservation Officers are provided with a locked storage cabinet or closet at their office where assigned and seized rifles or shotguns can be stored. In addition, when Conservation Officers take their assigned rifles or shotguns home, they are responsible for securing them in their personal locked cabinet.

Sidearms
Conservation Officers are issued two lockable cabinets to secure their sidearms. One is installed in their office while the other is installed in either their vehicle or at home. These cabinets are bolted either to the vehicle chassis or office/home wall.

Officer Sidearm Storage Cabinet

Department not able to access inventory system or firearms storage area

Our review identified that from July 2006 to December 2006 the Department was not able to access its firearms inventory system or its 40 rifles and shotguns in the locked storage area at the Headquarters in Corner Brook. The employee with the key to the door was seconded to the Department of Justice and did not leave the key with the Department. As a result, the Department could not update its inventory records or access its stored firearms. We note that at the time of our visit on 30 October 2006, 20 additional rifles and shotguns had been stored in a secure garage at a regional office because the Department could not access the storage area at Headquarters.

Conclusions

As a result of our review, we have concluded that:

- The inventory records of firearms are not accurate. We noted 321 errors and omissions in the inventory records, including 135 firearms (111 of which were sidearms) that were not recorded in the system. We note that the Department did not have access to its firearms storage room and inventory system for a period of six months because officials had no key. The key was with an officer who was seconded to another department.

- The Department does not have inventory controls in place over ammunition and pepper spray, and therefore could not readily provide information on purchases and amounts on hand. With no controls over ammunition, it is not possible to ensure that it is only being used for authorized purposes.

- There were instances where pepper spray had exceeded its manufacturer's recommended replacement date and therefore the pepper spray which the Conservation Officers were carrying may have been defective, putting them at unnecessary risk.

Recommendations

The Department should:

- ensure its firearms inventory system is accurate;

- record all firearms, ammunition and pepper spray in the firearms inventory system; and

- ensure that pepper spray canisters are replaced in accordance with the manufacturer's recommended replacement date.

2. Adequacy of Firearms Policy

Overview

The Department's Firearms Policy includes procedures to monitor compliance in such areas as the issuance and re-issuance of firearms, inspections and internal audits, reporting on violations, training, safe storage, transporting, handling, conditions for carrying firearms, accidents, use of force, care and maintenance, reporting of protected firearms, and disposition of firearms.

Firearms Policy deficient

Although the Firearms Policy manual deals with most areas relating to firearms, the Policy was deficient in that:

- ammunition is not required to be reconciled and accounted for;
- neither the age and condition of pepper spray is required to be recorded nor is pepper spray required to be reconciled and accounted for;
- there is no checklist and/or audit program for the Regional Compliance Managers to follow when conducting semi-annual Firearms Policy audits to ensure that all aspects of the Policy are appropriately considered;
- there is no requirement for periodic reports such as an annual report regarding all firearms under the control of the Department, a monthly reconciliation of ammunition or an annual use of force report;
- although damage to sidearms is required to be reported to the officer's supervisor, there is no similar policy relating to rifles and shotguns; and
- although Conservation Officers are required to return their sidearms to their Regional Compliance Manager for safe storage during absences from duty for periods of two to eight weeks and to Headquarters for periods greater than eight weeks, there is no policy requiring the return of rifles and shotguns during periods of leave.

In addition, although the Department's policy is that standard gauge shotguns and sidearms be provided to its Conservation Officers, it does not require that Conservation Officers use a standard rifle. All rifles used by the Department were acquired over time from individuals who, when appearing before the court on a regulatory violation, had their firearms forfeited by the courts to the Crown. As a result, the Department has to purchase 15 different types of ammunition for the various makes of rifles.

The Firearms Policy indicates that a Firearms Control Officer at the Headquarters' Legislation and Compliance Division is responsible for the recording and control of the Department's firearms. In particular, the Firearms Control Officer was to co-ordinate the implementation and administration of the sidearm program and related policies. However, the position was not filled even though $100,000 was approved by Cabinet in March 2005 to fund the position.

This situation may have contributed to the significant issues we identified regarding the lack of firearms inventory controls at the Department.

Conclusions

We concluded that the Firearms Policy is deficient in areas relating to:

- accounting for and using of ammunition and pepper spray;
- guidance for Regional Compliance Managers when conducting semi-annual firearms policy audits;
- requirements for periodic reports;
- reporting damage to rifles and shotguns; and
- returning rifles and shotguns during periods of leave.

We also found that officers are not provided a standard rifle and, as a result, the Department has to purchase 15 different types of ammunition for the various makes of rifles.

A Firearms Control Officer has not been appointed; therefore, it is not clear who has overall responsibility for the recording and control of the Department's firearms.

Recommendation

The Department should:

- review the Firearms Policy for deficiencies and update where necessary;
- consider standardizing rifles used by Conservation Officers; and
- appoint a Firearms Control Officer to provide overall responsibility for the recording and control of the Department's firearms.

3. Compliance with Firearms Policy

Non-compliance with policy

Our review identified that the Department was not always complying with requirements of its Firearms Policy and as a result, could not be assured that all firearms have been accounted for and violations recorded. We identified the following:

Missing firearm not reported

Missing Firearm

The Firearms Policy requires that any firearms that become unaccounted for (missing) be immediately reported verbally, followed by a written report to the Conservation Officer's supervisor, the Regional Compliance Manager, the Departmental Firearms Control Officer and the Director of Legislation and Compliance. The supervisor is responsible for reporting the incident to the police.

During our review in November 2006 we identified 1 instance where a rifle included on the Department's inventory list could not be accounted for. Although Departmental officials indicated that the missing rifle was immediately reported verbally to both the immediate supervisor and the Regional Compliance Manager, no written report was prepared nor had the police been informed. Two months after the incident, officials determined that the rifle had been destroyed.

As a result, had an incident occurred relating to this missing firearm, the police would not have known that a firearm had been missing.

Damaged sidearms not reported

Damaged Sidearms

The Firearms Policy requires Conservation Officers to immediately advise their Regional Compliance Manager of damaged sidearms and to return the sidearm to the Departmental Firearms Control Officer.

During our inspection of sidearms, we identified 2 instances where Conservation Officers had not reported to the Regional Compliance Manager that their sidearms were missing screws in the grip panel. This is a safety issue relating to the requirement for officers to have sidearms in proper condition.

Firearm transfers not documented

Transfer of Firearms

The Firearms Policy requires that Conservation Officers obtain a written receipt when transferring a firearm to a police agency or returning it to the owner. This is to protect the Department and provide a paper trail of the firearm's final disposal.

During our review, we identified 6 instances where officials indicated that Conservation Officers had transferred firearms (3 rifles and 3 shotguns) to a police agency (2 to the Royal Newfoundland Constabulary and 4 to the RCMP). However, receipts were not obtained for any of these transfers and the transfers were not recorded in the firearms inventory system. As a result, the Department could not demonstrate that the rifles and shotguns had actually been transferred.

Violation Reports not forwarded as required

Violation Reports

Violation Reports are used to record the particulars of forestry and/or wildlife violations, including the description and serial number of firearms seized. The Firearms Policy requires that Violation Reports be forwarded to the Regional Compliance Manager upon completion. If the violation involves a firearm, the report is to be forwarded to the Legislation and Compliance Division for review.

We found that Violation Reports were not always forwarded to the Regional Compliance Manager and the Legislation and Compliance Division for review and follow-up as required. Furthermore, Violation Reports often did not provide sufficient detail on the firearm to enable someone to identify it in the inventory system.

We reviewed Violation Reports relating to 150 seized firearms and found issues with 27 (18%) as follows:

- 19 firearms were seized but not recorded in the firearms inventory system - 5 of these were seized in 2005;
- 4 firearms were unable to be traced from the Violation Reports to the firearms inventory system; and
- 4 firearms had incorrect Violation Report dates recorded in the firearms inventory system.

As a result, the Department would not be aware of number and details associated with seized firearms.

Semi-annual audits not carried out as required

Semi-annual Audit

The Firearms Policy requires that the Regional Compliance Managers conduct a semi-annual audit of firearms.

During our review we found that:

- officials at the Western region indicated that they did not perform any semi-annual audits;
- officials at the Labrador region indicated that they did not perform any semi-annual audits of sidearms and only one semi-annual audit on rifles and shotguns for 2006; and
- officials at the Eastern region indicated that, although semi-annual audits were performed, no documentation was maintained.

As a result, the Department cannot ensure that policies and procedures are complied with and that the firearms inventory system is accurate.

Gunsmith inspections not carried out as required

Inspection

The Firearms Policy requires that an authorized gunsmith inspect each firearm before it is issued or reissued to ensure its safe operation. The regional office must keep a copy of the gunsmith's inspection on file and forward a copy to the Legislation and Compliance Division.

We found that the Department was not complying with the Policy as follows:

- Officials indicated that not all issued or reissued firearms had the required gunsmith inspection completed. Furthermore, for those that were inspected, as of December 2006 none of the 3 regional offices had provided the required gunsmith inspection reports to the Legislation and Compliance Division at Headquarters.

- In August 2006 an officer returned a sidearm to the Western regional office for safekeeping and was reassigned the same sidearm in September without the required gunsmith inspection.

- Although policy requires that a firearms maintenance history file be maintained for each firearm, the Department only maintained files on sidearms. Files were not maintained for either rifles or shotguns in use or for forfeited firearms to show the maintenance history or the condition of these firearms.

As a result, firearms were issued or reissued that may not be working properly.

Firearms not transferred to Headquarters as required

Transfer of Firearms

The Firearms Policy requires that Conservation Officers transfer rifles and shotguns, ordered forfeited to the Crown by the Court, to Headquarters by May of each year in order to arrange for either assignment or disposal. Our review of the 63 forfeited rifles and shotguns on hand indicated issues with 12 as follows:

- 11 rifles and shotguns that had been ordered forfeited before May 2006 were still at the Western regional office (1 of these dated back to August 2003); and

- 1 rifle that had been ordered forfeited in September 2003 was still at the Labrador regional office.

In addition, 1 rifle that had been found abandoned in a wooded area by a Conservation Officer in March 2005 was still at the Labrador regional office after the suspect denied ownership.

Because the Conservation Officers had not transferred the forfeited rifles and shotguns to Headquarters, the firearms were not assigned or disposed of as required. As a result, the Department did not comply with its Firearms Policy.

Sidearms not returned during absences

Firearm Storage During Absences

The Firearms Policy requires that Conservation Officers return their sidearms to their Regional Compliance Manager for safe storage during absences from duty for periods of two to eight weeks and to Headquarters for periods greater than eight weeks.

During our review of attendance records, we identified 37 instances where Conservation Officers were not complying with the policy which required that sidearms be returned and stored during absences. These findings indicate a security risk.

Conclusions

We concluded the Firearms Policy is not being complied with in several areas such as:

- no required written report had been prepared nor had the police been informed about a missing rifle;
- there were instances where Conservation Officers had not reported damaged sidearms to the Regional Compliance Manager as required;
- firearms were transferred to police agencies without obtaining the required receipt;
- violation reports were not completed as required;
- semi-annual audits were not carried out as required;
- not all issued or reissued firearms were inspected by a gunsmith;

- for firearms that were inspected by a gunsmith, the required gunsmith inspection reports were not provided to the Legislation and Compliance Division at Headquarters;
- firearms maintenance history files were not maintained for either rifles and shotguns in use or for forfeited firearms;
- forfeited rifles and shotguns are not returned to Headquarters as required; and
- sidearms were not returned during periods of extended leave.

Recommendations

The Department should comply with the Firearms Policy and should:

- ensure that reports are prepared to document missing firearms and that police are informed;
- ensure damaged sidearms are reported to the Regional Compliance Manager;
- obtain required receipts for firearms transferred to police agencies;
- complete violation reports as required;
- conduct semi-annual audits;
- ensure all issued or reissued firearms are inspected by a gunsmith and that gunsmith inspection reports are provided as required;
- maintain firearms maintenance history files for rifles and shotguns in use, and for forfeited firearms;
- ensure that forfeited rifles and shotguns are returned to Headquarters; and
- ensure sidearms are returned during periods of extended leave.

4. Use of Force Training

Overview

Law enforcement agencies must take reasonable steps to ensure that officers can defend themselves in accordance with a use of force policy which considers their safety and the safety of the general public. A significant component of a use of force policy relates to use of force training. Such training would cover areas such as use of firearms, defensive tactics, handcuffing techniques, tactical room entries and lectures on use of force techniques.

Our review indicated the following weaknesses:

No database to track use of force training

- The Department does not maintain a database to track the required annual sidearms recertification and use of force training. Therefore, there is no information readily available to show when officers are due for recertification training. As a result, officers may not have been provided with the necessary recertification within the required timeframe.

Policy outdated

- We identified seven instances where the policy referred to sections or paragraphs that did not exist. Officials indicated that the references were in error and related to the previous use of force policy.

Recertification Shoot, Deer Lake

Conclusions

We have concluded that:

- the Department does not maintain a database to track the required annual sidearms recertification and use of force training; and
- the Use of Force Policy is out of date.

Recommendations

The Department should:

- maintain a database to track the required annual firearms recertification training; and
- update the Use of Force Policy.

Department's Response

With reference to the general conclusions, I would like offer the following points:

- *At the time of the audit, accurate records (files) were kept of every sidearm and to which officers they were issued to using a manual inventory system. Sidearms have now been entered into the electronic Firearms Inventory system.*
- *There is a separate policy (see attached) with respect to the use of pepper (OC) spray. This policy indicates that the Regional Compliance Managers through the Pressure Point Control Tactics (PPCT) trainers are responsible for pepper spray and provides direction as to the type of information that is to be recorded prior to issuance to Conservation Officers. Also, there is an audit form referenced in the Firearms Policy (see attached) which provides direction with respect to the information to be collected regarding firearms during the annual audit.*

- *With reference to the records for annual recertification for sidearms and use of force training, a database is maintained.*

- *The Firearms Control Officer Position will be advertised and hopefully filled before the end of this fiscal year. As you have pointed out, this will hopefully help us to rectify some, if not all, of the issues you have raised in your report.*

In terms of your detailed observations, I would like to offer you some clarifications on your conclusions and details of our intentions regarding your recommendations.

1. FIREARMS INVENTORY MANAGEMENT

1A. Accuracy of Firearms Inventory.

- *111 of the 135 firearms that were not recorded in the computer inventory were side arms that were properly recorded in our paper inventory. As per your recommendation, sidearms have now been entered in the electronic inventory system and the inventory is now complete and up to date.*

- *From my perspective, the majority of the issues in this section were with long guns. The annual internal audit conducted in 2007 has addressed these outstanding issues. The report on the findings of the annual audit has been prepared and will be submitted to the Director of Legislation and Compliance.*

1B. Control Over Ammunition and Pepper Spray

- *The majority of issues cited in the AG review concern long gun ammunition. The department tracks the purchase and issuance of all ammunition for sidearms.*

- *There is a separate policy for pepper spray that covers the replacement and disposal of pepper spray. The department also maintains records on the issuance of pepper spray.*

1C. Safety and Security of Firearms

- *The statement that DNR did not have access to its inventory of long guns in the gun room located at the HQ in Corner Brook at the time of this audit is accurate. The DNR employee who was responsible for the inventory room was on assignment to the Department of Justice at the time of the audit. The key was returned to DNR on November 16th and remains with the department.*

Recommendations of the report

The Department should:

- *Ensure its firearm inventory system is accurate;*
- *Record all firearms, ammunition and pepper spray in the firearms inventory system and;*
- *Ensure that pepper spray canisters are replaced by its manufacturer's recommended replacement date.*

Response to recommendations

The Department agrees it will:

- *Ensure its firearm inventory system is accurate (this has been accomplished during the time period the audit was being conducted. Internal Firearms Audit Report has been prepared.);*
- *Record all firearms, sidearm ammunition and pepper spray in the firearms inventory system, and;*
- *Ensure that pepper spray canisters are replaced by its manufacturer's recommended replacement date.*

The Department would like to advise:

- *That the recommendation of standardizing rifles used by Conservation Officers may not be necessary or desirable when weighed against the benefits and associated costs of implementation. Conservation officers are currently equipped with the proper tools (rifles and shotguns) that can effectively deal with nuisance animals.*

2. ADEQUACY OF FIREARMS POLICY

- *There is a separate policy with respect to pepper spray which requires information to be recorded prior to issuance to conservation officers.*
- *There is a checklist to be completed during the annual audit and it is included in the Firearms Policy.*

- *The Firearms policy was updated in December, 2006. This is an ongoing process.*

Recommendations of the report

The Department should:

- *Review the Firearms Policy for deficiencies and update where necessary;*
- *Consider standardizing rifles used by Conservation Officers and;*
- *Appoint a Firearms Control Officer to provide overall responsibility for the recording and control of the Department's firearms.*

Response to recommendations

The Department agrees it will:

- *Review the Firearms Policy for deficiencies and update where necessary;*
- *Appoint a Firearms Control Officer to provide overall responsibility for the recording and control of the Department's firearms.*

The Department would like to advise:

- *That the recommendation of standardizing rifles used by Conservation Officers may not be necessary or desirable when weighed against the benefits and associated costs of implementation. Conservation officers are currently equipped with the proper tools (rifles and shotguns) that can effectively deal with nuisance animals. The rationale for the issuance of rifles and shotguns is not the same as the rationale for the issuance of sidearms (officer safety/use of force).*

3. COMPLIANCE WITH FIREARMS POLICY

- *An annual internal audit was completed in 2007. Final report is being prepared.*
- *Firearms are now inspected by gunsmith prior to transfer and issuance.*

Recommendations of the report

The Department should comply with the Firearms Policy and should:

- *Ensure that reports are prepared to document missing firearms and that police are informed;*
- *Ensure damaged sidearms are reported to the Regional Compliance Manager;*
- *Obtain required receipts for firearms transferred to police agencies;*
- *Complete violation reports;*
- *Conduct semi-annual audits;*
- *Ensure all issued or reissued firearms are inspected by a gunsmith and that gunsmith inspection reports are provided as required;*
- *Maintain firearms maintenance history files for rifles and shotguns in use, and for forfeited firearms;*
- *Ensure that forfeited rifles and shotguns are returned to Headquarters and;*
- *Ensure sidearms are returned during periods of extended leave.*

Response to recommendations

The Department agrees it should comply with the Firearms Policy and will:

- *Ensure that reports are prepared to document missing firearms and that police are informed;*
- *Ensure damaged sidearms are reported to the Regional Compliance Manager;*
- *Obtain required receipts for firearms transferred to police agencies;*
- *Complete violation reports;*

- *Conduct annual audits (as per current policy dated December 20, 2006);*

- *Ensure all issued or reissued firearms are inspected by a gunsmith and that gunsmith inspection reports are provided as required;*

- *Maintain firearms maintenance history files for rifles and shotguns in use, and for forfeited firearms;*

- *Ensure that forfeited rifles and shotguns are returned to Headquarters and;*

- *Ensure sidearms are returned during periods of extended leave.*

The Department will ensure compliance with the firearm policy. To assist in achieving compliance with things such as completing reports, maintaining files, obtaining receipts, reporting damaged sidearms, etc., staff, supervisors and directors can and will be directed to be more vigilant in these areas.

4. Use of Force Training

- *DNR does maintain database on sidearms and use of force training.*

- *The current use of force policy was updated in December, 2006.*

- *One of the audit objectives was to determine whether use of force training is provided to conservation officers. However, the report does not clearly acknowledge that DNR does provide the full range of use of force training to its officers.*

<u>Recommendations of the report</u>

The Department should:

- *Maintain a database to track the required annual firearms recertification training and;*

- *Update the Use of Force Policy*

Response to recommendations

The Department agrees it will:

- *Maintain a database to track the required annual firearms recertification training (the current database that is available should be expanded to include a complete history of training and recertification dates for all applicable individuals, this will ensure officers are provided the necessary recertification within the required timeframe) and;*

The Department would like to advise:

- *That the Use of Force Policy was updated on December 20, 2006 and the errors identified in the report have already been addressed.*

Office of the Auditor General
Newfoundland and Labrador

Highlights

Highlights of a review of the Department of Transportation and Works' Equipment Maintenance Program for the period 1 April 2006 to 31 March 2007.

Why our Office did this Review

The objectives of our review of the equipment maintenance program were to determine the age and composition of the heavy equipment fleet; determine whether the Department has an overall strategy for replacement of heavy equipment; assess compliance with the *Public Tender Act*; and assess the adequacy of management information systems in relation to monitoring and controlling the equipment maintenance program throughout the Province.

What our Office Recommends

The Department should:

- continue to reduce the age of its heavy equipment fleet;
- develop a formal replacement strategy for its heavy equipment fleet;
- comply with the *Public Tender Act*; and
- perform a review of the EMS and/or consider alternate systems with a view to addressing current system deficiencies.

What the Department Said

To provide balance to this report and to ensure full disclosure, the Department was asked to formulate a response to our findings and conclusions. The Department's response, verbatim, is included at the end of this report. Readers are encouraged to consider the Department's comments in this regard.

♦ ♦ ♦ ♦ ♦

To view the full report, refer to the web site www.gov.nl.ca/ag. For more information, call the Office of the Auditor General, 709-729-2700 or email adgmail@gov.nl.ca

Chapter 2, Part 2.18
DEPARTMENT OF TRANSPORTATION AND WORKS
Equipment Maintenance Program

The Department of Transportation and Works (the Department) is responsible for the construction and maintenance of the Province's road system including management of Government's fleet of vehicles. The equipment maintenance program for all of Government's fleet of light vehicles and heavy equipment consists of three sub-programs as follows:

Administration: management and administration of the equipment maintenance function, vehicle fleet policy and the cost of public liability insurance for the vehicle fleet.
Maintenance of equipment: equipment maintenance for Government's light vehicle fleet and heavy equipment.
Equipment acquisitions: acquisition of heavy equipment, light vehicles and communication systems used in heavy equipment.

What We Found

Our review indicated that there are significant weaknesses in the Department's equipment maintenance program for heavy equipment. For example:

- Despite recent increased investment in heavy equipment, primarily snow clearing equipment, much of the Department's heavy equipment fleet remains past the point where they can continue to operate economically. Although the Department has determined that repair costs become quite significant for heavy trucks 10 years old and greater and heavy equipment 20 years old and greater, our review indicated that:
  - of the 322 heavy trucks, 109 or 34% were 10 years old and greater.
  - of the 284 pieces of other heavy equipment 90 or 32% were 20 years old and greater and 24 of the 90 pieces were 30 years old and greater.

- There is no overall replacement strategy in place for heavy equipment which would assist in optimizing acquisition decisions and in determining the appropriate level of required funding for the future operation of the heavy equipment fleet. Current replacement decisions are made largely on an annual budgetary basis by region without the benefit of an overall analysis and a comprehensive replacement strategy.

  While the Department is expected to be allocated funding to 2010-11 to address most of the current replacement requirements, additional funds will be required to replace vehicles which are not currently past the age identified for replacement.

- The Department did not comply with the spirit of the *Public Tender Act* when it purchased 15 used loaders in June 2006. The terms and conditions of the tender were so specific that only the eventual supplier would be in a position to be awarded the tender. In particular, the Department set a maximum required bid of $2.5 million and reduced the quantity from 16 loaders to 15 to match the number of loaders available from the eventual supplier.

- Due to deficiencies in the Department's Equipment Management System (EMS), it was not possible to assess the costs associated directly with the heavy equipment fleet and whether recent investments in equipment have led to reductions in repair costs or down-time.

