REPORT OF THE

# Auditor General
## of New Brunswick

## Volume II
Performance Audit

# 2024

AUDITOR GENERAL OF NEW BRUNSWICK

VÉRIFICATEUR GÉNÉRAL DU NOUVEAU-BRUNSWICK

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AUDITOR GENERAL OF NEW BRUNSWICK | VÉRIFICATEUR GÉNÉRAL DU NOUVEAU-BRUNSWICK

Speaker of the Legislative Assembly
Province of New Brunswick

Madam,

As required under section 15(1) of the *Auditor General Act,* I am submitting Volume II of my Office's 2024 Report to the Legislative Assembly.

Respectfully submitted,

Paul Martin, FCPA, FCA
Auditor General

Fredericton, N. B.
December 2024

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# Chapter 1 - Auditor General's Comments

Our 2024 Volume II report includes four performance audit and information chapters:

- Child Death Investigation, Inquest and Review Process
- Access to Addiction and Mental Health Services
- Hotel Accommodations Policy
- Status Report on Implementation of Performance Audit Recommendations

**Child Death Investigation, Inquest and Review Process**
The death of a child (a person under 19 years of age) is a profound tragedy. Coroner Services, within the Department of Justice and Public Safety, is responsible for investigating these deaths and overseeing the Child Death Review Committee. Our audit found several areas of non-compliance with legislation, a lack of required public reporting, and improvements required in coroner training.

**Access to Addiction and Mental Health Services**
The Department of Health is responsible for the planning, funding, and monitoring of timely access to addiction and mental health services. We found wait times for treatment exceed performance measures established by the department, the budget for addiction and mental health services is not updated based on need, and reporting on access wait times was incomplete.

**Hotel Accommodations Policy**
The Department of Finance and Treasury Board is responsible for policy decisions governing employee travel related to hotel accommodation expenses. Our audit found an estimated $632,169 annually in forgone savings related to a policy change, lack of a documented business case for the decision to cease participation in the Government of Canada's Accommodations Directory program, and no analysis of potential savings or increased costs.

**Status Report on Implementation of Performance Audit Recommendations**
Our Office performs follow-up work on prior years' audits to determine the level of implementation of our recommendations. We obtained confirmations from audit entities for audit years 2020, 2021 and 2022, and have noted 57%, 100%, and 71% of our recommendations have been reported as implemented, respectively by year.

**Recognition**
We would like to recognize departmental staff for their assistance as we completed our work for this report. I also want to thank my audit team for their dedication and professionalism in fulfilling the mandate of the Office of the Auditor General of New Brunswick.

Paul Martin, FCPA, FCA
Auditor General

AUDITOR GENERAL OF NEW BRUNSWICK | VÉRIFICATEUR GÉNÉRAL DU NOUVEAU-BRUNSWICK

December 2024

# Child Death Investigation, Inquest and Review Process

## Department of Justice and Public Safety

Volume II – Chapter 2
2024 AGNB Annual Report

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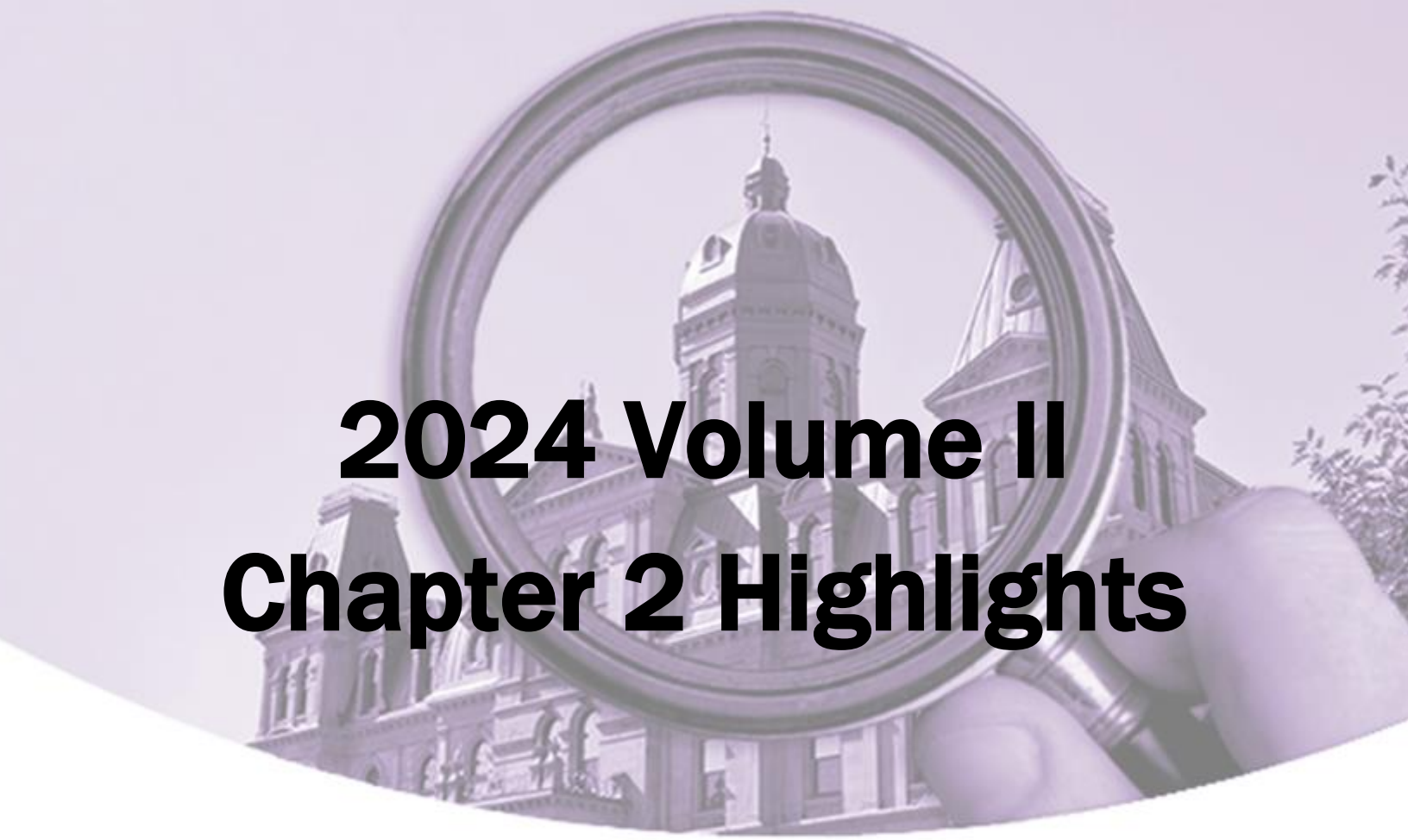


# 2024 Volume II Chapter 2 Highlights

| | |
|---|---|
| **Recommendations not provided to organizations as required** | **Inadequate public reporting** |
| **Child death investigations, inquests and death reviews are not always completed in a timely manner** | |

## Overall Conclusions

Our audit work concluded that the Department of Justice and Public Safety does not have systems and practices in place to ensure the effective completion of child death investigations, inquests, and reviews.

**Disclaimer**: The following report contains content related to child deaths that may be sensitive or difficult for some readers.

# Results at a Glance

## Child Death Investigation, Inquest and Review Process

**Systems and practices do not support effective completion of child death investigations, inquests and reviews**

### Findings

- Child death reviews are **not** always timely
- **Lack** of required public reporting
- Committee recommendations **not** provided to departments and organizations
- **34%** of coroners did **not** have all the required e-learning courses completed
- **Lack** of record retention

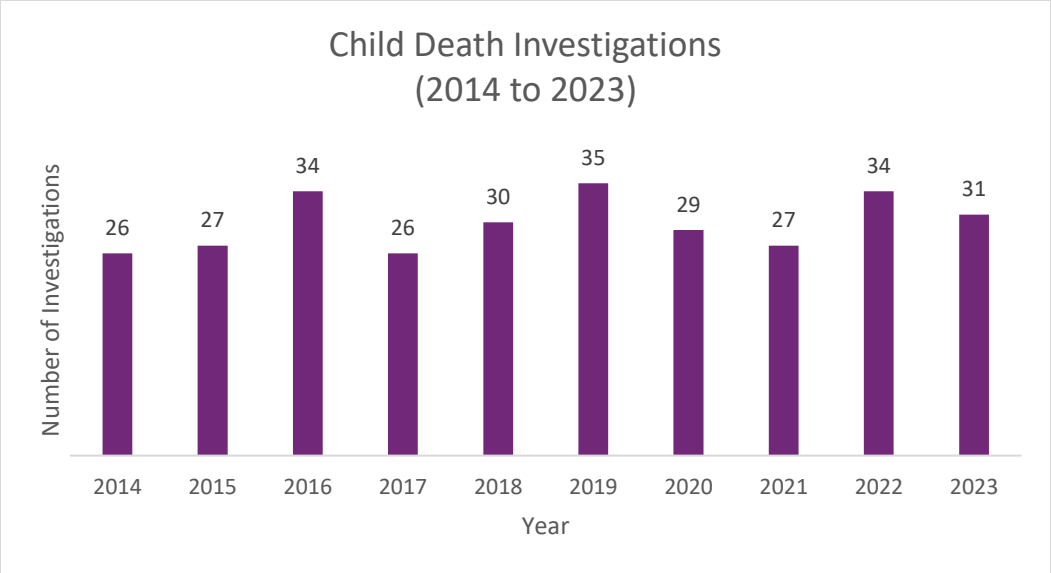
# About the Audit

## Introduction to the Audit

**2.1** The *Coroners Act* states a child death is defined as "*the death of a person who is under the age of 19 years*".

**2.2** In New Brunswick, 67 children died suddenly or under suspicious circumstances prompting investigations by Coroner Services within the Department of Justice and Public Safety for the period April 1, 2022 to June 30, 2024.

**2.3** In 2023, there were 31 child death investigations as noted in the graph below.




*Source: Prepared by AGNB based on data from the department (unaudited).*

## Why we Chose this Topic

**2.4** The loss of a child is a profound tragedy that strikes at the heart of families and communities in New Brunswick. In the wake of such an event, it is crucial that every aspect of the investigation, inquest (if applicable), and subsequent Child Death Review Committee review is conducted with the utmost diligence and integrity.

**2.5** Coroner Services is an independent and publicly accountable investigation of death agency and in recent years, the public reporting of the Child Death Review

Committee has been limited. Given its critical role, it is imperative to ensure that its processes and practices are robust, transparent and effective.

## Auditee

**2.6** Our auditee was the Department of Justice and Public Safety.

## Audit Scope

**2.7** We examined coroner files, death investigation summaries, Child Death Review Committee materials, and numerous other documents.

**2.8** The audit covered the period from April 1, 2022, to June 30, 2024. Information outside of this period was also collected and examined as deemed necessary. As part of our work, we interviewed key departmental staff, Child Death Review Committee members and related external parties.

**2.9** More details on the audit objective, criteria, scope, and approach we used in completing our audit can be found in Appendix II and Appendix III.

## Audit Objective

**2.10** Our audit objective was to determine if the Department of Justice and Public Safety has systems and practices in place to ensure the effective completion of child death investigations, inquests, and reviews.

## Conclusion

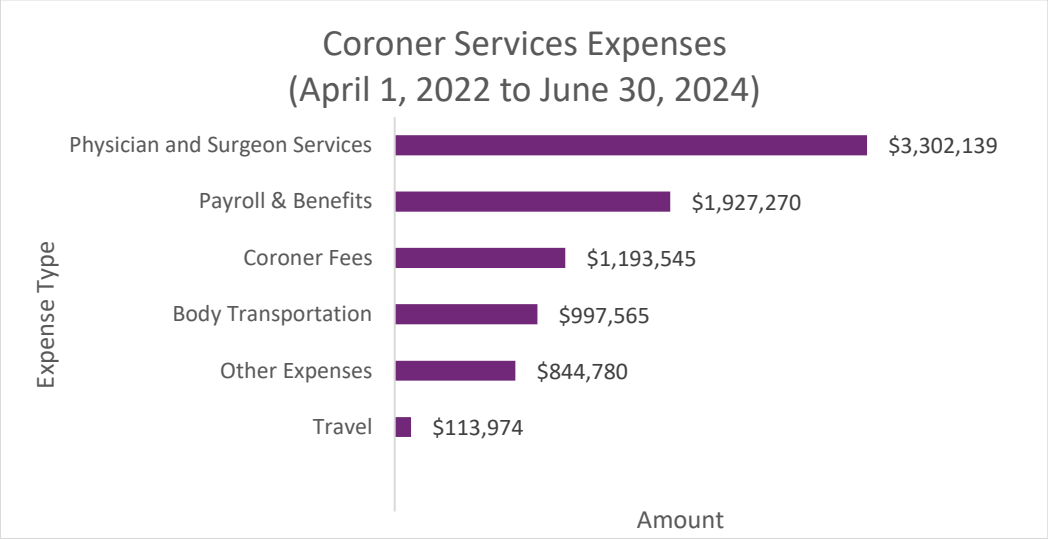
**2.11** Our audit work concluded that the Department of Justice and Public Safety does not have systems and practices in place to ensure the effective completion of child death investigations, inquests, and reviews. Overall findings are as follows:

- child death investigations, inquests and death reviews are not always completed in a timely manner
- improvements are required to ensure that coroners are adequately qualified and trained prior to completing death investigations
- recommendations made by the Child Death Review Committee intended to mitigate risks of unnatural deaths are not being provided to departments and relevant agencies in a timely manner and their impact is not monitored
- the department is not adequately reporting on the work of the Child Death Review Committee as per legislative and policy requirements

# Background

**2.12** Coroner Services is an independent and publicly accountable agency within the Department of Justice and Public Safety (the department) mandated by the *Coroners Act* to review all suspicious or questionable deaths in New Brunswick and conduct inquests as may be required in the public interest. Coroner Services also oversees the Child Death Review Committee (CDRC).

**2.13** Coroner Services' annual budget increased to $4 million in 2023-24 from $3 million in 2022-23. Total spending in our audit period of April 1, 2022 to June 30, 2024 was $8.4 million. Thirty nine percent of expenses are incurred for autopsy, toxicology, and other physician and surgeon expenses. The next largest expense is for payroll for full-time staff and fee-for-service community coroner fees. Coroner Services expenses for our audit period are detailed in the graph below.




*Source: Prepared by AGNB based on data from GNB's financial system (unaudited).*

**2.14** Coroner Services is the responsibility of the Chief Coroner who is assisted by two full time Deputy Chief Coroners.

**2.15** Five full-time Government of New Brunswick employees serve as regional coroners in Fredericton/ Woodstock, Moncton/ Miramichi, Saint John, Bathurst/ Campbellton and Edmundston and report to the Chief Coroner.

**2.16** As of June 30, 2024, there were also 36 active fee-for-service community coroners providing services primarily on nights and weekends across the province.

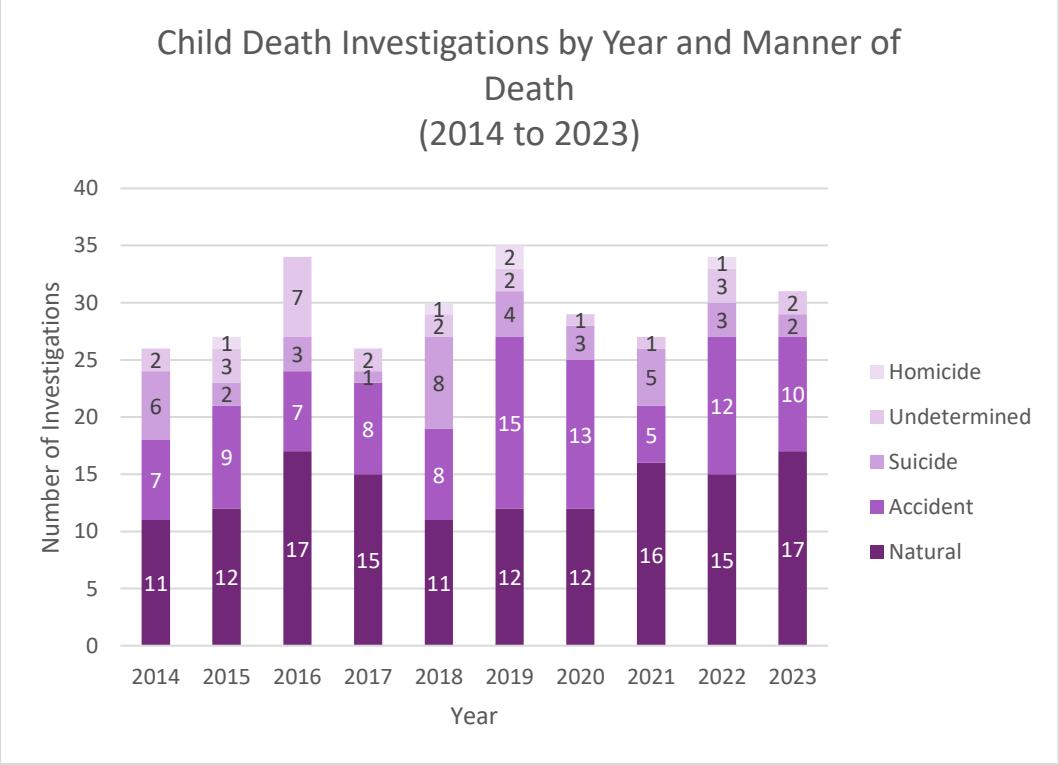
## Coroner Death Investigations

**2.17** The *Coroners Act* states a coroner must be immediately notified when a person dies as a result of violence, an accident, negligence, malpractice, during or following pregnancy in circumstances that might reasonably be attributable to the pregnancy, suddenly and unexpectedly, from disease or sickness for which there was no treatment given by a medical practitioner, or from any cause other than disease, natural causes or medically assisted death.

**2.18** When a coroner is notified of a death, the coroner shall view the body and make any investigation that is required to determine for each case the identity of the deceased and the facts as to how, when, where and by what means the deceased came to their death.

**2.19** Coroner Services investigates 21.7% of the approximate 7,500 total deaths per year in the province.

**2.20** The following chart details the number of child death investigations from 2014 to 2023 by manner of death.




*Source: Prepared by AGNB based on data from the department (unaudited).*

## Inquests

**2.21** Upon completing the death investigation, a coroner must make a declaration to a commissioner of oaths on their decision whether an inquest is necessary. The reasons for their decision are to be filed with the Chief Coroner in accordance with the *Coroners Act*. Inquests are recommended in less than 1% of investigations.

**2.22** Holding an inquest draws public attention to the many contributing causes of sudden and unexpected deaths. The intention of an inquest is not to make findings of legal responsibility or to assign blame but should serve three primary functions as a means:

- for a public ascertainment of facts relating to death
- of formally focusing community attention on and initiating community response to preventative death
- for satisfying the community that the circumstances surrounding the death of any of its members will not be overlooked, concealed or ignored

**2.23** It is expected that the inquest jury will make recommendations intended to mitigate risks of death in similar circumstances. The Chief Coroner is responsible for bringing the findings and recommendations arising out of inquests to the attention of appropriate persons, agencies and government departments.

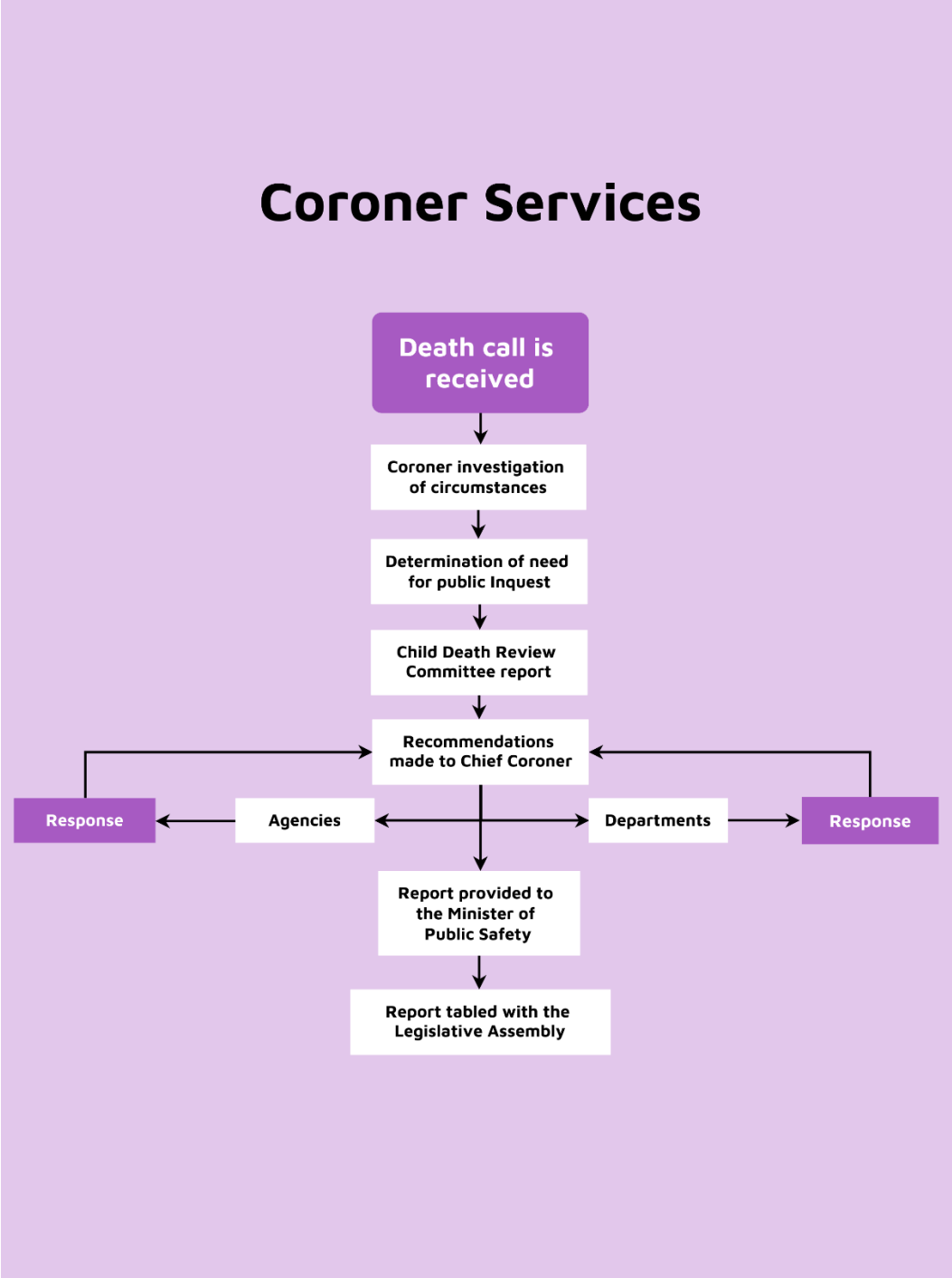
## Child Death Reviews

**2.24** The *Coroners Act* states the CDRC shall review a child death upon completion of an investigation, inquest, criminal investigation and criminal court proceedings, if applicable.

