GREAT LAKE TAUPŌ
Taupō District Council

ATTACHMENTS

Audit & Risk Committee Meeting

10 June 2019

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TAUPŌ DISTRICT COUNCIL
MINUTES OF THE AUDIT & RISK COMMITTEE MEETING
HELD AT THE COUNCIL CHAMBER, 107 HEUHEU STREET, TAUPŌ
ON MONDAY, 11 MARCH 2019 AT 10.00AM

PRESENT:	Mr Anthony Byett (in the Chair), Cr Barry Hickling, Cr Rosie Harvey, Cr Anna Park, Cr Maggie Stewart
IN ATTENDANCE:	Chief Executive, Head of Regulatory & Risk, Head of Finance & Strategy, Head of Operations, Head of Democracy, Governance & Venues, Infrastructure Manager, Manager Legal & Compliance, Risk Manager, Consents & Regulatory Manager, Building Technical Specialist, Democratic Services Officer
MEDIA AND PUBLIC:	Messrs Matthew Wilson and Andrew Carlson, AON Insurance

1 APOLOGIES

AR201903/01 RESOLUTION

Moved: Cr Barry Hickling
Seconded: Cr Maggie Stewart

That the apologies received from His Worship the Mayor, David Trewavas and Cr Rosanne Jollands be accepted.

CARRIED

2 CONFLICTS OF INTEREST

Nil

3 CONFIRMATION OF MINUTES

3.1 AUDIT & RISK COMMITTEE MEETING - 29 OCTOBER 2018

AR201903/02 RESOLUTION

Moved: Cr Anna Park
Seconded: Cr Barry Hickling

That the minutes of the Audit & Risk Committee meeting held on Monday 29 October 2018 be confirmed as a true and correct record.

CARRIED

4 REPORTS

4.1 PRESENTATION FROM AON - INSURANCE MARKET

Mr Matthew Wilson made a PowerPoint presentation (A2422513) and answered questions. The following points were noted:

- The period 2006-2016 was a relatively benign period for the insurance market globally. 2017 was the worst year on record for insurers and the main reason for this was extreme weather events as a result of climate change.
- Major earthquakes could also compromise local councils ability to buy insurance cover.

- There had been significant increases in liability premiums recently. Councils around the country had lodged large claims and were often the 'last man standing' in legal claims.
- Over the last four years, three insurers had received instructions not to write any more business with councils.
- The 'knowledge gap' was relevant in the infrastructure space, including above-ground mapping.
- Low value, high frequency losses were of most concern. What was Taupō District Council prepared to retain at its own risk, to reduce insurance premiums?
- The current 60:40 cost recovery arrangement with central government did not cover all costs incurred by a local authority in an event.
- Loss modelling would help inform future risk financing adequacy; accuracy of assumptions was also very important.
- Emerging risks included environmental impairment (pollution excluded unless sudden loss); and counterfeit / defective products.
- Flooding was a potential issue for inland councils as well as coastal councils.
- There was no difference from an insurance perspective between a council owning a civic administration building as opposed to leasing one.

In answer to a question, the Consents & Regulatory Manager confirmed that staff in the building team were aware of the need to look out for counterfeit and defective products.

AR201903/03 RESOLUTION

Moved: Cr Rosie Harvey
Seconded: Cr Anna Park

That the Audit & Risk Committee receives the information and thanks the AON representatives for their presentation.

CARRIED

4.2 MBIE AUDIT OF BUILDING ACT TERRITORIAL FUNCTIONS

The Consents & Regulatory Manager summarised the report and answered questions. The following points were noted:

- The IANZ audit of Taupō District Council had taken place the previous week. IANZ auditors had spent 3-4 days at Council and the report was due in 2-3 weeks. They had indicated that Taupō District Council would maintain its accreditation and staff were considering the auditors' suggestions for improvement.
- Although issued in November 2017, staff had waited until all actions had been completed before presenting the MBIE audit to the Committee.
- Staff aimed to audit around 25% of independent qualified person inspections.
- It had taken time to update compliance schedules, because resources were limited and the priority was ensuring buildings were safe.
- Two members of the business support team had up-skilled to assist the Building Technical Specialist.
- The Building Technical Specialist could not visit every site, but it was more efficient for him to accompany independent qualifed persons on complex site visits.
- Buildings to which the public had access were required to have warrants of fitness.

The Chief Executive added that Taupō District Council's building consent timeframes were excellent.

AR201903/04 RESOLUTION

Moved: Cr Barry Hickling
Seconded: Cr Rosie Harvey

That the Audit & Risk Committee receives the results of the MBIE audit dated 1 December 2017.

CARRIED

4.3 S&P RATING UPGRADE TO OUTLOOK POSITIVE

In answer to a question, the Head of Finance & Strategy advised that the positive rating was due in part to the changes Council had made to its financial strategy 8-10 years ago.

A member asked for Council to publicise the 'good news' story about the organisation's finances in a simple manner, to better inform people in the community that the financial outlook was a lot better than they may think. The Chief Executive advised that he would discuss this with the Head of Communications & Customer Relations.