  As the result of the issues of completeness and accuracy identified with the Department's EMS, the reliability and usefulness of information contained within the system is limited. The system is not operating as intended and as a result, management lacks the information required to effectively manage the Province's heavy equipment fleet.

Background

Mandate

The Department of Transportation and Works (the Department) is responsible for the construction and maintenance of the Province's road system. This includes:

- maintenance on over 9,400 kilometres of primary and secondary highways and community access roads;
- construction of new roads;
- management of road improvement projects; and
- management of Government's fleet of vehicles.

In order to achieve its mandate, the Department maintains a fleet of over 600 heavy equipment vehicles. Responsibility for the equipment maintenance program for these vehicles falls under two divisions of the Department's Transportation branch as follows:

- The Highway Maintenance Support Division is responsible for administration and policy development for all Government vehicles. This includes vehicle acquisition, maintenance and equipment cost data and related record storage.

- The Regional Operations (Roads) Division is responsible for the maintenance of Government's fleet of vehicles.

Organizational structure

In carrying out its roads program, the Department operates five regional depots [Headquarters is located at the Confederation Building.]:

- Avalon (White Hills, St. John's);
- Eastern (Clarenville);
- Central (Grand Falls-Windsor);
- Western (Deer Lake); and
- Labrador (Happy Valley-Goose Bay).

A network of 11 sub-division offices and 57 highways depots report to the regional depots. The highways depots include 32 permanent depots and 25 seasonal depots for winter maintenance. Depot staff perform maintenance procedures on the Department's heavy equipment vehicle fleet. Minor maintenance procedures are performed at the highways depots. Significant maintenance procedures are performed at the regional depots.

Figure 1

Department of Transportation and Works
Garage Area - White Hills Depot

Program costs

The equipment maintenance program for all of Government's fleet of light vehicles and heavy equipment consists of three sub-programs as follows:

- Administration: management and administration of the equipment maintenance function, vehicle fleet policy and the cost of public liability insurance for the vehicle fleet.
- Maintenance of equipment: equipment maintenance for Government's light vehicle fleet and heavy equipment.
- Equipment acquisitions: acquisition of heavy equipment, light vehicles and communication systems used in heavy equipment.

Figure 2 shows expenditures for fiscal years 2002-03 to 2006-07.

Figure 2

Department of Transportation and Works
Equipment Maintenance Expenditure and Revenue
Fiscal years 2002-03 to 2006-07
($000's)

Expenditure	2002-03	2003-04	2004-05	2005-06	2006-07
Administration					
Salaries	$1,178	$1,301	$1,251	$1,229	$1,235
Transportation and Communication	19	20	12	18	17
Purchased Services	685	1,303	1,389	1,327	1,067
Total Administration	**1,882**	**2,624**	**2,652**	**2,574**	**2,319**
Maintenance of Equipment					
Salaries	7,149	7,470	6,519	6,545	6,730
Transportation and Communication	91	106	60	113	138
Supplies	10,018	9,961	9,167	10,971	12,219
Purchased Services	694	747	537	771	663
	17,952	18,284	16,283	18,400	19,750
Revenue	(44)	(154)	(33)	(48)	(11)
Total Maintenance of Equipment	**17,908**	**18,130**	**16,250**	**18,352**	**19,739**
Equipment Acquisitions					
Property, Furnishings and Equipment	3,482	2,953	3,797	9,216	12,114
Revenue	(49)	(4)	(117)	(11)	(126)
Total Equipment Acquisitions	**3,433**	**2,949**	**3,680**	**9,205**	**11,988**
Total Equipment Maintenance	**$23,223**	**$23,703**	**$22,582**	**$30,131**	**$34,046**

Source: Departmental Statements of Expenditure and Related Revenue

As Figure 2 shows, the total cost of the equipment maintenance program for 2006-07 was $34.0 million. Total program expenditures increased significantly from $22.6 million in 2004-05 to $34.0 million in 2006-07, an increase of 50% in three years.

The increase was due primarily to expenditures on vehicle acquisitions which increased significantly from $3.8 million in 2004-05 to $12.1 million in 2006-07, an increase of over 200%.

In addition to vehicle acquisitions, expenditures for maintenance supplies increased 33% from $9.2 million in 2004-05 to $12.2 million in 2006-07. These increases were primarily due to increases in the cost of diesel fuel, vehicle component parts and shop supplies.

Audit Objectives and Scope

Audit objectives

The objectives of our review of the equipment maintenance program were to:

- determine the age and composition of the heavy equipment fleet;
- determine whether the Department has an overall strategy for replacement of heavy equipment;
- assess compliance with the *Public Tender Act*; and
- assess the adequacy of management information systems in relation to monitoring and controlling the equipment maintenance program throughout the Province.

Audit scope

Our review examined the equipment maintenance program for Government's heavy equipment fleet administered through the Department of Transportation and Works.

We completed our review in December 2007. It covered the period 1 April 2006 to 31 March 2007. Our review included discussions with departmental officials and examination of documentation at the Department and at the Avalon Regional depot.

Overall Conclusions

Our review indicated that there are significant weaknesses in the Department's equipment maintenance program for heavy equipment. For example:

- Despite recent increased investment in heavy equipment, primarily snowclearing equipment, much of the Department's heavy equipment fleet remains past the point where they can continue to operate economically. Although the Department has determined that repair costs become quite significant for heavy trucks 10 years old and greater and heavy equipment 20 years old and greater, our review indicated that:
  - of the 322 heavy trucks, 109 or 34% were 10 years old and greater.
  - of the 284 pieces of other heavy equipment 90 or 32% were 20 years old and greater and 24 of the 90 pieces were 30 years old and greater.
- There is no overall replacement strategy in place for heavy equipment which would assist in optimizing acquisition decisions and in determining the appropriate level of required funding for the future operation of the heavy equipment fleet. Current replacement decisions are made largely on an annual budgetary basis by region without the benefit of an overall analysis and a comprehensive replacement strategy.

  While the Department is expected to be allocated funding to 2010-11 to address most of the current replacement requirements, additional funds will be required to replace vehicles which are not currently past the age identified for replacement.
- The Department did not comply with the spirit of the *Public Tender Act* when it purchased 15 used loaders in June 2006. The terms and conditions of the tender were so specific that only the eventual supplier would be in a position to be awarded the tender. In particular, the Department set a maximum required bid of $2.5 million and reduced the quantity from 16 loaders to 15 to match the number of loaders available from the eventual supplier.

- Due to deficiencies in the Department's Equipment Management System (EMS), it was not possible to assess the costs associated directly with the heavy equipment fleet and whether recent investments in equipment have led to reductions in repair costs or down-time.

  As the result of the issues of completeness and accuracy identified with the Department's EMS, the reliability and usefulness of information contained within the system is limited. The system is not operating as intended and as a result, management lacks the information required to effectively manage the Province's heavy equipment fleet.

Detailed Observations

This report provides detailed audit findings and recommendations in the following sections:

1. Age and Composition of Heavy Equipment Fleet
2. Heavy Equipment Replacement Strategy
3. Compliance with the *Public Tender Act*
4. Management Information Systems

1. Age and Composition of Heavy Equipment Fleet

Overview

The Department uses more than 600 heavy equipment vehicles in maintaining the road system throughout the Province. It has been recognized that there is a need to improve the aging heavy equipment fleet. Older equipment is more costly to maintain and often results in increased down-time.

Figure 3 summarizes the age of the Department's heavy equipment fleet indicated as being operational as at 31 March 2007.

Figure 3

Department of Transportation and Works
Age of Heavy Equipment Fleet by Specification Category
As of 31 March 2007

Spec. #	Description	Average age (years)	Quantity			
			<10 years	10 to 20 years	>20 years	Total
	Heavy Trucks					
201	Dump truck tandem axle hopper dump	16	-	6	-	6
202	Dump truck tandem axle side spreader	6	196	69	-	265
222	Dump truck single axle side spreader	11	4	10	-	14
223	Dump truck single axle plain dump	16	-	1	-	1
225	Dump truck single axle with broom	13	-	1	-	1
231	Crew cab stake body truck	11	7	14	1	22
240	Tractor truck	9	2	4	-	6
251	Special purpose truck	4	3	-	-	3
253	Line striper truck	14	1	2	1	4
Sub-total		**7**	**213**	**107**	**2**	**322**
	Other Heavy Equipment					
301	Grader	25	1	12	26	39
321	Excavator plain	18	-	10	2	12
322	Backhoe 60 kw or 80 hp	11	10	6	1	17
323	Backhoe 67 kw or 90 hp	14	-	8	-	8
325	4x4x4 Backhoe	2	11	-	-	11
330	Snow blower > 50 hp	18	7	8	20	35
352	Loader > 119.3 kw or 159 hp	19	4	61	36	101
353	Loader > 134kw or 179 hp	11	9	21	-	30
354	Loader > 179 net hp	4	18	-	-	18
362	Special purpose heavy equipment	18	2	6	5	13
Sub-total		**17**	**62**	**132**	**90**	**284**
Heavy Equipment Fleet Total		**11**	**275**	**239**	**92**	**606**

Source: Departmental Equipment Management System

As outlined in Figure 3, as of 31 March 2007, there were 606 pieces of equipment in the Department's fleet. The Figure includes information on the average age of each vehicle class. Officials indicated that they have determined that repair costs become quite significant for heavy trucks 10 years old and greater and heavy equipment 20 years old and greater.

Our review of the heavy equipment fleet indicated that:

- of the 606 pieces contained in the heavy equipment fleet:
  - 331 or 55% were model year 1997 or older;
  - 275 or 45% were model year 1998 or newer; and
  - the average age of the fleet was 11 years (heavy trucks: 7 years; heavy equipment: 17 years). Heavy trucks are relatively newer than other heavy equipment with most being a 1998 model or newer. Many of the vehicles in this category would be used for snowclearing and have had significant increases in acquisitions in recent years.
- of the 322 heavy trucks:
  - 109 or 34% were 10 years old and greater.
- of the 284 pieces of other heavy equipment:
  - 90 or 32% are 20 years old and greater.
  - 24 of the 90 pieces were 30 years old and greater. Figure 4 shows the model and year of equipment that is 30 years or older.

Figure 4

Department of Transportation and Works
Other Heavy Equipment 30 Years or Older
As of 31 March 2007

Spec. #	Description	Quantity-Model Year									
		1963	1964	1969	1972	1973	1974	1975	1976	1977	Total
301	Grader	1	1	-	-	1	3	5	1	2	14
352	Loader > 119.3 kw or 159 hp	-	-	1	1	-	-	1	3	3	9
362	Special purpose heavy equipment (forklift)	-	-	-	-	-	-	1	-	-	1
Total		**1**	**1**	**1**	**1**	**1**	**3**	**7**	**4**	**5**	**24**

Source: Departmental Equipment Management System

As Figure 4 shows, a total of 24 pieces of heavy equipment were greater than 30 years old. These items ranged in age from 30 to 44 years old and fell into three equipment categories:

- 14 graders;
- 9 loaders; and
- 1 forklift.

It is clear that equipment is being used which is more than 10 to 20 years past the point where they can continue to operate economically. This results in additional costs to maintain the equipment as well as increased down-time. Due to information on maintenance and down-time not being available at the Department, we were unable to evaluate the impact on the aging equipment fleet.

Conclusion

As equipment increases in age and usage, the need for repairs and maintenance increases eventually to a point at which a vehicle can no longer operate economically. As a result, it is costing more to operate and maintain the fleet than it should.

Recommendation

The Department should continue to reduce the age of its heavy equipment fleet.

2. Heavy Equipment Replacement Strategy

Overview

The Department's 2006-2008 Strategic Plan includes goals and objectives related to the equipment maintenance program as shown in Figure 5.

Figure 5

Department of Transportation and Works
Heavy Equipment
Strategic goal and objectives
Fiscal years 2005-06 to 2007-08

2006 - 2008	Description	Measure	Indicators
Goal	By 2008, the Department of Transportation and Works will have reduced the number of pieces of equipment that are older than 10 years	Reduced number of equipment aged 10 years or greater	- Percentage of snowclearing equipment available for use has increased - Percentage of equipment age 10 years or greater has decreased
	Objective By 2007, the Department of Transportation and Works will have replaced 10 percent of its heavy equipment	(A)10 percent of equipment replaced	- Number of trucks replaced - Number of other heavy equipment replaced
		(B)Reduction in down-time	- Percentage of equipment available for use has increased - Replacement cost for parts has decreased
	Objective By 2008, the Department of Transportation and Works will have replaced 20 percent of its heavy equipment	Not stated	Not stated

Source: Departmental Strategic Plan 2005-06 to 2007-08

No fleet replacement strategy

Although the Department has established a goal and objectives related to the equipment maintenance program, our review indicated that there is no overall fleet replacement plan as evidenced by the following:

- an equipment needs assessment was not available for each region;
- the Department's maintenance system does not maintain enough information on operating and maintenance costs or down-time to determine if it is economical to continue to operate certain equipment;
- there are no criteria documented for equipment replacement based upon such factors as age, usage and historical maintenance and operating costs; and
- there is no methodology for prioritizing heavy equipment due for replacement on an overall fleet basis.

The Department is not able to determine its equipment requirements and/or which equipment should be replaced first. Furthermore, annual funding for equipment replacement is based primarily on judgment.

As a result, the Department is not able to effectively manage the replacement of its heavy equipment.

Details of our findings in relation to funding and replacement of heavy equipment are as follows.

Increase in funding

A Departmental request during the budget process for a significant increase in capital funding for heavy equipment in 2004-05 did not result in a significant increase in the funding level for heavy equipment acquisitions. However, an increase in capital funding did occur in 2005-06. The Department's budget proposal for 2005-06 stated that:

"*With the present historic funding level of $3.5 to $4 million, the Department must continue to operate at an inefficient level with an outdated fleet. This process results in a number of poor management decisions being regularly made on equipment to keep our main operation of winter highway maintenance functional. These include:*

- *Spending high repair funding on equipment that does not justify repairing due to age and/or mechanical condition.*

- *Keeping old equipment operational for "spare" purposes in order to remain operational when equipment is out of service more regular than normal.*

One can also say that without a major increase in funding, for the short term, that our existing fleet will accelerate the future repair costs and as well the out of service time will remain at an unacceptable level."

Based upon our review, the Department appears to be addressing its goal in terms of the number of pieces of heavy equipment replaced. The Department's 2005-06 Annual Report references the replacement of approximately 47 pieces of equipment at a total cost of $6.5 million. However, total Department costs for maintenance supplies under the equipment maintenance program have increased 33% in the past three years, as evidenced in Figure 2.

Due to problems identified with the Equipment Maintenance System (EMS) it was not possible to evaluate information for repair costs related solely to the heavy equipment fleet. Problems noted with the close out of job orders in the EMS mean that information on equipment down-time is not accurate. As a result, it is not possible to assess whether recent investments in heavy equipment are leading to related reductions in repair costs or down-time.

Replacement process

The Department has increased the planned level of funding for vehicle acquisitions to $10.5 million per year for 2005-06 to 2010-11. Approximately $1.0 million is allocated for light vehicles and about $9.5 million is allocated for heavy equipment. Through Government's budgetary process, the actual amount for vehicle acquisitions may vary.

Our review indicated that the process used to determine which vehicles to replace through available funding each year is primarily judgmental rather than a structured approach on a fleet-wide basis. Annually, officials in the five regional offices are advised of their approximate budget allocation for equipment acquisitions and are asked to review their needs and submit a priority listing to Head Office. The regional officials' ability to determine which vehicles need replacing is limited by the lack of information on maintenance costs and down-time in the Department's maintenance information system.

Officials at Head Office review and finalize the listing for each region. The Department officials indicated that factors considered included:

- funding available for heavy equipment acquisition;
- overall Departmental priorities (e.g. snowclearing equipment has been priorized); and
- demonstrated need for specific pieces of equipment.

Currently, the Department's emphasis is on replacing older equipment needed for snowclearing operations.

Funding inadequate to upgrade heavy equipment fleet

Purchase costs of heavy equipment vary depending upon classification and the amount of related equipment which must be installed. Departmental officials indicated an average replacement cost of about $180,000 for heavy trucks and $225,000 for other heavy equipment. Based on this we made the following replacement cost estimates for the fleet as at 31 March 2007:

- the estimated replacement cost of the Department's heavy equipment was $121.9 million; and
- the estimated replacement cost of heavy equipment at the desired replacement level (10 years for heavy trucks and 20 years for other heavy equipment) was $39.9 million.

By 2010-11, the Department is expected to have been allocated a further $38.0 million for heavy equipment replacement. While this funding may address most of the current replacement requirements, additional funds will be required to replace vehicles which are not currently past the age identified for replacement. Prior to 2010-11, additional funding may be required to replace vehicles which meet the age for replacement in the interim period. Additional maintenance costs and down-time will result if these vehicles are not replaced.

Conclusions

There is no overall replacement strategy in place for heavy equipment. Current replacement decisions are made largely on an annual budgetary basis by region without the benefit of an overall analysis and a comprehensive replacement strategy.

In addition, while the Department is expected to be allocated funding to 2010-11 to address most of the current replacement requirements, additional funds will be required to replace vehicles which are not currently past the age identified for replacement.

Recommendation

The Department should develop a formal replacement strategy for its heavy equipment fleet.

3. Compliance with the *Public Tender Act*

Overview

Equipment acquisitions for light vehicles, heavy equipment and communication equipment for 2006-07 totalled $12.1 million. We reviewed the two major contracts for the purchase of heavy equipment during the year totalling $7.7 million. This represents 64% of the total of all acquisitions. One of these contracts was for the purchase of 31 trucks equipped with snowclearing equipment ($5.4 million) and the second contract was for the purchase 15 used loaders ($2.3 million). Our review identified that the purchase of the 31 trucks was in accordance with the *Public Tender Act* but the purchase of the 15 used loaders did not comply with the spirit of the *Public Tender Act*. Details are as follows:

On 8 June 2006, the Department paid $2,343,750 excluding taxes to a supplier for 15 used loaders. The purchase resulted from the supplier being designated the preferred bidder (lowest tender meeting terms, conditions and specifications) on a tender call that closed on 11 April 2006.

Figure 6

Department of Transportation and Works
Used Loader - White Hills Depot

Spirit of *Public Tender Act* not complied with

Our review indicated that the Department did not comply with the spirit of the *Public Tender Act* in the purchase of the used loaders. In particular, the terms and conditions of the tender were so specific, including a maximum required bid of $2.5 million, that only the eventual supplier would be in a position to be awarded the tender.

Tender process

The original tender specified the purchase of 16 new, used or demo loaders meeting a set of vehicle specifications. Used loaders had to be model year 2002 or newer with less than 3,500 hours of operation. The total expenditure was not to exceed $2.5 million.

Our review of the tender file and discussion with officials of the Government Purchasing Agency and the Department indicated that:

- There were two tenders received. The eventual supplier was determined to be the successful bidder meeting the final requirements and specifications.

- The Department had prior knowledge of the availability of used loaders from the eventual supplier.

- The tender had been amended prior to closing date to change specifications contained in the original tender document by reducing the number of units to 15 instead of 16 (an official of the Department requested an amendment to the tender because the supplier communicated that only 15 units were available).

  Other changes in specification were also made to remove the requirement for air conditioning, shop manuals for each unit, and a heavy loader bucket with teeth (cutting edges were considered acceptable).

- The eventual supplier submitted a bid for *used* equipment at a unit price of $156,250 which equates to the maximum bid amount of $2.5 million divided by the original 16 units required. The other supplier tendered for *new* equipment at a unit price of $237,400, which totalled $3.5 million and therefore exceeded the required bid limit of $2.5 million. As well, the bidder did not meet specified delivery date for new equipment of 31 July 2006.

Conclusion

The Department did not comply with the spirit of the *Public Tender Act* when it purchased 15 used loaders. The terms and conditions of the tender were so specific that only the eventual supplier would be in a position to be awarded the tender. In particular, the Department set a maximum required bid of $2.5 million which effectively limited the tender award to the eventual suppler. The terms and conditions were also amended to reduce the quantity from 16 loaders to 15, again suggesting that the tender specifications were amended to ensure the tender was awarded to the eventual supplier.

Recommendation

The Department should comply with the spirit of the *Public Tender Act*.

4. Management Information Systems

Overview

The Equipment Management System (EMS) is an in-house designed database which serves as a comprehensive equipment management control system for all government vehicles. The system was developed many years ago to monitor and control heavy equipment operations. It was later expanded to include all of Government's vehicle fleet.

Data is input by staff at both the regional depots and headquarters. When a piece of heavy equipment is purchased, staff at regional depots assign a number and enter basic equipment information, such as:

- vehicle make and model;
- acquisition cost;
- purchase date; and
- user department code.

The system was designed such that costs for repairs and maintenance and vehicle utilization (meter readings) are recorded. Reports on vehicle utilization, costs and fuel usage could be generated from the system and distributed to user departments.

The Department's EMS was designed to interface with Government's Financial Management System (FMS) in order to record vehicle component costs.

Information on operating and maintenance costs is not readily available

We found that the Department is unable to analyze heavy equipment operating and maintenance costs, or down-time, because the information is not readily available from the EMS. Specifically:

- information recorded in the EMS for individual vehicles was incomplete and inaccurate; and

- Government's FMS is not used to distinguish operating and maintenance costs for heavy equipment and light vehicles.

As a result, information is not readily available to analyze maintenance and operating expenditures for heavy equipment.

Details of our findings in this area are as follows.

Information in the EMS is incomplete

Despite its design as a comprehensive equipment management system, Department officials indicated that a number of significant problems currently exist in terms of the recording and updating of information in the EMS. Matters affecting the completeness of information include:

- Information on repairs performed at outside private garages is not recorded in the system. Most work on heavy equipment is performed at depots; however, warranty work is performed on heavy equipment at outside garages.

- There are problems with the interface between Government's FMS and the Department's EMS in that the cost of vehicle components is not always being entered in the EMS. In addition, not all repair costs are recorded as required. As a result, the EMS does not contain the financial information on maintenance costs which are recorded in FMS. Officials indicated that this matter has been outstanding for some time and that they are currently following up to resolve this matter.

- Department officials indicated that operating costs such as fuel, oil and liquids are purchased using a corporate fuel card. The tender agreement indicates that oil companies should submit information on purchases to the Department in electronic form. The data would then input into the EMS. There were initial problems a number of years ago that have not been resolved. As a result, there is no EMS information available on vehicle operating costs.

- Information is not automatically updated as recorded in the system. Updates are only done on an ad hoc basis for reporting purposes.

As a result, the information in the Department's EMS is incomplete.

Information in the EMS is inaccurate

Matters affecting the accuracy of information maintained in the EMS include:

- Depot staff notify Headquarters of any changes in vehicle location or use. However, transfers of vehicles between depots and vehicles taken out of service for disposal are not always adjusted on a timely basis in the EMS.

  Officials indicated that they recognized this problem and planned to implement a procedure to ensure vehicle listings are periodically checked and adjusted.

- Information on the length of time a vehicle is out of service can be obtained from the system; however, officials indicated that due to the fact that an estimated 7,000 repair jobs within the system were not properly closed out (some greater than 2 years old) information on vehicle down-time is not accurate.

  It is important that the amount of down-time for heavy equipment be minimized. Down-time results in significant costs in terms of repair costs and lost service. As a result, the Department's EMS cannot generate reliable information on vehicles incurring significant down-time that should be considered for replacement.