**2.25** The CDRC is to conduct comprehensive reviews of all child deaths reported to a coroner in an effort to understand how and why children die with the intent to prevent future deaths and improve the health, safety and well-being of all children in New Brunswick.

**2.26** The *Coroners Act* states after a review has been conducted, the CDRC must submit a report, along with any applicable recommendations, to the Chief Coroner. Recommendations are to be provided to the relevant government department or outside organization. The report is also to be provided to the Minister of Public Safety and subsequently tabled in the Legislative Assembly.

**2.27** The following visual shows the process followed once a child death is reported to Coroner Services.




*Source: Prepared by AGNB.*

# Child Death Review Committee

**2.28** The Child Death Review Committee (CDRC) was enshrined in the *Coroners Act* in 2022 and is comprised of multi-disciplinary external experts who examine the deaths of:

- individuals under 19 that fall under a coroner's jurisdiction
- individuals under 19 who were either in the care of or had family members in contact with the Department of Social Development within 12 months before their death

**2.29** The *Coroners Act* states the CDRC must consist of at least seven members appointed by the Chief Coroner as following:

- a coroner
- a police officer nominated by the New Brunswick Association of Chiefs of Police
- two persons registered with the College of Physicians and Surgeons of New Brunswick
- a member in good standing of the Law Society of New Brunswick
- a person who represents the interests of a group of aboriginal people
- a member in good standing of the New Brunswick Association of Social Workers

**2.30** The committee is established as per legislation.

## Conflict of Interest Declarations Not Obtained

**2.31** Before the Chief Coroner appoints a qualified person as a member of the CDRC, Regulation 2022-68 under the *Coroners Act* (*Death Review Committee Regulation)* requires the Chief Coroner to obtain a statement from the person disclosing any actual or potential conflict of interest.

**2.32** The department was not able to provide documents confirming that conflict of interest statements were provided to the Chief Coroner prior to the qualified person becoming a member of the committee.

### Recommendation

**2.33 We recommend the Department of Justice and Public Safety ensure a statement disclosing any actual or potential conflicts of interest is obtained from the qualified person before they are appointed by the Chief Coroner as a member of the Child Death Review Committee.**

**2.34** The *Death Review Committee Regulation* states it is a conflict of interest for a member of the CDRC to:

- accept any fees, gifts, gratuities or other benefit that could reasonably be seen to influence any decision made by the member in the carrying out of their functions
- to hold an office or position, the duties, responsibilities or interests of which may interfere in any way with the member's duties, responsibilities and interests

**2.35** One member of the CDRC is employed by the Coroner Services to perform autopsies and post-mortem examinations. These reports assist coroners in determining cause and manner of death and are subsequently also reviewed by the CDRC.

**2.36** There were two occasions where the committee member who performed the autopsy also attended a CDRC meeting to review the death of the same child. Accepting compensation for autopsy reports could potentially influence the physician's decisions on the committee, and holding dual roles can interfere with their responsibility to evaluate their work objectively.

### Recommendation

**2.37 We recommend the Department of Justice and Public Safety ensure that mechanisms are in place to assess and disclose potential conflict of interest for each review started by the Child Death Review Committee.**

## Vice-Chairperson Not Appointed

**2.38** The Chair of the CDRC collects and distributes all materials to be reviewed prior to the committee meeting. Committee members do not have access to information without the assistance of the Chair. CDRC meetings are thus cancelled or postponed if the Chair is unable to attend.

**2.39** The members of the CDRC have not appointed a Vice-Chairperson as required by the *Coroners Act.* In the absence of the Chair, the Vice-Chair shall preside at the meetings of the CDRC. This is further reinforced in the Terms of Reference where it states: "*In order to ensure continuation of the functionality of the Child Death Review Committee, the members of the Committee in agreement with the Chairperson shall select from amongst its members a Vice Chairperson to serve as Chair when the Chairperson is not able to preside at a meeting of the Committee.*"

**2.40** In 2024, the Chair of the CDRC was unable to attend meetings from August – October and no further action has been taken by the committee on reviews outstanding in their absence.

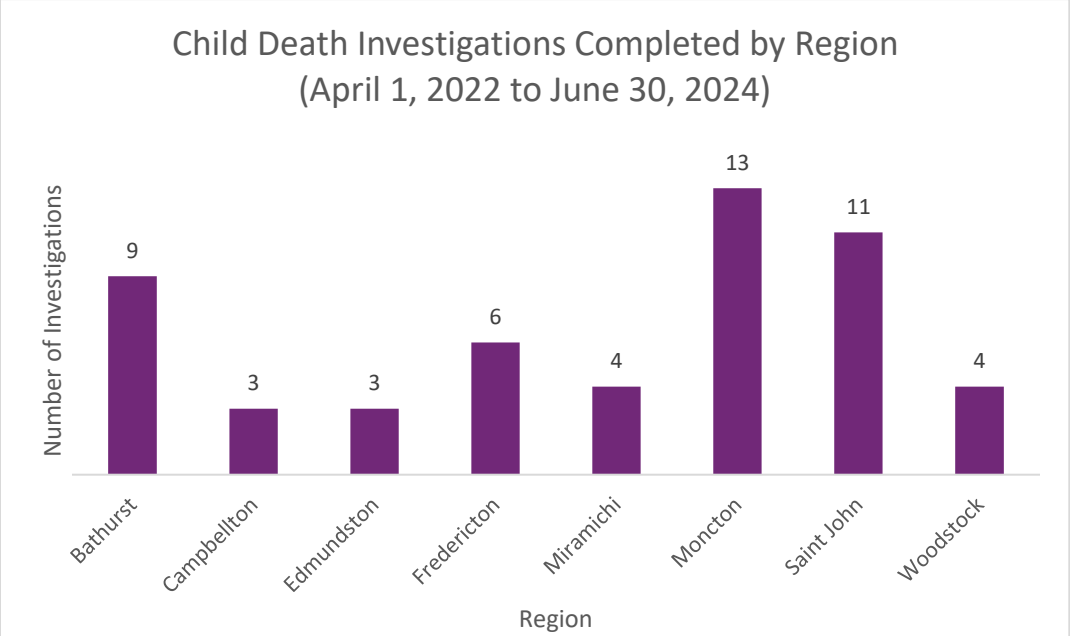
### Recommendation

**2.41 We recommend the Department of Justice and Public Safety ensure the Child Death Review Committee appoint a member of the committee to be the Vice-Chair so that a vacancy on the Child Death Review Committee does not impair the committee's capacity to act.**

# Coroner Investigations

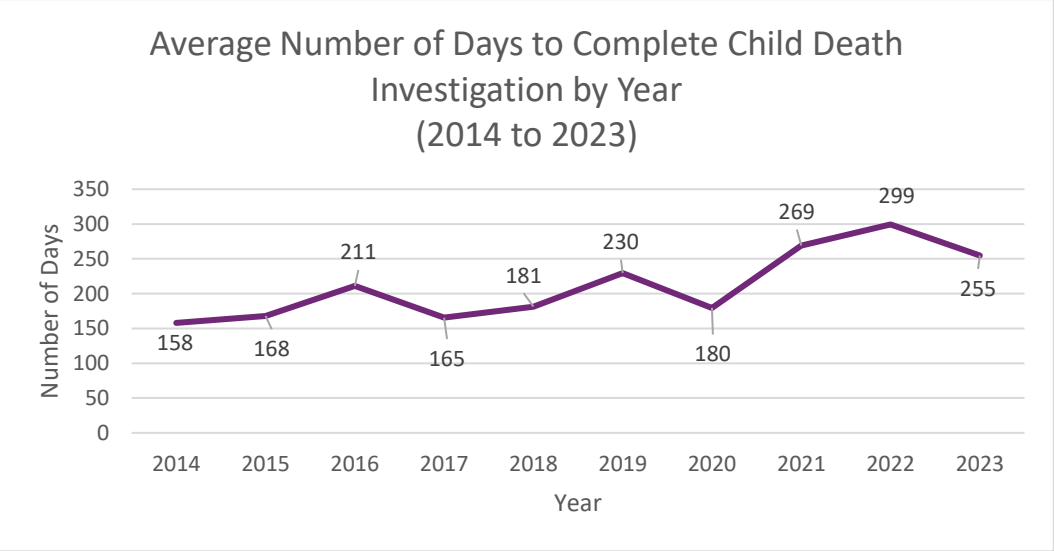
## Death Investigations Not Timely

**2.42** Of the 67 children who died suddenly or under suspicious circumstances prompting coroner investigations between April 1, 2022 and June 30, 2024, 53 death investigations were completed. The following graph shows numbers of completed investigations by region.




*Source: Prepared by AGNB based on data from the department (unaudited).*

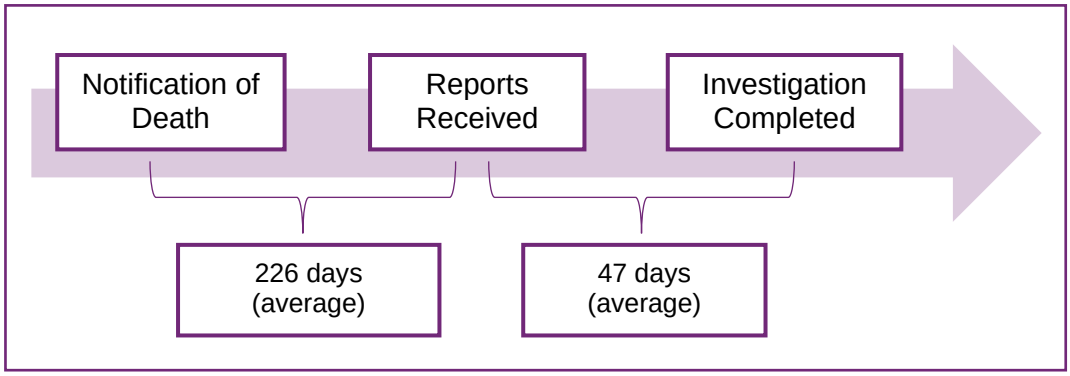
**2.43** Between April 1, 2022 to June 30, 2024, child death investigations took on average 2.5 times longer than adults (249 days for children compared to 100 days for adults). The average number of days to complete a child death investigation for the past ten years is detailed in the following diagram:



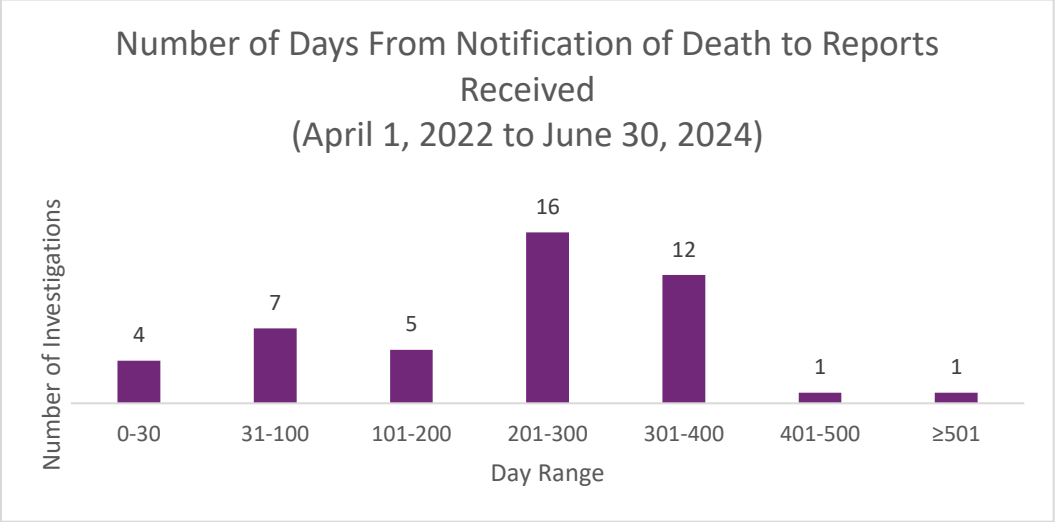

*Source: Prepared by AGNB based on data from the department (unaudited).*

**2.44** Upon notification of a death, a coroner is required to view the body, collect evidence and interview witnesses. To close an investigation file, a coroner often needs to receive various reports from external parties including autopsy and police reports to inform their decision on the cause and manner of death. The turnaround time for autopsy reports has been identified as a significant factor in the delay of closing investigation files.

**2.45** Of the 53 death investigations, 46 had autopsy and/or police investigation reports. As noted in the diagram below, the average time from date of notification of death to all reports received was 226 days.



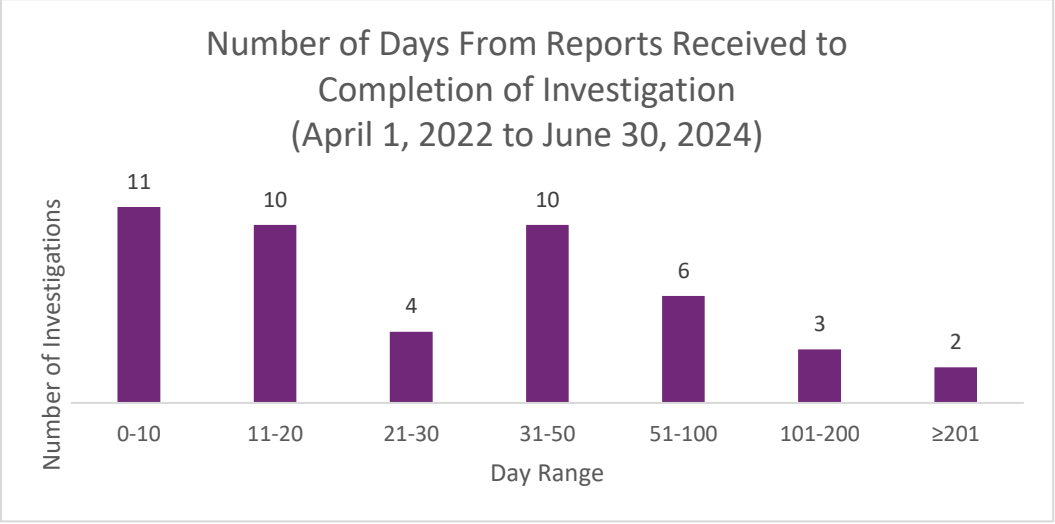
**2.46** As noted in the following graph, 76% of investigations took more than 100 days to receive all reports.




*Source: Prepared by AGNB based on data from the department (unaudited).*

**2.47** Once reports are received, the coroner is required to close the investigation file. A new service level agreement for community coroners was implemented in January 2024 (revised June 2024) which requires coroners to close their file within 30 days after receiving all relevant reports.

**2.48** The following graph details the length of time it took to close an investigation file after all reports had been received. While 54% of investigations took under 30 days to close, 21 investigations took longer than 30 days including two which exceeded 200 days.




*Source: Prepared by AGNB based on data from the department (unaudited).*

**Recommendation**

**2.49 We recommend the Department of Justice and Public Safety monitor outstanding death investigation case files and ensure timely completion in accordance with service level agreements.**

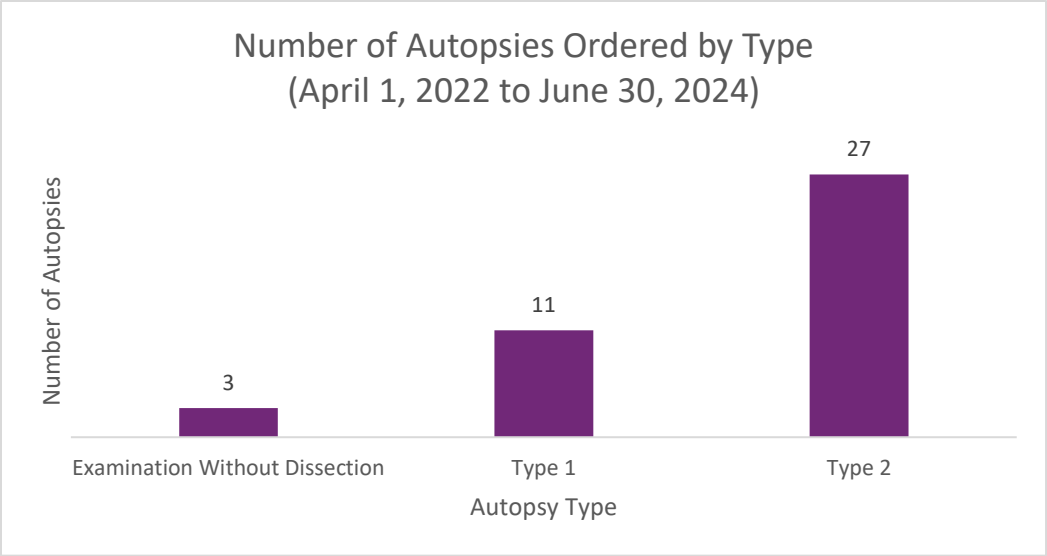
## Concerns with Pathology Services

**2.50** Autopsies are an important part of the death investigation process as they help to determine the probable cause of death. The coroner ordered autopsies in 77% of the child death investigation cases.

**2.51** As per the coroner training manual, there are three types of autopsies that can be ordered by a coroner:

- an examination without dissection is a thorough external examination of the body performed by a pathologist
- a type 1 autopsy involves a dissection of the body to aid in the determination of cause of death and is performed by a pathologist
- a type 2 autopsy involves a dissection of the body to aid in the determination of cause of death and is performed by a forensic pathologist

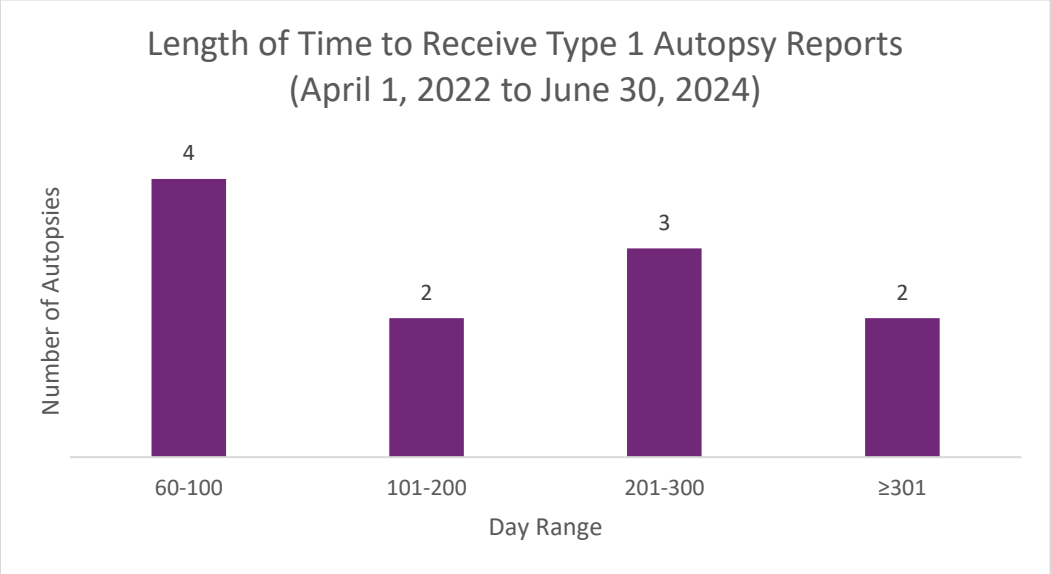
**2.52** The graph below shows number of autopsies ordered by type of autopsy.



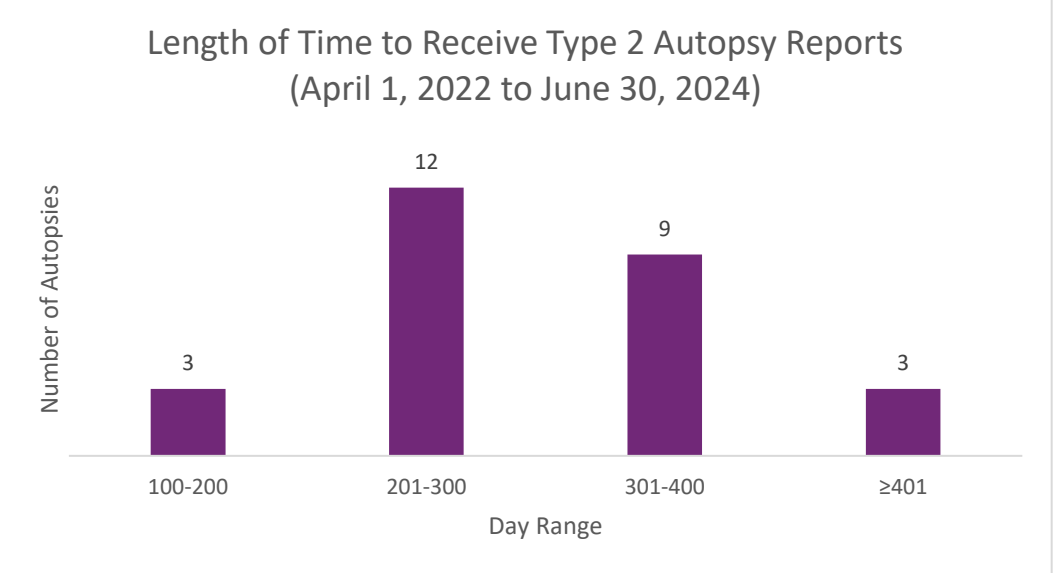

*Source: Prepared by AGNB based on data from the department (unaudited).*

**2.53** A pathologist performs an autopsy within a few days post-mortem. The work is dictated and transcribed into a formal report for Coroner Services. During our audit period, the average length of time to receive the completed report for a type 1 autopsy was 175 days and 304 days for a type 2 autopsy.