AR201903/05 RESOLUTION

Moved: Cr Maggie Stewart
Seconded: Cr Anna Park

That the Audit & Risk Committee receives the S&P research update report revising Taupō District Councils credit rating from AA stable outlook to AA positive outlook [A2406317] and their subsequent media release [A2406325].

CARRIED

4.4 ASSET MANAGEMENT PLANS - PEER REVIEW REPORT

The Infrastructure Manager introduced the report and answered questions. The following points were noted:

- Audit New Zealand had not provided any suggestions for improvement as a result of the audit of asset management plans via the audit of the Long-term Plan 2018-28.
- The approach to scoring was not about what level the asset management plan should be at; rather the focus was on what it is, and what may be missing from it. Missing references would have an impact on the score, but would be simple to fix up.
- No significant issues with Taupō District Council's asset management plans had been identified as a result of the audit.
- Council did not have a sustainability policy at present, although it was already a consideration for staff managing projects.

AR201903/06 RESOLUTION

Moved: Cr Barry Hickling
Seconded: Cr Anna Park

That the Audit & Risk Committee receives the Asset Management Peer Review Report (A2353516)

CARRIED

4.5 NEW ZEALAND TRANSPORT AGENCY INVESTMENT AUDIT REPORT

The Infrastructure Manager introduced the report and answered questions. The following points were noted:

- The frequency of NZTA audits of Taupō District Council (up to 10 years) indicated that this particular council was considered to be 'low risk'.

- The audit had taken place in winter, when the roading network (particularly unsealed roads) was not looking its best.
- Improvements were being made to data reporting.
- Overall the auditors were happy. They had identified things to be reported back to them by June 2019.
- Taupō District Council had a strong seal extension programme. Unsealed roads or parts of roads were difficult to maintain.

AR201903/07 RESOLUTION

Moved: Cr Maggie Stewart
Seconded: Cr Barry Hickling

That the Audit & Risk Committee receives the NZTA Investment Audit Report (A2371749)

CARRIED

4.6 6 MONTHLY REVIEW OF SENSITIVE EXPENDITURE

AR201903/08 RESOLUTION

Moved: Cr Anna Park
Seconded: Cr Rosie Harvey

That the Audit & Risk Committee receives the information in the Sensitive Expenditure Report Feb 2019 (A2407530) for the period 1 July 2018 to 31 December 2018.

CARRIED

4.7 ADOPTION OF ASSET DISPOSAL POLICY

AR201903/09 RESOLUTION

Moved: Cr Anna Park
Seconded: Cr Barry Hickling

That the Audit & Risk Committee recommends to Council that the proposed Asset Disposal Policy 2019 (A2376362) be adopted.

CARRIED

4.8 REVIEW OF GOVERNANCE RISKS

The Risk Manager summarised the report and attached analysis of the following risks: legal liabilities; inadequate strategic planning; underperforming Council; and not meeting obligations as the employer of the Chief Executive.

AR201903/10 RESOLUTION

Moved: Cr Rosie Harvey
Seconded: Cr Maggie Stewart

That the Audit & Risk Committee receives the review of governance risk report.

CARRIED

4.9 AUDIT & RISK COMMITTEE SCHEDULE OF POLICIES FOR REVIEW

Members agreed to add the Asset Disposal Policy to the schedule of policies for review.

In relation to the Committee's Terms of Reference, members asked the Head of Democracy, Governance & Venues to facilitate a discussion about the Terms of Reference, suggestions from which could be referred to the incoming Council following the October 2019 elections.

AR201903/11 RESOLUTION

Moved: Cr Rosie Harvey
Seconded: Cr Anna Park

That the Audit & Risk Committee receives the Schedule of Policies for review (A2411544).

CARRIED

5 CONFIDENTIAL BUSINESS

AR201903/12 RESOLUTION

Moved: Mr Anthony Byett
Seconded: Cr Anna Park

RESOLUTION TO EXCLUDE THE PUBLIC

I move that the public be excluded from the following parts of the proceedings of this meeting.

The general subject of each matter to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under section 48[1] of the local government official information and meetings act 1987 for the passing of this resolution are as follows:

General subject of each matter to be considered	Reason for passing this resolution in relation to each matter	Ground(s) under Section 48(1) for the passing of this resolution
Agenda Item No: 5.1 Confirmation of Confidential Portion of Audit & Risk Committee Minutes - 29 October 2018	Section 7(2)(g) - the withholding of the information is necessary to maintain legal professional privilege	Section 48(1)(a)(i)- the public conduct of the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under section 7
Agenda Item No: 5.2 Litigation Update	Section 7(2)(g) - the withholding of the information is necessary to maintain legal professional privilege	Section 48(1)(a)(i)- the public conduct of the relevant part of the proceedings of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under section 7

CARRIED

The meeting closed at 11.51am.

The minutes of this meeting were confirmed at the Audit & Risk Committee meeting held on 10 June 2019.