As a result, the information in the Department's EMS is inaccurate.

Lack of controls

There is currently no process in place to ensure the accuracy of information maintained within the Department's EMS. Specifically, there are no controls to improve the accuracy of information including:

- no input controls to prevent keying errors;
- no requirement to reconcile data entries which would improve the accuracy of information in the system;
- no comparison of financial information to amounts included in Government's FMS; and
- no current policy and procedures manual in use to provide guidance to depot staff on the system.

Management reports not available from EMS

Based on the design objective of the EMS, we would expect reports to be available to aid management in the monitoring, analysis and decision-making related to vehicles. This would include reports such as:

- repair and maintenance costs;
- overall operating costs;
- utilization;
- exception reports to identify problems such as:
    - vehicles not receiving scheduled preventative maintenance:
    - vehicles incurring significant costs or down-time; and
- comparisons by classification, region, etc.

The EMS has a very limited reporting capability. For example:

- Information on a specific vehicle (such as serial number, license plate number, engine size, vehicle make, vehicle year, assigned location and vehicle repair orders) can be viewed on line by officials at regional depots and Head Office, but there is no print function within the system.
- Officials indicated that a reports function was planned but the software overwrites necessary were never completed. As a result, the current version of the system has no reporting capability.
- Given the fact that the planned reporting component of the EMS was never completed, information must be requested on an ad hoc basis from IT staff working at the Department. A conversion process must be run using a separate software package when reporting is required. A limited number of vehicle inventory reports are being generated directly from the system on an ad hoc basis.

Conclusions

The operation of the EMS as a vehicle management system is inadequate. The lack of controls and issues with the completeness and accuracy of data mean that the information retained is unreliable and therefore not usable as designed for management's monitoring, analysis and decision making with regards to the vehicle fleet. As well, the current reporting capability of the system is also inadequate.

As the result of the deficiencies identified in the EMS, we have concluded that management lacks the required information to more effectively manage its vehicle fleet.

Recommendation

The Department should perform a review of the EMS and/or consider alternate systems with a view to addressing current system deficiencies.

Department's Response

The Department offers the following comments:

- *The Department does have a five (5) year strategy to reduce the average age of its heavy equipment fleet by investing approximately $10 million per annum in acquisition of new units. As noted in the expenditure summary table (Figure 2), annual equipment acquisition expenditures have increased significantly since 2004-05. In 2010-11 the Department will re-assess the age of its fleet and advance a revised strategy for continued capital investments in the fleet.*

- *The Department does not agree with the Auditor General's view that the purchase of fifteen (15) used loaders violated the Public Tender Act. As noted in the report, these units were purchased at a cost of $156,250 per unit, compared to a unit cost of $237,400 per unit offered by the other supplier. The Department therefore maintains that it accepted the lowest compliant bid, as per the* Public Tender Act.

- *The Department acknowledges that deficiencies do exist within the Equipment Management System (EMS). An internal task force, chaired by a senior director, has been mandated to review concerns over the EMS as well as other matters relating to maintenance of the heavy equipment fleet. Your findings will also be referred to the task force for appropriate action.*

CHAPTER 3

UPDATE ON PRIOR YEARS' REPORT ITEMS

CHAPTER 3
Update on Prior Years' Report Items

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CHAPTER 3
Update on Prior Years' Report Items

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3.1 Introduction

We conduct legislative audits to provide the House of Assembly with information on public sector accountability. Legislative audits are carried out to determine whether:

- Public money is being properly collected and accounted for;
- Expenditures are properly recorded and made for the purposes intended;
- Accounts are properly kept;
- Assets are adequately safeguarded; and
- Accounting and management systems and practices are adequate.

These legislative audits also determine whether the activities of Government departments and agencies have been carried out in compliance with legislation, Government policies and other authorities.

Monitoring the implementation of our recommendations is an important part of our obligation to report to the House of Assembly. Our objective is to monitor and report on the degree to which positive change has occurred as a result of the implementation of recommendations in our prior years' reports.

In 1996, we commenced a formal process of monitoring and updating the comments and recommendations included in our previous Annual Reports to the House of Assembly. It is our intention to monitor and update the recommendations in each Annual Report two years after it has been issued. Monitoring will continue until we are reasonably satisfied that issues are being adequately addressed or are no longer valid.

This chapter includes the results of these monitoring activities on our Annual Reports up to and including 2005.

Legislature

3.2.1 Office of the Child and Youth Advocate (2004 Annual Report, Part 2.1)

Introduction

In 2004, we completed a review of the Office of the Child and Youth Advocate. Our objective was to review the expenditures of the Office of the Child and Youth Advocate and to determine whether the expenditures were in accordance with the approved budget, and in accordance with legislative requirements.

Conclusions from our 2004 review

Our audit of the Office of the Child and Youth Advocate identified a number of serious concerns relating to the operations of the Office. These concerns related to poor management practices at the Office, operation of an unauthorized bank account which was sometimes used for inappropriate purposes, non-compliance with the *Public Tender Act*, travel without authorization, and questionable expenditures related to such things as travel, personal vehicle mileage claims, entertainment, parking spaces for employees and cellular telephones. There were instances where the Office of the Child and Youth Advocate did not comply with direction provided by the Commission of Internal Economy.

Accounting for the Office of the Child and Youth Advocate was performed by the Office of the Clerk of the House of Assembly. As a result of numerous accounting errors in the accounts of the Office of the Child and Youth Advocate, the expenditure details in the Province's Public Accounts were not correct. One of the errors resulted in a contravention of the *Financial Administration Act* which prohibits the issue of public money for purposes other than those authorized by the Legislature. Furthermore, the Office of the Child and Youth Advocate was not always provided with sufficient information to enable the Office to monitor its expenditures.

2006 update

In our 2006 annual report, we included an update on the Office of the Child and Youth Advocate's progress towards implementing the recommendations contained in our 2004 report. In response to our 2006 update request, the Office indicated that:

- all out-of-province travel was pre-approved by the Speaker of the House of Assembly using the journey authorization form for the Child and Youth Advocate and all staff travel out-of-province was also approved using the journey authorization form;
- travel claims for the Child and Youth Advocate were submitted in accordance with the policies and procedures for executive compensation travel;
- the Office of the Child and Youth Advocate complied with the *Public Tender Act* and the *Government Purchasing Agency Act* and had adopted the policies outlined in the *Government Purchasing Agency Customer Manual*;
- staff arrangements and salary scales had been restructured to align them with similar positions in Government and the House of Assembly;
- free parking had been eliminated for staff when staff levels were above the three spaces included in the lease; and
- the policy and procedures manual for cellular telephones in the Office had not been finalized; however, many of the procedures and policies for cell phone usage in Government had been adopted.

Update

In October 2007, we contacted the Office of the Child and Youth Advocate requesting an update as to any further progress on the comments and recommendations included in our 2004 report. The information provided by the Office in response to our request is outlined below.

2004 Recommendation

The Office of the Child and Youth Advocate should establish formal policies and procedures governing the provision and use of cellular telephones and ensure that all use is properly monitored.

Action Taken

The Office indicated that it now follows Government's General Policies for Cellular Phones. The Office stated that a copy of these policies is included in its own policy and has been distributed to all staff in hard copy.

3.2.2 Office of the Citizens' Representative (2004 Annual Report, Part 2.2)

Introduction

In 2004, we performed a review of the Office of the Citizens' Representative. Our objective was to review the expenditures of the Office of the Citizens' Representative and to determine whether they were in accordance with the approved budget, and in accordance with legislative requirements.

Conclusions from our 2004 review

Our audit of the Office of the Citizens' Representative identified a number of concerns relating to the operations of the Office. In particular, claims for private vehicle usage appeared excessive, private vehicle mileage was incorrectly claimed between the Citizens' Representative's permanent residence and the Office, there were inconsistencies related to private vehicle usage claims and travelling without authorization. In addition, there were management practice issues relating to such matters as cellular telephones and entertainment. Furthermore, there was an instance of non-compliance with the *Citizens' Representative Act* and another instance of non-compliance with the *Public Tender Act*.

Accounting for the Citizens' Representative Office is performed by the Office of the Clerk of the House of Assembly. As a result of numerous accounting errors in the accounts of the Office of the Citizens' Representative, the expenditure details in the Province's Public Accounts were not correct. Furthermore, the Office of the Citizens' Representative was not always provided with sufficient information to enable the Office to monitor its expenditures.

2006 update

In our 2006 annual report, we included an update on the Office of the Citizens' Representative's progress towards implementing the recommendations contained in our 2004 report. In response to our 2006 update request, the Office indicated that:

- it was complying with all sections of the *Citizens' Representative Act*;
- it was complying with the *Public Tender Act* in the acquisition of all goods and services;

- all out of Province travel was approved in advance by the Speaker and all staff travel was approved by Official Journey Authorization in accordance with public service guidelines;

- it was complying with Government's entertainment policy and Executive Compensation Travel Rules in all respects; and

- formal policies and procedures governing the use of cellular telephones were being developed and all use was properly monitored.

Update

In October 2007, we contacted the Office of the Citizens' Representative requesting an update as to any further progress on the comments and recommendations included in our 2004 annual report. The information provided by the Office in response to our request is outlined below.

2004 Recommendation

The Citizens' Representative should establish formal policies and procedures governing the provision and use of cellular telephones and ensure that all use is properly monitored.

Action Taken

The Office indicated it has reduced the number of cell phones from five to one cell phone and one BlackBerry wireless device. The cell phone is held by the Office Administrator and is issued to staff that travel outside the St. John's metropolitan area on business. The BlackBerry has been issued to the Citizens' Representative in order to provide him with contact to his staff while at outside meetings or travelling.

The Office also indicated that it complies with Government's General Policies for Cellular Phones (including BlackBerry units).

Executive Council

3.2.3 Inconsistent Compensation Practices (2005 Annual Report, Part 2.1)

Introduction

On 2 June 1994, Cabinet directed that Treasury Board advise all Government entities including boards, agencies and commissions that they should comply with compensation practices established for Government departments. In 2005, we reviewed the compensation practices of Crown-controlled corporations and agencies since the issuance of the directive from Cabinet in 1994.

Our objectives were to:

- Summarize and highlight the inconsistent compensation practices that continue to exist at boards, agencies and commissions; and
- Determine whether a compensation policy had been communicated to all Government entities including boards, agencies and commissions clearly outlining that compliance with compensation practices established for Government departments was mandatory.

Conclusions from our 2005 review

As a result of our review, we concluded the following:

- There are many examples of inconsistent compensation practices among Government entities. Many of the inconsistencies relate to the more senior officials at the entities. These officials are often aware of the inconsistencies and, in many instances, they continue to take the higher benefits despite being told to stop such practices.
- There has been no clear policy direction on the extent of conformity required by boards, agencies and commissions with Government compensation practices.

- Memorial University of Newfoundland and Newfoundland and Labrador Hydro have salary levels which are not consistent with those established for Government departments. Although Government and each of these entities use a job classification system, instances of higher pay for similar work occur as a result of different compensation standards.

- We continue to see that Government employees are not all compensated on a consistent basis. Furthermore, these inequities usually result in increased costs for Government.

Update

In October 2007, we contacted the Public Service Secretariat of Executive Council requesting an update as to the progress on the comments and recommendations included in our 2005 report. The information provided by the Secretariat in response to our request is outlined below.

2005 Recommendations

The Public Service Secretariat should consult with Government as to whether Government's compensation practices should be applied to all Government entities.

Government should consider articulating, communicating and imposing meaningful consequences on Government entities and/or persons who knowingly continue to disregard their direction regarding compensation practices.

Government should determine whether current inconsistent compensation practices (i.e. higher pay for similar classification) caused by not requiring its compensation standards be used by Memorial University of Newfoundland and Newfoundland and Labrador Hydro should continue.

Action Taken

The Public Service Secretariat indicated that:

- this is a very complex issue requiring extensive review and analysis particularly given the number and diversity of boards, commissions and agencies;

- the Public Service Secretariat is in the process of finalizing its review; and

- it is their intention to submit a paper to Treasury Board in early 2008 outlining policy options for their consideration.

Department of Education

3.2.4 Memorial University of Newfoundland (2005 Annual Report, Part 2.3)

Introduction

In 2005, we completed a review of Memorial University of Newfoundland. We conducted our audit to determine if:

- there were mechanisms in place to ensure the University is accountable to Government and the House of Assembly;
- Government, primarily through the Department of Education, is adequately involved in monitoring the financial performance of the University;
- the University follows a strong strategic plan; and
- the University uses a strong system of controls for its financial transactions and assets.

To achieve our objectives, we identified and assessed the University's systems and procedures in the following 6 sections:

Section 1 - Board Governance
Section 2 - Human Resources
Section 3 - Revenue
Section 4 - Purchasing
Section 5 - Facilities Management
Section 6 - Capital Assets

Conclusions from our 2005 review

We reached the following overall conclusions in our review of Memorial University of Newfoundland. We learned that the University is unique among all other Government entities in the way it is held accountable to Government and the House of Assembly. At the time of our review, the University was the *only* Government entity:

- not subject to all requirements of the *Transparency and Accountability Act*;

- not included in the Province's Consolidated Summary Financial Statements; and

- not compelled to have officials appear before Committees of the House of Assembly.

In our opinion, the University's accountability mechanisms were not adequate. Our review indicated that the Department of Education did not have significant involvement in monitoring the financial affairs of the University. We also found that, while the University did have a strategic framework, it could not be considered as a comprehensive strategic plan to direct its operations. The University was developing a more comprehensive strategic plan. We learned that weaknesses existed in the University's system of financial transaction and asset controls. There were significant inconsistencies in compensation practices between University employees and other public sector employees, as well as inconsistencies with the University's own policies. We also found that the University was not always complying with the *Public Tender Act*.

Update

In October 2007, we contacted Memorial University of Newfoundland requesting an update as to the progress on the comments and recommendations included in our 2005 report. The information provided by the University in response to our request is outlined below.

Board Governance

2005 Recommendations

The University should:

- *continue with its efforts to complete a strategic plan; and*

- *finalize management agreements with all Separately Incorporated Entities (SIEs).*

Action Taken

The University indicated that the Strategic Plan has been approved by the Board of Regents and submitted to Government. It also indicated that:

- Management Agreements are in place with six SIEs;

- Management Agreements are under development with respect to four others, two of which did not exist at the time of the review in 2005; and

- a Management Agreement is no longer required for another as it is planned to be integrated into the University.

Human Resources

2005 Recommendations

The University should:

- *ensure the University's recruitment policies are complied with and that compliance is documented;*

- *address the inaccuracies in the computer system used by the University for personnel and payroll purposes; and*

- *address the inconsistencies in leave management processes.*

Action Taken

The University indicated that its Department of Human Resources has implemented process changes in relation to the generation and delivery of "offer letters" prior to an employee's start date. It also indicated that an automated applicant tracking system (ATS) is under development, with implementation to occur in 2008. This ATS will automatically generate and deliver an electronic "offer letter" when an employee is hired.

Furthermore, the "Request to Fill" form which is designed to ensure appropriate approval is obtained prior to recruiting has been modified and posted online for all users. As well, Faculty leave is managed within the terms and conditions of the faculty collective agreement. These practices are consistent with other universities across Canada.

Revenue

2005 Recommendations

The University should:

- *increase its efforts in reviews of cash handling;*

- *address inconsistent controls over revenue recording; and*

- *consider whether independent appraisals should be obtained in assigning values for charitable receipts issued for tax purposes.*

Action Taken

The University indicated that with the aid of external experts, it has completed its audit of the cash handling procedures on the St. John's Campus, the Marine Institute Campus and the Sir Wilfred Grenfell College Campus. In excess of 90% of the recommendations and sub recommendations have been acted upon and the auditors advised that no improprieties were found.

As well, an internal audit project has commenced and the University is awaiting a draft report from the auditors.

Purchasing

2005 Recommendations

The University should:

- *comply with the* Public Tender Act *and University purchasing policies;*
- *ensure adequate documentation exists for all purchases;*
- *ensure payments are made only for eligible expenses;*
- *recover any overpayments as identified;*
- *ensure only authorized expenditures are made;*
- *address issues identified with the review of travel claims by source faculties, departments and divisions, and subsequent review at the Financial Administrative Services Division; and*
- *review controls over the use of University procurement cards.*

Action Taken

The University indicated that it has reviewed its procedures with regard to the *Public Tender Act* and believes that they provide very good control. In the past, the University has documented special situations which arose from time to time and will continue to do so.

It was further indicated that a private sector audit firm was commissioned to carry out a Travel Claims audit with regard to the University's controls over the processing of travel claims. The auditors advised that there were no improprieties and assigned a grade of satisfactory to the audit report. As well, the University's Department of Financial and Administrative Services has completed its staffing and process review of the travel claim section and has added another senior clerk position. The University is researching the feasibility of implementing a computerized system for travel claims.

The Department also reviewed the procedures and controls in place with respect to procurement cards and made adjustments to tighten controls.

Facilities Management

2005 Recommendations

The University should:

- *review its procedures for managing construction projects;*
- *comply with the* Public Tender Act *in approving change orders;*
- *address issues identified with Vehicle Fleet Management;*
- *update the University's 1986 Campus Master Plan;*
- *address maintenance work orders in a timely manner;*
- *address the significant deferred maintenance issue; and*
- *review its method of awarding Facilities Management contracts.*

Action Taken

The University indicated that additional controls have been implemented. Specification standards are generic to ensure an open bidding process. Acquisition and lease tenders are issued separately. Fuel, repair and licensing invoices are reconciled monthly by the user department and confirmation of the validity of charges forwarded to the Procurement Officer to support payment authorization. Vehicle logs have been sampled to test for non-compliance and a process established to continue regular sampling.

It was further indicated that all work on the Master Plan for the St. John's Campus is complete. The documents have been the focus of a broad consultation process and are now being finalized. All work on the Master Plan for the Sir Wilfred Grenfell College Campus is complete and the documents are in the process of being finalized.

As well, the University reviewed the methodology of evaluating standing offers with the potential for high variable costs. A weighted evaluation tool was implemented as part of the tendering process. Once awarded, a cost monitoring process is implemented. Requests for changes in contract commitments are submitted to the Financial Operations Officer for approval based on the applicability to the intent of the standing offer agreement.

Capital Assets

2005 Recommendations

The University should:

- *review the threshold used for recording capital assets;*
- *develop a formal policy and procedures manual to address how asset additions, transfers, disposals and other changes are to be handled and recorded;*
- *ensure its capital assets ledger is accurate; and*
- *review its process for selecting auctioneering services relating to the disposal of University assets.*

Action Taken

The University indicated that the capital assets ledger was reviewed and it was subsequently decided to conduct a thorough physical review of the capital asset inventory. This is currently underway and should be completed by 31 March 2008.

It was further indicated that local auctioneering firms have been contacted to assess interest in bidding on a contract to provide service to the University. Sample contracts that these companies have with other business entities have been reviewed but were determined not to be comprehensive enough to serve the University's needs. The Procurement Officer is currently preparing tender specifications that will address these needs. It is anticipated that a contracted, publicly tendered service will be in place no later than 1 April 2008.

3.2.5 Seconded Positions (2005 Annual Report, Part 2.4)

Introduction

In 2005, we performed a review of seconded teachers within the Department of Education. The objective of our review was to determine whether secondments in the Department of Education were in accordance with the Department's secondment policy.

Conclusions from our 2005 review

As a result of our review, we concluded that the Department:

- did not comply with its own secondment policy relating to teachers. For example, secondments were being used to fill positions in excess of the Department's three-year limit, contracts were not in place for seconded teachers and seconded teachers were promoted to management positions;
- contravened the spirit and intent of Government's recruitment process (i.e. the Merit Principle) by filling some seconded positions without a job competition;
- did not comply with Government's redundancy policy;
- did not comply with the *Portability of Pensions Act* as individuals on secondment who were subsequently transferred to permanent positions continued to pay into a pension plan even though they did not belong to the group the plan was designed for; and
- did not comply with Government's salary differential policy.

Update

In October 2007, we contacted the Department requesting an update as to progress on the comments and recommendations included in our 2005 report. The information provided by the Department in response to our request is outlined below.

2005 Recommendation

The Department should comply with Government and Departmental policy with regard to secondments.

Action Taken

The Department indicated that in the absence of a Provincial policy on secondments, it developed its own in May 2000. The challenges this created were acknowledged in the Department's original response. Subsequently, on 23 February 2005, the Public Service Commission approved its government-wide policy with respect to secondments.

Furthermore, the Department indicated that on 6 October 2005 the Public Service Commission provided direction to the Department. As a result the Department now advertises all positions in accordance with Commission policy and follows a merit-based competitive process. While teachers may be seconded from school boards in accordance with the Newfoundland and Labrador Teachers' Association Collective Agreement, the Department's action is to temporarily appoint them to these positions. Hence the individuals may remain in the position past the one year they would be allowed if assigned to the position in the absence of a Public Service Commission competitive process.

2005 Recommendation

The Department should comply with the Portability of Pensions Act.

Action Taken

The Department indicated that it recognizes its responsibility to comply with the provisions of the *Portability of Pensions Act* as well as with all legislation pertaining to provincial pensions. However, it is very important that the individuals within the Department who fill these select positions have appropriate backgrounds in education. The Department will continue to work with the Pensions Division of the Department of Finance to ascertain a solution.

2005 Recommendation

The Department should comply with Government policies for hirings and promotions, and the payment of redundancy, salary differentials, and retroactive amounts.

Action Taken

The Department indicated that it is now in compliance with government policies with respect to hiring and promoting individuals seconded from the education system and seeks appropriate authority from the Public Service Secretariat, the Public Service Commission and Treasury Board as required.

The payments of redundancy, salary differentials and retroactive amounts have all been addressed in accordance with government policy since the Auditor General's findings.

Department of Environment and Conservation

3.2.6 Solid Waste Management (2004 Annual Report, Part 2.13)

Introduction

In 2004, we reviewed solid waste management in the Province. Although the planning and delivery of waste management in Newfoundland and Labrador is the direct responsibility of municipalities and communities, the Province holds overall responsibility for the development and enforcement of policies, regulations and standards related to the municipal management of waste. The departments of Environment and Conservation (development of policies and standards), Municipal Affairs (provision of funding, resources and direction to municipalities and regional waste management committees) and Government Services (inspection of facilities and determination of compliance with established standards) are all responsible for the overseeing of waste management. The Multi-Materials Stewardship Board (MMSB) also has an integral role in the Province's waste management initiatives through its recycling, public awareness and funding programs.

The objectives of our review were to determine what progress the Province has made towards a Province-wide waste management system and whether the Province had systems in place to monitor and regulate waste management activities.

Conclusions from our 2004 review

As a result of our review, we concluded the following:

- The Province has a significant issue to deal with regarding waste management. The problem has resulted because historically, we have not recycled, there was no strategy as to either the number of landfill sites or their location, there was little control over access to the sites or what was being dumped, open burning and incinerators were commonly used, and the landfill sites were not lined.

- In 1989, at a meeting of the Canadian Council of Ministers of the Environment, Government set a goal to reduce the amount of waste going for disposal by 50% by the year 2000. However, in 2002, Newfoundland and Labrador had a waste diversion rate of only 9%, the lowest rate of waste diversion of any province in Canada, compared to the 27% diversion rate averaged by the other Atlantic Provinces.