**2.54** The following charts represent the length of time to receive written reports for completed type 1 and 2 autopsies, respectively.




*Source: Prepared by AGNB based on data from the department (unaudited).*




*Source: Prepared by AGNB based on data from the department (unaudited).*

**2.55** Coroner Services informed us they began to use services outside the province to complete type 2 autopsies where they can obtain a service standard of 90 days.

**2.56** Of the 27 type 2 autopsies performed, 44% (12) were completed by a general pathologist not certified in forensic pathology as required by the training manual.

**2.57** In one child death investigation file reviewed, the brain had not been sent away for the neuropathology exam ordered by the coroner. The error was discovered a year into the investigation and resulted in the report being received after 418 days.

### Recommendations

**2.58 We recommend the Department of Justice and Public Safety develop service level standards for pathology services with roles and responsibilities and expected turnaround times for completed reports.**

**2.59 We recommend the Department of Justice and Public Safety ensure forensic type 2 autopsies are performed by certified forensic pathologists as per the training manual. If this is no longer deemed practical and/or necessary, the training manual should be updated accordingly.**

## Inconsistencies Found in Application of Policies and Training Manual

**2.60** We noted the department's Pediatric Autopsies Policy does not align with the training manual related to autopsies. As per policy:

- children five years and younger shall have a type 2 autopsy
- children six years and older shall have a type 1 autopsy unless a type 2 is deemed necessary

**2.61** However, the training manual advises a type 2 autopsy for all child deaths under the age of two.

**2.62** We noted:

- 73% (19 of 26) of children aged 5 years and younger had a type 2 autopsy performed
- 70% (19 of 27) of children aged 6 to 18 years had a type 1 or type 2 autopsy performed

**2.63** Additionally, 28% (15 of 53) of child death investigations did not have a type 1 or type 2 autopsy as required by policy.

### Recommendation

**2.64 We recommend the Department of Justice and Public Safety ensure that coroner death investigation policies and training materials are reviewed and updated to ensure clarity and consistent application**.

# Inquests

**2.65** An inquest can be recommended by the coroner assigned to the investigation or by the CDRC.

**2.66** Between April 1, 2022 and June 30, 2024, three child deaths were recommended by the coroner or CDRC to undergo an inquest. Of these three inquests, one had been completed as of the time of our audit.

- inquest #1 – CDRC recommended on June 13, 2022 and completed on November 6, 2023 – November 8, 2023
- inquest #2 – CDRC recommended on February 19, 2023 and completed outside the audit period on November 4, 2024 – November 6, 2024
- inquest # 3 – Coroner declared inquest necessary on June 22, 2022, CDRC recommended July 19, 2022, no inquest held to date

## Clearly Defined Procedures

**2.67** There is a detailed Office of the Chief Coroner Inquest Manual, last updated in 2021. The manual includes procedures on how to hold an inquest, required forms and a checklist outlining what documentation is required to be included in a completed inquest file to ensure proper records management and demonstrate compliance with legislation.

## Inquest Files Missing Required Documents

**2.68** Appendix 1 of the Inquest Manual requires the inquest file to include the material listed on the Inquest File Checklist including documents supporting legislated processes. This file is to be forwarded upon completion to the Chief Coroner.

**2.69** For the one child death inquest held during the audit period, we found a box containing various documents. However, upon review, we noted the following information required by legislation was missing:

- Notification of Inquest which includes a copy of the Coroner's Declaration with grounds as to whether an inquest into a death is necessary
- Coroner's Certificate stating the coroner examined and found each person named in the certificate to be qualified to serve as a juror
- Form of Inquisition that certifies the jury's verdict
- recommendations made by the jury

**Recommendation**

**2.70 We recommend the Department of Justice and Public Safety ensure that inquest files contain all required documentation.**

## Lack of Documentation to Support Rationale for Decisions Made

**2.71** For inquest #3, the coroner made a declaration to hold an inquest. The inquest was not held and the child's death was sent for CDRC review. The Chief Coroner's decision not to hold this inquest prior to CDRC review was not documented.

**2.72** The CDRC subsequently recommended this death for an inquest. The Office of the Chief Coroner Annual Report 2022 stated "*due to an ongoing police investigation, an inquest will not be held at this time*". At the time of our audit, a date was not set to hold the inquest and we have been informed by the Chief Coroner an inquest will not be held by Coroner Services. There was no documentation for the rationale of this decision.

**Recommendation**

**2.73 We recommend the Department of Justice and Public Safety ensure the rationale to hold or not hold an inquest is documented.**

## Timeliness of Inquests can be Improved

**2.74** There are no established timelines for the preparation and conduction of an inquest. However, the Inquest Manual states that it is "*desirable that once the decision has been made to hold an inquest, it be held as soon as possible*".

**2.75** The one child inquest held during the audit period occurred over three-days and was completed 513 days after the recommendation was made. This is a total of 987 days from the date of death to the inquest being held.

**2.76** One child death inquest completed in November 2024 subsequent to our audit period took 935 days from the date of death.

**2.77** While there are various factors that may impact timeliness of holding an inquest, documented expected timelines would assist the department in ensuring timely information.

### Recommendation

**2.78 We recommend the Department of Justice and Public Safety establish timelines for when an inquest has been ordered to when the inquest is held.**

# Child Death Review

## Non-Compliance with Legislation

**2.79** The *Coroners Act* requires that each month, the Chief Coroner shall report to the CDRC all child deaths of which a coroner has been notified and approve the CDRC to conduct a review.

**2.80** The Terms of Reference state, "*upon being notified of a child's death, the Chief Coroner shall request, in writing, the Chair of the CDRC to convene a review*".

**2.81** We were informed that these responsibilities have been delegated to the Chair of the CDRC, the committee's coroner representative. However, the *Coroners Act* does not provide the Chief Coroner authority to delegate these responsibilities.

### Recommendations

**2.82 We recommend the Department of Justice and Public Safety ensure that the Chief Coroner reports monthly all child deaths to the Child Death Review Committee as required by the *Coroners Act*.**

**2.83 We recommend the Department of Justice and Public Safety ensure that the Chief Coroner provides written approval to the Child Death Review Committee to conduct a review as required by the *Coroners Act*.**

**2.84** The *Coroners Act* states that after a child death review has been conducted, the CDRC shall submit a report to the Chief Coroner. However, we determined that the committee only prepares reports if:

- there are recommendations to be made, or
- the child was either in the care of or had family members in contact with the Department of Social Development within 12 months before their death

**2.85** For child deaths reviewed by the CDRC where no report has been written, there are meeting minutes confirming a review took place but there is no documented rationale or explanation why recommendations were not required.

**2.86** During our audit period, the CDRC completed 39 child deaths reviews, however, only produced 26 reports.

### Recommendation

**2.87 We recommend the Department of Justice and Public Safety ensure the Child Death Review Committee prepares a report for each child death reviewed as required by legislation.**

## Lack of Procedures for Child Death Reviews

**2.88** The *Coroners Act* requires the Chief Coroner to establish a CDRC for the following purposes:

a) review the facts and circumstances of child deaths in the province
b) identify and monitor trends and risk factors in child deaths
c) advise the Chief Coroner on medical, legal, social and other matters to improve the safety of children and prevent the occurrence of child deaths
d) determine whether further evaluation of a child death is necessary or desirable in the public interest

**2.89** The CDRC has an established committee Terms of Reference document, however, it does not outline committee member roles and responsibilities.

**2.90** We could also find no evidence of documentation to assist committee members in ensuring consistent application of expected review procedures.

### Recommendations

**2.91 We recommend the Department of Justice and Public Safety ensure that Child Death Review Committee member roles and responsibilities are documented.**

**2.92 We recommend the Department of Justice and Public Safety develop detailed child death review procedures.**

## Child Death Reviews Not Always Timely

**2.93** The *Coroners Act* requires the CDRC to review the facts and circumstances of a child death upon completion of:

- a coroner's death investigation
- an inquest, if required
- a criminal investigation and criminal court proceedings, if required

**2.94** The *Coroners Act* requires the CDRC submit a report to the Chief Coroner within 120 days of commencing their review unless an extension has been granted.

**2.95** Of the 20 CDRC reports we tested, 16 met the legislated requirements. Of the four reports that did not:

- three reports took between 200-300 days
- one report took more than 450 days

**2.96** The committee Terms of Reference has reduced the time to submit the same written report to the Chief Coroner to 45 days from notification. Based on the 45 days, our audit testing for 20 written reports determined:

- only one met the 45-day target
- five reports took between 45 to 99 days
- 12 reports took between 100 to 500 days
- two reports took more than 500 days

## Meetings Not Held Regularly

**2.97** The *Coroners Act* requires the CDRC to meet as often as is necessary for the proper exercise of its duties and functions.

**2.98** We obtained meeting minutes for 13 meetings held by the committee during our audit period.

**2.99** With no appointment of a Vice-Chairperson, CDRC meetings are cancelled if the Chair is unable to attend.

**2.100** We noted there were 32 child deaths (2022 to 2023) recorded in the child death information system that we could find no evidence of a CRDC review.

### Recommendation

**2.101 We recommend the Department of Justice and Public Safety ensure that the Child Death Review Committee meets as often as necessary to meet Terms of Reference and Legislative requirements.**

# Coroner Qualification and Training

## Coroner Personnel Files Missing Key Information

**2.102** There are two types of death investigation systems in Canada: the coroner's system and the medical examiner's system. In New Brunswick, death investigations are completed by coroners. While both systems provide for the investigation of sudden and unexpected deaths, the medical examiner system is science-based and performed by physicians.

**2.103** There are no legislated requirements to be qualified as a coroner in New Brunswick. However, job descriptions as of 2023 specify a coroner must have:

- a background in investigative, legal, medical or emergency services
- a clean criminal record check
- a post-secondary education in a related field
- minimum of five years experience

**2.104** Of the 59 personnel files provided for coroners who worked during the audit period, we noted missing documentation including:

- 24% (14) did not contain a criminal record check
- 19% (11) did not contain a resume that indicated qualifications had been met

**2.105** We also noted one instance of a coroner with no personnel file whatsoever.

### Recommendations

**2.106 We recommend the Department of Justice and Public Safety ensure criminal record checks are obtained for all coroners and retained in personnel files.**

**2.107 We recommend the Department of Justice and Public Safety ensure adequate documentation of coroner qualifications are obtained and retained in all personnel files.**

# Improvements Required in Coroners Training

## No Documented Training Requirements

**2.108** There are no legislated or policy requirements for coroner training. However, we were informed that all coroners are required to complete the following courses through GNB e-learning:

- Orientation and Introduction to Coroner Work
- Initial Investigation Critical Decision Points
- Cause and Manner of Death
- Registration of Death
- Naloxone-Narcan Policy Review
- Respiratory Protection – Fundamental Awareness

### Recommendation

**2.109 We recommend the Department of Justice and Public Safety document the mandatory training requirements in policy for all coroners.**

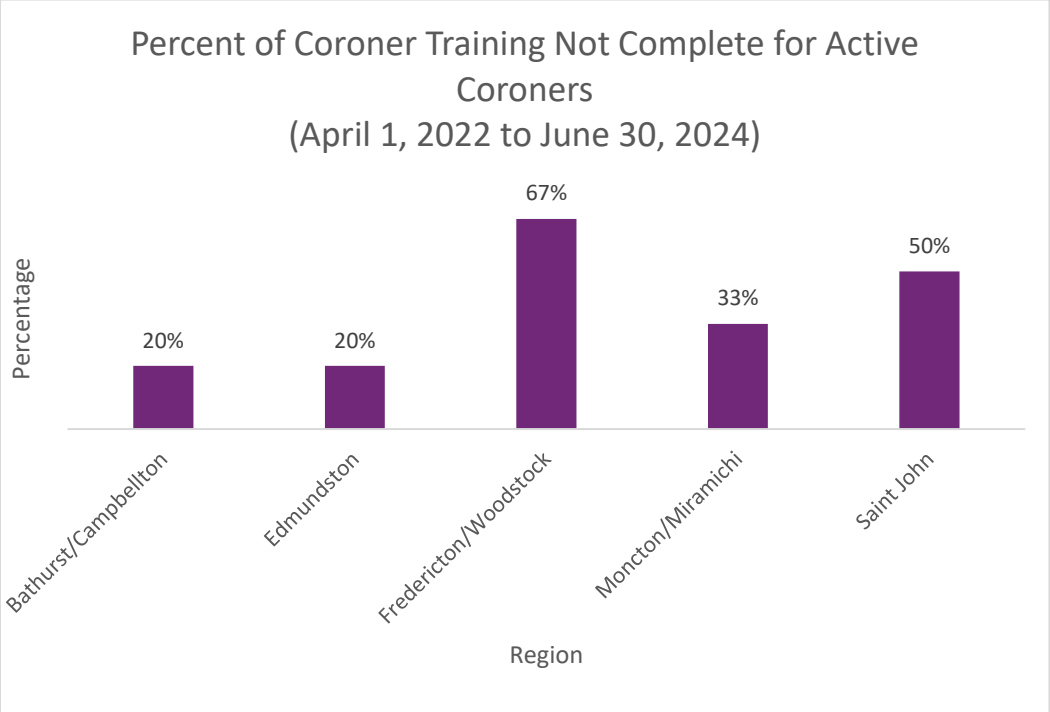
## Coroner Training Not Completed

**2.110** The department does not monitor the completion of the required coroner e-learning courses.

**2.111** As part of our audit, we reviewed e-learning course completion status reports for 41 coroners and determined:

- 34% (14) did not have all the e-learning courses completed
- three community coroners hired during our audit period had been assigned a death investigation case but had not completed the training requirements

**2.112** As per the following graph, the regions with the highest rate of required coroner e-learning training not complete were Fredericton/Woodstock and Saint John.




*Source: Prepared by AGNB based on data from the department (unaudited).*

### Recommendation

**2.113 We recommend the Department of Justice and Public Safety ensure coroners complete all required training before undertaking their first death investigation.**

## Lack of Required Competencies Identified

**2.114** Coroners receive on the job training by means of job-shadowing. There has been no defined duration or required documented competencies before a coroner is ready to conduct death investigations independently.

### Recommendation

**2.115 We recommend the Department of Justice and Public Safety establish clear job-shadowing requirements, specifying the duration and skills required to ensure a structured and effective learning of necessary competencies.**

### New Training Requirements Established

**2.116** As of May 2024, coroners were required by the department to take the following additional courses through the Death Investigation Training Academy:

- Professional Conduct - Skill and Attributes
- Preparedness Mindset for Investigators
- Scene Arrival, Assessment, and Documentation
- Collecting and Documenting Evidence from the Body
- Practical Report Writing
- Implications in Cause, Manner, and Time of Death Rulings
- 12 Critical Mistakes Made at a Death Scene

**2.117** Regional coroners are also required to complete additional courses by November 12, 2024 to gain an American Board of Medicolegal Death Investigators certification. The department informed us the certification will be required training for all regional coroners going forward.

## Performance Appraisals Established

**2.118** The department was able to provide us with documentation detailing adequate performance appraisals for all five regional coroners.

**2.119** Prior to the completion of our audit, there were no formal mechanisms in place to monitor the performance of community coroners. However, the department has informed us they are in the process of implementing a new performance management process that includes the status of file closure standards.

## Opportunity for Improvement in Peer Review Process

**2.120** The department has established a peer review process whereby each coroner's death investigation is reviewed by another coroner prior to completion. All of the 3,844 files reviewed showed evidence of some level of peer review. However, the system reported 24 instances where the assigned coroner was also the reviewer.

**2.121** There is also no documented guidance pertaining to consistent application of the peer review process despite the fact the department has noted the quality and completeness of death investigations as a risk.

### Recommendation

**2.122 We recommend the Department of Justice and Public Safety develop guidance for the peer review process to ensure consistent application and independence.**

## Trends and Risks are Identified and Monitored

**2.123** The *Coroners Act* states it is the purpose of the CDRC to identify and monitor trends and risk factors in child deaths. The CDRC Terms of Reference states the CDRC is to, from time to time, review deaths collectively in an effort to identify trends or gaps in services and programs and to advise the Chief Coroner.

**2.124** The CDRC has identified trends through their reviews which has resulted in recommendations and reports on child unsafe sleeping conditions.

**2.125** A collective analysis using data from the Coroner Death Investigation System was also completed during the audit period to summarize the deaths of youth under the age of 18 for the period of 2013 to 2023.

**2.126** A further risk factor of suicides in youth aged 10-14 years being deemed accidental deaths was investigated in a comprehensive report.

## Reports and Recommendations Not Provided to Departments and Agencies

**2.127** The CDRC was established by the *Coroners Act* for purposes including advising the Chief Coroner on matters to improve the safety and prevent the occurrence of child death as well as determining whether further evaluation of a child death is necessary or desirable in the public interest.

**2.128** From April 1, 2022 to June 30, 2024, the CDRC had completed 39 child death reviews and made 20 recommendations in eight reports.

**2.129** The *Coroners Act* requires the Chief Coroner to provide a copy of the CDRC report, together with the Chief Coroner's comments, if any, in response to the recommendations to any relevant government departments, agencies and the Child, Youth and Senior Advocate.

**2.130** Timely provision of recommendations to relevant organizations is critical in mitigating the risks of similar unnatural deaths. Through the committee Terms of Reference, the department has further committed to providing recommendations to relevant government departments and agencies within ten days of receiving the CDRC's report.

**2.131** Of the 20 recommendations made during our audit period:

- eight were made to the Office of the Chief Coroner
- one was made to the Department of Justice and Public Safety
- 11 were made to external departments and agencies

**2.132** We were informed formal correspondence is not provided to the department when recommendations are made by the CDRC to the Department of Justice and Public Safety or the Office of the Chief Coroner.

**2.133** Three child death reviews resulted in 11 recommendations to various external departments and agencies. However, the department was unable to provide documentation demonstrating they had been provided to the relevant organizations. The following table, summarizes the 11 recommendations and number of days outstanding as of June 30, 2024.

| Department or Agency | Number of Recommendations | Number Days Outstanding |
|---|---|---|
| Minister of Education and Early Childhood Development | 3 | 712 |
| NB Association of Chiefs of Police, NB RCMP | 1 | 13 |
| NB College of Pharmacists | 2 | 13 |
| NB College of Physicians and Surgeons, Nurses Association of NB | 1 | 13 |
| Public Health | 1 | 444 |
| Social Development | 3 | 444 |
| **Grand Total and Average** | **11** | **360** |

**2.134** As part of our audit, we confirmed that the Department of Education and Early Childhood Development, Department of Health (Public Health), and Social Development had not received the reports and recommendations.

**2.135** It is crucial for committee recommendations to be provided to the relevant departments to ensure timely and effective changes are implemented. These recommendations often highlight critical areas needing improvement and provide actionable steps to enhance safety, well-being, and overall outcomes. The following describes the recommendations made in the three CDRC reports that had not been provided to the departments.

**2.136** Child #1 – The Child Death Review Committee report dated July 19, 2022 resulted in three of five recommendations made to external departments and agencies. The Child Death Review Committee recommends:

- *"the Minister of Education and Early Childhood Development ensure that all staff working in schools who have contact with the children undergo the Assist Training. It is recommended that this training be mandatory.*

- *the Minister of Education and Early Childhood Development ensure that all employees in schools be provided with suicide prevention training along with a list of resources they can reach out to if they encounter a child who has suicidal ideations.*

- *the Minister of Education and Early Childhood Development that the school curriculum include education on mental health and the resources available. Education should also have a component on how men, process their mental struggles differently due to cultural difference and gender roles."*

**2.137** Child #2 - The Child Death Review Committee report dated April 13, 2023 resulted in four of six recommendations made to external departments and agencies. The Child Death Review Committee recommends:

- *"Social Development meets with Directors from New Brunswick's Indigenous Nations to create a Structured Decision-Making Model assessment that would be inclusive of the Indigenous population and would consider barriers, needs, intergenerational trauma, strengths, and protective factors specific to the population.*

- *Social Development in cases where a child who is receiving services dies while in the care of their parents, and in cases where parents would have other children in their care, that in addition to consulting the police to inquire if at first glances there is a criminal aspect, would then verify with the coroner following the autopsy that there is no concerns brough to light that could affect the surviving children.*

- *Social Development provides an information session to the Office of the Chief Coroner, more specifically to all Regional Supervising Coroners, on their services and how to contact them if there is a need to make a referral.*

- *Public Health re-evaluate their book series "Loving Care" that is being provided to new parents. Particularly page 70 of their book where they talk about "Safe Places to Sleep". Bed-Sharing should not be included in the book as a safe practice. When bed sharing is mentioned, it should include a discloser that bed sharing increases the risk of sudden infant death syndrome. Public Health should consult the statement released by the*

*Government of Canada. The release is called "Message from the Minister of Health on Canada's Second Annual Safe Sleep Week 2023", released March 13th, 2023. Public Health should re-evaluate their approach to safe sleep based on the information provided in this news release. Safe sleep should be discussed with expecting mother and actively part of the case plan for any mother accessing their services post-birth."*

**2.138** Child #3 – The Child Death Review Committee report dated June 17, 2024 resulted in four recommendations made to external departments and agencies. The Child Death Review Committee recommends:

- *"the New Brunswick College of Pharmacist change their "Practice Directive: Opioid Agonist Treatment (OAT)". Take home doses should be provided in the form of suboxone to make it less attractive to young children and vulnerable people.*

- *the New Brunswick College of Pharmacist include in their "Practice Directive: OAT" that a knowledge sheet should be provided to the patient with information on the risk this medication poses to children and vulnerable people when the patient being treated with an opioid agonist treatment is approved for take home doses.*

- *the College of Physician and the Nurses Association of New Brunswick direct pediatrician and primary care provider to talk about the dangers of prescription medication to infants with their care takers; especially when the infant starts getting mobile.*

- *the New Brunswick Association of Chiefs of Police and the New Brunswick Royal Canadian Mounted Police provide a refresher to their members, in the manner deemed appropriate by their organization, that child deaths should be treated as suspicious. Especially in cases where the cause of death is not evident E.g.: trauma from a car crash as opposed to a death in a residential setting."*

**2.139** The department does not track the recommendations made by the CDRC to ensure they are provided to departments and agencies and responses are received.