.....
CHAIRPERSON

CIVIL AVIATION AUTHORITY
OF NEW ZEALAND
Te Mana Rererangi Tūmatanui o Aotearoa

D-NZAP-02 (DW1361289-0)

09 May 2019

Kim Gard Taupo Airport Authority
RD 2
Taupo
3378

Dear Kim

Approval of Safety Management System

I am pleased to advise that your Safety Management System has been accepted, and enclose an amended version of your Operations Specifications reflecting this.

Implementation of your Safety Management System is an important milestone for your organisation. As you are aware, by certifying your SMS we have deemed the system to be *present* and *suitable*. I'd encourage you to continue to build on the work you've done as you lead your organisation toward a fully *operational* and *effective* system.

On behalf of the Director of Civil Aviation, I would like to thank you and your team for your cooperation and effort during this important activity.

Yours sincerely

Nick Jackson
Acting Manager Aeronautical Services Unit

Level 15, 55 Featherston Street, Wellington 6011 – PO Box 3555, Wellington 6140, New Zealand
Tel: +64 4 560 9400, Fax: +64 4 569 2024, Email: info@caa.govt.nz, Web: www.caa.govt.nz

New Zealand Government

CIVIL AVIATION AUTHORITY OF NEW ZEALAND

Part 139
Approvals Specification
Taupo Airport Authority

This Specification forms part of Certificate No. AD36161 granted pursuant to CAR Part 139.

1. Address For Service

Taupo Airport Authority
1105 Anzac Memorial Drive
Wharewaka
Taupo 3378

2. Other Business Trading Names

Nil

3. Aerodrome Type and Facilities

Taupo Airport

Aerodrome Type

Domestic

4. Nominated Senior Persons

Title per CAA Rule	Name	Company Title	CAA No
Chief Executive	Mr M E Groome	Chief Executive	16870
Senior Persons			
Other Senior Person	Ms K Gard	Operations Manager	58903
System for Safety Management	Mr S T Petersen	Safety Manager	13559

5. System For Safety Management

Accepted.

Exposition Reference: *TAA SMS Manual Section ii page 6 of 70, Revision 3 dated 31/01/2019*
CAA W/R For Changes: *19/139/36*

6. Aerodrome Limitations

Runway 11 not available for take-off.
Taxiway to threshold Runway 17 not available during take-off or landing of SAAB 340 aircraft or larger on Runway 17/35.

7. Qualifying Aerodrome Certification

Nil

8. Exemptions

Docket	Rule Reference	Rule Description	Expires
18/EXE/65	CAR 139.103(b)(3)	Aerodrome maintenance	

AD36161 Taupo Airport Authority

Accepted By: ..... Dated 09 May 2019

Replaces Certificate Supplement Dated 28 February 2019

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Facility:	AC Baths
Assessor name:	Dot Leggett Lane
Pool manager name:	Ryno Nienaber
Date:	14 Feb 2019

Supervision	
CRITERIA: All lifeguards must hold current & valid PLSA or PLPC **HOW: Sight current & valid PLSA or PLPC certificates for all lifeguards**	
ESSENTIAL COMPONENTS:	
• Evidence that all staff have undergone PLSA or PLPC training and assessment	Achieved
• Evidence that all lifeguards have completed an induction PRIOR to working on Poolside	Achieved
• The PLPC assessment has taken place and paperwork sent to Skills Active within one month of starting work on Poolside	Achieved
• NOP must clearly state that lifeguards or staff members, who do not hold a current and valid PLSA (for one month from date of starting on poolside) or PLPC will not be included in any supervision ratios.	Achieved
• All qualified lifeguards must have completed First aid units 26551 and 26552 (6400, 6401 & 6402) as a minimum first aid qualification	Achieved
NOTE: Assessors must be satisfied that the correct process has occurred and an honest attempt has been made by the Facility to provide evidence of their staff qualifications.	
Total number of lifeguards on the facility roster = a) Skills Award b) PLPCa) Skills Award: 0 b) PLPC: 21	
CRITERIA: Every body of water is supervised by a qualified lifeguard (when open for use) at all times. Qualified means holding a current PLSA (within one month of training) or PLPC. **HOW: Review facility normal operating procedures (NOPs) relating to supervision.**	
ESSENTIAL COMPONENTS: **NOP must detail:**	
• A PLPC lifeguard must be rostered on and available at all times. (This is the minimum, it is recommended that a PLPC lifeguard is rostered on and POOLSIDE at all times)	Achieved
• All lifeguards must be able to retrieve an object from the deepest part of the pool	Achieved
NOP must detail the way in which the pool should be supervised including reference to:	
• The minimum number of lifeguards	Achieved
• The area of water and physical obstacles each lifeguard supervises (E.G glare, dead water)	Achieved