- This Province had a disproportionate number of waste disposal sites compared to the other Atlantic Provinces. In 2004, the Province had 201 waste disposal sites versus a combined total of 25 disposal sites for the other three Atlantic Provinces.

- A report prepared by Government's Waste Management Advisory Committee in October 2001 indicated that incinerators in our Province produce more than one-third of the total volume of dioxins and furans from municipal incineration in Canada. Open burning, which was not measured and was common in more than half of the other sites in the Province, produced even more dioxins and furan emissions.

- The Multi-Materials Stewardship Board (MMSB), which had a mandate to develop, implement and manage effective waste management programs, takes its direction from the Department of Environment and Conservation (the Department). However, the Department had not identified programs to adequately address all significant areas for waste diversion (e.g. paper and organic which accounted for 67% of waste). Furthermore, MMSB was not meeting its beverage recycling program targets and there were issues relating to its used tire recycling program.

- In April 2002, a Provincial Waste Management Strategy was issued indicating that a Province-wide modern waste management system would be implemented by 2010 at a projected cost of $150 - $200 million. However, there were funding and timing concerns with the implementation of the Strategy. Neither the timing of required funding nor the source (Federal, Provincial or municipal) of this funding was identified in the Strategy. In addition, the Strategy did not include annual targets to measure progress towards the various initiatives such as diverting waste, closing unlined landfill sites and constructing new lined sites.

- In 2004, there were 201 unlined landfill sites in the Province. The use of a liner controls the escape of leachate and provides for its recovery and treatment to minimize potential environmental consequences. While the Strategy did not indicate that all unlined sites would be remediated, it was likely that some sites would require remediation at a significant cost.

- Government did not have complete and accurate information available on its landfill sites to determine the status of each site for use in planning, implementation, and monitoring of these sites.

2006 update

In our 2006 annual report, we included an update on the progress made by the Department of Environment and Conservation and the Department of Municipal Affairs towards implementing the recommendations contained in our 2004 report item. At that time the Department of Environment and Conservation indicated that the implementation of the Waste Management Strategy had been impeded due to lack of significant funding but that the Department of Municipal Affairs had recently acquired a major source of funding and the capacity now existed to move forward. The Department of Municipal Affairs, in consultation with the Department of Environment and Conservation were in the process of developing a Cabinet Paper outlining the process for moving forward on the Waste Management Strategy.

The Department of Environment and Conservation also indicated that they had worked with the Multi-Materials Stewardship Board to launch two new strategic waste diversion programs over the past two years: a regional-community based fibre (paper-cardboard) recycling initiative, and a Province-wide residential (backyard) composting program. The Department further indicated that new strategic waste diversion and recycling initiatives were under consideration and that standards relating to Municipal Solid Waste Containment Landfills should be available in 2006-07.

The Department of Municipal Affairs indicated that the full implementation of the Strategy would not result by 2010 as funding to undertake the work could not be secured until 2006 via the Federal Gas Tax Agreement. A revised approach that better recognized the financial and environmental requirements of the undertaking was being prepared for Government's consideration. A schedule of required funding would be completed as part of the implementation process for the Strategy. The Department of Municipal Affairs also indicated that they were continuing to update the Waste Management Information System in consultation with the Department of Environment and Conservation.

Update

In October 2007, we contacted the Department of Environment and Conservation and the Department of Municipal Affairs requesting an update as to the progress on the comments and recommendations included in our 2004 report. The information provided by the departments in response to our request is outlined below.

2004 Recommendation

Government should ensure that the Province moves towards a modern waste management system and implements the Provincial Waste Management Strategy by the planned 2010 completion date.

Action Taken

The Department of Municipal Affairs indicated that on 8 May 2007 the Ministers of Municipal Affairs and Environment and Conservation announced implementation of a $200 million multi-year Provincial Waste Management Strategy with full Province-wide modern waste management implementation by 2020. The Department of Municipal Affairs has now initiated action to begin the implementation of this long-term strategy. In approving implementation of the strategy, Cabinet agreed to alter two specific elements of the 2002 strategy.

First, the environmental standard of lined sites is not required for existing sites where it is demonstrated to the Department of Environment and Conservation's satisfaction that the geological features are such that the site provides effective protection to the environment.

Secondly, all target dates were advanced in consideration of the implementation delay. The new target dates are:

2007	Eliminate open burning in the Avalon Region. Establish Regional Services Boards in Central and on the Avalon by December.
2010	Avalon Region site fully operational. Eliminate open burning in Central Region.
2011	Central site fully operational. Eliminate open burning in Western Region.
2016	Western Region site fully operational.
2020	All non-host waste management regions fully integrated.

2004 Recommendation

Government should develop a schedule to indicate when the Provincial Waste Management Strategy's estimated $150 million to $200 million funding will be required and identify the source of this funding, e.g. Federal, Provincial, and municipal.

Action Taken

The Department of Municipal Affairs indicated that capital costs will be supported through an allocation of approximately 30% of the Gas Tax revenue, which will provide $22 million by 2010, and the Department of Municipal Affairs will contribute $22 million over the same period from its annual capital works allocations. With the continuation of the Gas Tax Agreement which has been announced by the Federal Government, an additional $10 million will be targeted annually beyond 2010 for implementation of this strategy. In addition, Government is pursuing other funding avenues to support capital and operational costs.

2004 Recommendation

The Department of Environment and Conservation should ensure that the MMSB is proactive in its efforts to increase opportunities for waste diversion.

Action Taken

The Department of Environment and Conservation indicated that they continue to work closely with the MMSB. In addition to two new strategic waste diversion initiatives that were implemented in the past two years, namely a Province-wide, residential (backyard) composting program and a regional-community based fibre (cardboard-paper) recycling program, MMSB is partnering with 15 regional waste management authorities throughout the Province to put in place the necessary infrastructure and programs to support comprehensive waste diversion activities in all areas of the Province. This is being pursued in the context of the implementation plan for the Provincial Waste Management Strategy that was released by the Government of Newfoundland and Labrador in May 2007 which sets a target of 50% waste diversion by 2015.

Additionally, MMSB launched a major new Province-wide public education campaign in the fall of 2006 that is focused on overall waste reduction in the Province (known as the "Get to Half" campaign). Other strategic Province-wide waste diversion and recycling activities that are currently being advanced for implementation by the Department of Environment and Conservation and MMSB include a paint recycling program and an electronics waste diversion program.

2004 Recommendation

The Department of Environment and Conservation should formalize Environmental Standards for Municipal Solid Waste Containment Landfills.

Action Taken

The Department of Environment and Conservation indicated that the Province is moving towards a modern waste management system through the implementation of the Waste Management Strategy with a target completion date of 2020. The Plan was announced at a joint press release on 8 May 2007 by the Ministers of Environment and Conservation and Municipal Affairs. The Department of Environment and Conservation under the strategy is responsible for the environmental standards for the municipal solid waste containment landfills. Funding of the strategy is the responsibility of the Department of Municipal Affairs.

The Department of Environment and Conservation has prepared working drafts of the planned environmental standards including municipal solid waste containment landfills. Others in working drafts include: solid waste transfer stations, material recovery facilities, municipal solid waste compost facilities, and construction and demolition of waste disposal sites. The standard for landfill closure is still being developed. In addition, the Department of Environment and Conservation had determined a need for affiliated standards: educational component (completed), household hazardous waste (in progress) and scrap metals storage.

2004 Recommendation

The Department of Municipal Affairs should continue the process of updating the Waste Management Information System.

Action Taken

The Department of Municipal Affairs indicated that the data in the Waste Management Information System (WMIS) continues to be input by the Department of Government Services' Environmental Protection Officers. The Department of Municipal Affairs has prioritized with OCIO the need to further develop the report generation aspect of WMIS in 2008.

3.2.7 Water Quality Management (2004 Annual Report, Part 2.15)

Introduction

In 2004, we reviewed the management of water quality by Government. The objective of our review was to determine whether Government's commitments outlined in the May 2001 report *Source to Tap - Water Supplies in Newfoundland and Labrador* had been met.

The review did not address areas for which municipalities had primary responsibility - water treatment and water system operation and maintenance.

Conclusions from our 2004 review

As a result of our review, we concluded that Government had not met all its commitments outlined in its *Source to Tap* report and was not always complying with provincial standards for monitoring drinking water.

Specifically:

- *Source protection* - As of October 2003, 256 of the 532 (48%) public water supplies were not protected. Under the *Water Resources Act*, the Department of Environment and Conservation may designate areas around a public water source as protected.

- *Water Quality Monitoring* - The Department of Environment and Conservation was not conducting Trihalomethanes (THM) and other chemical water quality testing in accordance with the commitment contained in the *Source to Tap* report or in accordance with Provincial standards. The number of communities and public water supplies in the Province known to have THM levels above the maximum acceptable concentration was increasing. In addition, the Department of Government Services was not conducting microbiological water testing in accordance with the

Source to Tap report commitment or in accordance with Provincial standards. Such testing determines the total coliforms and E. coli in water supplies.

- *Water Quality Reporting* - Government had not met commitments made in the *Source to Tap* report regarding reporting of water quality data. These include reporting annually to the House of Assembly, providing drinking water quality data to the public, and reporting annually to the operator of each public water supply system in the Province.

- *Regulatory inspection and mitigation planning* - The Department of Environment and Conservation was not inspecting water systems under the *Water Resources Act* in accordance with the commitment contained in the *Source to Tap* report. The commitment to conduct these inspections was at least once per year; however, the Department indicated that inspections are conducted only when operational problems are encountered, or in response to an infrastructure needs assessment or proposed upgrade.

- *Operator education and training* - Certification of water system operators was on a voluntary basis with mandatory certification being an area that required further attention.

2006 update

In our 2006 annual report, we included an update on the Department of Environment and Conservation's progress towards implementing the recommendations contained in our 2004 report. In response to our 2006 update request, the Department indicated that:

- One additional surface water supply and 34 groundwater supplies were designated as protected water supply areas. In addition, 10 water supply areas were amended to protect the entire drainage areas and two protected water supplies were amended to refine the delineation of the drainage areas.

- Approximately 3,454 inorganic tap, inorganic source, THM, and HAA samples were scheduled to be collected from public water supplies (based on the Provincial Standard with additions for HAA testing as there was no current guideline). Of these scheduled samples, 2,472 were collected. The discrepancy was due partially to the inaccessibility of some sources and partially due to a vacancy in the Watershed Management position at the Department's Corner Brook regional office.

- Formal inspections of water systems were undertaken if problems were reported or noted. In the prior fiscal period, 72 inspections were carried out pertaining to water and sewer related activities. Public groundwater wells and other selected wells were inspected on a regular basis to ensure compliance with the *Water Resources Act*. Approximately 286 inspections of public groundwater suppliers were carried out in the prior fiscal period. Approximately 28 inspections were carried out on protected water supplies to address development concerns and to update the land use inventory.

- All water supplies were generally visited four times per year if chlorinated and twice a year otherwise. Most communities were visited by the mobile training unit annually. Government Service Centre Environmental Health Officers also visited a water supply at least monthly.

- There was no requirement for mandatory certification of water system operators and it would continue to promote training initiatives and gradually work toward the certification of all water operators.

Update

In October 2007, we contacted the Department of Environment and Conservation requesting an update as to any further progress on the comments and recommendations included in our 2004 report. Information provided by the Department in response to our request is outlined below.

2004 Recommendation

Government should continue with efforts to protect the remaining public water supplies in the Province through designating areas around public water resources as protected under the Water Resources Act.

Action Taken

The Department indicated that:

- in 2005-06, 12 water supply areas were protected and one was repealed; and

- in 2006-07, 16 water supply areas were protected and 2 were repealed.

2004 Recommendation

Government should conduct THM, other chemical water quality testing and microbiological water quality testing in accordance with the commitment contained in the Source to Tap *report and in accordance with the provincial standards.*

Action Taken

The Department indicated that:

- Chemical sampling and testing of public water supplies has resumed as normal since the vacant position in the Corner Brook office has been filled. It now has a web page where the annual water testing schedule for the coming year is posted. The schedule for 2007-08 is now posted and it is detailed to show the sample type, time and location for each public water supply in the Province.

- For the western region:

  - in 2005-06, 1,050 samples were scheduled and 863 (82%) were actually collected; and

  - in 2006-07, 1,051 samples were scheduled and 977 (93%) were actually collected.

- The western regional office includes Labrador where:

  - in 2005-06, 212 samples were scheduled and 204 (96%) were collected and;

  - in 2006-07, 262 samples were scheduled and 244 (93%) were actually collected.

- While every reasonable effort will be made to collect all of the drinking water quality samples listed in the schedule, circumstances such as inaccessibility to the site, lack of necessary chlorination, sample spoilage, or other factors will result in a certain percentage of missed samples. Data gaps will be filled on a priority basis.

- Special inspections are generally undertaken if problems were reported or noted as follows:
  - in 2005-06, there were 121 water and sewer inspections, 35 public groundwater supply inspections and 25 protected surface water inspections.
  - in 2006-07, there were 87 water and sewer inspections, 275 public groundwater supply inspections and 48 protected surface water inspections.
- In addition to this, staff visit each public water supply 2 or 4 times per year as per the sampling schedule and once per year in connection with on-site training.

3.2.8 Petroleum Storage Systems (2005 Annual Report, Part 2.6)

Introduction

In 2005, we performed a review of petroleum storage tanks within the Department of Environment and Conservation and the Department of Government Services. The objectives of our review were to determine whether the Department of Environment and Conservation and the Government Service Centres' have satisfactory systems and processes in place to:

- administer the petroleum storage system registration process under the *Storage and Handling of Gasoline and Associated Products Regulations, 2003*;
- adequately monitor, through the inspection process, the condition of storage systems within the Province to protect the environment on a proactive basis; and
- enforce compliance with environmental legislation and conditions of approval.

Conclusions from our 2005 review

As a result of our review, we concluded that Government had taken steps to determine the number and type of petroleum storage systems in the Province; however, improvements were required in the registering and inspection of these systems and enforcing compliance with legislation. Specifically:

- only 3,125 of the estimated 7,000 petroleum storage systems were registered, and information obtained during the registration process was not verified;
- inspections were not always performed by the Government Services Centres in accordance with the Inspection Frequency Guide;
- information in the Department's database was not used to assess risk for inspection scheduling purposes;
- inspections of used oil facilities were not performed from October 2004 up to our review in March 2005;
- issues identified during inspections were not always followed up or tracked;
- none of the 24 abandoned tanks in four locations that we reviewed were removed as required by the *Storage and Handling of Gasoline and Associated Products Regulations, 2003*; and
- enforcement actions, such as stop work orders, were not taken against facilities that have not registered petroleum storage tanks as required.

Update

In October 2007, we contacted the Department of Environment and Conservation and the Department of Government Services requesting an update as to progress on the comments and recommendations included in our 2005 report. Information provided by the Departments in response to our specific recommendations is outlined below.

2005 Recommendation

The Department of Environment and Conservation should ensure compliance with its legislative requirements and work closely with the Department of Government Services to ensure that all requirements of their Memorandum of Understanding are met.

Action Taken

The Department of Environment and Conservation stated that it continues to work closely with the Department of Government Services to implement the Memorandum of Understanding between the Departments. The Department Environment and Conservation provided the following comments on two databases:

1. Certificate of approval database (tanks issued approvals under pre 2004 system)

To date, information on 5,837 approved tank systems (including tank modifications) have been compiled into a Certificate of Approval database. These tank systems were approved between 1982 and May 2004.

Of the 5,837 approved tank systems, 1,572 tank systems have been classified as follows:

- 1,195 have been linked to registration numbers (7 of the 1,195 are not in use; 16 of the 1,195 are approvals to modify);
- 103 are no longer in use and not registered;
- 261 are approvals to modify and may not have an associated registration number; and
- 13 have been removed from the site.

Therefore, there are 4,265 approved tank systems left to review. It should be noted that there are approved tank systems which have not been compiled into the database and therefore the number of approved tank systems left to review (4,265) will increase. Efforts to contact owners are ongoing.

To date, in an ongoing process, 2,342 Certificates of Approval have been scanned into a pdf format. This eliminates the need for paper copies and makes access and sharing between the Government departments much easier.

2. Registration database (post 2004 system)

Information on all applications which have been forwarded from the GSC has been entered into the Registration database. Applications are continuously received from the GSC and entered as received. Of the 3,550 registrations, 1,533 indicated the Certificate of Approval number. That leaves 2,017 which did not indicate the Certificate of Approval number. Tanks installed since June 2004 would not have an associated Certificate of Approval. Records indicate that there were 331 tanks installed since 2004. Therefore, 1,686 registrations are being followed up to determine the Certificate of Approval number.

The registration numbers in the database have been thoroughly reviewed and it was noted that there were gaps in the registration numbers (which should be consecutive), duplicated registration numbers and registration applications forwarded to the GSC which were not returned to the Department with registration numbers. The Departments of Environment and Conservation and Government Services are currently working to resolve these issues.

2005 Recommendation

The Department of Government Services should ensure that all petroleum storage systems have been registered as required under the Storage and Handling of Gasoline and Associated Products Regulations, 2003.

Action Taken

The Department of Government Services indicated that it is responsible for receiving applications for petroleum storage tank registrations, and assigning a registration number which is provided to the applicant. A copy of the application is then forwarded to the Department of Environment and Conservation for recording in their GAP database. That Department advises that, to date, a total of 3,554 tanks have been registered since the requirement changed from a Certificate of Approval process in 2004 to a registration requirement. Environment and Conservation further indicates that information on 5,837 approved tank systems (including tank modifications) is compiled into a separate Certificate of Approval database (tanks approved between 1982 and May 2004). More detailed information would be available from that Department.

While the Department of Environment and Conservation has provided the GS regional offices with their database information, "live" database access is still not available due to software restrictions. Database improvements recommended by Government Services have not yet been incorporated by the Department of Environment and Conservation and Office of the Chief Information Officer. Discussions on resolving these outstanding issues and the overall responsibility for management of the database are planned for the near future.

With respect to approvals for used oil facilities, a total of 99 Certificates of Approval had been issued by March 31, 2006. A further 58 Certificates have been issued up to January 10, 2008. Certificates of Approval for new used oil storage systems are issued on an on-going basis as applications are received and approved.

2005 Recommendation

The Department should ensure that inspections are completed in accordance with the Inspection Frequency Guide.

Action Taken

The Department of Government Services indicated that the Inspection Frequency Guide currently requires the Department to inspect all service stations and bulk plants on an annual basis and complete an inspection report. Mobile tanks are not part of any scheduled inspection but may still be inspected from time to time. In 2005-06, a total of 509 service stations were inspected for 100% inspection frequency and 71 bulk storage plants were inspected (100% completion). In 2006-07, a total of 509 service stations were inspected (100%) and 71 out of 72 bulk storage facilities were inspected (98.6%). The remaining facility is a small facility in a very remote community in Labrador. A planned inspection for 2006-07 had to be cancelled due to adverse weather conditions. Alternatives to annual inspections for such remote sites will be examined in consultation with the Department of Environment and Conservation.

2005 Recommendations

The Department of Government Services should ensure that:

- *information collected during inspections is verified; and*
- *inspection information is captured and identified deficiencies are followed up.*

Action Taken

The Department of Government Services indicated that Environmental Protection Officers (EPOs) note any deficiencies during their inspections and follow up with the owner/operator as necessary. Inspection forms are in duplicate and the original is signed by the owner/operator and provided directly to them by the EPO at the time of inspection. Any deficiencies noted are followed-up by the Environmental Protection Officer and discussed on a regular basis with their manager.

Audit-type reviews of the dips and reconciliations are performed and during their scheduled inspections inspectors review monthly summaries on site of any recorded daily losses from facility operators. The *Gasoline and Associated Products Regulations* also require the operator to inform the Department immediately of losses above normal as indicated by four (4) consecutive reconciliations (normal means an apparent loss of 1% of the capacity of the storage tank). If losses are above normal, the Department would normally require the submission of records for the previous two years to determine whether further investigation is necessary.

2005 Recommendation

The Department of Government Services should ensure that information in its databases is used to assess risk for purposes of scheduling future inspections.

Action Taken

The Department of Government Services indicated that service station inspections and bulk plant inspections are not entered into an electronic database but are kept on spreadsheets by individual inspectors. Regular discussions with supervisory staff are used to identify any significant problems or concerns which may lead to a differential risk assessment and a change in the inspection requirements.

2005 Recommendation

The Department of Government Services should ensure that all abandoned petroleum storage tanks are removed.

Action Taken

The Department of Government Services indicated that Environmental Protection Officers are required to note any abandoned tanks identified during field inspections. Owners are subsequently written and advised of the legal requirements to remove these tanks. Abandoned bulk plants are addressed in consultation with the Department of Environment and Conservation as some of the major bulk plant facilities have more than one site and it is more beneficial to deal with them on a company wide basis rather than one by one. The Department is in the process of undertaking a review of specific sites and any outstanding issues which may require further action.

Department of Finance

3.2.9 Tax Expenditures (2004 Annual Report, Part 2.17)

Introduction

In 2004, we reviewed tax expenditure programs offered by the Province. Tax expenditures can be defined as foregone tax revenues, due to special exemptions, deductions, rate reductions, rebates, credits and deferrals that reduce the amount of tax that would otherwise be payable.

The objectives of our review were to identify the various tax expenditure programs in place, obtain an estimate of their annual cost, and to examine and assess the processes in place for their approval, monitoring, evaluation and reporting.

Conclusions from our 2004 review

As a result of our review, we concluded the following:

- The Province offers a significant number of tax expenditure programs; however, details of the impact of the various tax expenditure programs were not provided to Members of the House of Assembly as part of the annual budget approval process. We identified $215.5 million in foregone revenue resulting from these tax expenditure programs.

- There was no process in place to formally set target objectives for tax expenditure programs which would facilitate the measurement and monitoring of the results of the programs against desired objectives. As a result, no information was provided to the House of Assembly on the effectiveness of these programs.

2006 update

In our 2006 annual report, we included an update on the Department of Finance's progress towards implementing the recommendations contained in our 2004 report. In response to our 2006 update request, the Department indicated that it:

- had been reporting tax expenditures in the Estimates document since 2005, in accordance with a recommendation in the 2004 Auditor General's Report;
- regularly worked with the Department of Innovation, Trade and Rural Development (INTRD) to assess the progress of certain tax expenditures;
- reviewed data from its administrative files to assess the capital raising achievements of the Direct Equity Tax Credit program;
- in conjunction with INTRD, had frequent dialogue with the sole registrant under the Province's Labour-Sponsored Venture Capital Tax Credit program and monitored the program's success;
- worked with the Newfoundland and Labrador Film Development Corporation in the review of film credit applications and as part of that process observed the impacts of the credit upon the film industry;
- evaluated programs for tax expenditures during legislative reviews; and
- planned to review practices used by the Federal Government and the other provinces in order to identify and implement more effective ways of monitoring tax expenditures.

Update

In October 2007, we contacted the Department of Finance requesting an update as to any further progress on the comments and recommendations contained in our 2004 annual report. The information provided by the Department in response to our request is outlined below.

2004 Recommendation

The department responsible for a tax expenditure program should establish a process to set target objectives which would facilitate the measurement and monitoring of the results of the programs against the desired objectives. Resulting performance against these objectives should be periodically reported to the House of Assembly.