### Recommendations

**2.140 We recommend the Department of Justice and Public Safety provide recommendations made by the Child Death Review Committee to relevant departments and agencies in writing and in accordance with the timelines set in the Terms of Reference.**

**2.141 We recommend the Department of Justice and Public Safety track recommendations made by the Child Death Review Committee to ensure completeness of reporting.**

**2.142 We recommend the Department of Justice and Public Safety monitor responses to the recommendations and request updates as required to ensure accountability.**

# Public Reporting

## Public Reporting Incomplete and Not Timely

**2.143** The *Coroners Act* does not require public reporting specifically pertaining to the work of the CDRC. However, the committee Terms of Reference requires recommendations to be made public within 30 days of the Chief Coroner receiving the CDRC report.

**2.144** However, the department informed us that tabling of the Office of the Chief Coroner Annual Report (annual report) in the Legislature is how they publicize the recommendations made by the CDRC.

**2.145** Of the 20 recommendations made during our audit period, only two were made public through the 2022 annual report, 521 days from the date the committee made the two recommendations. We also noted an error in the annual report where a child death review was reported as having no recommendations when the CDRC had provided a recommendation to the Office of the Chief Coroner.

**2.146** The 2023 annual report has yet to be released. As of June 30, 2024, recommendations made by the CDRC are on average 435 days outstanding without having been publicly reported as summarized in the following table:

| Department or Agency | Number of Recommendations Pending Release | Average Number Days Outstanding |
|---|---|---|
| Justice and Public Safety | 1 | 444 |
| Minister of Education and Early Childhood Development | 3 | 712 |
| NB Association of Chiefs of Police, NB RCMP | 1 | 13 |
| NB College of Pharmacists | 2 | 13 |
| NB College of Physicians and Surgeons, Nurses Association of NB | 1 | 13 |
| Office of the Chief Coroner | 6 | 572 |
| Public Health | 1 | 444 |
| Social Development | 3 | 444 |
| **Grand Total and Average** | **18** | **435** |

### Recommendation

**2.147 We recommend the Department of Justice and Public Safety improve transparency of the work of the Child Death Review Committee, and as a minimum, publicly report recommendations made by the Child Death Review Committee within 30 days as stated in the Terms of Reference.**

## Reporting to the Minister and Legislative Assembly Not in Accordance with *Coroners Act*

**2.148** The *Coroners Act* requires CDRC recommendations be provided to the Minister of Public Safety within six months of the Chief Coroner receiving a report which is then to be laid before the Legislative Assembly as soon as possible.

**2.149** Only two of 20 recommendations made during our audit period had been provided to the Minister and subsequently tabled at the Legislature.

**2.150** The two recommendations included in the 2022 annual report were tabled 521 days following the date the committee made the two recommendations.

**Recommendation**

**2.151 We recommend the Department of Justice and Public Safety ensure that recommendations made in Child Death Review Committee reports are provided to the Minister of Public Safety within six months of the Chief Coroner receiving a report and tabled in the Legislature as soon as possible.**

## Inadequate Record Retention

**2.152** GNB employees are responsible to manage information they create or receive in accordance with GNB Information Management Policy AD-7114 and are expected to keep and file records that:

- support business operations
- demonstrate that a business transaction took place
- are required by legislation
- protect the rights of citizens and the government
- provide evidence of compliance with accountability or other business requirements
- have business, financial, legal, historical, or research value to the government or citizens of the Province

**2.153** Records provide evidence of a business activity, decision, or transaction related to the functions and activities of the Government of New Brunswick and should be managed in a records management system that ensures they are readily available to those who need them.

**2.154** The *Archives Act* states a "record" means "*correspondence, memoranda, forms and other papers and books; maps, plans and charts; photographs, prints and drawings; motion picture films, microfilms and video tapes; sound recordings, magnetic tapes, computer cards and other machine-readable records; and all other documentary materials regardless of physical form or characteristics*" that are or have been "*prepared or received by any department pursuant to an Act of the Legislature or in connection with the transaction of public business, preserved or appropriated for preservation by a department, containing information on the organization, functions, procedures, policies or activities of a department, or other information of past, present, or potential value to the Province…*"

**2.155** There were instances the department was unable to provide us with requested documents. Examples included:

- dates when reports from CDRC were submitted to the Chief Coroner
- correspondence on recommendations to departments and agencies
- inquest forms
- coroner and committee personnel files

## Recommendation

**2.156 We recommend the Department of Justice and Public Safety ensure that Coroner Services is managing records in accordance with government policy and legislation.**

# Appendix I: Recommendations and Responses

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.33** | ensure a statement disclosing any actual or potential conflicts of interest is obtained from the qualified person before they are appointed by the Chief Coroner as a member of the Child Death Review Committee. | Agree<br><br>JPS will ensure that all existing members of the Child Death Review Committee have a signed conflict of interest disclosure statement on file by December 2024. Likewise, all potential new appointees to the CDRC will be required to provide a statement disclosing actual or potential conflicts of interest prior to their appointment. | December 2024 |
| **2.37** | ensure that mechanisms are in place to assess and disclose potential conflict of interest for each review started by the Child Death Review Committee. | Agree<br><br>JPS will ensure mechanisms are in place to assess and disclose potential conflicts of interest for each review started by the CDRC. | December 2024 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.41** | ensure the Child Death Review Committee appoint a member of the committee to be the Vice-Chair so that a vacancy on the Child Death Review Committee does not impair the committee's capacity to act. | Agree<br><br>JPS will appoint a Vice-Chair by the end of the 2024 calendar year. Additionally, roles and responsibilities of Committee members will be clarified in accordance with recommendation 2.91. | December 2024 |
| **2.49** | monitor outstanding death investigation case files and ensure timely completion in accordance with service level agreements. | Agree<br><br>The Department of Justice and Public Safety has a Service Level Agreement in place specifying a 30-day standard for completion of death investigations. This standard is used as a Key Performance Indicator for the Department. | Complete |
| **2.58** | develop service level standards for pathology services with roles and responsibilities and expected turnaround times for completed reports. | Agree<br><br>JPS has already begun work in this area. The Coroner Services Branch work plan for 2024-25 includes the development of service level standards for pathology services. Work is expected to be complete by Q4 of 2024-25. | March 31, 2025 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.59** | ensure forensic type 2 autopsies are performed by certified forensic pathologists as per the training manual. If this is no longer deemed practical and/or necessary, the training manual should be updated accordingly. | Agree<br><br>The Department adjusted its process in October 2024 to ensure that all type 2 autopsies will be conducted by certified forensic pathologists. | Complete |
| **2.64** | ensure that coroner death investigation policies and training materials are reviewed and updated to ensure clarity and consistent application. | Agree<br><br>JPS will begin updating its policies and training materials immediately. This will be a key work plan item for Coroner Services the 2025-26 fiscal year. | September 30, 2025 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.70** | ensure that inquest files contain all required documentation. | Agree<br><br>JPS currently retains all required documentation for inquest files, however, some are electronic and some are paper. We agree that one file reviewed was missing a document. Storage and filing standards will be reviewed and improved to ensure that information is accessible and organized. JPS is actively recruiting additional administrative support to support records management for Coroner Services. | December 2024 |
| **2.73** | ensure the rationale to hold or not hold an inquest is documented. | Agree<br><br>The Department of Justice and Public Safety currently tracks and documents rationale on whether to hold or not hold an inquest. This information is found in investigative reports, Coroner's Declaration, and inquest tracking documents. | Complete |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.78** | establish timelines for when an inquest has been ordered to when the inquest is held. | Agree<br><br>JPS will adopt standard timelines based on analysis of the process and comparable systems in other jurisdictions. This review will begin immediately, and standards are expected to be in place by the end of the 2024-25 fiscal year. | March 31, 2025 |
| **2.82** | ensure that the Chief Coroner reports monthly all child deaths to the Child Death Review Committee as required by the *Coroners Act*. | Agree<br><br>As of the date of this response, JPS has implemented a revised process wherein the Chief Coroner reports all child deaths monthly to the CDRC as required by legislation. | Completed November 2024 |
| **2.83** | ensure that the Chief Coroner provides written approval to the Child Death Review Committee to conduct a review as required by the *Coroners Act*. | Agree<br><br>As of the date of this response, JPS has implemented a revised process wherein the Chief Coroner provides written approval to the CDRC to conduct a review as required by legislation. | Completed November 2024 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.87** | ensure the Child Death Review Committee prepares a report for each child death reviewed as required by legislation. | Agree<br><br>JPS will immediately implement a system to ensure the CDRC prepares a report for all child deaths reviewed, as required by legislation. | December 2024 |
| **2.91** | ensure that Child Death Review Committee member roles and responsibilities are documented. | Agree<br><br>JPS will review and enhance the CDRC Terms of Reference, roles and responsibilities beginning immediately and this is expected to be completed by the end of the 2024-25 fiscal year. | March 31, 2025 |
| **2.92** | develop detailed child death review procedures. | Agree<br><br>JPS will review and update existing procedures beginning immediately with expected completion by end of the 2024-25 fiscal year. | March 31, 2025 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.101** | ensure that the Child Death Review Committee meets as often as necessary to meet Terms of Reference and Legislative requirements. | Agree<br><br>JPS acknowledges the discrepancies between the *Coroners Act* and the Committee Terms of Reference and therefore will immediately adjust the Terms of Reference timelines to adhere to legislative requirements. | December 2024 |
| **2.106** | ensure criminal record checks are obtained for all coroners and retained in personnel files. | Agree<br><br>All personnel files will be reviewed and updated by the end of the calendar year to ensure all have valid criminal record checks. | December 2024 |
| **2.107** | ensure adequate documentation of coroner qualifications are obtained and retained in all personnel files. | Agree<br><br>JPS is working to improve records management strategies for Coroner Services and is actively recruiting additional administrative support to support records management. In the interim, all documentation of existing coroner qualifications will be organized in a consistent location by the end of the calendar year. | December 2024 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.109** | document the mandatory training requirements in policy for all coroners. | Agree<br><br>JPS will document mandatory training requirements in policies and procedures as part of a global review. | March 31, 2025 |
| **2.113** | ensure coroners complete all required training before undertaking their first death investigation. | Agree<br><br>JPS will establish and document detailed training requirements for coroners and add to policies and procedures. | March 31, 2025 |
| **2.115** | establish clear job-shadowing requirements, specifying the duration and skills required to ensure a structured and effective learning of necessary competencies. | Agree<br><br>Similar to above, JPS will establish guidelines and add to policies and procedures. | March 31, 2025 |
| **2.122** | develop guidance for the peer review process to ensure consistent application and independence. | Agree<br><br>JPS will begin the development of guidance for the peer review process in 2024 and will incorporate into policies and procedures. | March 31, 2025 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.140** | provide recommendations made by the Child Death Review Committee to relevant departments and agencies in writing and in accordance with the timelines set in the Terms of Reference. | Agree<br><br>JPS will ensure that all CDRC recommendations are provided to relevant departments and agencies in writing within a timeline to be established upon review of CDRC policies and procedures. | March 31, 2025 |
| **2.141** | track recommendations made by the Child Death Review Committee to ensure completeness of reporting. | Agree<br><br>JPS will immediately review practices and adjust as needed to ensure effective documentation and tracking of CDRC recommendations. | December 2024 |
| **2.142** | monitor responses to the recommendations and request updates as required to ensure accountability. | Agree<br><br>While the Department agrees in principle that updates on the implementation of CDRC recommendations would be desirable, it lacks legislative authority to compel other departments to act. | N/A |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.147** | improve transparency of the work of the Child Death Review Committee, and as a minimum, publicly report recommendations made by the Child Death Review Committee within 30 days as stated in the Terms of Reference. | Agree<br><br>JPS notes that the Terms of Reference for the CDRC currently specify a different timeframe for public reporting than the *Coroners Act*. The Department will update the Terms of Reference and other policies and procedures to ensure alignment with the Act and will ensure that Committee recommendations are made public. | March 31, 2025 |
| **2.151** | ensure that recommendations made in Child Death Review Committee reports are provided to the Minister of Public Safety within six months of the Chief Coroner receiving a report and tabled in the Legislature as soon as possible. | Agree<br><br>JPS will immediately take action to ensure that CDRC reports are provided to the Minister of Public Safety within six months as specified in the *Coroners Act*. | December 2024 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Justice and Public Safety:** | | | |
| **2.156** | ensure that Coroner Services is managing records in accordance with government policy and legislation. | Agree<br><br>The Coroner Services Branch is in the process of improving records management processes to ensure a consistent format and location for records. Recruitment is ongoing for an additional administrative support person, and training for Coroner Services staff on records management is planned for March 2025. | March 31, 2025 |

# Appendix II: Audit Objective and Criteria

The objective and criteria for our audit of the Department of Justice and Public Safety are presented below. The Department of Justice and Public Safety and their senior management reviewed and agreed with the objective and associated criteria.

| | |
|---|---|
| **Objective** | **To determine if the Department of Justice and Public Safety has systems and practices in place to ensure the effective completion of child death investigations, inquests, and reviews** |
| Criterion 1 | The Child Death Review Committee is established as per legislation. |
| Criterion 2 | Child death investigations, inquests and death reviews are completed in a timely manner with clearly defined procedures and with adequate documentation to support the rationale for decisions made. |
| Criterion 3 | Coroners have adequate qualifications and are appropriately trained. |
| Criterion 4 | Trends and risks factors in child deaths are identified and monitored to understand how and why children die. |
| Criterion 5 | The Child Death Review Committee is providing recommendations in a timely fashion and are monitoring the impact of those recommendations in order to improve the safety of children and prevent the occurrence of child deaths. |
| Criterion 6 | There are adequate reporting mechanisms in place to ensure transparency of the Child Death Review Committee's work. |

# Appendix III: Independent Assurance Report

This independent assurance report was prepared by the Office of the Auditor General of New Brunswick on the Department of Justice and Public Safety and its child death investigation, inquest and review process. Our responsibility was to provide objective information, advice, and assurance to assist the Legislative Assembly in its scrutiny of the Department of Justice and Public Safety with respect to child death investigation, inquest and review process.

All work in this audit was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook – Assurance.

The Office of the Auditor General of New Brunswick applies the Canadian Standard on Quality Management 1 – Quality Management for Firms That Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements. This standard requires our office to design, implement, and operate a system of quality management, including policies or procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of Chartered Professional Accountants of New Brunswick and the Code of Professional Conduct of the Office of the Auditor General of New Brunswick. Both the Rules of Professional Conduct and the Code are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

In accordance with our regular audit process, we obtained the following from management:

- confirmation of management's responsibility for the subject under audit
- acknowledgement of the suitability of the criteria used in the audit
- confirmation that all known information that has been requested, or that could affect the findings or audit conclusion, has been provided
- confirmation that the findings in this report are factually based

**Period covered by the audit:**

The audit covered the period between April 1, 2022 to June 30, 2024. This is the period to which the audit conclusion applies. However, to gain a more complete understanding of the subject matter of the audit, we also examined certain matters outside of this period as deemed necessary.

**Date of the report:**

We obtained sufficient and appropriate audit evidence on which to base our conclusion on November 27, 2024, in Fredericton, New Brunswick.

AUDITOR GENERAL
OF NEW BRUNSWICK

VÉRIFICATEUR GÉNÉRAL
DU NOUVEAU-BRUNSWICK

December 2024

# Access to Addiction and Mental Health Services

## Department of Health

Volume II – Chapter 3
2024 AGNB Annual Report

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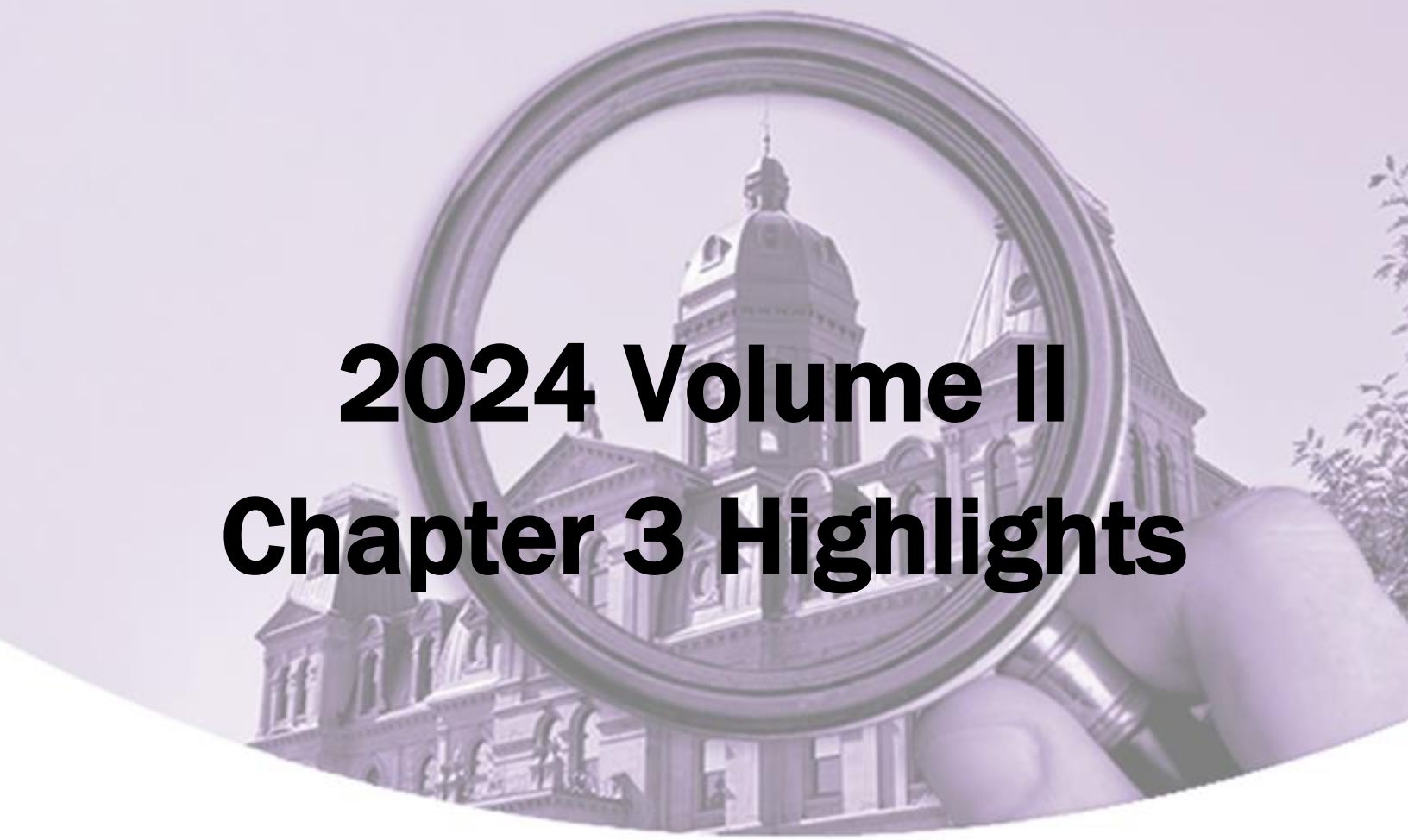


# 2024 Volume II Chapter 3 Highlights

| Wait times exceed established targets | Mental Health Services Advisory Committee inactive | Budgets not based on actual need |
|---|---|---|

## Overall Conclusions

Our audit work concluded that the Department of Health does not have mechanisms in place to ensure timely access to, and adequate reporting on, addiction and mental health services. Overall findings are that the Department of Health has not:

- ensured timely access to addiction and mental health services
- monitored the need or planned resource allocation in accordance with demand for addiction and mental health services
- ensured adequate public reporting on access to addiction and mental health services, including wait times

# Results at a Glance

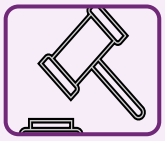
# Access to Addiction and Mental Health Services

**Access to addiction and mental health services is not timely**

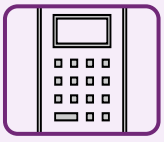
**Findings**

Department of Health **lacks** performance measures pertaining to wait times between referral and assessment

Wait times for treatment **exceed** established Department of Health performance measures



**Non-compliant** with the *Mental Health Services Act*



Budget for addiction and mental health services is **not based on need**

**Incomplete** public reporting on access wait times

# About the Audit

## Introduction to the Audit

**3.1** The Department of Health's Addiction and Mental Health Services branch, in conjunction with the Regional Health Authorities, works closely with other government departments, community organizations, and people with lived experience to deliver addiction and mental health services for New Brunswickers.