• Supervision techniques and supervision of different activities	Achieved
• How lifeguards communicate	Achieved
• Leaving poolside procedures	Achieved
• After-hours groups must be lifeguarded within supervision ratios by a facility employed PLPC lifeguard	Achieved
A facility schematic/s should be included detailing:	
• Recommended Static Positions	Achieved
• Patrolling routes	Achieved
The NOP should give poolside lifeguards as much information as they need to make informed minute-by-minute decisions on supervising the pool without being over prescriptive and too lengthy. The following are some useful headings:	
• Personal appearance and conduct of lifeguards (talking, grooming, uniform etc)	Achieved
• Identification of hazards/risks	Achieved
• Poolside first aid	Achieved
Customer behaviour	
1. Acceptable behaviour	Achieved
2. Unacceptable behaviour	Achieved
• Supervision of different customer groups, (children, youth, special needs etc)	Achieved
• Supervision of different activities, (lane swimming, diving boards etc)	Achieved
It is desirable that the normal operating procedures be cross referenced to any other similar procedures, EG:	
1. EAP	Achieved
2. Health and Safety policies	Achieved
NOTE: Evidence will be required to back up the written policies in the NOP – eg training schedule showing induction. How the pool determines its supervision policies and sets out its plan are the domain of that particular pool. The assessors' task is to verify that the essential components are present. Some pools do not publish detailed supervision policies. If this is the case an oral description backed up with poolside observations and lifeguard questioning will suffice.	
Facilities with dedicated Learn to Swim Pools, Private Pools and/or Spa pools, Saunas and steam rooms	

• Learn to Swim Pools, Private pools must have signage clearly visible to say the area of water is not supervised by a lifeguard	Achieved
• NOP must clearly state procedures for dealing with the private pools/spa and sauna/steam rooms relative to the facility, for example (but not limited to)	Achieved
• Time restriction	Achieved
• Hydration advice	Achieved
• How these are monitored (eg, alarms, regular checks)	Achieved
• Minimum age for use (i applicable)	Achieved
• Minimum number of people	Achieved
• Who is in charge in an emergency	Achieved
• How staff communicate with each other (E.G Teachers from the LTS pool communicate to the lifeguards in the main pool	Achieved
The above list is a guide only – the detail is the domain of that particular pool.	

Dedicated Learn to Swim Facility	
Dedicated stand-alone Learn to Swim Facility (ie not within a complex that has other aquatic activities and is ONLY open for structured lessons)	
• NOP must clearly state either qualified lifeguards are on pool deck OR LTS instructors are qualified lifeguards, in the water teaching but within the supervision ratios	Not applicable
• Signage to say the area is not actively supervised by a lifeguard	Not applicable
• Clear documented procedures covering (but not limited to):	Not applicable
• What happens if an instructor has to leave the water	Not applicable
• Who is in charge of an emergency situation	Not applicable
• How staff communicate with each other	Not applicable

Emergency Action Plan	
CRITERIA: Existence of an Emergency Action Plan **HOW: Evidence of the EAP is clearly apparent**	
ESSENTIAL COMPONENTS	
• All lifeguards must have easy access to a current EAP	Achieved
• EAP must be in manual format with poolside emergency signage to compliment procedures	Achieved
EAP must succinctly specify the actions to be taken in every reasonably foreseeable emergency. In most cases this will be limited to pool and facility emergencies. It should include reference to the following:	
• Who is in charge	Achieved
• Nature and location of emergency equipment	Achieved
• Key steps in dealing with an emergency	Achieved
• Pool rescue	Achieved
• Medical alert, (choking, asthma, angina/heart attack, serious cuts, fractures and dislocations etc)	Achieved
• Building evacuation	Achieved
• Major first aid	Achieved
• Spinals	Achieved
• Aftercare for victims and staff	Achieved
• A flowchart summary of the key steps in dealing with an emergency should be available to lifeguards	Achieved
• A pool manual cross referencing health and safety policies, pool supervision policies, Normal Operating Procedures and Emergency Action Plan should be available to lifeguards giving them one-stop-shop access to the "big picture"	Achieved
• Evidence that regular (minimum quarterly) staff training occurs including staff training plans and signed staff training records	Achieved

Pool Alone

CRITERIA: Existence of a policy relating to child supervision HOW: Review facility NOPs relating to child supervision	
ESSENTIAL COMPONENTS:	
• NOP must set an age below which a child may not swim unaccompanied and thus becomes a pool alone. Minimum age is under 8 years	Achieved
• NOP must detail supervision of under 5's in the pool and include provision for ratios of adult to child(ren)	Achieved
• NOP must give some guidelines on effective enforcement	Achieved

Risk Management Plan	
CRITERIA: Existence of a pool water risk management plan. **HOW: Evidence of a pool water quality risk management plan (RMP) is clearly apparent**	
ESSENTIAL COMPONENTS:	
• PRMP is onsite, easily accessible has been reviewed annually (review report completed) and updated where necessary	Achieved
• PRMP identifies all of the significant risks for each element of the pool system.	Achieved
• PRMP identifies the critical points of the pool system.	Achieved
• PRMP identifies the barriers to contamination (including staff training and/or qualifications, staffing levels, sampling programmes, calibration of analysers).	Achieved
• PRMP quantifies the risks.	Achieved
• PRMP identifies measures to prevent, reduce or eliminate the risks.	Achieved
• PRMP identifies necessary improvements to the pool to manage the risk. Improvements are prioritised & there is a timetable for implementing the improvements.	Achieved