Action Taken

Regarding the Department's progress in their review of best practices used by the Federal government and the other provinces, the Department indicated that:

- the Tax Policy Division has included this exercise in its work planning activities for 2007-08;
- the Division will develop a best practice procedural document for tax expenditure monitoring and tax proposal analysis; and
- preliminary research and planning has already started, but the major portion of the work on the project will occur over the next couple of months when the task is delegated to the successful candidate of a job competition currently underway in the Division.

3.2.10 Labrador Transportation Initiative Fund (2005 Annual Report, Part 2.8)

Introduction

In 2005, we completed our review of the Labrador Transportation Initiative Fund. The objective of our review was to determine the current status of the Labrador Transportation Initiative Fund and whether there are sufficient funds to operate the Labrador ferry service in perpetuity.

Conclusions from our 2005 review

As a result of our review, we concluded the following:

- Although Government received approximately $350 million in 1997 to operate the Labrador ferry service in perpetuity, the Fund, after only nine years, was expected to be depleted in 2007.

- After 2007, Government would have to fund the operations of the Labrador ferry service through its budgetary process estimated at a net cost of approximately $18 million per year.

- Government originally planned to use the Fund to pay for Phases I and II of the highway at an estimated cost of $190 million. However, Government used the Fund for other initiatives and a portion of Phase III of the highway. Therefore, total funded costs were estimated to be approximately $262.3 million - $72.3 million in excess of original plans.

The Fund would not be sufficient to operate the Labrador ferry service in perpetuity because:

- $238 million had been spent and an additional $24.6 million was expected to be spent on the construction of Labrador highways. Therefore, approximately 63% of the Fund and earned interest would be used for highway related construction.

- Reductions in ferry operating costs expected from the increased use of the highway had not materialized. In fact, ferry operating costs (net of passenger and freight revenues) had increased.

Update

In October 2007, we contacted the Department of Finance requesting an update as to any progress on the comments and recommendations contained in our 2005 annual report. The information provided by the Department in response to our request is outline below.

Action Taken

The Department indicated that, as at the fiscal year ending 31 March 2007, the Fund had expended a total of $239.4 million on the Trans Labrador Highway, $151.2 million for Coastal Labrador ferry operations and $26.1 million on provincial roads, ferry terminals and other related costs. During February 2007, the last reimbursement cheque to the Department of Transportation and Works was issued from the Fund, which fully depleted all remaining funds.

Although the Fund has been fully depleted, the remaining construction on the Trans Labrador Highway will continue to be dealt with through Government's annual budgetary process. As for the ferry operations, the Department of Transportation and Works will be responsible for maintaining operations which, again, will continue to be handled through Government's annual budgetary process.

Department of Fisheries and Aquaculture

3.2.11 Aquaculture Program (2004 Annual Report, Part 2.18)

Introduction

In 2004, we reviewed the Aquaculture Program. The objectives of our review were to determine whether the Department of Fisheries and Aquaculture was:

- ensuring that the aquaculture industry was developing in accordance with the objectives stated in the Newfoundland and Labrador Aquaculture Strategic Plan;
- complying with the license and inspection requirements stated in the *Aquaculture Act* and *Regulations* and established policies and procedures; and
- addressing deficiencies identified in our 1998 report.

Conclusions from our 2004 review

As a result of our review, we concluded the following:

- The Province was not doing a good job supporting the development of the aquaculture industry and there was no successful development of the industry since 1999.
- The Province had little involvement in ensuring the Aquaculture Strategic Plan was implemented on an overall basis. Recommendations to deal with industry debt load, the lack of capital and the high cost of production were not fully addressed.

- The majority of companies holding commercial aquaculture licenses were contributing little to aquaculture production.

- The Department was issuing new aquaculture licenses without always ensuring they had sufficient information to determine whether applicants had the financial capability to carry out aquaculture operations.

- Aquaculture sites were operating without valid licenses because the Department was not ensuring the licenses were being renewed on a timely basis.

- Aquaculture sites were being renewed each year without ensuring the sites were in compliance with the *Aquaculture Act* and *Regulations* and when it was not clear whether the aquaculture sites were being properly utilized.

- The Department was not performing regular inspections to determine whether aquaculture sites were complying with the *Aquaculture Act* and *Regulations*. The results of inspections that were performed were not adequately documented in the inspection report.

- There were two aquaculture sites with improper shore fastened moorings which were a potential public safety hazard. The Department did not have the authority under the *Aquaculture Act* to remove them.

2006 update

In our 2006 annual report, we included an update on the Department's progress towards implementing the recommendations contained in our 2004 report item. At the time, the Department indicated that it was making improvements to both the licensing and inspection aspects of the aquaculture program including: an upgrading of data management tools; improving the license renewal process; providing additional resources to its inspection program; and reviewing its policy framework.

In particular, the Department indicated that: it had not introduced regulations specifically addressing aquaculture development because of the need to remain flexible and responsive with the needs of the aquaculture industry; the *Aquaculture Regulations* were amended to permit the Province to change license expiry dates to allow for a more timely renewal of expiring licenses; as a result of investment prospecting there was new investment in aquaculture in the Province which was expected to increase production in 2007 and 2008; a total of 161 out of 174

active sites were inspected during 2005; it was in the process of ensuring that inspection records from various inspection related program areas were maintained in the primary aquaculture registry; and the *Aquaculture Act* was amended to provide the Minister of Fisheries and Aquaculture with the authority to remove shore fastened mooring systems that pose a safety hazard.

Update

In October 2007, we contacted the Department of Fisheries and Aquaculture requesting an update as to any further progress on the comments and recommendation included in our 2004 report. The information provided by the Department in response to our request is outlined below.

2004 Recommendation

The Department should comply with the Aquaculture Act *and* Regulations.

Action Taken

The Department indicated that changes to the licensing and inspection programs have better positioned it to comply with the requirements in the *Act* and *Regulations* at this time. The Department is actively reviewing its entire organizational structure and its IT needs, in conjunction with related OCIO efforts, to ensure that it has the appropriate resources and program delivery structure to fulfill its mandate.

2004 Recommendation

The Department should establish Regulations *related to aquaculture development.*

Action Taken

The Department indicated it did not establish any regulations regarding aquaculture development. The Department's current strategy for industry development is being detailed in various policy documents to allow for timely revision to meet the needs of a rapidly maturing industry. The Department indicated it is involved in the process of developing, with the Federal, provincial and territorial governments, a national strategy to address governance and support of the aquaculture industry in Canada and is awaiting the conclusion of this strategy development process before addressing any substantive regulatory change that may be required.

2004 Recommendation

The Department should ensure aquaculture licenses are renewed by 31 December each year.

Action Taken

The Department indicated that it was not able to renew all licenses for 2007-08 prior to expiry of the previous license, but would continue to work on improvements to internal processes and communications with licensees to improve the timeliness of the renewal process.

2004 Recommendation

The Department should ensure aquaculture sites are inspected at least annually, as required by policy, to ensure compliance with the Aquaculture Act *and* Regulations *and Department Policy.*

Action Taken

The Department indicated that in 2007 a second position was approved for aquaculture inspections; however, an internal competition resulted in the position not being filled and an external competition has since been initiated but is not yet complete. The Department also indicated that additional equipment resources (boat and truck) were purchased and will be available when the position is filled.

The Department indicated that, for 2007, the inspection program has to date completed 163 of 172 initial site inspections. The Department indicated that it is also conducting an internal review to ensure that it is appropriately structured to deliver its mandated programs in the rapidly evolving fisheries and aquaculture sectors.

2004 Recommendation

The Department should revise reports used by inspectors to clearly indicate whether aquaculture sites are complying with the requirements of the Aquaculture Act *and* Regulations*, and Departmental Policy.*

Action Taken

The Department indicated that inspection requirements mandated by section 6(3) of the *Aquaculture Act* are not completed by a single inspection/inspector. As the Department expands its resource capacity in response to the growing aquaculture industry, the delivery of the various programs that include an inspection component mandated under the *Aquaculture Act* are being evaluated. The Department also indicated that it has not fully developed a central registry for documentation pertaining to its inspection programs; however, it does document various inspection requirements noted in the *Aquaculture Act*.

Department of Government Services

3.2.12 School Bus Safety Program (2004 Annual Report, Part 2.21)

Introduction

In 2004, we reviewed the provincial school bus safety program administered through the Motor Registration Division (MRD) of the Department of Government Services. The objectives of our review were to determine whether:

- there were established policies, procedures, standards and guidelines in place to adequately reflect school bus safety processes;
- practices in place were adequate in addressing program objectives; and
- management received information necessary for planning, decision making, control and ensuring compliance with legislative responsibilities.

Conclusions from our 2004 review

As a result of our review, we concluded the following:

- There was a high incidence of serious defects identified during school bus inspections performed by MRD staff. Some of the defects resulted in school buses being taken out of service. The significance of this was increased given the fact that MRD did not routinely perform surprise inspections on school buses. Instead, operators were given advance notice of upcoming inspections. Therefore, it was likely that there were school buses on the province's highways that did not meet the required safety standards.

- Brake meters used by MRD to assess braking efficiency on school buses were not being recalibrated every two years as recommended by the manufacturer to ensure they were accurate. As a result, school buses may have been determined by MRD inspectors to have safe brakes, when they did not.

- Not all school bus inspections were completed by an authorized inspection station in that the Official Inspection Stations were not licensed at the time the inspections were completed.

- The MRD did not perform the required annual inspection for all Official Inspection Stations operated by school bus contractors.

2006 update

In our 2006 annual report, we included an update on the Department of Government Services' progress towards implementing the recommendations contained in our 2004 report. In response to our 2006 update request, the Department indicated that:

- All brake meters had been recalibrated in accordance with the manufacturer's recommendations and were on a regular schedule of recalibration once every two years.

- MRD was currently examining alternatives for renewal of Official Inspection Station (OIS) licenses, including financial penalties for failure to renew by the deadline, automatic suspension letter generation, and the potential for online renewal to facilitate the process.

- Outstanding annual OIS inspections were expected to be completed by January 2007.

- MRD was currently conducting a workload analysis to determine its ability to meet the demands of the annual OIS inspection process. MRD was also reviewing the need for an annual inspection regime from a public safety perspective and whether a more comprehensive facility/license renewal regime based upon a biannual schedule might be a more viable alternative. This review would include examination of the penalties and fines for non-compliance.

Update

In October 2007, we contacted the Department of Government Services requesting an update as to whether any further progress has been made in developing alternatives for renewal of Official Inspection Station (OIS) licenses and the annual inspection process by MRD officials for OIS sites. The information provided by the Department in response to our request is outlined below.

2004 Recommendation

The Department of Government Services should address the issue of school bus inspections being performed by unlicensed inspection stations.

Action Taken

The Department indicated that it has:

- reviewed options to facilitate more timely payment of annual license renewal fees for official inspection stations. Following the completion of a government-wide project on internet payment options, MRD plans to implement an online payment option for license renewal fees;

- implemented automatic suspension notices for late payments;

- commenced a review of the database used to manage the Official Inspection Station program; and

- has not completed a review of imposing financial penalties and fines for non-compliance.

2004 Recommendation

The Department of Government Services should perform inspections of Official Inspection Stations as required.

Action Taken

The Department indicated that all OIS are inspected on an annual basis. With respect to workload analysis for management of the OIS inspection process, priority has been given to ensuring all OIS facilities are inspected annually. As a result of a number of changes in senior management at Motor Registration over the past two years, the workload analysis has been delayed. The Department hopes to complete the workload analysis over the next few months.

3.2.13 Special Permits and In-Transit Permits (2004 Annual Report, Part 2.22)

Introduction

In 2004, we reviewed the issuing of Special Permits and In-Transit Permits by the Motor Registration Division (MRD) of the Department of Government Services. The objective of our review was to determine the policies, procedures, standards and guidelines governing the issuance of these permits.

Conclusions from our 2004 review

As a result of our review, we concluded the following:

- In 2003, there were 165 Special Permits issued to allow mobile cranes and construction equipment, which exceeded the defined limits for weight and/or dimensions, to travel on the Province's roads. These vehicles were not required to have an annual inspection performed and therefore may be unsafe for travel on the Province's roads.

- Highway Enforcement Officers did not complete a mechanical inspection of mobile cranes and construction equipment when these vehicles were stopped on the Province's roads from time to time.

- In-Transit Permits issued for unlicensed and/or unregistered vehicles may contribute to the existence of unsafe vehicles on the Province's roads because no inspection of the vehicle was required.

- Certain mobile crane operators may be obtaining In-Transit Permits because the cumulative cost of these permits was cheaper than the annual licensing fees.

2006 update

In our 2006 annual report, we included an update on the Department of Government Services' progress towards implementing the recommendations contained in our 2004 report. In response to our 2006 update request, the Department indicated that:

- Following a review of policies and reference to Cabinet regarding policy options for these permits, a formal procedure was enacted to eliminate the in-transit process for commercial vehicle transport. The current process is a single-trip permit requiring application to the Motor Registration Division (MRD) and review by the Registrar of Motor Vehicles. The application requires a valid vehicle safety inspection, insurance certificate, and review by the National Safety Code engineer for safety compliance. These permits are now issued centrally from the MRD headquarters in Mount Pearl.

- It had been further directed by Cabinet to develop a plan with respect to mobile cranes and other heavy construction equipment. The plan was currently under development and would be submitted to Cabinet in 2007. The plan may require legislative or other regulatory changes to implement.

Update

In October 2007, we contacted the Department of Government Services requesting an update as to the progress made in the development of a plan with respect to mobile cranes and other heavy equipment. The information provided by the Department in response to our request is outlined below.

2004 Recommendation

The Department of Government Services should continue with efforts to review and address issues surrounding Special and In-Transit permits.

Action Taken

Per the Department's 2006 response, in-transit permits have been eliminated for commercial vehicle transport and replaced with a single trip permit. The single trip permit requires the vehicle to have a valid vehicle inspection safety inspection, insurance certificate, review and recommendation by the National Safety Code Section for safety compliance and final sign off by the Registrar of Motor Vehicles.

Oversized vehicles, such as mobile cranes and other heavy equipment, must also comply with the new requirements under the single trip permit, in addition to existing requirements under special permits. The Department's submission of a plan to Cabinet with respect to special permits for such vehicles is still under research and development. It is hoped that this can be finalized over the next few weeks. It should be noted, however, that any legislative or other regulatory changes required to implement new measures could require additional time, particularly any changes that might require approval of the House of Assembly.

Department of Health and Community Services

3.2.14 Central West Health Corporation (2005 Annual Report, Part 2.10)

Introduction

In 2005, we performed a review of the Central West Health Corporation. The objectives of our review were to:

- review the financial position and operating results of the Corporation; and
- determine if expenditures were properly approved, monitored, controlled, and complied with the *Public Tender Act* and *Regulations.*

Conclusions from our 2005 review

As a result of our review, we concluded that we had concerns with the Corporation's financial management practices, and that a lack of Corporation policy and adherence to Government policy led to questionable transactions. Specifically:

- The Corporation incurred operating deficits without obtaining the approval of the Minister.
- The Corporation was not adequately monitoring, reporting and collecting its accounts receivable, particularly its patients' receivable.
- The Corporation's compensation practices were not consistent with Government policy, including the payment of paid leave to management employees prior to their termination, the payment of overtime to management staff during strike action at double-time, incorrectly applied salary differential to one senior employee, and excess termination benefits paid to two senior employees.
- Certain expenditures were either unsupported, contrary to Corporation policy or inconsistent with Government policy. Issues were identified with senior management and Board travel claims, medical staff relocation/recruitment expenditures, medical education allowances, and Board expenditures.
- The Corporation did not comply with the *Public Tender Act* and *Regulations.*

The Corporation is now part of the Central Regional Health Authority.

Update

In October 2007, we contacted the Central Regional Health Authority requesting an update as to progress on the comments and recommendations included in our 2005 report. The Authority's response to our request is outlined below.

The Authority indicated that one of the first items that the Board reviewed at amalgamation was the status and recommendations that had come from the review of the Central West Health Corporation. The Authority indicated that this was done for a number of reasons not the least of which was to ensure policies and procedures being put in place for the new organization complied with Government policy and any specific legislation. Furthermore, the Authority indicated that it has embarked on a substantial project of integrating policies and procedures of all departments and as such, the recommendations from the review were taken into consideration.

With regards to specific recommendations the Authority reported the following:

2005 Recommendation

The Corporation should not incur deficits without the explicit prior approval of the Minister of Health and Community Services.

Action Taken

The Authority indicated that it has been sufficiently funded to date to meet its budgeted operating needs and has not run a deficit for government reporting purposes. The Authority also indicated that communications occur regularly with the Department of Health and Community Services on the financial position and projections are supplied to the Department.

2005 Recommendation

The Corporation should ensure its accounts receivable are properly classified and accurately aged.

Action Taken

The Authority indicated that it has completed two years of operations on which external audits have been performed. Even though the Authority is still working on financial systems integration and the receivable levels have been raised by external auditors, there has not been any issue regarding classification and aging brought to the Authority's attention.

2005 Recommendation

The Corporation should be consistent with Government compensation policies with regards to paid leave, overtime pay, salary differentials, and termination benefits.

Action Taken

The Authority indicated that it is committed to following Government compensation policies and practices. A comparison of the legacy Board's human resources policies with Government's human resources policies was completed in 2006. Any discrepancies were addressed and the Authority feels that the policies in place are consistent with Government's.

2005 Recommendation

The Corporation should monitor travel expenditures to ensure compliance with Corporation policy and consistency with Government policy.

Action Taken

The Authority indicated that as with all expenditures, travel is monitored at the appropriate management and finance level. The Authority's travel policies are considered to be in compliance with Government's policy and travel claims are monitored against the Authority's stated travel policies. The Authority recognizes that because of the large geographic area and the number of employees travelling on any particular day there will be issues with the economy of travel and judgment will have to be made when reviewing travel claims. This will always be an area for review in the Authority and one of the standing items that the Authority's Internal Audit Department needs to review from time to time.

2005 Recommendation

The Corporation should ensure relocation expense reimbursement is consistent with Government policy.

Action Taken

The Authority indicated that it is following Government policy on relocation expense reimbursement.

2005 Recommendation

The Corporation should comply with the Public Tender Act *and* Regulations.

Action Taken

The Authority indicated that its stated policy is to comply with the *Public Tender Act* and *Regulations.* This is another area that the Authority's Internal Audit Department has on its work plans.

3.2.15 Newfoundland and Labrador Prescription Drug Program (2005 Annual Report, Part 2.11)

Introduction

In 2005, we reviewed the Newfoundland and Labrador Prescription Drug Program (NLPDP). The NLPDP is operated by the Department of Health and Community Services (the Department) and provides assistance in the purchase of pharmaceuticals and some related medical supplies to residents of the Province who qualify for benefit coverage.

This assistance is provided to three main groups of residents: income support recipients, senior citizens and special needs patients. Clients of the income support and seniors programs can obtain prescribed drugs by presenting their valid NLPDP drug card to a pharmacy. Drugs and supplies for the special needs program are obtained directly from the Health Sciences Centre. Residents of the Province who qualify for full benefit coverage under the Department of Human Resources, Labour and Employment (HRLE) and persons of low income with high drug cards approved for a drug card by either HRLE or the Integrated Health Authorities are covered under NLPDP's income support program. Residents of the Province who are registered for Old Age Security Benefits and who are in receipt of the Guaranteed Income Supplement are covered under the seniors program. Residents with specific disorders with high drug costs are covered under the special needs program.

The objectives of our review were to assess the adequacy of the Department's management practices relating to the NLPDP and to assess the adequacy of processes at the Department to identify and address drug abuse.

Conclusions from our 2005 review

As a result of our review, we concluded the following:

- Program costs increased from $53.2 million in 1997 to $101.9 million in 2005, an increase of $48.7 million or 92%. During the same time, the number of clients decreased from 112,206 to 93,284 (a 17% decrease); however, the number of prescriptions increased from 2,131,526 to 2,677,369 (a 26% increase).

- While new drug therapies, higher per capita drug usage and the Province's aging population were significant factors in the dramatic increase in drug costs, we were concerned that poor management practices were not ensuring that program costs were minimized. For example, unlike other provinces there was no

on-line, real-time claims system to provide necessary management information on a timely basis. In another example, because of the lack of cooperation from pharmacies regarding the provision of client information, the Department's ability to audit a sufficient number of pharmacies was severely diminished. At the time of our review in 2005, there were 275 pharmacies in the Province; however, only 6 audits had been undertaken since 2002.

- The Program was the only one in Canada without specific legislation to guide its operations. We would expect such a framework to specify such things as the responsibilities and accountabilities of Government, pharmacies and doctors, as well as provide enforcement provisions. The presence of legislation would also provide information for the Members of the House of Assembly on the effectiveness of this Program.

- Prescription drug abuse in the Province had been documented at least as far back as 1988. There were two components to the drug abuse problem, i.e. client abuse and indiscriminate prescribing by physicians. To deal with "double doctoring", the Department had a system in place which restricted the use of a drug card to a single pharmacy. However, we found that the Department only selected the top 20 clients visiting multiple physicians and pharmacies for review which may not be adequate. We also found that drug cards were not always restricted by the Department of Human Resources, Labour and Employment (HRLE) on a timely basis. In addition, there were no substantive measures in place to deal with suspected indiscriminate prescribing by a relatively small number of general practitioners until the health and safety concerns related to Oxycontin became public.

- Lack of controls over drug cards provided the potential for drug abuse. We identified instances where the issuance of manual drug cards, in emergency situations, by the various HRLE district offices was not in accordance with Departmental policy. In particular: in one office there was no record of blank manual drug cards issued to professional staff, in two offices there were no records of blank manual drug cards on hand, and in one office there were inadequate controls over voided drug cards.

- There were inconsistent criteria applied by HRLE and the Integrated Health Authority staff in issuing drug cards because of inconsistent policies for determining eligible client expenditures. We found one instance where a client was refused a drug card at a HRLE district office but was approved for a card for the same time period at an Integrated Health Authority office.

Update

In October 2007, we contacted the Department of Health and Community Services and the Department of Human Resources, Labour and Employment requesting an update as to the progress on the comments and recommendations included in our 2005 report. The information provided by the departments in response to our requests is outlined below.

2005 Recommendation

The Department of Health and Community Services should be more proactive in ensuring that program costs are minimized.

Action Taken

The Department indicated that increasing annual drug subsidy program costs is consistent with the experiences in other provinces across Canada. There are many factors that influence this growth, including the following:

- While the number of beneficiaries on the program has declined, the average age of those covered continues to increase. Increasing age of recipients generally means an increase in need for medications;
- The appearance of new drugs to treat conditions which were previously untreatable;
- The introduction of new, more expensive therapies that present improvements over existing, lower costs therapies;
- Changes in the price of drug therapies; and
- Trends toward the use of community-based drug treatments as an alternative to in-hospital care, or in some cases, surgical interventions.

Growth under the Foundation Plan (formerly the Income Support Drug Program) and the 65Plus Plan (formerly the Senior Citizens Drug Subsidy Program) in 2006-07 and thus far into 2007-08 is under 5%. This is the lowest annual growth rate seen in 10 years.

Our annual growth has consistently been less than that reported by the Canadian Institute for Health Information (CIHI) as the national average for public drug programs.

The Department has implemented numerous policies and procedures to ensure that drug program expenditures are associated with appropriate, cost-effective, and evidence-based provision of pharmaceuticals for its beneficiaries. Specific measures include:

- The use of expert Atlantic and National Review Committees to review the clinical and pharmacoeconomic evidence available for drug products and make evidence-based recommendations with respect to coverage. This enables the Department to make fully informed decisions with respect to drug coverage.