**3.2** The *Mental Health Services Act* governs the conduct and coordination of mental health services in New Brunswick. The Minister of Health is responsible for supporting mental health services, pursuant to this Act. The Minister responsible for Addictions and Mental Health Services oversees the Addiction and Mental Health Services branch.

## Why we Chose this Topic

**3.3** Timely access to addiction and mental health services is crucial to improve health outcomes for New Brunswickers.

**3.4** More than one in five New Brunswickers experience an alcohol or drug use disorder in his or her lifetime, and nearly one in ten New Brunswickers use health services for a mood or anxiety disorder each year.

## Auditee

**3.5** Our auditee was the Department of Health.

## Audit Scope

**3.6** We examined the planning, funding, monitoring, and reporting on provincial addiction and mental health services to assess access to these services.

**3.7** The audit covered the period from April 1, 2022 – March 31, 2024. Information outside of this period was collected and examined as deemed necessary. As part of our work, we reviewed relevant policy, legislation, guidelines, and data on addiction and mental health services. Departmental staff were interviewed.

**3.8** More details on the audit objective, criteria, scope, and approach we used in completing our audit can be found in Appendix II and Appendix III.

## Audit Objective

**3.9** Our audit objective was to assess whether the Department of Health has mechanisms in place to ensure timely access to, and adequate reporting on, addiction and mental health services.

## Conclusion

**3.10** Our audit work concluded that the Department of Health does not have mechanisms in place to ensure timely access to, and adequate reporting on, addiction and mental health services. Overall, we found the Department of Health has not:

- ensured timely access to addiction and mental health services
- monitored the need or planned resource allocation in accordance with demand for addiction and mental health services
- ensured adequate public reporting on access to addiction and mental health services, including wait times

# Background

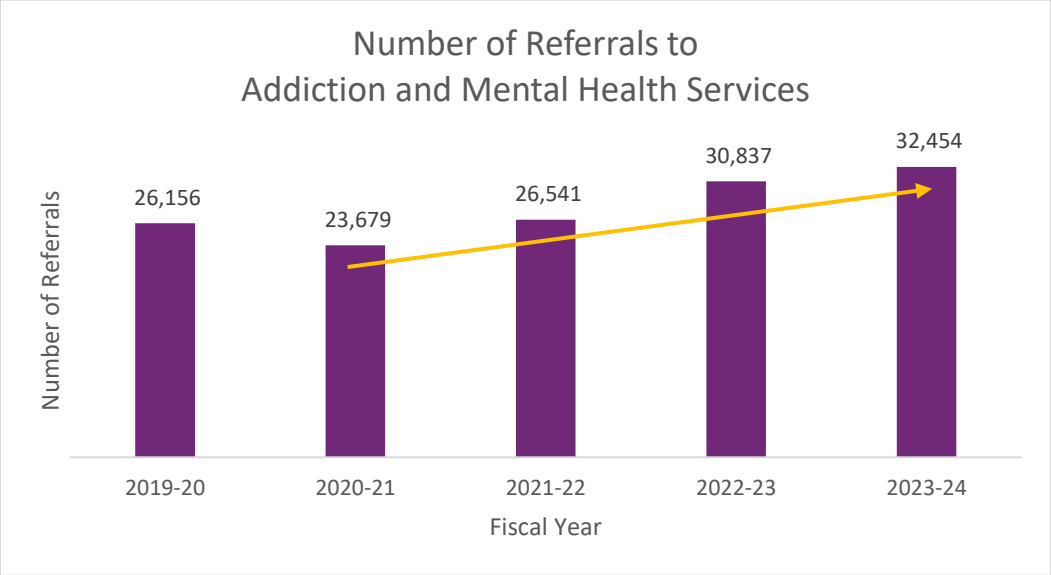
**3.11** The Department of Health (the department) is responsible for the planning, funding, and monitoring of provincial addiction and mental health services (AMHS). The Addiction and Mental Health Services branch oversees the delivery of AMHS throughout the two Regional Health Authorities (RHAs) and across the seven health zones.

**3.12** Delivery of AMHS is governed by the *Mental Health Services Act*, as well as a set of provincial operational guidelines, which give direction to managers, service providers, and others involved in the care and support of individuals with lived experience of addiction and/or mental health issues and their families. These guidelines are expected to promote efficiency and represent a collaborative effort between the RHAs and the department.

**3.13** The *Regional Health Authorities Act* provides for the delivery and administration of health services. Pursuant to this Act, the Minister is responsible for strategic direction, the provincial health plan, and the accountability framework for the provincial health care system.

**3.14** The department's Inter-Departmental Addiction and Mental Health Action Plan states, "*Wait times for new high priority addiction and mental health referrals have been on the rise, with less than 50% of high priority cases receiving treatment within national benchmarks. This coupled with an estimated 51% of New Brunswickers identified as being at risk of developing negative mental health impacts as a result of the unprecedented COVID-19 pandemic suggests that the need for support/service will continue to rise.*"

**3.15** In New Brunswick, over the last five years, more than 20,000 individuals have been referred to AMHS per year and the number has increased steadily. The graph below shows a 37% increase since the start of the COVID-19 pandemic. In 2022-2023 and 2023-2024 there were over 30,000 referrals each year.




*Source: Prepared by AGNB based on data from the department (unaudited).*

**3.16** As of April 12, 2024, 5,019 referrals were waiting for addiction and mental health services.

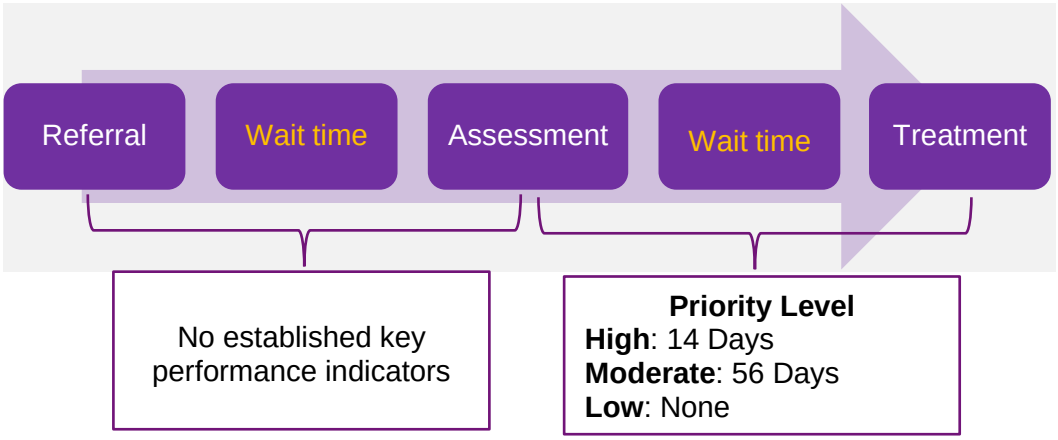
# Performance Measurement Requires Improvement

## No Key Performance Indicators for Referral to Assessment

**3.17** Access to the majority of the department's adult, and child and youth AMHS is delivered in three stages: the referral, the assessment, and treatment. The referral is the initial request for service, and the assessment involves an appointment with the client where a clinician completes a standardized assessment tool to help determine if service is required and the individual's priority level. Treatment is initiated when a referral is opened as a case for higher-intensity ongoing AMHS.

**3.18** The *Regional Health Authorities Act* stipulates that the department is responsible for direction on establishing performance measures.

**3.19** The following table outlines the stages of the addiction and mental health services process and includes key performance indicators (KPIs):




**3.20** No KPIs have been established for expected wait time between referral and assessment. However, the department has established KPIs for the expected wait time between assessment and treatment, which includes:

- high priority: a maximum of 14 days
- moderate priority: a maximum of 56 days

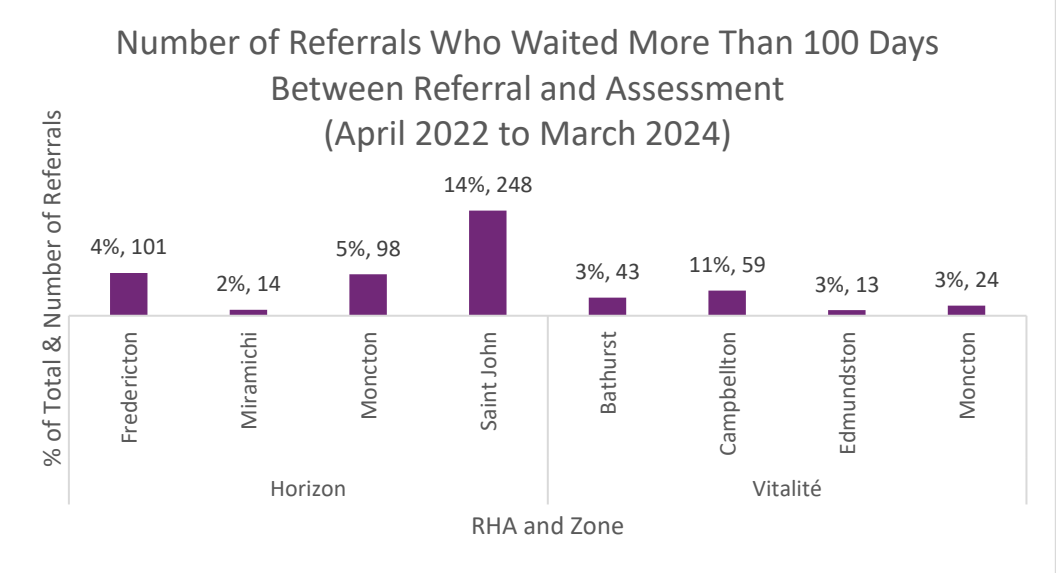
**3.21** The department has defined priority levels for those waiting for treatment as:

- high: unstable with potential to deteriorate quickly
- moderate: displays some adaptability to cope due to protective factors
- low: clients do not meet service provision criteria and are referred elsewhere (no expected wait time from assessment to treatment)

**3.22** Although the department does not have KPIs for wait times between referral and assessment, we examined data for the past two years and found:

- wait times vary between health zones
- 600 waited more than 100 days to be assessed
- of those, 22 waited between 366 and 529 days

**3.23** The following graph shows the percentage and actual number of referrals that waited more than 100 days for an assessment by health zone within each RHA:



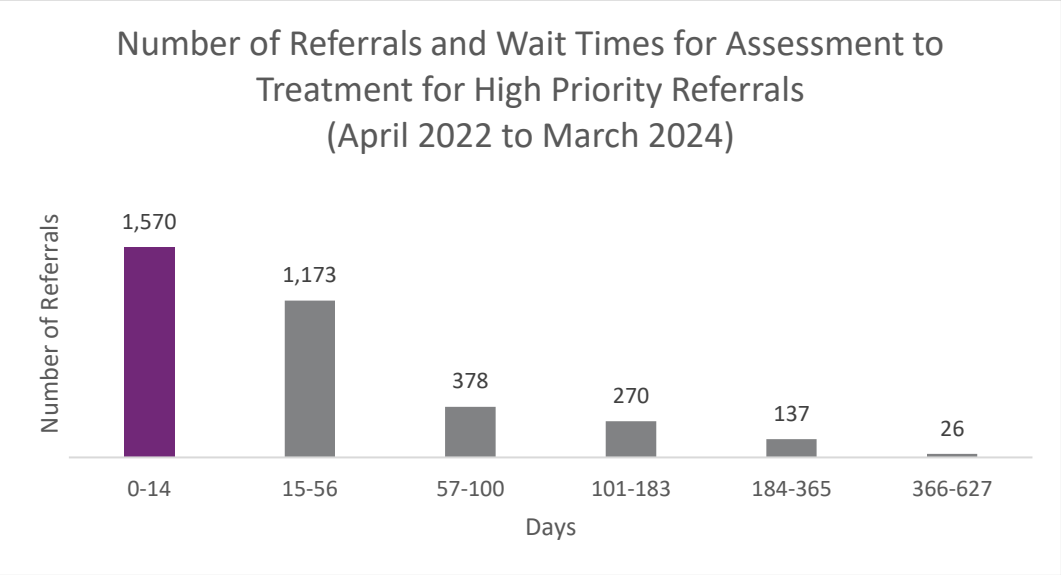

*Source: Prepared by AGNB based on data from the department (unaudited).*

## Recommendation

**3.24 We recommend the Department of Health establish measurable key performance indicators pertaining to the wait time between referral and assessment.**

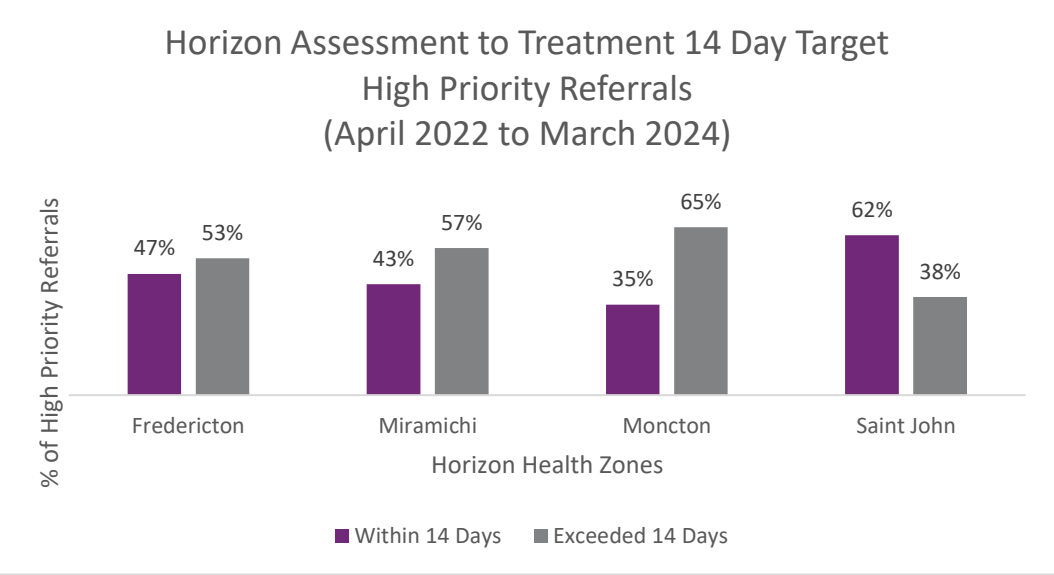
## Wait Times Exceed Department's Established Performance Measures

**3.25** The department's KPI for expected wait time between assessment and treatment for cases that have been defined as high priority is 14 days. Our analysis showed between 2022 and 2024 the KPI was only met 44% of the time. Four hundred and thirty-three people waited more than 100 days, with one individual who waited 627 days. The graph below details the number of referrals and wait times between assessment and treatment.

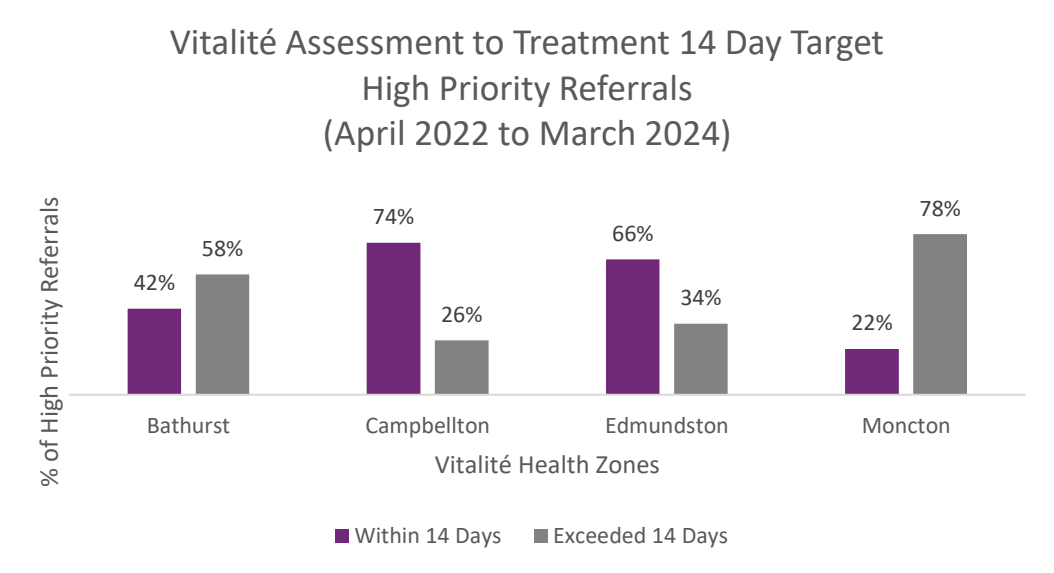



*Source: Prepared by AGNB based on data from the department (unaudited).*

**3.26** The following graphs show the percentage of referrals that met the high priority wait time per health zone within each RHA:

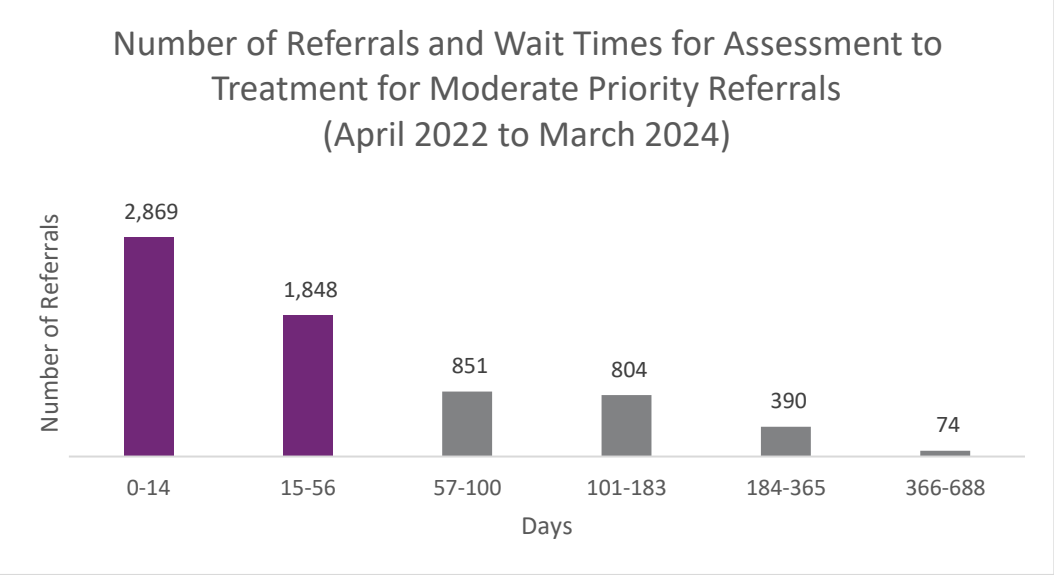



*Source: Prepared by AGNB based on data from the department (unaudited).*



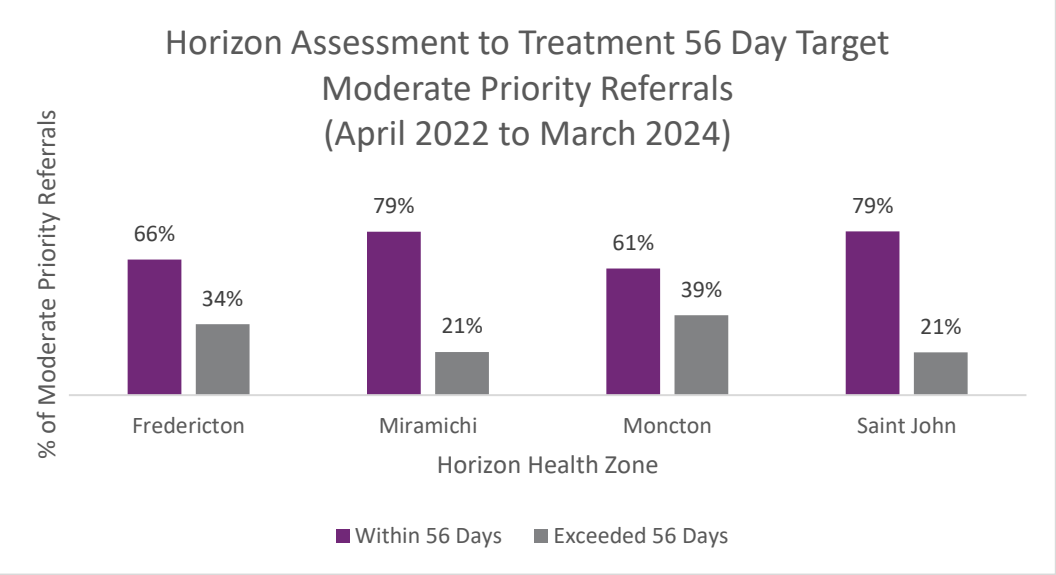

*Source: Prepared by AGNB based on data from the department (unaudited).*

**3.27** The department's KPI for expected wait time between assessment and treatment for referrals that have been defined as moderate priority is 56 days. Our analysis showed between 2022 and 2024 the KPI was met 69% of the time, but 74 referrals waited between 366 - 688 days. The graph below details the number of referrals and wait times between assessment and treatment:

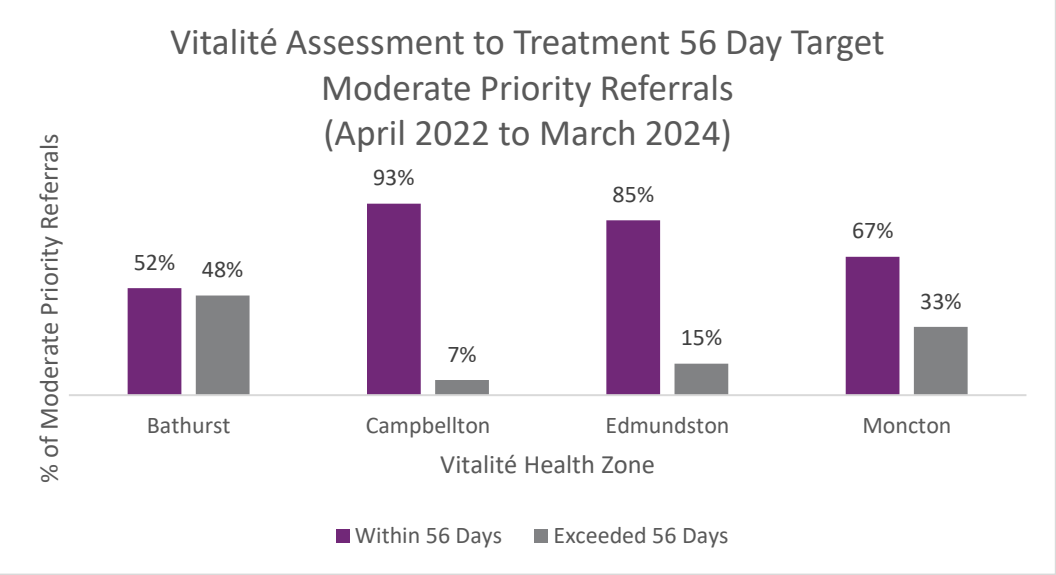



*Source: Prepared by AGNB based on data from the department (unaudited).*

**3.28** The following graphs show the percentage of referrals that met the moderate priority wait time per health zone within each RHA:

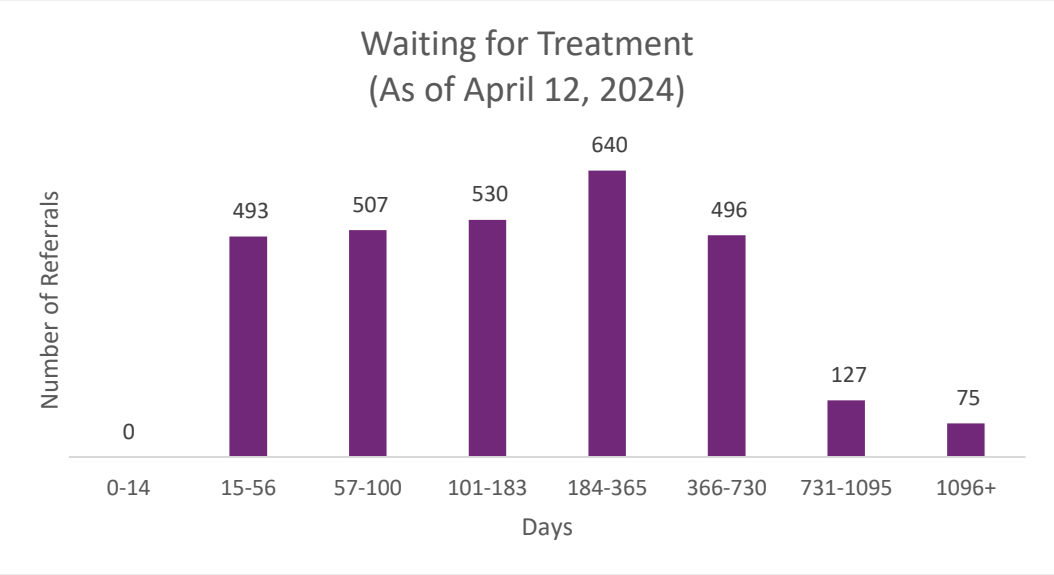



*Source: Prepared by AGNB based on data from the department (unaudited).*




*Source: Prepared by AGNB based on data from the department (unaudited).*

**3.29** As of April 2024, there were 2,868 assessments waiting for treatment. The graph below shows the breakdown of these wait times, including 698 (24%) individuals who have been waiting over one year. Of these, 75 individuals have been waiting over three years.




*Source: Prepared by AGNB based on data from the department (unaudited).*

**3.30** While we were able to analyze wait times from the department's own data, they do not regularly monitor this information to understand where the excessive wait times are. Such analysis would assist the department in understanding where the gaps are and facilitate timely intervention.

## Recommendation

**3.31 We recommend the Department of Health monitor addiction and mental health services wait times to identify and address risks to achieving timely service delivery.**

## Lack of Analysis for Cases Closed Without Treatment

**3.32** Between April 2022 and March 2024, AMHS received a total of 63,291 referrals. Of these, 21,039 (33%) were closed without treatment. The following graph details the number of referrals closed by reason:


*Source: Prepared by AGNB based on data from the department (unaudited).*

**3.33** We examined the three most common reasons for case closure and found high-priority referrals waited an average of 124 days but were closed without treatment. The three most common reasons for closure without treatment represent 69% (14,492) of referrals, as detailed in the table below.

| Referral status reason | % referrals closed without treatment | Average wait time | # high priority | Average wait time high priority |
|---|---|---|---|---|
| Client did not attend | 36% | 42 days | 248 | 124 days |
| Unable to locate client | 19% | 50 days | 152 | 120 days |
| Client withdrew | 14% | 68 days | 196 | 129 days |

*Source: Prepared by AGNB based on data from the department (unaudited).*

### Recommendation

**3.34 We recommend the Department of Health, in collaboration with the Regional Health Authorities:**

- **analyze the data and address the high number of addiction and mental health referrals that are closed without treatment to ensure individuals' needs are being met**
- **continuously monitor the data regarding closed referrals without treatment**
- **address root causes as they arise by Regional Health Authority and/or by health zone**

## Lack of Provincial Training

**3.35** The department does not provide training for AMHS clinicians on the provincial operational guidelines, including the application of the standardized assessment tools and priority level assignment. A lack of comprehensive, mandatory training for staff can result in inconsistent application of the guidelines among clinicians and health zones across the province and can impact the measure of performance outcomes.

### Recommendation

**3.36 We recommend the Department of Health, in collaboration with the Regional Health Authorities, develop and implement mandatory training for the application of provincial operational guidelines for all addiction and mental health services staff.**

# Non-Compliance with the *Mental Health Services Act*

## Mental Health Services Advisory Committee Not Meeting

**3.37** The *Mental Health Services Act* governs certain planning activities, including the establishment of a Mental Health Services Advisory Committee. Section 4 states:

> *There is established an advisory committee called the Mental Health Services Advisory Committee, which shall advise the Minister on:*
>
> *(a) the need, supply and delivery of mental health services,*
>
> *(b) issues respecting mental health and mental health services referred to the Committee by the Minister or instantiated by the Committee, and*
>
> *(c) matters related to the development and improvement of community-based support systems for persons suffering from mental disorders.*

**3.38** Section 6(1) of the *Mental Health Services Act* states, "*the Committee shall meet at least four times in each year.*" Additionally, section 2(c) establishes the committee as the "*coordinating body for government and community agencies dealing with mental disorders and mental health services*" and section 2(e) states this committee is responsible to "*establish, monitor and review standards respecting mental health services*".

**3.39** The Minister of Health is responsible for appointing members to the Mental Health Services Advisory Committee and for overseeing its activities. We found the committee did not meet during our two-year audit period; it last met in June 2018.

**3.40** Therefore, the department is non-compliant with the *Mental Health Services Act*, as this committee has not met in accordance with the meeting schedule (i.e., at least 4 times each year). We also found the department did not assess the risk associated with this non-compliance.

## Recommendation

**3.41 We recommend the Department of Health comply with the *Mental Health Services Act*, including the requirements related to the Mental Health Services Advisory Committee and its meeting schedule and duties.**

# Budgeting and Planning for Addiction and Mental Health Not Based on Need

**3.42** According to New Brunswick's provincial health plan (2021): "*Over the past five years, the demand for addiction and mental health services has increased 16 per cent. Requests from adults are up nine per cent, while youth service needs are up 33 per cent.*"

**3.43** Pursuant to section 5 of the *Regional Health Authorities Act*, the Minister of Health is responsible for strategic direction, and conducting financial and human resource planning for the health system, which includes addiction and mental health services. Furthermore, the department has a duty to assess the need for mental health services in New Brunswick. The Minister of Health shall be advised on these needs, in accordance with section 4 of the *Mental Health Services Act*. Having a monitoring strategy is a key component of both strategic and financial planning.

**3.44** The Department provides the AMHS budget amounts based solely on historical budget amount. The RHAs complete Community Health Needs Assessments, however, the department did not use the assessments in AMHS budget preparation. Without an adequate assessment of needs, the department cannot budget appropriately for the needs of the population.

**3.45** In addition, we found the department is not monitoring the addiction and mental health services budget use within the RHAs. Without this monitoring function, the department cannot ensure funds are being allocated to AMHS resources efficiently.

## Recommendation

**3.46 We recommend the Department of Health, in collaboration with the Regional Health Authorities, develop its base budget for addiction and mental health services based on an updated/current needs assessment of the New Brunswick population.**

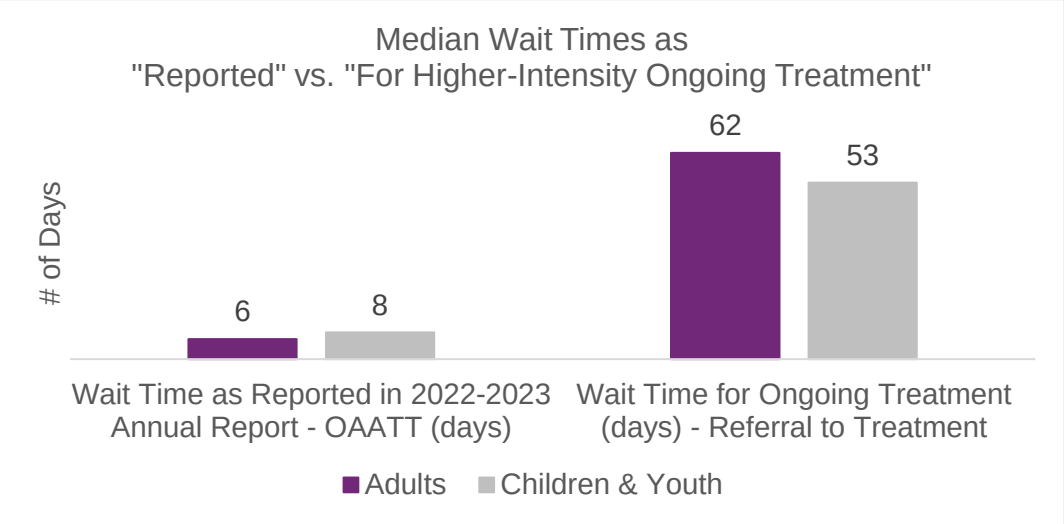
**3.47 We recommend the Department of Health develop a process to monitor addiction and mental health services budget use within the Regional Health Authorities to ensure resources were used as intended.**

# Inadequate Public Reporting

## Incomplete Public Reporting on Access Wait Times

**3.48** In the 2022-2023 Annual Report, we found the department only reported on One-at-a-Time Therapy (OAATT). OAATT is a single session therapy that focuses on the client's strengths and resources. The department did not report on wait times for higher-intensity ongoing treatment. We also reviewed the department's 2021-2022 Annual Report and noted no wait times were reported for AMHS.

**3.49** We compared reported OAATT wait times to overall wait times for higher-intensity ongoing AMHS from the time of referral to treatment in the graph below.




*Source: Prepared by AGNB based on data from the department (unaudited).*

**3.50** As noted in the previous graph, median wait times for higher-intensity ongoing treatment are significantly longer than for OAATT.

**3.51** As stipulated under the government's Administration Manual Policy AD-1605, within its annual report, departments *"…should give a clear account of goals, objectives and performance indicators. The report should show the extent to which a program continues to be relevant, how well the organization performed in achieving its plans and how well a program was accepted by its client groups."*

**3.52** Due to the policy requirement to "*give a clear account of goals, objectives and performance indicators*", we would encourage the department to report on access to AMHS, including wait times.

## Reporting Lacks Links to Impacts and Outcomes

**3.53** As one of its five action areas, the provincial health plan includes *"Access to Addiction and Mental Health Services"*, within which nine deliverables are outlined. The New Brunswick Health Council (NBHC) is tasked with reporting on these deliverables on behalf of the department on a quarterly basis. As of April 1, 2024, NBHC reported eight of these deliverables have been completed.

**3.54** The department, however, has not reported on the impact of completing these deliverables on access to AMHS.

### Recommendation

**3.55 We recommend the Department of Health provide timely public reporting on access to addiction and mental health services, including wait times and the impact of deliverables.**

# Appendix I: Recommendations and Responses

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Health:** | | | |
| **3.24** | establish measurable key performance indicators pertaining to the wait time between referral and assessment. | Agree<br><br>The Department of Health will establish a measurable key performance indicator pertaining to the wait time between the referral and assessments.<br><br>This work will be done in collaboration with the Regional Health Authorities. | Q1 2025-2026 |
| **3.31** | monitor addiction and mental health services wait times to identify and address risks to achieving timely service delivery. | Agree<br><br>The Department of Health will establish a continuous monitoring process for the wait times to identify risks and inform continuous improvements to be implemented by the Regional Health Authorities. | Q2 2025-2026 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Health:** | | | |
| **3.34** | in collaboration with the Regional Health Authorities:<br>• analyze the data and address the high number of addiction and mental health referrals that are closed without treatment to ensure individuals' needs are being met<br>• continuously monitor the data regarding closed referrals without treatment<br>• address root causes as they arise by Regional Health Authority and/or by health zone | Agree<br><br>The Department of Health, in collaboration with the Regional Health Authorities will analyze the data related to the number of in referrals closed without treatment and establish a continuous monitoring process for this data. | Q3 2025-2026 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Health:** | | | |
| **3.36** | in collaboration with the Regional Health Authorities, develop and implement mandatory training for the application of provincial operational guidelines for all addiction and mental health services staff. | Agree<br><br>The Department of Health, in collaboration with the Regional Health Authorities is updating the provincial guidelines. As the guidelines get finalized, the Department of Health will provide the directive to both Regional Health Authorities to ensure mandatory training is provided to staff. | Q1 2026-2027 |
| **3.41** | comply with the *Mental Health Services Act*, including the requirements related to the Mental Health Services Advisory Committee and its meeting schedule and duties. | Agree<br><br>The Departmental of Health will establish the Mental Health Services Advisory Committee as required within the *Mental Health Services Act*. | Q4 2024-2025 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Health:** | | | |
| **3.46** | in collaboration with the Regional Health Authorities, develop its base budget for addiction and mental health services based on an updated/current needs assessment of the New Brunswick population. | Agree<br><br>The Department of Health will assess current base budget for addiction and mental health programs and services as well as service delivered within the RHA's.<br><br>We will establish a process in collaboration with the Regional Health Authorities to identify the needs of the population. | Q1 2026-2027 |
| **3.47** | develop a process to monitor addiction and mental health services budget use within the Regional Health Authorities to ensure resources were used as intended. | Agree<br><br>The Department of Health will establish a process of reporting from the RHA's to the Department of Health to ensure resources are used as intended and focused on meeting the intended outcomes. | Q1 2026-2027 |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Health:** | | | |
| **3.55** | provide timely public reporting on access to addiction and mental health services, including wait times and the impact of deliverables. | Agree<br><br>The Department of Health will work with both Regional Health Authorities on key performance indicators and a process to make public reports accessible including wait times and the impact of deliverables. | Q1 2026-2027 |

# Appendix II: Audit Objective and Criteria

The objective and criteria for our audit of the Department of Health are presented below. The Department of Health and their senior management reviewed and agreed with the objective and associated criteria.

| | |
|---|---|
| **Objective** | **To assess whether the Department of Health has mechanisms in place to ensure timely access to, and adequate reporting on, addiction and mental health services.** |
| Criterion 1 | The Department of Health should ensure timely access to addiction and mental health services. |
| Criterion 2 | The Department of Health should monitor the need for addiction and mental health services and plan resource allocation in accordance with demand. |
| Criterion 3 | The Department of Health should ensure adequate public reporting on access to addiction and mental health services, including wait times. |

# Appendix III: Independent Assurance Report

This independent assurance report was prepared by the Office of the Auditor General of New Brunswick on the Department of Health and its access to addiction and mental health services. Our responsibility was to provide objective information, advice, and assurance to assist the Legislative Assembly in its scrutiny of the Department of Health with respect to addiction and mental health services.

All work in this audit was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook – Assurance.

The Office of the Auditor General of New Brunswick applies the Canadian Standard on Quality Management 1 – Quality Management for Firms That Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements. This standard requires our office to design, implement, and operate a system of quality management, including policies or procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of Chartered Professional Accountants of New Brunswick and the Code of Professional Conduct of the Office of the Auditor General of New Brunswick. Both the Rules of Professional Conduct and the Code are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

In accordance with our regular audit process, we obtained the following from management:

- confirmation of management's responsibility for the subject under audit
- acknowledgement of the suitability of the criteria used in the audit
- confirmation that all known information that has been requested, or that could affect the findings or audit conclusion, has been provided
- confirmation that the findings in this report are factually based

**Period covered by the audit:**

The audit covered the period between April 1, 2022, to March 31, 2024. This is the period to which the audit conclusion applies. However, to gain a more complete understanding of the subject matter of the audit, we also examined certain matters outside of this period as deemed necessary.

**Date of the report:**

We obtained sufficient and appropriate audit evidence on which to base our conclusion on November 27, 2024, in Fredericton, New Brunswick.

AUDITOR GENERAL
OF NEW BRUNSWICK

VÉRIFICATEUR GÉNÉRAL
DU NOUVEAU-BRUNSWICK

December 2024

# Hotel Accommodations Policy

## Department of Finance and Treasury Board

Volume II – Chapter 4
2024 AGNB Annual Report

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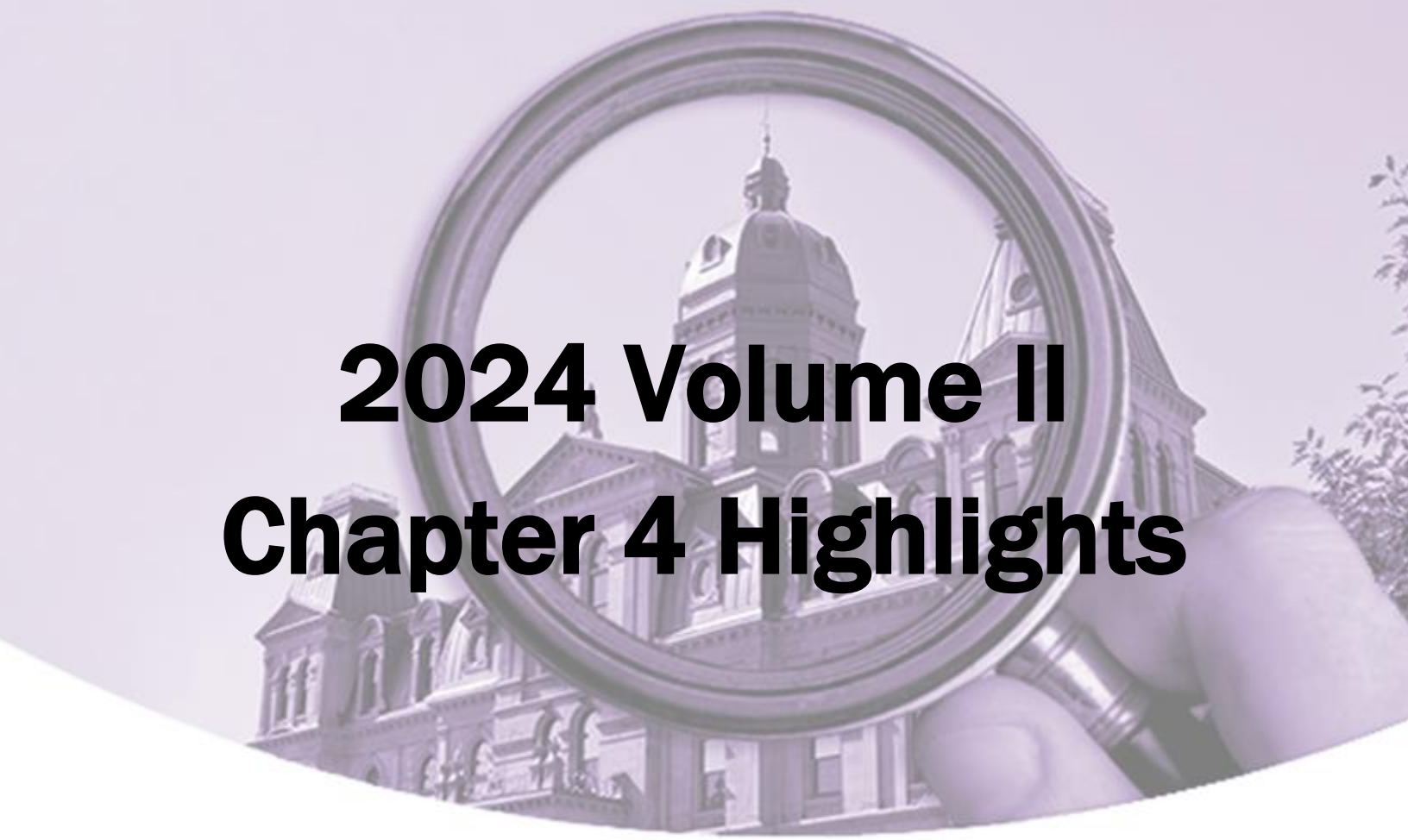


# 2024 Volume II Chapter 4 Highlights

| | | |
|---|---|---|
| **No analysis was performed of estimated costs related to travel policy change** | **Lack of Treasury Board approval for policy change** | **Current employee travel policy is unclear and potentially misleading** |
| **Potential savings of $632,169 annually if Government of Canada's Accommodations Directory Program rates were used** | | |

## Overall Conclusions

Our audit work concluded that the Department of Finance and Treasury Board's travel policy on employee hotel expenses does not reflect prudent fiscal management. Overall findings are as follows:

- no business case including quantitative and qualitative analysis was prepared to support the decision to cease participation in Government of Canada's Accommodations Directory Program
- there were potential annual savings of $632,169 that could have been achieved through use of the Government of Canada's accommodation rates
- current hotel travel policy could mislead employees to continue using government hotel rates for which they are not eligible

# Results at a Glance

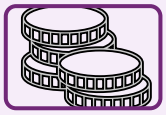
# Hotel Accommodations Policy

## Insufficient Analysis for Policy Change

## Findings

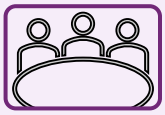
**Lack** of documented business case for policy decision to cease participation in the Government of Canada's Accommodations Directory program

Analysis supporting policy change **did not** adequately consider quantitative and qualitative factors



**No** analysis was performed of potential savings or increased costs

**$632,169 annually** in estimated forgone savings



**Lack** of Treasury Board approval for policy change

**24%** of hotel stays tested had a lower federal directory rate for the same hotel as was used by a Government of New Brunswick employee

Current employee travel policy guidance to seek government rates is unclear and potentially misleading

# About the Audit

## Introduction to the Audit

**4.1** The Department of Finance and Treasury Board is responsible for policy planning and development and is mandated to provide the strategic direction for the prudent fiscal management of the Government of New Brunswick.