Health and Safety	
CRITERIA: Confirm the operation of a health and safety management process **HOW: Review facility NOPs relating to health and safety**	
ESSENTIAL COMPONENTS:	
• Documented process whereby hazards/risks are identified and recorded, they are managed by being minimised or eliminated	Achieved

• Documented process for recording and investigating employee accidents and notifiable death, injury, illness and incident	Achieved
• Documented process for recording customer accidents	Achieved
• Documented process for recording customer notifiable death, injury, illness and incident	Achieved
• Documented process for wet and dry rescues	Achieved
• A record is kept of all customer accidents requiring further medical attention	Achieved
• There is documented evidence that the information gathered from the above reporting procedures is scrutinised and used to make changes (if necessary) designed to improve safety, for example Health & Safety Meeting minutes. Evidence sighted of last four meetings	Achieved
• Provide chemical inventory for all chemicals on site as per Health & Safety at Work Act (Hazardous Substance Regulation 2017)	Achieved
NOTE: This section is not designed to supersede any more thorough HEALTH AND SAFETY PROCESS a pool may have. It is not designed to fulfil legislative or contractual obligations under the HSE Act or OSH. It is a few fundamental pointers to assist the pool manager in providing a safe environment for employees and customers.	

Water Quality	
CRITERIA: Water testing programme compliant with NZS 5826:2010. **HOW: Review facility NOPs relating to water quality.**	
ESSENTIAL COMPONENTS: **NOP must specify:**	
• Lowest and highest values for the relevant chemical constituents within the parameters contained in NZS 5826:2010 **Comments:**	Achieved
• A frequency of testing that meets the minimum set in NZS 5826:2010 **Comments:**	Achieved
• The detail and frequency of microbiological tests	Achieved
1. Tests must be scheduled a minimum of monthly	Achieved

2. Tests must include: • Faecal Coliforms or E. coli • Staphylococcus aureus • Pseuduomonas aeruginosa • Standard plate count	Achieved
• Four weeks water chemical value tests as specified by the assessor must confirm the presence of chemicals between the lowest and highest values set in NZS 5826:2010 **Comments:**	Achieved
• Four separate sets of microbiological tests as specified by the assessor must confirm the absence of pathogens of the time above the highest value set in NZS 5826:2010	Achieved
• Visual check of records, testing procedures and pool laboratory to confirm that written evidence does correspond to what actually occurs at the facility.	Achieved
• Must detail the water treatment qualifications held by the relevant staff. **Comments:**	Achieved
• Procedure must cover actions in response to – faecal solids, vomit, diarrhoea, blood and an incident in a confirmed cryptosporidium outbreak and notifiable disease outbreak and reporting requirements..	Achieved
• Procedure must specify – type of contamination and response, removal of solids and semi-solids (Vacuuming), filtration and turnover, evacuation times, disinfection for each pool.	Achieved
• That faecal accident, especially those involving diarrhoea, are recorded.	Achieved

Water Quality (On site)

Water Quality Including Pool Contamination

CRITERIA: Confirmation that staff understand and apply the faecal accident procedure.
HOW: Questioning to verify that staff understand the faecal accident procedure.

ESSENTIAL COMPONENTS:	Achieved
• A visual check of records and equipment. • Questioning of frontline staff to determine that if a faecal accident occurred it would be dealt with in accordance with the procedure • Visual check of records, testing procedures and pool laboratory to confirm that written evidence does correspond to what actually does occur at the facility.	
NOTE: Every lifeguard is not expected to know the entire procedure. They must be able to perform the first response to avoid contamination of pool customers and then know where to access further information or advice.	

Supervision (On site)

CRITERIA: Confirmation that all pools are supervised according to NOP.
HOW: Visual check and questioning to verify that staff understand and apply pool supervision policy.

ESSENTIAL COMPONENTS: • All water open for use is supervised by a lifeguard • Any closed water is closed with a barrier or its access is supervised by a lifeguard • Lifeguards must have an understanding of the rationale behind the individual pools procedures and a grasp of the information contained in the procedures; at a level whereby they are able to make sound decisions on how they supervise the pool on a minute by minute, second by second basis • Lifeguards are not required to know or even recognise the technical terms or even names of procedures • Lifeguards should be asked to quote actual examples of the application of pool supervision procedure (unless they just do not happen) • Lifeguards should be given hypothetical situations and asked for their response. The response should mirror the rationale behind procedures • Lifeguard in charge must have an understanding of the rationale behind the procedures and a grasp of the information contained in the procedures • Lifeguard in charge should be asked to quote pool supervision ratios • PLSA Lifeguards will be asked to confirm a PLPC staff member is always rostered on with them • Lifeguards should be asked about after-hours bookings and who is rostered on.	Achieved
Facilities with Learn to Swim Pools, Private Pools/Spas	
• Private pools/spas must have signage clearly visible to say the area of water is not supervised • Lifeguards should be familiar with the guidelines of use as per the NOP	Achieved
Dedicated stand-alone Learn to Swim Facility	Not applicable
• Lifeguards and/or instructors should be familiar with the guidelines of use as per the NOP • Signage clearly visible to say that the facility is not supervised by a lifeguard	Not applicable

Emergency Action Plan (On site)