- The use of special authorization for a growing list of drug products to ensure that use of those specific products is in keeping with evidence and cost-effective approaches to pharmaceutical treatment.

- Drug utilization review processes to identify beneficiaries that may be abusing/misusing medication.

- Involvement in Federal/Provincial/Territorial (FPT) work related to pharmaceuticals management.

- Ensuring that the Newfoundland and Labrador Interchangeable Drug Products Formulary process is efficient, and able to provide low-cost generic alternatives for use by the Province's residents in a timely manner, while ensuring that decisions made under this process are based on solid scientific evidence.

- Enhancements in the program's technology have also been put in place with the roll-out of the new on-line real-time computer adjudication system in May 2007. This new system provides real-time on-line adjudication of pharmacy claims and immediate feedback at the pharmacy level of the potential abuse/misuse of medications obtained under NLPDP. The new system was developed with enhanced functionality for Audit, as well as a Business Intelligence tool to provide substantively enhanced

reporting capability for program management purposes. Reports in the Business Intelligence tool are in validation stage and it is hoped the tool will be fully functional by the end of January 2008.

2005 Recommendation

The Department of Health and Community Services should resolve the issues with the Pharmacists' Association of Newfoundland and Labrador (PANL) and reinstate the complete claims audit process.

Action Taken

The Department indicated that they have made great efforts to resolve issues with PANL and audit processes over the past couple of years. Progress to date includes the following:

- In 2005, a NLPDP Policy and Audit Issues Working Group was established to provide an open forum for pharmacist representatives to discuss issues regarding the NLPDP with Department representatives.

- An Agreement was signed between Government and the Pharmacists' Association of Newfoundland and Labrador. This Agreement came into effect 10 July 2007 and expires 31 March 2011.

- This new Agreement required the establishment of an Audit Committee consisting of Department and PANL representatives. This committee will review the audit process, with a view to maintaining best practices.

- The new *Pharmaceutical Services Act* addresses a number of issues including audit, audit recoveries, and audit appeals. The Regulations to the *Act*, which are currently being drafted, will also define a number of aspects regarding the audit process.

- The Department is planning on implementing a Claims Monitoring System (CMS) for NLPDP. With CMS, a regular sample of claims would be identified for which pharmacies would be requested to provide documentation to the Department for review. The intent of CMS is to monitor claims and educate pharmacists on proper billing practices, while allowing necessary corrective action to be taken on a timely basis. PANL has indicated an interest in CMS. A similar system was introduced in 2006 with the endorsement of the Medical Association, to review claims submitted by physicians under the Medical Care Plan.

2005 Recommendation

The Department of Health and Community Services should consider developing legislation for introduction in the House of Assembly to guide all aspects of the NLPDP.

Action Taken

The Department indicated that work began on the drafting of legislation in the summer of 2006. Consultations were held in November 2006, with the *Act* introduced and passed in the House of Assembly in December 2006. The *Pharmaceutical Services Act* was proclaimed in effect on 31 January 2007.

This legislation addresses issues such as: overall accountabilities and responsibilities for the program; privacy/information sharing with respect to beneficiaries of the NLPDP, which enables information sharing with organizations such as the Canada Revenue Agency for income information related to the new Access Plan; the role of the Department in monitoring prescribing of concern, or utilization of concern on the part of beneficiaries; the role of audit with respect to pharmacy billings to the program; as well as broader pharmaceutical issues such as the Newfoundland and Labrador Interchangeable Drug Products Formulary, and the Tamper Resistant Prescription Drug Pad Program.

The Regulations to the *Pharmaceutical Services Act* are currently being drafted and it is hoped that they will be implemented in the near future.

2005 Recommendation

The Department of Health and Community Services should continue to address double doctoring by clients and suspected indiscriminate prescribing by physicians.

Action Taken

The Department indicated that with respect to the issue of potential double doctoring by clients, numerous changes have been made with respect to monitoring, reporting, and intervention. The *Pharmaceutical Services Act* now outlines the process used to identify, investigate, intervene (with the restriction of a drug card to one pharmacy) and report to police, where deemed necessary, any clients suspected of double doctoring.

Interventions, such as the restriction of drug cards, are no longer actioned by the Department of Human Resources, Labour and Employment. This activity is now the responsibility of the Department of Health and Community Services, specifically the Stephenville Office. This modified approach means that all activities associated with identification, review and action with respect to these concerns are now under the Department of Health and Community Services. At this time, new restrictions are being actioned within 10 days of notifying the beneficiary of the results of a Drug Utilization Review.

The Medication Review Committee referenced in the *Pharmaceutical Services Act* has also been working on particular problem cases where normal interventions do not appear to have been successful. As a result of its work, on 6 February 2006 two individuals suspected of violating Section 4(2) of the *Controlled Drugs and Substances Act* (i.e. double doctoring) were reported to the Royal Newfoundland Constabulary.

With respect to the monitoring of physician prescribing, subsequent to the passage of the *Medical Act, 2005* which provided improved powers to the College of Physicians and Surgeons in the investigation of complaints, the Department adopted a new reporting process where prescribing physicians that appear to be outside the norm with respect to prescribing controlled substances would be reported to the College for investigation. The first report to the College was made in November 2005. Nine physicians were reported and in accordance with the legislation, the College was asked to investigate any concerns. Based on information received from the College, these nine physicians remain under active investigation.

The Department has also improved its methodology for identifying physicians with concerns regarding prescribing practices. A framework for a Physician Prescribing Practice Profile System has been developed jointly by Pharmaceutical Services, Physician Services, and Audit and Claims Integrity. This system will statistically compare a physician's prescribing practices for monitored drugs to that of other physicians in that specialty group and identify physicians with statistically aberrant prescribing habits for consideration of reporting to the College of Physicians and Surgeons.

2005 Recommendation

The Department of Health and Community Services should work with the Department of Human Resources, Labour and Employment (HRLE) and the Integrated Health Authorities to ensure that consistent criteria are applied in issuing drug cards.

Action Taken

The Department indicated that with the 31 October 2007 launch of the NLPDP Assurance Plan, the ability for HRLE or the Health Authorities to issue a "drug card only" has ceased. Residents with high drug costs can now apply for assistance under the new Assurance Plan and one consistent eligibility test is applied. All administrative responsibilities for eligibility and card issuance now rest with the Stephenville Office of the Department of Health and Community Services.

2005 Recommendation

The Department of Human Resources, Labour and Employment should comply with policies established to control manual drug cards.

Action Taken

The Department of Human Resources, Labour and Employment (HRLE) indicated that in 2006, direction was provided to staff in relation to ensuring manual drug cards were strictly controlled. The task of managing these cards was assigned to specific administrative staff who recorded all cards in an official book whereby cards had to be signed out by staff who then became responsible for them. By April 2006, these cards were only used by staff providing 'on-call' services, as all clients were then on the financial system, Client Automated Pay System (CAPS), where lost cards or cards for new members in the family (common reasons why

manual cards were used) could be reprinted or issued within the system, as opposed to using manual cards. As well, letters confirming restricted coverage were sent directly to the appropriate pharmacy, as opposed to manual cards being used to restrict coverage and then placed in the physical file.

Since the implementation of the NLPDP's new registration and adjudication system in March 2007, manual cards are no longer used by HRLE staff. Any surplus cards have been returned to NLPDP. The implementation of the new system has also addressed concerns raised in the report regarding the restriction of drug cards. NLPDP now enters drug card restrictions directly into their own system in consultation with the client, and HRLE is no longer involved with the setting of the restrictions. As well, with the introduction of the real-time adjudication system, a card can be restricted almost immediately. Previously, a card could not be restricted unless the current card was retrieved or expired so there were issues with timeliness.

3.2.16 Personal Care Homes (2005 Annual Report, Part 2.12)

Introduction

In 2005, we completed a review of Personal Care Homes to determine whether there were adequate systems and processes in place to ensure that Government was enforcing the *Personal Care Home Regulations* with respect to licensing, monitoring and premises inspections. Our review covered the period from 1 April 2002 to 31 January 2005 and included an examination of: legislation and policies, correspondence, personal care home files and resident subsidy files. We also conducted interviews with staff of the Department of Health and Community Services, three Regional Health and Community Services Boards - St. John's, Eastern, and Central, and the Department of Government Services.

Conclusions from our 2005 review

Department inadequately monitors Boards

In our 2005 report item, we reported that the Department of Health and Community Services was not doing an adequate job in determining whether the regional health and community services boards were complying with *Personal Care Home Regulations* and Departmental policies.

Care assessments inconsistent

The Department did not assess whether residents were receiving a consistent and adequate level of care. Residents are assigned a level of care by board staff using an assessment process which requires significant professional judgment. The Department did not review resident assessments to ensure consistency across the Province.

No performance indicators

The Department had not established performance indicators which could be used to assess the effectiveness of the personal care home program in providing residents with the required care. As a result, the Department could not conclude whether the personal care home program was producing the desired results.

Boards not fully complying with *Regulations*

The regional health and community services boards were not fully complying with the *Personal Care Home Regulations* and Departmental policies. Our review of the activities at the boards disclosed serious concerns relating to how personal care homes were licensed, monitored and inspected. Examples of deficiencies noted in our review of 24 homes during the period April 2002 to January 2005 indicated that:

- licensing standards were not enforced;
- monitoring of care standards require improvement; and
- annual fire and life safety, and environmental health inspections were not completed within the required annual time frame.

Non-compliant home issued licence

In July 2002, the St. John's Regional Health and Community Services Board decided that it could not approve the licence of a home which did not meet building standards for minimum room sizes. Based on a complaint, the Board determined in March 2003 that the home was operating without a licence. The home continued to operate without a licence and in June 2003 the Minister of Health and Community Services directed the Board to issue the licence to the home even though it did not meet licensing requirements. Based on this direction, the Board issued the licence in September 2003.

Update

In October 2007, we contacted the Department of Health and Community Services requesting an update as to the progress on the comments and recommendations included in our 2005 report. The information provided by the Department in response to our request is outlined below.

2005 Recommendations

Department of Health and Community Services

The Department of Health and Community Services should:

- *review the regional boards' licensing, monitoring, and assessing activities to ensure its overall responsibilities are met;*
- *provide timely and clear direction to the regional boards;*
- *assess whether residents are receiving a consistent and adequate level of care; and*
- *establish performance indicators.*

Regional Health and Community Services Boards

Licensing

The boards should monitor activity and documentation within the homes to ensure licensing requirements are met.

Monitoring

The boards should:

- *ensure annual reviews are performed and documented as required;*
- *plan, conduct and document routine monitoring; and*
- *ensure homes submit all documentation required.*

Inspecting

The boards should ensure that annual fire and life safety, and environmental health inspections are conducted for all personal care homes.

Subsidy

The boards should:

- *ensure annual reassessments are performed as required; and*
- *promptly recover any overpayments.*

Action Taken

The Department indicated that:

- A review of the subsidy rate structure has been completed. In July 2006, Government increased the subsidy from $1,138 to $1,500 per resident per month. The new rate is inclusive of night security funding and the $29,000 annual grant for night security has been eliminated. This rate change was provided to assist home owners to comply with the Department's operational standards for personal care homes. The rate increase also permitted over 500 individuals to qualify for a public subsidy that were not eligible prior to the rate change.
- In July 2006, the new operational standards for personal care homes was released as a working document to the regional health authorities and the personal care homes. This manual clearly sets out the standards that the Department of Health and Community Services, the Regional Health Authorities and the personal care home owners must follow. The final operational standards policy manual was released April 2007.
- A monitoring framework has been introduced in the personal care home sector. The personal care home owners are required to report on care indicators as well as provide census information on a monthly basis. Staff from the regional health authorities must visit and complete quarterly reports on resident care and compliance with operational standards. Standardized reports for both the owner and the RHA have been developed by the Department of Health and Community Services and are intended to be submitted electronically in conjunction with an analysis of the monthly care reports completed by the owners.

- The RHA must also complete a full annual review of all residents and the personal care home. This detailed report will also be submitted to the Department of Health and Community Services and contains the compliance level of each home to each standard.
- Personal care home owners began submitting monthly reports to the regional health authorities in August 2007 and the authorities will provide their first quarterly submission to the Department on 30 December 2007. The Department and the regional health authorities believe that the new monitoring framework will assist to measure the effectiveness of the personal care home program.
- As outlined in its previous report, it does not have the staffing resources to enable it to perform an audit function related to resident care assessments. However, the new monitoring framework will allow the Department to assess the work being done by the regional health authorities in this regard.

Department of Human Resources, Labour and Employment

3.2.17 Income Support Program (2005 Annual Report, Part 2.15)

Introduction

In 2005, we reviewed the income support program at the Department of Human Resources, Labour and Employment. The objectives of our review were to:

- document the processes the Department used to monitor the program;
- determine if the monitoring was adequate; and
- determine if the Department's client database was accurate enough to enable it to deliver and monitor its income support program.

Conclusions from our 2005 review

As a result of our review, we concluded that:

- The interface process was not always performed or acted upon in a timely manner and did not include a formal process for communicating results to senior staff or Executive.
- While the Telephone Eligibility Confirmation process worked well to reveal errors, ultimately saving the Department money, it was not being applied widely enough. Furthermore, there was no evidence that errors identified had been corrected in the Department's database.
- Divisional offices were not being audited frequently enough.
- Cycle reviews were not always completed in accordance with established frequency.
- Investigations were taking too long to complete.
- The Department had not established performance indicators which could be used to assess the effectiveness of the integrity measures which were designed to increase assurance that only eligible clients were receiving income support and that employment support was being provided to clients in cases where it would be beneficial.

Update

In October 2007, we contacted the Department of Human Resources, Labour and Employment requesting an update as to the progress on the comments and recommendation included in our 2005 report. The information provided by the Department in response to our request is outlined below.

2005 Recommendation

The Department should complete interface procedures in a timely manner.

Action Taken

The Department indicated that interfaces are now completed in a timely manner, in that they are in the Client Automated Pay System (CAPS) and are automatically uploaded on a monthly basis.

2005 Recommendation

The Department should follow-up on the results of interface procedures in a timely manner.

Action Taken

The Department indicated that interfaces are now followed up in a timely manner through communication via telephone, e-mails to Program Supervisors and Regional Directors. As well, the Provincial office staff have direct contact via meetings and visits to the respective regions. The Department also indicated that it recognizes the benefits of maintaining a close liaison with the regions and that continuing to stress the importance of actioning interfaces in a timely manner will mitigate the necessity of setting up excessive numbers of overpayments in the future.

2005 Recommendation

The Department should provide for the communication of interface procedure results to senior staff or Executive.

Action Taken

The Department indicated that quarterly reports on interfaces have been developed and are generated summarizing the results on a cumulative, quarterly basis, or as required by senior staff or the Executive. The Department also indicated that it has established a broader statistical, financial and non-financial reporting system to capture the data.

2005 Recommendation

The Department should consider wider application of the telephone eligibility confirmation process.

Action Taken

The Department indicated that it has given serious consideration to the suggestion of expanding the role of Telephone Eligibility Confirmation (TEC) workers and has implemented several new TEC initiatives since the 2005 Report. The Department also indicated that TEC staff are now regularly utilized to: obtain confirmation of school attendance from clients in support of the High School Incentive Allowance; conduct surveys for the Career, Employment and Youth Services Division; and process legal

name changes in CAPS as per the Vital Statistics data match. The Department also indicated that it may consider additional roles for TEC staff where they deem it appropriate and necessary.

2005 Recommendation

The Department should document the process followed to correct errors identified through the telephone eligibility confirmation process.

Action Taken

The Department indicated that a process has been implemented by its Provincial Office to ensure that appropriate follow-up is taken and documented when errors are identified in TEC. Where necessary, TEC staff immediately forward an e-mail to the respective TEC contact person and/or Income Support Supervisor to take corrective action. The Department also indicated that corrective measures, financial or non-financial, are recorded on a spreadsheet for statistical purposes and are monitored by TEC staff. Such documentation is shared with the Manager of Eligibility Assurance Services.

2005 Recommendation

The Department should conduct more frequent audits of district offices.

Action Taken

In its response to our original report item, the Department indicated that the Internal Audit Division would conduct more frequent audits of district offices once the conversion to the CAPS was completed. The Department indicated that the Internal Audit Division reduced the frequency of audits during the conversion period and as a result, no audits were completed in 2005-06. In addition, no audits were conducted in 2006-07 even though the conversion was completed in April 2006. The Department indicated that there was significant staff turnover in the Internal Audit Division in early 2006 and it did not fill the positions as changes were being considered to the composition and reporting structure of the Division. The revised organizational structure has now been approved. The Department indicated that an audit manager has been hired and staffing of the two auditor positions is nearing completion. As a result, regular and frequent district office audits will recommence during the current fiscal year.

2005 Recommendation

The Department should complete cycle reviews in accordance with established frequency.

Action Taken

The Department indicated that cycle reviews are completed in accordance with the established frequency. The Fall 2006 Review Cycle was performed on Review Cycles 1.2, 1.3 and 2, and the Spring 2007 Review Cycle was performed on Review Cycles 1.2, 1.3 and 3.

2005 Recommendation

The Department should complete all investigations.

Action Taken

The Department indicated that as of 21 November 2007 there were a total of 15 investigations outstanding beyond the four month criteria. The Department indicated that although legislation guiding investigations requires them to be completed within four months, there may be valid reasons for cases not being closed as required. These reasons would include: lengthy delays in obtaining required information, the reassignment of cases between eligibility assurance staff, and a delay in officially closing a case although the investigative process itself has concluded. The Department indicated that Provincial office staff are following up with the regions to determine why cases remain outstanding.

The Department also indicated that in an effort to alleviate some of these concerns in future, the Income Support Division has developed a means of tracking outstanding investigations and will now monitor assigned investigations on a regular basis to ensure cases are closed in a timely manner.

2005 Recommendation

The Department should establish performance indicators to assess the effectiveness of the integrity measures.

Action Taken

The Department indicated that it is in full agreement with the establishment of performance indicators to assess the effectiveness of integrity measures within the Income Support Program.

The Department indicated that they have undergone a period of change over the past several years with the implementation of a new service delivery model. The last region to 'go live' with the service delivery model was the Labrador region in February 2007.

The Department also indicated that their service delivery model is still evolving and management remains involved in determining the correct complement of staff required and where refinements are necessary to provide a quality service to clients along with financial accountability. The Department indicated that as they move beyond these refinements, it will be in a much better position to consider the concept of performance indicators as they relate to eligibility assurance services.

3.2.18 Newfoundland and Labrador Housing Corporation Employee Computer Purchase Loan Program (2005 Annual Report, Part 2.16)

Introduction

In 2005, we completed a review of the employee computer purchase loan program. We interviewed Corporation staff and examined the Corporation's policies, documentation and financial information related to the program.

Conclusions from our 2005 review

In our 2005 report item, we reported that all departments, boards, agencies and commissions, for which Government is the ultimate employer, are using public money to compensate employees. Therefore, it would be reasonable to expect that similar compensation practices would be consistently applied. However, the Newfoundland and Labrador Housing Corporation provided its employees with computer purchase loans. Such a purchase program was not available for employees in central government. As a result, this compensation practice was inconsistent with Government's compensation practices.

Offering this sort of loan program exposes the Corporation to unnecessary risk. To illustrate, the program was briefly suspended in 2004 when the Corporation discovered that an employee received a computer purchase loan even though a computer had not been purchased. In this case, it was determined that insufficient documentation was provided. Eventually, a senior official was terminated and two others were suspended.

Since 1989, the Corporation had advanced approximately $1 million to over 200 employees for 538 computer purchase loans. However, it had not determined the additional costs of administering the program such as staff time in administration, payroll and accounting.

Update

In October 2007, we contacted Newfoundland and Labrador Housing Corporation requesting an update as to the progress on the comments and recommendation included in our 2005 report. The information provided by the Corporation in response to our request is outlined below.

2005 Recommendation

The Newfoundland and Labrador Housing Corporation should ensure that its compensation practices are consistent with Government's compensation practices.

Action Taken

The Corporation acknowledged our recommendation but its position on this program remains the same. In its reply to our 2005 annual report, the Corporation stated its position on this issue and explained in detail the reasoning behind the decision to keep this program.

The Corporation indicated that this program is achieving its objectives and continues to be a tremendous success. It has the full support of the Management and the Board of Directors.

Department of Innovation, Trade and Rural Development

3.2.19 EDGE Program (2004 Annual Report, Part 2.28)

Introduction

In 2004, we performed a review of the EDGE program. The objectives of our review were to assess whether :

- EDGE corporations were properly assessed, approved and monitored; and
- Program objectives, performance indicators and measurable targets had been established, and actual results were measured and reported against these targets.

Conclusions from our 2004 review

As a result of our review, we concluded the Department of Innovation, Trade and Rural Development (the Department) was not determining whether its program objectives were being met or whether the EDGE program was a success. Specifically, applications were not being approved on a timely basis, specific targets for the program had not been established by the Department, the management information system used by the Department was not being used for monitoring and periodic reporting, EDGE corporations were not always providing annual reports to the Minister as required, information on all incentives provided were not captured by the Department, and incentives provided to some EDGE corporations were not adequately supported.

2006 update

In our 2006 annual report, we included an update on the Department's progress towards implementing the recommendations contained in our 2004 report.

In response to our 2006 update request, the Department indicated that they had not developed a computerized management information system to replace the former computerized system for EDGE; however, they may pursue this option in the future. The Department also indicated that they had preliminary discussions with the Department of Finance regarding the selection of appropriate indicators and the establishment of appropriate targets, and the measurement and assessment of these indicators and targets; however, a consensus on how to proceed had not been arrived at.

Update

In October 2007, we contacted the Department requesting an update as to any further progress on the comments and recommendations contained in our 2004 annual report. The information provided by the Department in response to our request is outlined below.

2004 Recommendation

The Department should ensure the EDGE management information system is used in the monitoring and reporting of the EDGE program.

Action Taken

The Department stated that, during the summer of 2007, an individual was hired to develop a computerized management information system for the EDGE program. This system was developed using a Lotus program. All EDGE files have been entered into this database and are updated on a timely basis. The computerized management information system has become an important tool for maintaining up-to-date records and also for monitoring and reporting on the EDGE program.

2004 Recommendation

The Department should ensure performance indicators are clear, measurable performance targets for these indicators are established, actual results are assessed against these targets, and results are reported to the House of Assembly.

Action Taken

The Department once again indicated that they have held discussions with the Department of Finance with regards to developing and setting performance indicators and measurable performance targets for the EDGE program. The Department indicated that while they hope to resolve this matter as quickly as possible, no consensus has been reached to date.

3.2.20 xwave Contracts (2004 Annual Report, Part 2.30)

Introduction

In 2004, we reviewed the Amended and Restated Service Level Agreement (SLA) and the Amended and Restated Industrial Benefits Agreement (IBA) between Government and xwave. The SLA outlines Government's commitments to xwave for the purchase of information technology (IT) services. The IBA outlines commitments made by xwave relating to targets for new IT business to be brought to the Province, new job creation, and subcontracting of Government and non-Government work to other information technology providers in the Province. The Office of the Chief Information Officer (OCIO) has been given responsibility for Government's obligations under the SLA, while the Department of Innovation, Trade and Rural Development is responsible for Government's obligations under the IBA and also for monitoring xwave's compliance with the IBA.