**4.2** Government Policy AD-2801 provides guidance on hotel accommodation expenses and states that "*employees booking a hotel room are responsible for seeking government employee rates, or any special discounted rates, whichever is lower… Booking a hotel room above the normal standard room or government rate requires prior approval and justification.*"

**4.3** The policy applies to:

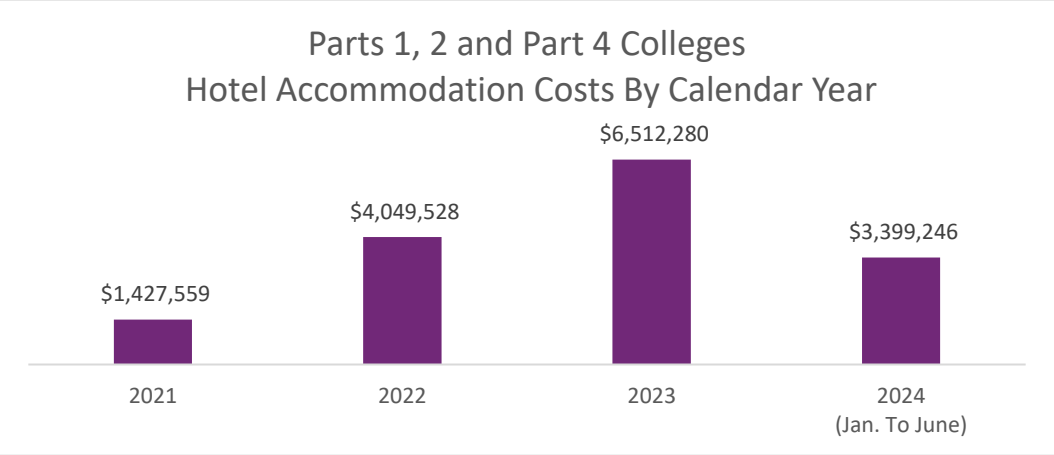
- management and non-union employees of Parts 1, 2, and 3 of public service
- unionized employees of Parts 1, 2, and 3 of public service except as may be otherwise provided by collective agreements
- individuals employed on a personal service contract
- individuals employed on a casual/temporary basis

**4.4** Under the *Financial Administration Act*, Treasury Board may "*determine and regulate the payments that may be made to persons employed in the public service by way of reimbursement of travelling or other expenses...*"

**4.5** We also found that travel policies for the New Brunswick Community College (NBCC) and Collège Communautaire du Nouveau-Brunswick (CCNB) both refer to the Government of Canada's accommodations directory.

## Why we Chose this Topic

**4.6** Hotel accommodation expenses for Part 1 and 2 of public service (and the community colleges from Part 4) were as follows:




*Source: Prepared by AGNB based on travel claim data (unaudited).*

**4.7** Part 3 hotel accommodation costs were not readily available, however, assuming hotels were similar portions of total travel as Parts 1 and 2 (and the community colleges from Part 4), we estimate that costs for Part 3 are as follows:


*Source: Prepared by AGNB based on travel claim data (unaudited).*

**4.8** Following a reduction in travel expenses during the COVID-19 pandemic, government employee travel has been increasing. Hotel costs have increased since the pandemic, and we felt it important to review the business case behind a significant policy change related to government hotel travel.

## Auditee

**4.9** Our auditee was the Department of Finance and Treasury Board (the department). We also obtained audit evidence from various other departments, school districts and crown corporations relating to travel claim testing.

## Audit Scope

**4.10** We examined the department's role in policy planning and development as it relates to employee hotel accommodations expenses.

**4.11** The audit covered the period from January 1, 2023, to June 30, 2024. Information outside of this period was also collected and examined as deemed necessary. As part of our work, we reviewed employee travel claims, relevant policy, legislation, contracts, guidance on policy interpretation and support for policy changes.

**4.12** More details on the audit objective, criteria, scope, and approach we used in completing our audit can be found in Appendix II and Appendix III.

## Audit Objective

**4.13** Our audit objective was to assess whether the Department of Finance and Treasury Board's travel policy is reflective of prudent fiscal management as it relates to employee related hotel expenses.

## Conclusion

**4.14** Our audit work concluded that the Department of Finance and Treasury Board's travel policy on employee hotel expenses does not reflect prudent fiscal management.

# Background

**4.15** Prior to January 1, 2023, the Government of New Brunswick (GNB) participated in the Government of Canada's Accommodation Directory Program (GCADP), which granted access to federally negotiated accommodations rates at numerous hotels worldwide.

**4.16** GCADP is based on a series of supply arrangements between the Government of Canada and suppliers of accommodations, through which discounted nightly rates are offered to identified users of GCADP when travelling on official government business. Each year the Government of Canada solicits these arrangements from accommodations properties in the form of daily rates.

**4.17** Each participating hotel offers distinct daily rates that can be searched in an online directory available to identified users or in some cases accessed directly on hotels' websites.

**4.18** Public Services and Procurement Canada (PSPC) oversees GCADP and has mechanisms for taking corrective action in cases of overcharges and sub-par accommodations quality through their GCADP contract management division. Suppliers are required to provide accommodations that are safe, clean and comfortable at the government rate offered in the directory.

**4.19** Identified users include departments, boards and agencies of the Government of Canada. Provincial and territorial governments that pay an annual participation fee are also considered identified users.

**4.20** The cost of participation in GCADP for the 2022 calendar year was $14,850.

**4.21** GNB ceased participation in GCADP effective January 1, 2023.

**4.22** The expenses for the 10 departments with the highest hotel accommodation spend between January 1, 2024 and June 30, 2024 are as noted below:


*Source: Prepared by AGNB based on travel claim data (unaudited).*

## Inadequate Analysis for Policy Change

**4.23** Despite the fact GNB ceased participation in the federal hotel directory program effective January 1, 2023, the department did not update Policy AD-2801 to remove references and links to the hotel directory until May 2023.

**4.24** Prior to this change, the policy noted that:

- it was an employee responsibility to "*[use] the government's designated online tools when required such as [the] Accommodation Directory*"
- negotiated rates in the directory were linked to in the policy and were to be used by employees on official government business travel
- hotel charges that exceeded negotiated rates for hotels listed in the directory required justification for the overage
- hotel charges at hotels not listed in the directory required justification and prior approval, and reimbursement could not exceed the maximum negotiated rates for the area

- employees were required to always request the government rate

**4.25** The updated policy now states that, "*employees booking a hotel room are responsible for seeking government employee rates, or any special discounted rates, whichever is lower…Booking a hotel room above the normal standard room or government rate requires prior approval and justification.*"

**4.26** We inquired with the department regarding what analysis was performed to support leaving GCADP and the associated policy change.

## Quantitative Analysis

**4.27** There was no documented analysis to support the decision to cease participation in the federal hotel directory program. The department informed us that, "*a review of the $14,850 subscription for participation in the Government of Canada accommodation directory revealed that it did not meet the expected value, leading to the decision not to proceed with payment,*" and that "*the return on investment was deemed insufficient due to the lack of demonstrated evidence of cost savings or measurable benefits.*" There was no business case detailing anticipated cost savings or increased expenditures.

**4.28** The department informed us they reviewed activity on the GNB Travelling for Work Intranet page and noted that there was no activity on GNB's link to the electronic hotel directory, or on the click-through to the federal page between January 2019 and March 2022.

**4.29** This analysis, however, would not have accounted for the directory and/or government rates being accessed via other means such as through a search engine or hotel website.

**4.30** The department did not review actual hotel expenditures to determine the extent to which employees were utilizing government rates as per the directory. They did not perform a quantitative analysis of whether savings had been achieved by using GCADP, nor has one been performed subsequently to determine if expenditures have increased.

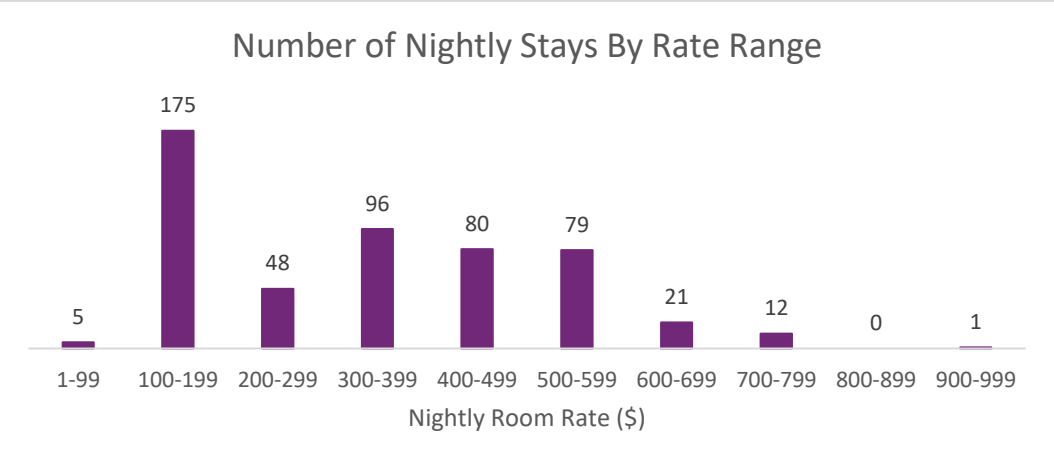
### Hotel Rate Testing

**4.31** To determine the financial impact of the decision to cease participation in GCADP, we performed testing of hotel expenses in GNB employee travel claims from January 1, 2024 to June 30, 2024, comparing these claims to rates in the directory at the same or nearby hotels. From this period, we tested a random sample of 140 travel claim reimbursements for hotel costs and also examined the 60 highest hotel claim reimbursements in Parts 1 and 2.

**4.32** Our analysis showed potential annual savings of $479,484 per year in Parts 1 and 2 and the colleges – equating to approximately 32 times the 2022 cost of participation in GCADP of $14,850.

**4.33** Only two account codes are used for all travel costs in Part 3 (travel in province and travel out of province), therefore, actual costs are not readily available for hotel accommodations only. If similar trends occurred in Part 3, as were observed in Parts 1 and 2 and the colleges, we estimate savings could be an additional $152,685 annually.

**4.34** For context, we noted that 113 nights in our sample had a cost of $500 or more per night. An overview of nightly room rates we observed can be seen below:




*Source: Prepared by AGNB based on travel claim data.*

**4.35** Some items of note observed in our testing were:

- 7 employees attended a conference in Barcelona for 4-6 nights at a total accommodation cost of $19,346 with foregone savings of $7,304. This trip included one employee expensing accommodations at $997 for one night.
- An employee stayed at a Disney World Resort for 5 nights at $414 per night, when nearby hotels had nightly GCADP rates of $209 available, for forgone savings of $1,025.
- 4 employees stayed 5 nights in Phoenix, Arizona at an average nightly rate of $567, when nearby hotels had GCADP rates of $168, for total forgone savings of $6,665. $2,357 of these savings related to one employee.
- 8 employees attended the same conference in Toronto, staying at 3 different hotels. Two of these hotels had GCADP rates available of $209 and $309 per night, respectively, while the 7 employees staying in these hotels all paid different nightly rates, ranging from $260 to $719 per night. Total forgone savings for this trip were $10,281.

## Qualitative Analysis

**4.36** The department's analysis to cease participation in the federal program did not consider qualitative benefits of the directory.

**4.37** As GCADP represents a series of contracts between the federal government and service providers, participation entitles identified users to the negotiated rates, meaning users are able to claim a refund in the event that they are overcharged.

**4.38** The directory preface notes that should an establishment refuse to give the government rate to an employee of an identified user, they may contact GCADP management for assistance.

**4.39** 24% of the items tested in our sample had a lower GCADP rate for the same hotel as was used by a GNB employee – rates that would be guaranteed through GCADP.

**4.40** Participation in GCADP offers the qualitative benefit of ensuring that all employees receive a reduced rate that is consistent each night and for each employee, and that recourse is available if they are overcharged. Such benefits were not considered in the department's analysis supporting withdrawal from GCADP.

### Recommendation

**4.41 We recommend the Department of Finance and Treasury Board evaluate its decision to cease participation in the federal hotel directory program and to prepare documented business cases, including comprehensive quantitative and qualitative analysis, to support its decision.**

# Lack of Treasury Board Approval

**4.42** Policy AD-1101 section 6.2 states, "*Treasury Board (the Committee) is responsible for authorizing additions to the AMS (Administrative Manual System) or changes to current ADs that are of a financial, personnel or administrative nature.*"

**4.43** We requested the board of management minute detailing approval and were informed that the amendment was not taken to Treasury Board for approval.

### Recommendation

**4.44 We recommend the Department of Finance and Treasury Board ensure that policy changes of a financial, personnel or administrative nature are approved by Treasury Board (Board of Management).**

## Lack of Clarity in Policy and Guidance

**4.45** Despite no longer participating in GCADP, Policy AD-2801 still instructs employees to seek government rates.

**4.46** The department indicated that participation in GCADP was not a prerequisite for booking a government rate, and that this supported the decision to cease participation, as "*using the lowest rate available, regardless of whether it is a government rate, provides better value for government.*"

**4.47** Some rates listed as government rates available directly through a hotel's website are in fact GCADP rates, for which GNB employees are no longer eligible.

**4.48** We found that by making it the employee's responsibility to continue to seek government rates with no clarification on what government rates GNB employees are eligible to use, the amended policy lacks clarity and could be misinterpreted as guidance to continue to use GCADP rates.

**4.49** We also found through our testing that it is often not clear on a travel claim or hotel invoice whether a government rate was applied. As such there is no way for an expense approver to verify that a government or discounted rate was applied, and which discount type was used.

### Recommendation

**4.50 We recommend the Department of Finance and Treasury Board ensure that policy and guidance related to hotels clearly outline employee responsibilities as they relate to hotel travel expenses.**

# Appendix I: Recommendations and Responses

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Finance and Treasury Board:** | | | |
| **4.41** | evaluate its decision to cease participation in the federal hotel directory program and to prepare documented business cases, including comprehensive quantitative and qualitative analysis, to support its decision. | Agree<br><br>The Department of Finance and Treasury Board will identify and assess opportunities to strengthen its travel policies and directives, including consideration of the federal directory program. | March 31, 2025 |
| **4.44** | ensure that policy changes of a financial, personnel or administrative nature are approved by Treasury Board (Board of Management). | Agree<br><br>The Department of Finance and Treasury Board will ensure that policy changes of a financial, personnel or administrative nature are submitted to Treasury Board either for approval or as information items, as required by policy AD-1101. | Immediately |

| Par. # | Recommendation | Department's Response | Target Implementation Date |
|---|---|---|---|
| **We recommend the Department of Finance and Treasury Board:** | | | |
| **4.50** | ensure that policy and guidance related to hotels clearly outline employee responsibilities as they relate to hotel travel expenses. | Agree<br><br>The Department of Finance and Treasury Board will review the policy and guidance related to hotels, identify opportunities to further clarify employee responsibilities and enhance approval processes. Additionally, the Department of Finance and Treasury Board will work with other departments to increase employee awareness of their responsibilities under the policy and that adherence is appropriately enforced. | March 31, 2025 |

# Appendix II: Audit Objective and Criteria

The objective and criteria for our audit of the Department of Finance and Treasury Board are presented below. The Department of Finance and Treasury Board and their senior management reviewed and agreed with the objective and associated criteria.

| | |
|---|---|
| **Objective** | **To assess whether the Department of Finance and Treasury Board's travel policy is reflective of prudent fiscal management as it relates to employee related hotel expenses.** |
| Criterion 1 | Employee hotel expense directives and/or policy should be based on sound quantitative and qualitative analysis. |
| Criterion 2 | Requirements and guidance pertaining to employee hotel expenses should be clearly documented in policy. |

# Appendix III: Independent Assurance Report

This independent assurance report was prepared by the Office of the Auditor General of New Brunswick on the Department of Finance and Treasury Board and its Travel Expense Policy (AD-2801) as it relates to hotel accommodations. Our responsibility was to provide objective information, advice, and assurance to assist the Legislative Assembly in its scrutiny of the Department of Finance and Treasury Board with respect to its policy on hotel accommodations.

All work in this audit was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook – Assurance.

The Office of the Auditor General of New Brunswick applies the Canadian Standard on Quality Management 1 – Quality Management for Firms That Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements. This standard requires our office to design, implement, and operate a system of quality management, including policies or procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of Chartered Professional Accountants of New Brunswick and the Code of Professional Conduct of the Office of the Auditor General of New Brunswick. Both the Rules of Professional Conduct and the Code are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

In accordance with our regular audit process, we obtained the following from management:

- confirmation of management's responsibility for the subject under audit
- acknowledgement of the suitability of the criteria used in the audit
- confirmation that all known information that has been requested, or that could affect the findings or audit conclusion, has been provided
- confirmation that the findings in this report are factually based

**Period covered by the audit:**

The audit covered the period between January 1, 2023, to June 30, 2024. This is the period to which the audit conclusion applies. However, to gain a more complete understanding of the subject matter of the audit, we also examined certain matters outside of this period as deemed necessary.

**Date of the report:**

We obtained sufficient and appropriate audit evidence on which to base our conclusion on November 27, 2024, in Fredericton, New Brunswick.

AUDITOR GENERAL
OF NEW BRUNSWICK

VÉRIFICATEUR GÉNÉRAL
DU NOUVEAU-BRUNSWICK

December 2024

# Status Report on Implementation of Performance Audit Recommendations

Volume II – Chapter 5
2024 AGNB Annual Report

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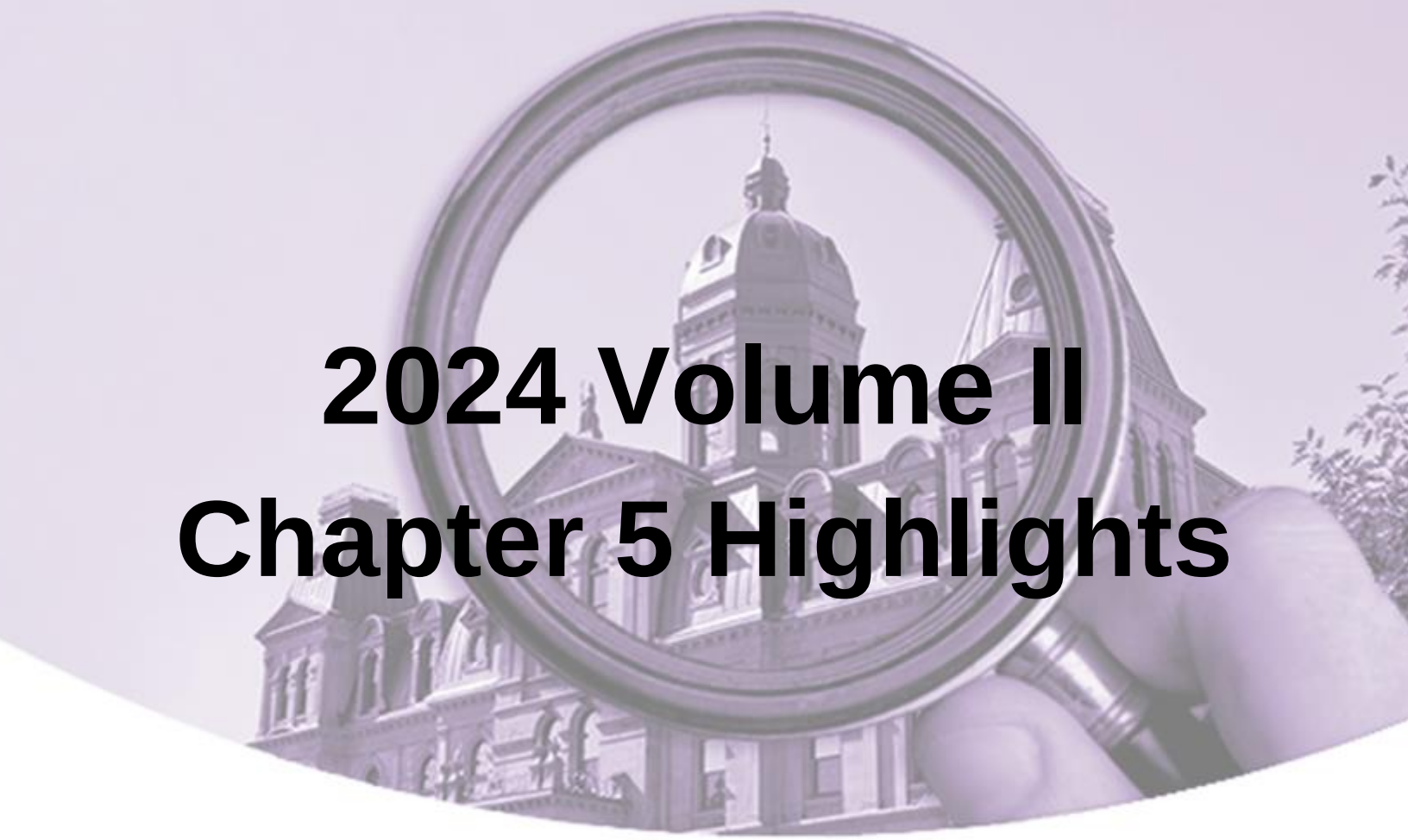


# 2024 Volume II Chapter 5 Highlights

This chapter is a tool for the Public Accounts Committee (PAC) and the public to hold government departments, commissions and crown agencies accountable for the implementation of prior performance audit recommendations.

| 2020 audits | 2021 audits | 2022 audits |
|---|---|---|
| 57% implementation | 100% implementation | 71% implementation |
| **Public Accounts Committee should hold departments accountable for the implementation of our recommendations** | | |

# Results at a Glance

## % of Recommendations Implemented

| Year | Chapter Title \| Total Number of Recommendations \| | % of Recommendations Implemented |
|---|---|---|
| 2020 | Timber Royalties - Department of Natural Resources and Energy Development \|8\| | 100% |
| | School Infrastructure Planning - Department of Education and Early Childhood Development and School Districts\|14\| | 86% |
| | Electronic Medical Record Program - Department of Health \|7\| | 86% |
| | Auditor General's Access to Vestcor Significantly Limited \|5\| | 40% |
| | Update on Nursing Home Planning and Aging Strategy - Department of Social Development \|6\| | 33% |
| | Ambulance Services - Department of Health & EM/ANB Inc. \|21\| | 29% |
| | NB Power Debt Challenges \| 2 \| | 0% |

| Year | Chapter Title \| Total Number of Recommendations \| | % of Recommendations Implemented |
|---|---|---|
| 2021 | Risks Exist to Govt Oversight of Crown Agencies - Executive Council Office \|5\| | 100% |
| | Covid-19 Funding - NB Workers' Income Emergency Benefit - Department of Post-Secondary Education, Training and Labour \|15\| | 100% |
| | Funding for Rural Internet - Regional Development Corporation and Opportunities New Brunswick \|13\| | 100% |
| | Crown Agency Salaries and Benefits \|2\| | 100% |
| | Residential Energy Efficiency Programs - Department of Natural Resources and Energy Development, NB Power \|7\| | 100% |

| Year | Chapter Title \| Total Number of Recommendations \| | % of Recommendations Implemented |
|---|---|---|
| 2022 | Liquor Industry Development in New Brunswick - New Brunswick Liquor Corporation \|19\| | 89% |
| | Contaminated Sites - Department of Environment and Local Government \|17\| | 76% |
| | Environmental Trust Fund - Department of Environment and Local Government \|9\| | 67% |
| | Oversight of the Employee Health and Dental Benefit Plan - Department of Finance and Treasury Board \|14\| | 43% |

# Background

## Follow-Up Work Process

**5.1** This follow-up chapter reports on implementation of recommendations from our 2020 – 2022 performance audit reports.