CRITERIA: Confirmation that staff understand and apply the pools EAP. HOW: Visual check and questioning to verify that staff understand EAP.	
ESSENTIAL COMPONENTS: • Lifeguards must be able to outline the essential elements of the appropriate response to every reasonably foreseeable emergency. • That the assessor is satisfied a victim would receive care expected from an entry level lifeguard using Pool Lifeguard Practising Certificate as the benchmark. • Lifeguards are not required to know or even recognise the technical terms or even names of procedures. • Lifeguards should be asked to quote actual examples of the application of the pool EAP (unless they just do not happen). • Lifeguards should be given hypothetical situations and asked for their response. The response should mirror the rationale behind procedures. • Senior lifeguards should know the plan backwards and be able to adapt it to cater to the more unlikely situations, e.g. multiple casualties. • Formal EAP training is given regularly.	Achieved

Pool Alone (On site)

CRITERIA: Confirmation that staff understand and apply the pools child supervision policy.
HOW: Visual check and questioning to verify that staff understand child supervision policy.

ESSENTIAL COMPONENTS:	Achieved
• Any signage must be clear and visible. • Any signage must not contradict pool policy • All signage be professionally written from quality materials to allow maximum visibility and efficiency. **Front counter staff** must be expert at the enforcement of pool alone as they are the primary enforcer • Front counter staff should be asked to quote actual examples of pool alone instances (unless they just do not happen) • Front counter staff should be given hypothetical situations and asked for their response. The response should mirror policy • Front counter staff should be asked how they would respond to a child below the minimum age being "dumped" at the pool front gates **Poolside staff** must be expert at the identification of, and corrective action relating to, unsupervised children under minimum age • Poolside staff should be asked to quote actual examples of pool alone instances (unless they just do not happen or the staff member has not dealt with any) • Poolside staff should be given hypothetical situations and asked for their response. The response should mirror policy	

Health and Safety (On site)

CRITERIA: Confirmation that staff understand and apply the pools health and safety policy.
HOW: Visual check and questioning to verify that staff understand health and safety policy.

ESSENTIAL COMPONENTS:	Achieved
• A visual check of records and question poolside staff to confirm that the specified recording of near misses, accidents, notifiable death, injury, illness and incidents and review processes (H&S minutes) occur. • Annual Incident Review has been returned to NZRA Quality Programme Coordinator. • A visual check of signage, spills kits, Personal Protection Equipment (PPE) and MSDS for all chemicals on site in accordance with the Health & Safety at Work Act 2015 (Hazardous Substance Regulation 2017). • A visual check that staff members have induction and training on chemical storage, use and disposal.	

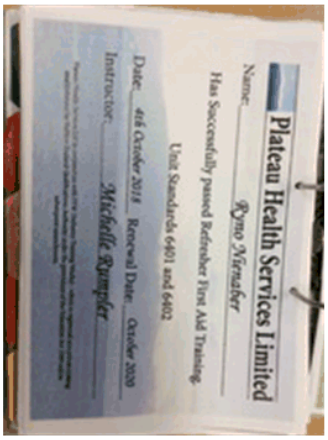
Field manager's signature

Appendix - Photos

Section: Supervision

Question:

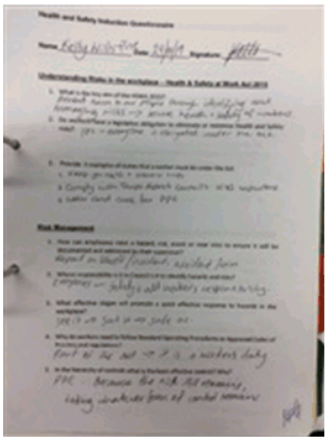
- All qualified lifeguards must have completed First aid units 26551 and 26552 (6400, 6401 & 6402) as a minimum first aid qualification

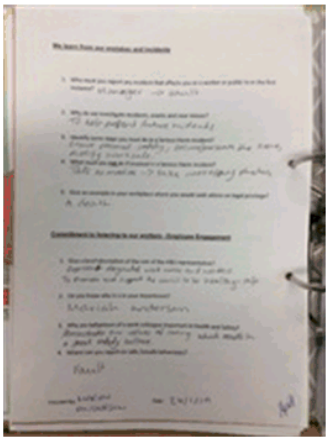


Section: Supervision

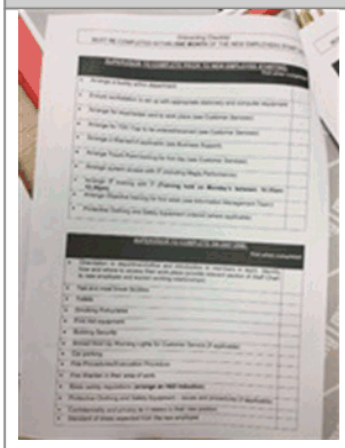
Question:

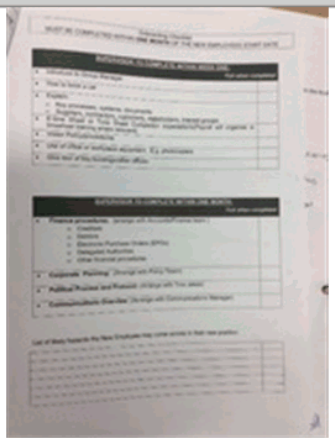
- Evidence that all lifeguards have completed an induction PRIOR to working on Poolside

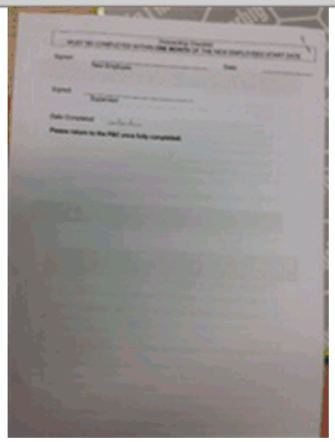


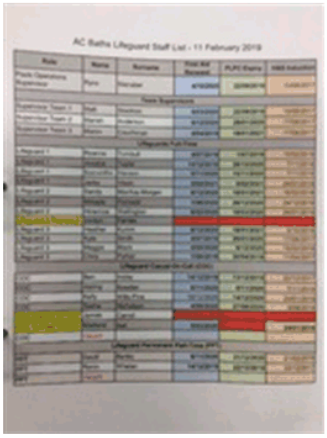


Appendix - Photos





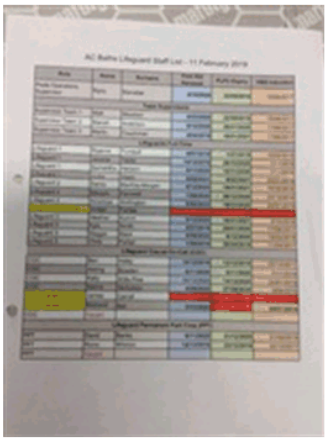




Section: Supervision

Question:

- Evidence that all staff have undergone PLSA or PLPC training and assessment

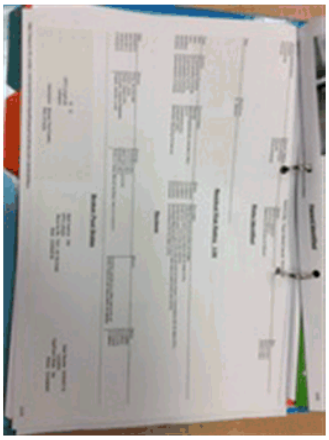
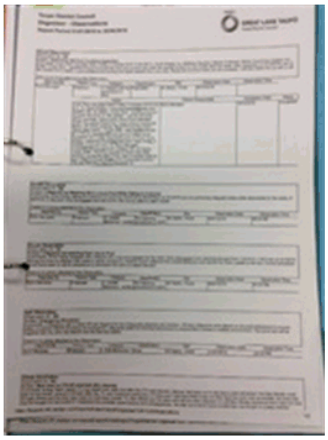


Appendix - Photos

Section: Health and Safety

Question:

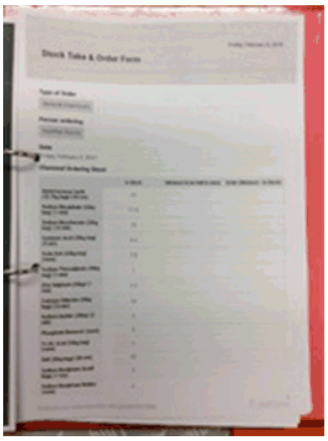
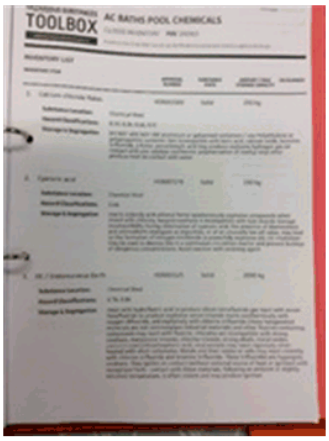
- Documented process whereby hazards/risks are identified and recorded, they are managed by being minimised or eliminated

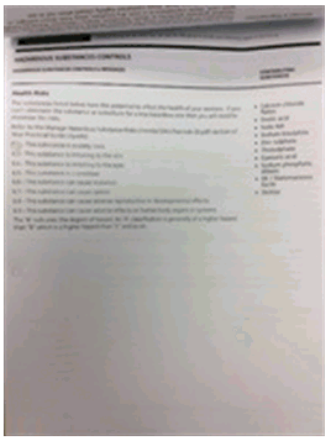




Section: Health and Safety

Question:

- Provide chemical inventory for all chemicals on site as per Health & Safety at Work Act (Hazardous Substance Regulation 2017)