The objectives of our review were to:

- determine whether the parties complied with the agreements;
- review the process Government had in place to monitor compliance with the Industrial Benefits Agreement; and
- determine whether Government had identified performance indicators (other than those included in the Industrial Benefits Agreement) which would indicate whether the objectives of the privatization (e.g. stimulation of the local IT industry) had been met.

Conclusions from our 2004 review

As a result of our review, we concluded the following:

- Although xwave did not meet its obligation to contract out $2 million in work to local IT businesses for 2002, Government did not charge any liquidated damage as allowed under the IBA.

- xwave did not meet its obligation to create 55 new jobs by 31 March 2004, and indicated that it would not meet its overall employment commitments by 2007.

  Instead of imposing liquidating damages allowed under the IBA, Government negotiated a settlement for a single lump-sum payment of $2.4 million which represented the liquidated damages resulting from xwave's employment shortfalls and discharged xwave from its employment creation commitments.

- Government was not monitoring the IT sector to determine progress towards its original goal of stimulating growth in innovative technologies and information industries in the Province by privatizing Newfoundland and Labrador Computer Services (NLCS) in 1994.

2006 update

In our 2006 annual report, we included an update on the Department of Innovation, Trade and Rural Development's progress towards implementing the recommendations contained in our 2004 report.

In response to our 2006 update request, the Department indicated that it was allocated $900,000 for general industry development from the $2.4 million settlement from xwave and that it had been working with the industry association, NATI, on several projects. The Department also indicated that NATI was also developing an industry strategy, which should be completed early in the new year. Initiatives identified in that report would be funded from the general industry development fund.

The Department further indicated that in 2005-06 it commissioned a study to establish a baseline for key indicators for the information and communications technology (ICT) sector. The Department indicated that additional work was required as a result of the study and that a consultant was retained for 2006-07 to complete this work. Once the work was completed, there would be a baseline by which the Department would be able to measure growth in the ICT sector.

Update

In October 2007, we contacted the Department of Innovation, Trade and Rural Development to determine whether any projects had been funded from the $900,000 general industry development fund and the resulting impact of these projects on the development of the industry. We also enquired whether a baseline for key indicators for the ICT sector had been established and whether the Department was monitoring growth in the ICT sector in the Province.

Action Taken

In response to our request, the Department indicated that several projects have been funded from the general industry development fund and that Government continues to work with NATI on industry development. As a result of the strategy employed by NATI, young students are being educated about the opportunities in the ICT sector. This work will continue for at least two years with enrolment in post secondary institutions being used as an indicator of success.

The Department also indicated that the establishment of baseline indicators for the ICT sector has moved forward. The additional work required after the initial study has now been completed and the revised report is being assessed by various groups within the ICT sector. A follow-up study is planned for the next fiscal year so that the Department can assess the effectiveness of initiatives in the sector.

3.2.21 Investment in a Manufacturing Company (2005 Annual Report, Part 2.17)

Introduction

In 2005, we reviewed investments by two Government entities - the Newfoundland and Labrador Industrial Development Corporation (NIDC) and the Department of Innovation, Trade and Rural Development (INTRD) - in a manufacturing company located in the City of Mount Pearl. A total of $750,000 had been invested by Government in the manufacturing company. This amount consists of a $450,000 loan provided by NIDC in 2001 and another $300,000 loan provided by INTRD in 2004.

The affairs of NIDC are managed by a board of directors appointed by the Lieutenant-Governor in Council and administered by Department of Finance employees.

The objective of our review was to document Government's financial involvement in the manufacturing company and review the approval and monitoring processes used by NIDC and INTRD relating to their investments in the manufacturing company.

Conclusions from our 2005 review

As a result of our review, we concluded the following:

- An investment in a manufacturing company had occurred contrary to the recommendations of officials of the Department of Finance and officials of the Department of INTRD;

- The company was not in compliance with two conditions relating to the $300,000 loan, which were:

  - It violated a requirement to maintain 30 full-time employees in the Province. Employee levels at the time of our review stood at 17.

  - It had to submit financial statements to Government for each fiscal period that the loan was outstanding. At the time of our review, financial statements for the year ended 31 July 2005 had not yet been received.

Update

In October 2007, we contacted the Department of Finance and the Department of Innovation, Trade and Rural Development (INTRD) requesting an update as to progress on the comments and recommendations contained in our 2005 annual report. The information provided by the departments in response to our request is outlined below.

2005 Recommendation

The Department of Finance, Newfoundland and Labrador Industrial Development Corporation and the Department of Innovation, Trade and Rural Development should continue to closely monitor Government's investments in the company.

Action Taken

Department of Finance

The Department indicated that NIDC has received audited financial statements of the company for the year ended 31 July 2005. The Department has also been provided with unaudited, internally prepared financial statements for the year ended 31 July 2006 and for the eight month period ending 31 March 2007.

Department of Innovation, Trade and Rural Development

The Department indicated that it has received audited financial statements of the company for the year ended 31 July 2005. The Department has also received internally prepared financial statements for the year ended 31 July 2006 and interim statements for the period ended 31 March 2007.

The Department further indicated that it has delayed any amendments to the debenture pending the conclusion of a tentative purchase offer for the company. This may conclude in the current calendar year or early in 2008.

Department of Justice

3.2.22 Newfoundland and Labrador Legal Aid Commission (2004 Annual Report, Part 2.33)

Introduction

In 2004, we reviewed the legal aid application process at the Newfoundland and Labrador Legal Aid Commission. The objectives of our review were to determine whether:

- sufficient documentation was contained in applicant files to demonstrate that legal aid was provided or denied in accordance with the provisions of the *Legal Aid Act* and *Legal Aid Regulations*;
- the Commission was collecting the amounts applicants had agreed to contribute towards their legal fees; and

- there were processes to monitor the cost of legal aid to individual applicants.

Conclusions from our 2004 review

As a result of our review, we concluded that:

- The decision to provide legal aid was not always supported. In particular:
  - Individuals who indicated they were in receipt of income support received legal aid even though there was no documentation to indicate they were in receipt of income support.
  - Individuals not in receipt of income support received legal aid even though they did not provide all information on liquid assets, income and expenses required to assess whether they were eligible.
  - The Commission was not consistent in applying basic living and transportation allowance rates to applications for individuals in similar circumstances and who did not provide any documentation to support increases in these allowances.
  - Legal merit assessments were not typically documented.
- Many of the accounts receivable from clients had been outstanding in excess of ten years and had little collection activity.
- The Commission did not have a system in place to monitor the costs of providing legal aid services to various legal aid clients.

2006 Update

In our 2006 annual report, we included an update on the Commission's progress on the recommendations contained in the 2004 report. At that time, the Commission indicated that:

- it was correct in approving applications that were approved and in rejecting applications that were rejected;
- it had no concerns, overall, with regard to legal merit assessments of applications;

- it would further pursue having the permission of the Minister of Justice to write off those accounts that have been determined to be uncollectible; and

- that it was satisfied that its most recent information system was workable and that it was working on more detailed reports.

Update

In October 2007, we contacted the Newfoundland and Labrador Legal Aid Commission requesting an update as to any further progress on the comments and recommendations included in our 2004 report. The information provided by the Commission in response to our request is outlined below.

2004 Recommendations

The Commission should ensure that legal aid is only provided to applicants who qualify financially and whose cases have legal merit.

The Commission should ensure that all required documentation is on file to support financial and legal merit assessments.

Action Taken

The Commission indicated that it has required applicants to provide copies of their income support file numbers since 2005.

2004 Recommendation

The Commission should continue efforts to recover those accounts receivable considered collectible. For those accounts not considered collectible, the Commission should seek the direction of Treasury Board as to their final disposition.

Action Taken

The Commission indicated that its staff continues to work on the write off of its doubtful accounts. Under the *Regulations* the Minister of Justice's approval is required to write off accounts receivable.

The Commission further indicated that a significant amount of staff time has been committed to this issue this fiscal year with the hope of resolving a number of accounts receivable by year end.

2004 Recommendation

The Commission should have a system to provide accurate information necessary to monitor legal aid costs by individual cases.

Action Taken

The Commission indicated that the Legal Aid Management Information System is providing accurate information necessary to monitor legal aid cost by individual cases.

3.2.23 Royal Newfoundland Constabulary (2005 Annual Report, Part 2.18)

Introduction

In 2005, we performed a review of the Royal Newfoundland Constabulary (RNC). The objective of this review was to assess whether the RNC's management practices and control systems were adequate in the following areas:

1. Planning and reporting
2. Human resource management
3. Purchasing and tendering
4. Information technology
5. Information management
6. Inventory

Conclusions from our 2005 review

As a result of our review, we concluded the following:

- There were weaknesses in planning and reporting practices. This was evident in that:
  - the long-term strategic plan expired in 2004 and had not been updated;
  - a system to report on plan objectives had not been implemented;
  - operational plans had not been developed for any of the 14 divisions;

- a multi-year training plan had not been developed and approved; and
- all quarterly quality reviews were not submitted by 7 of 14 Divisions for 2004.

- There were weaknesses in human resource management, including:
  - Administrative Time - The RNC did not have a system in place to monitor the amount of time members spend on administrative tasks. The RNC had hoped to achieve this objective by introducing the Integrated Constabulary Automated Network (ICAN) system; however, we found that the ICAN system was not being used to generate reports to determine if the objective was being met.

    In 2002, the RNC purchased a Mobile Report Entry module, four lap top computers and related software for a total cost in excess of $52,000. However, the computers were never installed in the police cars.
  - Staffing - We identified two staffing areas in need of attention within the RNC: the ratio of members to civilian employees and the lack of performance evaluation systems.
  - Overtime - We found that overtime costs continued to increase and represented a significant cost to the RNC.

    The Resource Utilization System (RUS) was expected to provide all necessary information for the RNC Executive to monitor and control overtime. However, RNC officials indicated that the RUS was unable to produce the required detailed reports to adequately monitor overtime.
  - Sick Leave - The issues of significant sick leave among members and the link between sick leave and overtime, both of which were identified as issues by the Department of Justice in March 2004, were a concern.

- There were weaknesses in the RNC's purchasing and we found instances of non-compliance with legislation regarding financial controls and tendering. The RNC contravened the *Public Tender Act* in that it did not always call public tender for purchases greater than $10,000 and did not always obtain either three quotes or establish a fair and reasonable price for purchases $10,000 and less. We also found that the RNC contravened the *Financial Administration Act* by ordering goods and services without encumbering funds. The RNC was not following sound financial management practices in that purchase orders, providing the required authorization, were not being prepared until after the receipt of goods and services and related invoices. There were also examples where documentation to support payments was inadequate.

- The RNC was not complying with its own rules regarding information systems management. While there were clearly established policies and procedures in place to ensure the security of automated systems, these policies and procedures were not being followed.

- There were weaknesses in information management. Police investigation files were not being reviewed in a timely manner to ensure that all tasks associated with investigating and concluding files were carried out. Also the records sign-out database, that was used by the Information Management Division to record files removed from and returned to the Division, was not accurate.

- There were significant weaknesses over inventory of computers, quartermaster store items, and office furniture and equipment at the RNC. Although there were inventory control procedures to record acquisitions, disposals and transfers, these procedures were not always complied with.

  In addition, there was no tracking and reporting of vehicle mileage, fuel consumption and maintenance for police vehicles. Furthermore, there were no policies covering preventive maintenance and replacement.

  The Property Control Centre was used to store evidence which was found, seized or confiscated. We found that systems and controls at the Property Control Centre were not adequate.

In October 2007, we contacted the RNC requesting an update as to the progress on the comments and recommendations included in our 2005 report. The information provided by the RNC in response to our request is outlined below.

Update

2005 Recommendation

With regards to planning and reporting, the RNC should:

- *update its long-term strategic plan and implement operational plans for each division;*
- *report on plan objectives;*
- *develop a multi-year training plan;*
- *comply with its internal audit standards of performance; and*
- *monitor quality reviews.*

Action Taken

The RNC indicated that:

- The finding of the Auditor General that the long-term strategic plan of the Royal Newfoundland Constabulary (RNC) expired in 2004 is correct. Government has implemented a new approach to strategic planning through the *Transparency and Accountability Act.* Pursuant to this approach, the RNC will no longer develop a strategic plan but will play a role in developing the multi-year strategic plan for the Department of Justice (the Department). The Department's operational plan will flow from the Department's strategic plan. The RNC's branch work plan will flow from the Department's operational plan. Resources are currently not available to author the branch work plan. A request to continue to rebuild the staffing level of the Planning and Research Section has been submitted as part of the 2008-09 budget submission. Specifically, a Policy, Planning and Research Analyst position has been requested. However, while the RNC has not had the resources to prepare a branch work plan, it is currently participating in the Department of Justice Workforce Planning process.

- A multi-year training plan is currently in development. Much work has been done with respect to prioritizing training as a result of feedback from Divisional Commanders. The findings of the Commission of Inquiry presided over by Former Chief Justice of the Supreme Court of Canada, the Right Honourable Antonio Lamer, P.C., C.C. are providing significant input for this training plan. Furthermore, a new civilian position of Training Officer is currently under recruitment and, when filled, will assist in the development of the multi-year training plan.

- A new civilian management position, Operational Audit and Compliance Manager, was filled in October 2007. The Audit Branch has been replaced by the Operational Audit and Compliance section. The Operational Audit and Compliance Manager is currently conducting an internal firearms audit. Once this audit is completed, the manager will be reviewing policy sections titled Audit Branch and Quality Review. These two sections will be replaced by a new section titled Operational Audit and Compliance. This new section will be completed in the last quarter of the fiscal year. Quality reviews will no longer be conducted. The areas that were formerly reviewed under quality reviews now fall within the audit scope of Operational Audit and Compliance. The audit manager will also be researching the composition, duties, and communications channels of an audit committee to facilitate the establishment of the audit committee in the last quarter of the fiscal year.

2005 Recommendation

With regards to human resource management, the RNC should:

- *monitor the amount of time members spend on administrative tasks;*
- *pursue a lower police/civilian ratio as a means to lower salary costs and free up RNC members to perform core police operational duties;*
- *ensure position descriptions are in place for all employees;*
- *ensure performance evaluations are completed for all members and civilian staff;*
- *monitor overtime costs; and*
- *continue to closely monitor sick leave by members.*

Action Taken

The RNC indicated that:

Administrative Time

This issue required some clarification so we subsequently wrote the Auditor General who responded in correspondence dated 2 June 2006 as follows:

"This section of the report refers to having technology in place to monitor and possibly reduce the administrative time incurred by the Royal Newfoundland Constabulary's frontline members. Administrative in this instance refers to preparation of reports, files and forms required in the course of their police work. These are duties that would normally require them to return to Headquarters. The installation of the laptop computers would allow the completion of this documentation in the field thus reducing time. In addition, when the ICAN system was introduced it was supposed to generate reports that could be used to monitor this administrative time to ensure that the time spent was appropriate."

Currently, the ICAN system is not able to provide the information required to monitor the "administrative" time spent by officers in their frontline duties and the RNC does not have the necessary resources to add such a system or any plans to do so in the foreseeable future. Furthermore, the RNC believes the costs to implement such a system would likely outweigh the benefits to be gained. However, the RNC is very conscious of the administrative demands on officers and are approaching this from two angles: (1) adding additional civilian personnel and (2) increasing and/or upgrading technology.

In the case of civilian personnel the RNC has added a total of 28 new civilian personnel in the 2006-07 and 2007-08 fiscal years and some of these will reduce administrative demands on officers. In several cases, the new civilian positions will replace the officers and allow them to be reassigned to frontline duties.

With respect to technology the RNC has continued to increase and/or upgrade desktops and laptop computers with the assistance of the OCIO. The Lamer Inquiry Report which was released in June 2006 recommended that greater financial resources should be allocated to the development of the RNC through acquiring and improving equipment and utilizing technology. It also recommended that the RNC assess its current technological needs with reference to other Canadian police forces and to recommend both what is required and an implementation plan. In response to this recommendation, the firm of Deloitte, in cooperation with

officials of the RNC and OCIO, has developed a multi-year Strategic IT Plan for the RNC. Once implemented, this will introduce technological improvements which will improve access to information, preparation of documentation in the field, and reduce duplication of work.

Most recently, the RNC has purchased five Blackberries as a pilot project for frontline officers in the Patrol Division on the Northeast Avalon which provides access to the Motor Registration Division system for vehicle inquiries. If successful, additional Blackberries will be purchased for officers in 2008.

Staffing

In the 2005 Auditor General's Report it was noted that the ratio of uniformed to civilian staff at the RNC was 4.06:1 whereas the Canadian National Average was 2.70:1. The RNC can now report that this ratio has improved to 3.57:1 and have requested additional civilian personnel in the 2008-09 budget submission which, if approved, would help improve this ratio further.

The Auditor General had noted that in March 2005 there were 50 RNC members performing non-operational duties. However, it is important to note that the officers located in the Telephone Reporting Centre, Professional Standards, Community Services Section, the Training Section and most of the positions in Quality Performance must continue to be occupied by uniformed officers in view of the nature of the work they perform. In the St. John's Communications Centre the RNC concurs that the dispatchers could be civilian personnel. However, the shift supervisors will remain as Sergeant positions. In addition, it was noted that even in the case of some positions which do not need to be occupied by uniformed personnel, the officers are performing meaningful work and if not performed by a medically accommodated officer would need to be done by new civilian personnel.

The RNC acknowledges that it does not have detailed job descriptions for all of the individual police officers performing non-operational duties. However, it does have competencies for each rank within the RNC. Still, it does not have the resources to prepare detailed job descriptions for all officers at this time.

In the case of civilian staff, as is common throughout the public service, there is no formal performance evaluation system in place. However, the RNC is aware that the Provincial Government is introducing a work planning initiative for civilian staff in the future. In addition, all staff members are still provided with feedback and coaching; although a formal written performance evaluation system is not yet in place.

The RNC has also developed a comprehensive Personal Performance Development Plan (PPDP) for all uniformed personnel which is now being implemented. This major program was developed with the assistance of an external consultant and will include performance evaluations for officers throughout the RNC.

Overtime

The RNC continues to closely monitor overtime expenditures. In February 2007 the Payroll function was transferred from the control of the RNC to the control of the Department of Finance. RNC officials review weekly overtime reports on a timely basis when received from the Department of Finance. As noted in the response to the original audit report, overtime is also controlled through the approval process and reviewed during the budget monitoring process.

Sick Leave

Many officers work 12 hour shifts. Therefore, a 12 hour shift of sick leave equals 1.5 days which increases accordingly a daily average based on an 8 hour day. Previously, it was noted that the average number of sick leave days used by RNC members in 2004-05 was approximately 13 days (central government average was 11.57 days for full-time permanent staff).

There has been no improvement in the sick leave usage of officers for the 2006-07 fiscal year. However, despite the physical demands of policing, impact of shift work and higher rates of injury, the average days per officer per year is only marginally higher than central government employees. Furthermore, the total uniformed complement is still at 1989 levels (371 officers) and this level of resources has placed additional stress and workload on current officers.

The RNC would like to note; however, that it has hired 84 new recruits since 2005 and are planning on hiring 28 more recruits in 2008 and 30 recruits in 2009 and 2010. In addition, there are significant numbers of members currently eligible to retire (74 officers) reflecting the higher age demographic of the uniformed work force. The number of pension eligible officers increases to 208 officers in 2012, therefore these officers will be replaced by younger recruits which will reduce the average age of the workforce significantly during this period. In addition, these new officers will only be entitled to earn 12 days of sick leave per year rather than the 24 days per year for more senior officers.

Most recently, the Chief of Police has issued a routine order, as a follow up to a change in past practice issued during RNCA negotiations, to increase the requirement for medical certificates when officers are absent from work. Specifically, when a police officer has been awarded forty-eight (48) hours of sick leave, with or without a note, consecutive or not, further sick leave will only be awarded upon provision of a medical certificate satisfactory to the Chief of Police.

2005 Recommendation

With regards to purchasing and tendering, the RNC should ensure:

- *compliance with the* Public Tender Act *and the* Financial Administration Act*;*
- *purchase orders are prepared prior to receipt of goods and services; and*
- *documentation in support of payments is adequate.*

Action Taken

The RNC indicated that the Finance Division of the Royal Newfoundland Constabulary closely monitors compliance with the *Public Tender Act*, Guidelines for Hiring Consultants, GPA Rules and Regulations, the *Financial Administration Act* and the Comptroller General Rules and Regulations regarding back up for payments. Staff have been provided training on the proper rules regarding purchasing. GPA officials are consulted on purchasing decisions when required and all personnel are provided feedback as required.

2005 Recommendation

With regards to information technology and information management, the RNC should:

- *comply with its back-up and disaster recovery procedures;*
- *conduct timely reviews of investigative files;*
- *conduct timely reviews of all records that are signed out and overdue; and*
- *regularly review its records sign-out database for accuracy.*

Action Taken

The RNC indicated that:

- As of December 2007, approximately 6,000 diary dates remain outstanding as compared to the 21,000 overdue diary dates at the time of the review. Overdue diary dates will be updated when permitted by operational requirements. It is important to note that overdue diary dates on the ICAN system are expected. Overdue diary dates on the ICAN system does not mean that investigations are not completed in a timely manner by the member.

- A number of internal IMD audits have been completed. The 2007 internal IMD audit showed the following results: 5,623 operational files signed out, 21 files still remain outstanding. During the 2005 audit, it was noted that there were 380 files or documents with overdue return dates.

- The RNC is pursuing new IT initiatives with the assistance of the OCIO. We have included in the 2008-2009 budget submission the MDT-MRE-AVL (Mobile Data Terminal Mobile Report Entry Automatic Vehicle Locator) project. MDT-MRE-AVL will provide police officers with the ability to perform their system-related duties from their cars. It will include: Communication to/from COMM Centre, messaging between themselves, electronic CAD (Computer Aided Dispatch), visual representation (GIS) and historical data of the car movement, streamlined data entry and reduction of paper and forms, RMS (Records Management System)/CAD/PIP (Police Information Portal)/CPIC (Canadian Police Information Centre) queries from the cars. MRE is also intended for use in-house as it is the most effective way to implement data entry into the ICAN (Integrated Constabulary Automated Network) system for all users. This project will consist of multiple phases (different business processes will be affected), most of which require the infrastructure to come first. This will save officers considerable time travelling to/from HQ to process information, thus allowing them more time for police work. It is the best mechanism for providing data entry capability to more than 300 sworn members and civilian staff. It will drastically reduce the paper flow that currently exists and improve the efficiency of the organization as a whole. The use of numerous internal forms will be eliminated and production of external forms should improve.

- The RNC is eager to increase its ICAN usage for its operations and recognize the value. Completing the implementation of the ICAN system was identified as the highest priority in the OCIO/RNC Strategic Plan.

2005 Recommendation

With regards to inventory control, the RNC should:

- *strengthen controls over all inventory, including moveable capital assets, quartermaster stores, and the Property Control Centre;*
- *define and communicate a vehicle maintenance and replacement policy; and*
- *monitor fuel consumption and mileage.*

Action Taken

The RNC indicated that:

- Since 2005, it has added several resources to the Facilities and Assets Section, namely an Administrative Officer I, a Clerk IV (currently under recruitment) and a Clerk Typist III. These new permanent civilian resources will perform a variety of administrative functions for the entire section.
- The Inventory Control policy section is currently being reviewed by the Operational Audit and Compliance Manager and will be updated by the Planning and Research section pending the completion of the ongoing internal firearms audit. Also, the RNC has requested OCIO to conduct a complete review of the IT systems for inventory.
- In the case of the Property Control Centre itself, this area has traditionally been staffed by medically accommodated police officers. However, in the RNC's view this area should be civilianized. This would provide dedicated resources that have skills in the area of administration and inventory control. As well, this would provide more consistent resources since medically accommodated officers sometimes have higher levels of sick leave (in fact, one officer is now on long term sick leave). Therefore, the RNC has requested that two new permanent civilian Property Control Officer positions be created in the 2008-09 budget process. Once approved and filled these staff will provide increased control over court exhibits.