**5.2** We do not provide an update in the year following the initial publication of our performance audit reports as we allow departments, commissions, and crown agencies the opportunity to act on our recommendations.

**5.3** In years two to four we obtain confirmation from management on the level of implementation.

**5.4** In year four, additional work may be conducted on some high-risk areas to ensure implementation aligns with our office's expectations.

**5.5** See Appendix I: About our Status Report on Implementation of Performance Audit Recommendations.

# Implementation of 2020 Recommendations

**5.6** Overall, 57% of our 2020 recommendations have been implemented as of August 31, 2024. As this is the last year our office provides status updates on these recommendations, additional details are noted below.

## School Infrastructure Planning – Department of Education and Early Childhood Development and School Districts

Volume I, Chapter 2

### Chapter Background

**5.7** Our audit objective was to determine whether the Department of Education and Early Childhood Development (EECD) and school districts are making evidence-based decisions for prioritizing major capital projects for school infrastructure (estimated cost greater than $1 million), and capital improvement projects for existing school infrastructure (estimated cost from $10,000 to $1 million).

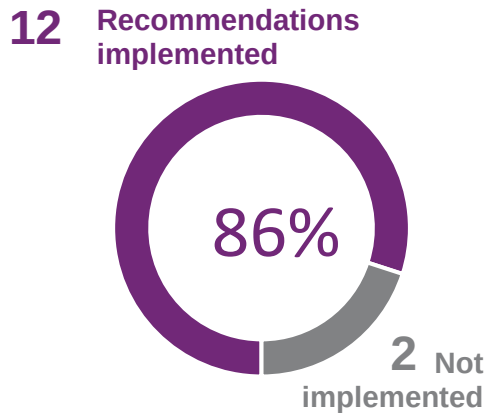
**5.8** In our 2020 report, we found improvements were required in the following areas:

- province-wide long-term school capital planning
- funding prioritization process
- quality of facility condition data

**5.9** We made 14 recommendations to EECD.

### 2024 Implementation Status

**5.10** 86% of our recommendations have been implemented.



# Ambulance Services – Department of Health & EM/ANB Inc.

Volume I, Chapter 3

## Chapter Background

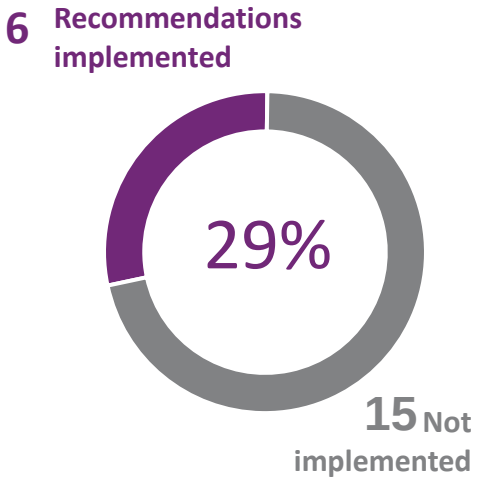
**5.11** Our audit objectives were to determine whether the Department of Health's governance structures and processes established for EM/ANB set a framework for effective oversight; and whether EM/ANB's contract for ambulance services is designed and managed to achieve expected objectives.

**5.12** In our 2020 report, we found improvements were required in the government's legislative framework and governance structure for ambulance services and its contract with Medavie Health Services New Brunswick.

**5.13** We made 21 recommendations.

## 2024 Implementation Status

**5.14** 29% of our recommendations have been implemented.



# 2008 Timber Royalties – Department of Natural Resources and Energy Development

Volume I, Chapter 4

## Chapter Background

**5.15** Our objective of this follow-up review was to determine if the Department of Natural Resources and Energy Development had fully implemented four recommendations made in our 2008 Office of the Auditor General report chapter 5 entitled "*Department of Natural Resources – Timber Royalties".*

**5.16** In our 2020 report, we found improvements remained in collection and utilization of data in the crown timber royalty rate-setting process.

**5.17** We made eight recommendations.

## 2024 Implementation Status

**5.18** 100% of our recommendations have been implemented.

# Electronic Medical Record Program – Department of Health

Volume II, Chapter 2

## Chapter Background

**5.19** The objectives of this audit were to determine:

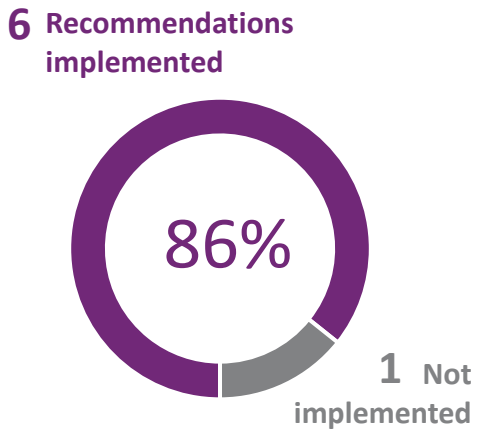
- if the Provincial Electronic Medical Record (EMR) program was implemented as intended and has achieved its planned outcomes
- if the Department of Health monitored EMR funding to mitigate risk to the taxpayer and to ensure compliance with the funding agreements

**5.20** In our 2020 report, we found improvements were required in government's oversight over the EMR program funding and implementation.

**5.21** We made seven recommendations.

## 2024 Implementation Status

**5.22** All but one recommendation has been implemented.



## NB Power Debt Challenges

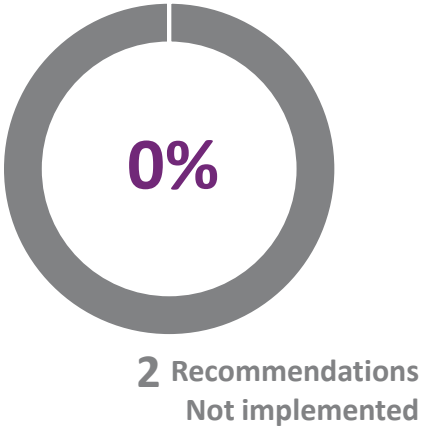
Volume II, Chapter 3

### Chapter Background

**5.23** In this chapter, we examined a 10-year trend analysis on NB Power's key financial ratios related to debt. We also compared these NB Power ratios to relevant peer utilities in Canada and reviewed New Brunswick's regulatory environment.

**5.24** In our 2020 report we found improvements were required to NB Power's debt reduction plan and forecasting process.

**5.25** We made two recommendations.




### 2024 Implementation Status

**5.26** None of our recommendations have been implemented.

## Update on Nursing Home Planning and Aging Strategy – Department of Social Development

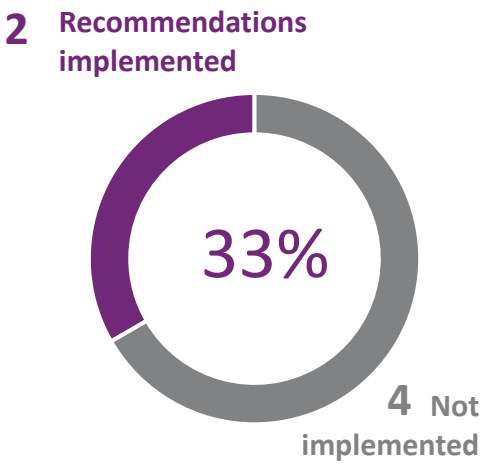
Volume II, Chapter 4

### Chapter Background

**5.27** In this chapter, we assessed the implementation status of the recommendations made in our 2016 report to the Department of Social Development on Nursing Homes.

**5.28** In our 2020 report, we found improvements were required in the implementation of government's nursing home plans, the Aging Strategy and public reporting.

**5.29** We made six recommendations.




### 2024 Implementation Status

**5.30** 33% of our recommendations have been implemented.

# Auditor General's Access to Vestcor Significantly Limited

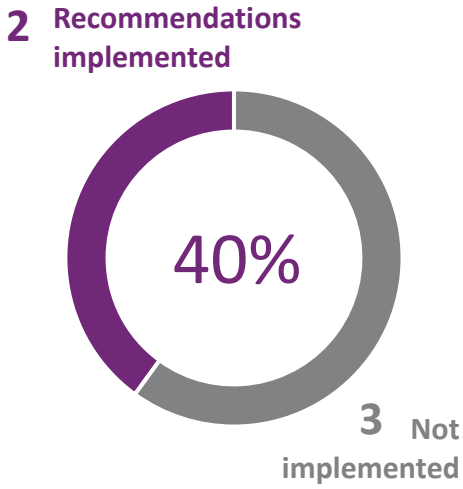
Volume II, Chapter 5

## Chapter Background

**5.31** The purpose of this chapter was to inform the Legislative Assembly of the difficulties we faced when trying to gain access to information at Vestcor.

**5.32** In our 2020 report, we found limitations in access to critical information, which raised concerns about transparency and accountability in the management of public pension funds.

**5.33** We made five recommendations.




## 2024 Implementation Status

**5.34** 40% of our recommendations have been implemented.

# Conclusion

**5.35** We encourage the Public Accounts Committee to hold the departments, commissions, and crown agencies accountable for the recommendations that have not been implemented as noted in Appendix II.

# Appendix I: About our Status Report

The Status Report on Implementation of Performance Audit Recommendations is not an audit and does not express an audit opinion. Management is responsible for implementing our recommendations from past performance audits. To ensure this report is credible, we obtained confirmation from departments, commissions, and crown agencies that the information to be reported is accurate and complete.

This report is conducted under the authority of the *Auditor General Act*. In conducting our work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of Chartered Professional Accountants of New Brunswick and the Code of Professional Conduct of the Office of the Auditor General of New Brunswick. Both codes are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

**Period covered by the status report:**

2020, 2021 and 2022

**Date of the status report:**

We concluded our work on the Status Report on Implementation of Performance Audit Recommendations on November 27, 2024, in Fredericton, New Brunswick.

# Appendix II: Recommendations from 2020 Chapters Not Implemented

## School Infrastructure Planning
## Department of Education and Early Childhood Development and School Districts
2020, Volume I, Chapter 2

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| 2.116 | We recommend the Department, in consultation with school districts, develop and maintain a centralized asset inventory that contains details of all major facility components to support the Department's capital planning. |
| 2.117 | We recommend the Department develop and enforce data collection standards and requirements for the uniform collection and aggregation of facility data across all school districts. |

## Ambulance Services
## Department of Health & EM/ANB Inc.
2020, Volume I, Chapter 3

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| 3.51 | We recommend the Department formalize the mandate and governance for EM/ANB in legislation and provide mandate letters to EM/ANB with the annual budget approval. |
| 3.70 | We recommend EM/ANB enabling legislation to strengthen and clarify board authority with respect to hiring, compensation, performance and termination of the CEO. |
| 3.71 | We recommend the board hire an independent CEO upon future contractual amendment or renegotiation. |
| 3.77 | We recommend the board evaluate EM/ANB's annual corporate plans as part of its review of the CEO and MHSNB's performance and compare them to EM/ANB's annual report and obligations to the Department. |
| 3.78 | We recommend the board establish a performance management framework for EM/ANB and evaluate its performance annually. |
| 3.103 | We recommend EM/ANB calculate budget surplus payments based on flexible budget amounts which reflect the anticipated spending for the fiscal year. |
| 3.108 | We recommend the board define restrictions around budget surplus payments to exclude circumstances which may decrease the quality of the delivery of ambulance services. |
| 3.135 | We recommend EM/ANB introduce a more balanced suite of key performance indicators as the basis for performance-based payments to incentivize MHSNB toward high performance in all New Brunswick communities. |
| 3.152 | We recommend the Department and EM/ANB introduce controls to minimize the frequency of use of full deployment exemptions or discontinue the use of exemptions. |
| 3.153 | We recommend the EM/ANB board require MHSNB revise the System Status Plan to update the detailed specifications as to the ambulances, facilities and human resources required to be deployed to achieve performance standards. |
| 3.163 | We recommend the Department and EM/ANB revise the exemption approval guide to prevent the invalid use of full deployment exemptions or discontinue the use of exemptions. |

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| 3.191 | We recommend the board implement progressive performance targets to incentivize MHSNB to achieve continuous improvement for the duration of the contract. |
| 3.192 | We recommend EM/ANB improve tracking, and follow-up of strategic and corporate initiatives and include measurable outcomes in its plans. |
| 3.193 | We recommend the board expand key performance indicators for performance-based payments to include all areas of operations, such as human resources, fleet and official languages. |
| 3.206 | We recommend the Executive Council Office review the Conflict-of-Interest Regulation under the *Conflict of Interest Act* and amend the regulation to include all relevant Crown corporations in Schedule A, including EM/ANB Inc. |

## Electronic Medical Record Program
## Department of Health
2020, Volume II, Chapter 2

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| 2.61 | We recommend the Department of Health ensure regular audits are carried out on future programs to evaluate achievement of program outcomes and funding recipients' compliance with funding terms. |

## NB Power Debt Challenges
2020, Volume II, Chapter 3

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| 3.59 | We recommend NB Power prioritize debt reduction by developing a firm and well-defined debt management plan to achieve the mandated debt to equity target by 2027. The plan should comprise:<br>• achievable annual key performance indicators (KPI) including a debt reduction amount and debt to equity ratio; and<br>• a requirement to report annually within NB Power's annual report:<br>i. any deviation from the annual KPIs;<br>ii. reasons if KPIs are not met; and<br>iii. an adjusted action plan to reach 2027 target date. |
| 3.84 | We recommend NB Power, to improve its forecasting process, quantify the impact of likely uncertainties in the 10 Year Plan, such as fuel prices, hydro flow, Point Lepreau capacity factor, weather events, etc. |

## Update on Nursing Home Planning and Aging Strategy
## Department of Social Development
2020, Volume II, Chapter 4

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| 4.46 | We continue to recommend the Department of Social Development evaluate whether there is an economic benefit to providing nursing home beds under the for-profit operated model versus the traditional model. This should include a comparison of actual costs and quality of service. |
| 4.73 | We recommend the Department of Social Development develop performance indicators with specific targets for each action item under the Aging Strategy, in collaboration with relevant stakeholders. |
| 4.74 | We recommend the Department of Social Development develop a formal process for monitoring action items under the Aging Strategy and verifying implementation. |
| 4.88 | We recommend the Department of Social Development publicly report actual outcomes compared to planned or expected outcomes under the Aging Strategy and the Nursing Home Plan. Reporting should provide explanations for gaps between plans and results. |

## Auditor General's Access to Vestcor Significantly Limited
2020, Volume II, Chapter 5

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| 5.9 | We recommend the Minister of Finance and Treasury Board propose the *Auditor General Act* be amended to list Vestcor (and all related entities) as auditable entities to ensure the Auditor General has unrestricted access to conduct both performance and financial audits as the Auditor General deems necessary. |
| 5.10 | We recommend the Minister of Finance and Treasury Board under section 12 of the *Auditor General Act*, request the Auditor General conduct a performance audit of Vestcor (and all related entities) that includes unrestricted access to Vestcor by the Auditor General. |
| 5.12 | We recommend the Minister of Finance and Treasury Board propose the *Vestcor Act* be amended to require Vestcor (and all related entities) to:<br>- file an annual report with the Clerk of the Legislative Assembly; and<br>- appear before the Public Accounts Committee. |

NOTE: All recommendations from our 2021 chapters have been self-reported as implemented.

# Appendix III: Recommendations from 2022 Chapters Not Implemented

## Liquor Industry Development in New Brunswick – New Brunswick Liquor Corporation

2022, Volume I, Chapter 2

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| 2.44 | We recommend the New Brunswick Liquor Corporation develop a communications and engagement plan for its interaction with local producers to establish:<br>• terms of engagement with local producers;<br>• objectives and targets against which to measure the effectiveness of local producer engagement; and<br>• required monitoring and reporting on the effectiveness of local producer engagement in developing the local liquor industry. |
| 2.92 | We recommend the New Brunswick Liquor Corporation complete a comprehensive review and update of its pricing strategy and mark-up structure to ensure:<br>• all product listing status types are included;<br>• the process, decision criteria and documentation requirements for special agreements outside the standard mark-up structure are clearly included; and<br>• business practices align with the pricing strategy, the mark-up structure, and the purposes prescribed in the *New Brunswick Liquor Corporation Act*. |

## Oversight of the Employee Health and Dental Benefit Plan – Department of Finance and Treasury Board

2022, Volume I, Chapter 3

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| 3.32 | We recommend FTB re-evaluate the Plan's operational structure to determine whether there is a more effective governance model. |
| 3.48 | We recommend the Department of Finance and Treasury Board develop and implement a cost containment strategy to stabilize costs while ensuring future sustainability of the Plan. |
| 3.53 | We recommend the Department of Finance and Treasury Board in consultation with Standing Committee on Insured Benefits, establish a risk management process, including an independent assessment of third-party risk management practices. |
| 3.62 | We recommend the Department of Finance and Treasury Board evaluate whether the Plan administration contract with Vestcor provides best value for money, such as by completing an RFI for Vestcor's services. |
| 3.65 | We recommend the Department of Finance and Treasury Board in collaboration with Standing Committee on Insured Benefits:<br>• Clarify the cost allocation among the different benefit plans administered by Vestcor; and<br>• Ensure Vestcor expenditures are eligible and accurate prior to payment. |
| 3.72 | We recommend the Department of Finance and Treasury Board in collaboration with Standing Committee on Insured Benefits, establish and communicate performance objectives with specific metrics to measure Plan performance, including third-party contracts. |

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| 3.80 | We recommend the Department of Finance and Treasury Board analyze claims data periodically to identify:<br>• unusual claim patterns; and<br>• suspected fraud or other types of anomalies. |
| 3.85 | We recommend the Department of Finance and Treasury Board benchmark Plan performance against relevant industry benefit data. |

## Contaminated Sites - Department of Environment and Local Government

2022, Volume II, Chapter 2

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| 2.31 | We recommend the Department of Environment and Local Government make more contaminated sites information readily available to the public on its website. |
| 2.54 | We recommend the Department of Environment and Local Government<br>• create a plan and establish a timeline to process all outstanding open contaminated site files; and<br>• periodically review the plan against actual results to ensure work will be completed according to the timeline. |
| 2.61 | We recommend the Department of Environment and Local Government standardize the information recorded in the Occurrence Database by Regional Inspectors across the province. |
| 2.72 | We recommend the Department of Environment and Local Government<br>• create performance targets for the occurrence process and compare actual results against performance targets on a regular basis; and<br>• publicly report on the performance metrics of the occurrence process. |

## Environmental Trust Fund – Department of Environment and Local Government

2022, Volume II, Chapter 3

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| 3.35 | We recommend the Department of Environment and Local Government:<br>• identify a single authority with the responsibility for overseeing the administration of the Environmental Trust Fund (ETF); and<br>• develop Terms of Reference document to clarify and define the roles, responsibilities and expectations of the Advisory Board. |
| 3.40 | We recommend the Department of Environment and Local Government<br>• develop a strategy and annual plans for the ETF, with clearly defined objectives, performance measures and targets; and<br>• link the annual budget to program objectives as part of ongoing annual planning. |
| 3.76 | We recommend the Department of Environment and Local Government measure and report the expected and actual results for all projects funded by the ETF. |