- Maintenance costs are currently tracked manually by the Vehicle Fleet Manager. However, the RNC has now requested a resource through the Opening Doors Program to develop and create spreadsheets and databases, to enter the cost data and prepare reports for the Vehicle Fleet Manager so as to better monitor and analyze vehicle maintenance costs, fuel consumption and mileage in the future.

- It should also be noted that in 2007 the RNC developed a new tender for vehicle maintenance on the Northeast Avalon, in cooperation with GPA. This resulted in two garages now performing the maintenance, one in East District and one in West District. This has resulted in significantly improved service on vehicles and better administrative control for billing.

- The AVL portion of the MDT-MRE-AVL project will track mileage per police vehicle and be used to monitor fuel consumption.

- Finally, with regards to vehicle replacement within the RNC, this is now based on a review of the mileage, maintenance costs and age of vehicles. A budget of $500,000 is assigned annually for this purpose and the vehicles to be replaced are selected based on these factors. This approach has worked well and a total of 18 - 20 vehicles are replaced annually depending upon the cost and type of vehicles being replaced.

Department of Municipal Affairs

3.2.24 Fire Commissioner's Office (2004 Annual Report, Part 2.35)

Introduction

In 2004, we performed a review of the Fire Commissioner's Office. The objectives of our review were to assess whether:

- the Fire Commissioner was adequately carrying out the provisions of the *Fire Prevention Act, 1991*;

- the Fire Commissioner had adequate systems and practices in place to deliver Provincial fire prevention and protection programs; and

- expenditures were approved, monitored and in compliance with Government policies.

Conclusions from our 2004 review

As a result of our review, we concluded that the Fire Commissioner's Office needed to do more in inspecting and evaluating the firefighting capabilities of the 297 fire departments throughout the Province and in providing training to the approximately 6,100 firefighters. Specifically:

- over the past 5 years, only 5 of the 297 fire departments were formally inspected;

- inspections identified serious deficiencies related to breathing apparatuses, vehicles, number of firefighters responding, and training;

- since 1991, only 700 firefighters received training to the level of Firefighter I;

- information was not maintained on how many of the 6,100 firefighters are trained; and

- an annual report had not been prepared since 1999 due to the inadequacy of the information system and monitoring information captured by the Fire Commissioner's Office.

2006 update

In our 2006 annual report, we included an update on the Department's progress towards implementing the recommendations contained in our 2004 report. At the time, the Department indicated that the Fire Commissioner's Office had been working with OCIO on the acquisition of a new Incident Reporting Management System (RMS) and continued to provide a schedule of training for locations all throughout the Province ensuring adequate training opportunities are provided. The Department also indicated that a joint working committee was established in 2006 to develop a minimum level of training required, staff workload and planning/development initiatives have been ongoing, Fire Department inspections are being conducted on an ongoing basis, and that vehicle cost analyses were conducted and two new vehicles were acquired.

Update

In October 2007, we contacted the Department requesting an update as to any further progress on the comments and recommendations included in our 2004 report. The information provided by the Department in response to our request is outlined below.

The Department indicated a new agency, Fire and Emergency Services Newfoundland and Labrador (FES-NL) was established in April 2007 and assumed responsibility for the administration and operation of Fire and Emergency Services in Newfoundland and Labrador. Its mandate is to develop and maintain a fire and emergency management system in Newfoundland and Labrador to mitigate against, prepare for, respond to and recover from fires and other major emergencies and disasters. To this end, the Department also indicated FES-NL is well engaged in organizational renewal, comprehensive planning, program and policy development, legislative and regulatory reform, and development of a strategy for communications and public education. This work includes, among many others, operational issues located within the Fire Commissioner's Office. With regards to specific recommendations the Department reported the following:

2004 Recommendation

The Department should develop and implement a system for the tracking of fire reports to ensure that all reports are complete and received.

Action Taken

The Department indicated that the request for the acquisition of a new Incident Reporting Management System, which was anticipated to be operational in 2007, was not funded in the budget process; however, FES-NL has requested funding again in the upcoming budget.

2004 Recommendation

The Department should develop standards (e.g. response times and firefighting capabilities) for fire departments.

Action Taken

The Department indicated that the joint working committee continued to work with the Newfoundland and Labrador Association of Fire Services (NLAFS) in the development of a minimum standard for firefighters in this province. The Working Group established three levels of competency for firefighting: Orientation level; Exterior/Defensive level; and Interior/Offensive level.

Early in 2007 the Working Group completed the draft of the Orientation level and started a province-wide consultation process with the fire service. Comments were received at presentation sessions and by fax and email. In June 2007 the final draft was presented and approved at the NLAFS Annual Convention.

It was also indicated that the Office of the Fire Commissioner is currently working on the curriculum program for delivery to fire departments and firefighters in 2008. In the meantime, the Working Group continues its work on the remaining two levels and expects to have a draft standard ready for consultation in the spring of 2008.

2004 Recommendation

The Department should prepare and submit an annual report.

Action Taken

The Department indicated that the FES-NL (Office of the Fire Commissioner) is unable to produce an accurate Annual Fire Loss Report due to the lack of a suitable fire loss data management system. It is anticipated that actual programming work on this system will start in 2008-09.

3.2.25 Municipal Inspections (2004 Annual Report, Part 2.36)

Introduction

In 2004, we completed a review of municipal inspections to determine if the Department had adequate systems and procedures in place to ensure that financial information prepared by the municipalities was being submitted and monitored, and municipal inspections were being performed in accordance with the legislation.

Conclusions from our 2004 review

In our 2004 annual report, we concluded that:

- the Department of Municipal and Provincial Affairs did not always receive budgets and financial statements of municipalities within the deadlines established under the *Municipalities Act*;
- annual municipal inspections were not being performed in accordance with the *Act*; and
- the new Municipal Information Management System (MIMS) did not have all required information input into the system.

2006 update

In our 2006 annual report, we included an update on the Department's progress towards implementing the recommendations contained in the 2004 report. At that time, the Department indicated that:

- it was developing ownership responsibilities for the input of data in MIMS and it was seeking approval to hire a MIMS Coordinator to ensure that data is accurate and inputted on a timely basis;
- it had instituted a notification and follow-up process with the municipalities to ensure budgets and financial statements are submitted as required by legislation. Municipalities which do not comply will have their Municipal Operation Grants put on hold and applications under the Capital Works Program will not be considered until such time as they are in compliance. In addition, the Gas Tax Agreements require the timely submission of these accountability documents as a prerequisite to the release of Gas Tax Funds;
- the Regional Offices review the auditor's management letter and any issues identified during the audit are followed up with the municipality. This may be done by telephone or site visit depending on the issue; and
- staffing issues have prevented the establishment of a schedule of inspections. However, Regional Offices are very familiar with the municipalities in their regions thus are able to give attention to the municipalities that require more attention than others, especially municipalities that received assistance under the Debt Relief Program. Departmental policy with respect to Councils having to submit financial evaluation reports prior to applying for capital works and other borrowings provides opportunity for assessment and inspection. It also avoids municipalities being approved for new funding initiatives unless they can afford them.

Update

In October 2007, we contacted the Department of Municipal Affairs requesting an update as to any further progress on the comments and recommendations included in our 2004 report. The information provided by the Department in response to our request is outlined below.

2004 Recommendation

The Department should:

- *ensure that data entered into its Municipal Information Management System (MIMS) is accurate and is input on a timely basis;*
- *take action to ensure that budgets and financial statements are submitted in compliance with the* Municipalities Act;
- *follow-up on all issues identified by the municipalities' auditors; and*
- *establish a frequency for municipal inspections given that the annual inspection requirement has been removed from the* Municipal Affairs Act.

Action Taken

The Department indicated that:

- a Municipal Information Management System (MIMS) Coordinator was hired in May 2007 to help manage the system and improve the quality and timeliness of data management;
- ownership responsibilities for the input of data in MIMS continues to be a high priority of the MIMS Coordinator. The system is being worked on to ensure that data is accurate and entered on a timely basis;
- the notification and follow-up process with municipalities continues to ensure budgets and financial statements are submitted as required by legislation. Municipalities which do not comply are being denied access to the Capital Works Program. Their applications are not being considered until such time as they are in compliance. In addition, the recent Gas Tax Agreements require the timely submission of these accountability documents as a prerequisite to the release of Gas Tax Funds. A staff member has been assigned to manage this system; and

- the Regional Offices act on the auditor's management letter and deal with any issues identified in an appropriate manner.

3.2.26 "911" Emergency Response Service (2005 Annual Report, Part 2.19)

Introduction

In 2005, we performed a review of the 911 emergency response service within the Department of Municipal Affairs. The objective of our review was to assess the adequacy of the coverage of the land based 911 emergency response service in the Province.

Conclusions from our 2005 review

As a result of our review, we concluded that:

- The Province is the only Atlantic province without province-wide coverage from land based 911 emergency services. Only 40% of the population and less than 10% of the communities on the island portion of the Province have access to this 911 service. Labrador had no land based 911 service.

- The 911 services operating in the Province were "basic" 911 services compared to "enhanced" 911 services in other Atlantic provinces.

Update

In October 2007, we contacted the Department requesting an update as to the progress on the comments and recommendation included in our 2005 report. The information provided by the Department in response to our request is outlined below.

The Department indicated that a new agency, Fire and Emergency Services Newfoundland and Labrador (FES-NL) was established in April 2007 and assumed responsibility for the administration and operation of Fire and Emergency Services in Newfoundland and Labrador. Its mandate is to develop and maintain a fire and emergency management system in Newfoundland and Labrador to mitigate against, prepare for, respond to and recover from fires and other major emergencies and disasters. To this end, FES-NL is well engaged in organizational renewal, comprehensive planning, program and policy development, legislative and regulatory reform, and development of a strategy for communications and public education. This work includes, among many others, developmental work on important issues like 911. With regards to the specific recommendation, the Department's response is outlined below.

2005 Recommendation

The Province should consider whether a Province-wide land based 911 emergency response service should be implemented.

Action Taken

The Department indicated that this issue has been around for quite some time and is perhaps, more complex than it appears on the surface. In 1997, Municipal Affairs conducted a review and the projected cost for enhanced 911 services (province-wide) at that time was $10 million. More recently, discussions occurred in 2006 and 2007 with telecommunications firms about 911 and while companies may be prepared to develop and provide services that could deliver enhanced 911, other matters such as the lack of civic addressing for the Province, remain an outstanding hurdle. The absence of a comprehensive list of civic addresses throughout the entire Province and all of its communities, could pose a significant impediment to a potential 911 call. For example, how would a centralized 911 operator direct emergency responders to an emergency location when street numbers and addresses do not exist? At the present time, our emergency response system, especially in rural areas relies heavily on volunteer firefighters and emergency responders, and it appears to be working and working well. That being said, however, the new Agency has been directed by the Minister to explore this issue further in the coming year.

3.2.27 Municipal Assessment Agency (2005 Annual Report, Part 2.20)

Introduction

In 2005, we reviewed the Municipal Assessment Agency (the Agency). The objectives of our review were to determine whether the Agency:

- followed established legislation, policies and procedures with respect to conducting property assessments; and
- complied with Government and Agency policies and procedures relating to its expenditures.

Conclusions from our 2005 review

As a result of our review, we concluded the following:

- Property sales inspections were not completed - At the time of our review, nearly half of the 20,055 properties sold during the period 2002 to 2005 were never inspected.

- Full inspections were not completed - Contrary to policy, approximately 74% of inspections did not include an interior inspection of the property. A contributing factor to this situation was that there was no follow-up if the property owner was not home.

- Guidance to assessors was not provided - Staff at the Agency indicated that, as a result of the lack of guidance provided to assessors, there were inconsistencies in the completion of assessment forms.

- Target for 10 year inspections was not achieved in 2005 - The *Assessment Act* requires that all properties be visited for inspection at least once every 10 years. The Agency inspected only 6% of properties in 2005 instead of its target of 10%. Not achieving this target in any given year increases the risk that all properties will not be inspected by 2008 as required.

- Application of statistical measures revealed potential inaccuracies in assessed property values - When the Agency applied statistical measures to the 49 municipalities in the Province which had sufficient property sales to apply the measures, it was revealed that 5 municipalities had poor assessment quality, 4 municipalities lacked good appraisal uniformity in properties with similar characteristics, and 29 municipalities had high-value properties undervalued.

- Database anomalies - There was no indication, during our review, that database anomalies were being addressed.

- Travel expenses non-compliant - Although the Agency had adopted Government's travel policy, we found instances of non-compliance.

- Consultant hired without an objective evaluation - In 2003, without the use of an objective means of evaluation such as the Province's *Consultant's Guidelines*, the Agency selected a consultant to design and implement a new management structure.

- There were instances where expenditures were incurred that were not consistent with Government policy.

Update

In October 2007, we contacted the Municipal Assessment Agency requesting an update as to progress made on the comments and recommendations contained in our 2005 report. The information provided by the Agency in response to our request is outlined below.

2005 Recommendation

The Agency should plan the timing and location of inspections to ensure policy and legislation requirements are being met and resources are used efficiently.

Action Taken

The Agency indicated that it completes property inspections in accordance with policy and legislation. The Agency indicated that it directs staff to complete full property inspections whenever access is gained to a property.

The Agency indicated that they are on target to complete the ten year time frame for re-inspection of property, although this requirement was removed from the legislation in December 2006.

In addition, the Agency indicated that, following completion of the re-inspection program (anticipated for 2008), it will develop criteria to target re-inspections consistent with the life cycle of real property.

2005 Recommendation

The Agency should conduct sales inspections on a more timely basis.

Action Taken

The Agency indicated that they are on target to complete the validation process for all sales to be used in the assessment and revaluation process. The Agency indicated that property sales are reviewed, visited and validated in accordance with policy and good assessment practice. The Agency indicated that it has implemented a sales validation policy.

The Agency also noted that the *Assessment Act, 2006* provides that *"Where the assessor is not in receipt of information to indicate that alterations have taken place which may significantly affect the real property's value, the assessor may dispense with an inspection of it."* The Agency also noted that their policy does not contradict the legislation and is consistent with good assessment practice.

2005 Recommendations

The Agency should conduct data collection in accordance with policy.

The Agency should develop written instructions to direct assessors in completing the Field Data Record and other collection documents.

Action Taken

The Agency indicated that it completes property inspections in accordance with policy and legislation. The Agency indicated that it directs staff to complete full property inspections whenever access is gained to a property.

The Agency indicated that it has developed a property classification module and distributed the module to all field staff and regional offices. The Agency also indicated that it implemented a revised field data collection policy.

Furthermore, the Agency indicated that additional documentation is provided to field staff regarding the inspection and data collection process and training is provided when necessary. In addition, the Agency indicated that annual reviews of training needs and requirements have been implemented for all field staff.

2005 Recommendation

The Agency should continue to address potential issues revealed as a result of applying the quality control measures.

Action Taken

The Agency indicated that the needs of a quality assessment program are varied and challenging. The Agency indicated that it supports staff participation in professional accreditation programs, professional associations and best practice symposiums to ensure that it is aware of the measures for a quality assessment program, giving due consideration to the available financial resources of its clients. In addition, the Agency indicated that it continues to participate in the Canadian benchmarking network and uses the results from the network studies to identify best practices within Canada for possible implementation by the Agency.

The Agency also indicated that it uses statistical measures, primarily ratio studies, to highlight areas for additional review. The Agency noted that these studies have been developed for use in jurisdictions with a high reliance on computer assisted mass appraisal methods, such as multiple regression analysis. In addition, the Agency indicated that, within their jurisdiction, they rely less on statistical valuation methods. Instead, the Agency indicated that it uses ratio studies to direct additional reviews by assessors. The Agency indicated that its practice now requires the assessor to file a report of his/her actions following receipt of the ratio study results.

2005 Recommendation

The Agency should ensure that database anomalies identified in the exception reports are addressed promptly and that the action taken is recorded.

Action Taken

The Agency indicated that it continues to review its practice with respect to database anomalies. The Agency indicated that its staff have noted that there is a need to develop a method to identify permitted exceptions to ensure these exceptions are not returned on future anomaly reports.

The Agency indicated that its systems staff have identified the need for modifications requiring a time and materials contract with a third-party system provider to resolve a number of issues identified by valuation and field staff. The Agency indicated that it has deferred these modifications while it is reviewing possible software upgrades that would make the modifications unnecessary. In addition, the Agency indicated that it is continuing to review the filtering criteria to ensure that staff time is not spent addressing issues that affect non-valuation data.

Furthermore, the Agency indicated that data anomalies, once identified, are forwarded to the assessor for review and correction, where necessary. The Agency indicated that if subsequent reports identify corrections which have not been made the issue is raised to the supervisory level for follow-up.

2005 Recommendation

The Agency should ensure that the adopted policies are followed when expenses are incurred/claimed and apply an objective process for selecting future consultants.

Action Taken

The Agency indicated that the Board has reviewed the issues identified in our 2005 Report. As a result of this review, the Agency noted the following:

- administrative practices have been reviewed and an additional manager position, Manager of Payroll and Accounts, has been created to ensure there is compliance with all Agency policies for expenses;
- the Agency's internal controls framework is discussed with its external auditors on an annual basis;
- all items raised in management letters have been addressed; and
- the Agency complies with Government policy directives that apply to Crown corporations.

In addition, the Agency indicated that it has established an objective process for selecting consultants. This process has established a lower threshold than Government's in all instances as the lower threshold better reflects the size of the Agency.

Department of Transportation and Works

3.2.28 Vacant/Surplus Properties and Unused Space (2005 Annual Report, Part 2.21)

Introduction

In 2005, we completed a review of Government's vacant / surplus buildings and unused space. Our review covered the period from 1 April 2000 to 31 December 2004 and included discussions with staff, a review of files and other documentation at the Department of Transportation and Works and the four regional offices.

Conclusions from our 2005 review

In our 2005 report item, we reported that Government was not efficiently managing Government-owned vacant/surplus properties. Government did not have a long term strategy for the disposal or alternate use of Government-owned vacant/surplus properties. As a result, vacant/surplus properties continued to deteriorate while the Department of Transportation and Works incurred ongoing operational costs and increasing environmental remediation costs. More attention must be paid to timely environmental remediation of these sites and their subsequent disposal, re-use or re-sale.

Update

In October 2007, we contacted the Department of Transportation and Works requesting an update as to the progress on the comments and recommendations included in our 2005 report. The information provided by the Department in response to our request is outlined below.

2005 Recommendation

Government should develop a long-term strategy for the disposal or alternate use of Government-owned vacant/surplus properties.

Action Taken

In a letter to the Auditor General of 22 January 2007 the Department advised that it has a clear policy with respect to inventory of vacant properties and pointed out the process it has in place.

2005 Recommendations

The Department should:

- *ensure its building inventory database is current and accurate through regular updates;*
- *determine environmental remediation and demolition costs for all vacant/surplus properties;*
- *implement a process to deal with the timely disposal of vacant/surplus properties or identify alternate uses for them; and*
- *continue the process to determine if there is any existing unused space within existing leased or owned buildings which could be better utilized.*

Action Taken

The Department indicated that it has been successful in dealing with a significant amount of vacant and unused space. A number of buildings have already been demolished or are in the process of being demolished (e.g. former Grace, Sir Thomas Roddick, Fogo, Harbour Breton and Janeway Hospitals; all buildings at the former Salmonier Correctional Facility, etc.). Others have been sold (e.g. former Children's rehab Building, former Boy's Home, Main Building, Whitbourne) or are in the process of being offered for sale. In this regard the former Janeway Properties are currently being marketed and several smaller buildings throughout the Province have been offered to towns.

As well, re-development work at the former Museum Building, Duckworth Street, St. John's is nearing completion. The building will now house offices of the Departments of Human Resources, Labour and Employment and Justice. In conjunction with the Department of Tourism, Culture and Recreation plans for the re-development and interpretation of the Colonial Building are progressing.

The Department acknowledges that there remains some vacant buildings to deal with. In this respect it has a further 8 buildings (total of 12,913.6 m^2) for which there is no market or re-use potential which it intends to demolish in future years as funds permit. Nevertheless, the Department has aggressively pursued this issue and will continue to do so with its remaining surplus buildings.

CHAPTER 4

SPECIAL REPORTS

Reports under Section 15 of the *Auditor General Act*

House of Assembly

Section 15 of the *Auditor General Act* requires that *"Where during the course of an audit, the auditor general becomes aware of an improper retention or misappropriation of public money or another activity that may constitute an offence under the Criminal Code or another Act, the auditor general shall immediately report the improper retention or misappropriation of public money or other activity to the Lieutenant-Governor in Council."*

In January 2006, the Office commenced a review of constituency allowances claimed by Members of the House of Assembly. This initial review resulted in the issuance of 9 reports relating to excess constituency allowances claimed by 5 Members, 2 reports relating to double billings by 2 Members, as well as 1 report on issues relating to payments made by the House of Assembly to certain suppliers. The reports were provided to the Lieutenant-Governor in Council and tabled in the House of Assembly.

In addition to the above reports, in July 2006, the Lieutenant-Governor in Council requested that the Office review all constituency allowances paid to Members of the House of Assembly for the period covering the fiscal years 1990 to 2006. A report on the first part of this review, relating to excess constituency allowance claims, was included in item 2.1 of my *Report to the House of Assembly on Reviews of Departments and Crown Agencies for the Year Ended 31 March 2006* which was provided to the Speaker of the House of Assembly in January 2007. The report on the second part of the review relating to the appropriateness of expenditures claimed and adequacy of supporting documentation was included in my *Report to the House of Assembly on a Review of Constituency Allowance Claims from 1989-90 through to 2005-06* which was provided to the Speaker of the House of Assembly in September 2007.

Report under Section 16 of the *Auditor General Act*

Fibre Optic Deal

Section 16 of the *Auditor General Act* requires that *"The auditor general may, where in his or her opinion such an assignment does not interfere with the auditor general's primary responsibilities under this Act, whenever the Lieutenant-Governor in Council so requests or the House of Assembly or the Public Accounts Committee by resolution so requires, inquire into and report on a matter relating to the financial affairs of the province or to public property or inquire into and report on a person or organization that has received financial aid from the government of the province or in respect of which financial aid from the government of the province is sought."*

On 2 November 2006, Government announced it would *"...invest $15 million, over the next two fiscal years on the installation of a fully redundant fibre optic link which will run from St. John's to Halifax along two diverse routes to connect the national carriers into mainland Canada."* On 22 November 2006, the House of Assembly passed a resolution requesting that the Office *"...investigate all the details and circumstances of the fibre optic deal."*

The report resulting from this review was included in my *Report to the House of Assembly on a Review of the "Fibre Optic Deal"* which was provided to the Speaker of the House of Assembly in September 2007.

Access to Reports

Special reports issued by the Office of the Auditor General are available on the Office's web site at: http://www.gov.nl.ca/ag/reports.htm