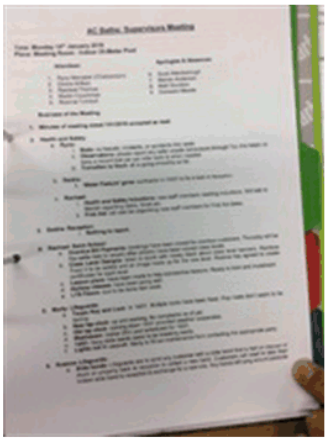


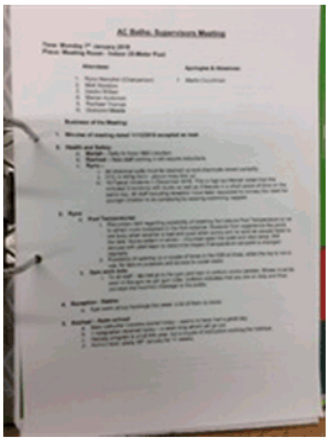
Section: Health and Safety

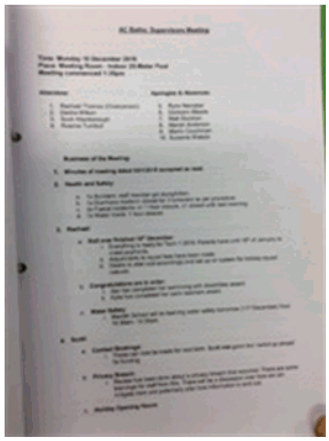
Question:

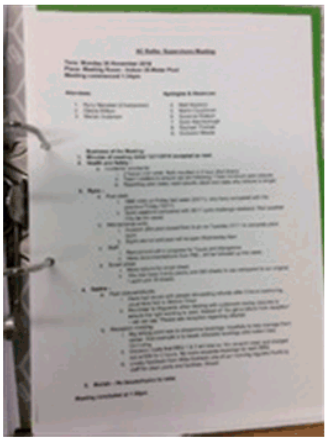
- There is documented evidence that the information gathered from the above reporting procedures is scrutinised and used to make changes (if necessary) designed to improve safety, for example Health & Safety Meeting minutes. Evidence sighted of last four meetings

Appendix - Photos





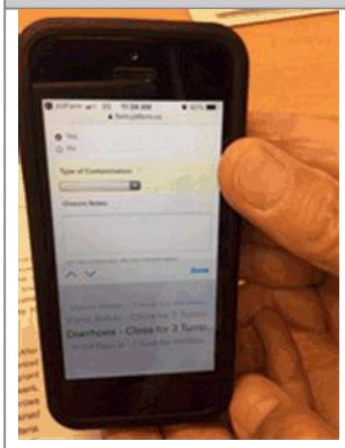
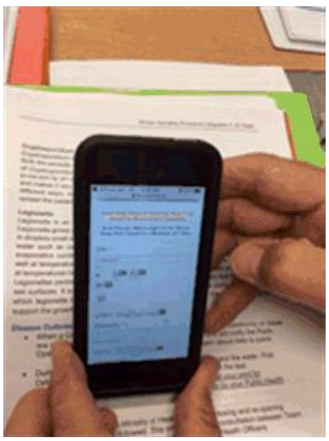




Section: Water Quality

Question:

- Procedure must cover actions in response to – faecal solids, vomit, diarrhoea, blood and an incident in a confirmed cryptosporidium outbreak and notifiable disease outbreak and reporting requirements..

Appendix - Photos		
		
Section: Water Quality		
Question: • That faecal accident, especially those involving diarrhoea, are recorded.		
		

Facility:	Genesis Energy Turangi Aquatic Centre
Assessor name:	Dot Leggett Lane
Pool manager name:	Suzanne Watson
Date:	14 Feb 2019

Supervision	
CRITERIA: All lifeguards must hold current & valid PLSA or PLPC **HOW: Sight current & valid PLSA or PLPC certificates for all lifeguards**	
ESSENTIAL COMPONENTS:	
• Evidence that all staff have undergone PLSA or PLPC training and assessment	Achieved
• Evidence that all lifeguards have completed an induction PRIOR to working on Poolside **Comments:**	Achieved
• The PLPC assessment has taken place and paperwork sent to Skills Active within one month of starting work on Poolside	Achieved
• NOP must clearly state that lifeguards or staff members, who do not hold a current and valid PLSA (for one month from date of starting on poolside) or PLPC will not be included in any supervision ratios.	Achieved
• All qualified lifeguards must have completed First aid units 26551 and 26552 (6400, 6401 & 6402) as a minimum first aid qualification	Achieved
NOTE: Assessors must be satisfied that the correct process has occurred and an honest attempt has been made by the Facility to provide evidence of their staff qualifications.	
Total number of lifeguards on the facility roster = a) Skills Award b) PLPCa) Skills Award: 0 b) PLPC: 8	
CRITERIA: Every body of water is supervised by a qualified lifeguard (when open for use) at all times. Qualified means holding a current PLSA (within one month of training) or PLPC. **HOW: Review facility normal operating procedures (NOPs) relating to supervision.**	
ESSENTIAL COMPONENTS: **NOP must detail:**	
• A PLPC lifeguard must be rostered on and available at all times. (This is the minimum, it is recommended that a PLPC lifeguard is rostered on and POOLSIDE at all times)	Achieved
• All lifeguards must be able to retrieve an object from the deepest part of the pool	Achieved
NOP must detail the way in which the pool should be supervised including reference to:	
• The minimum number of lifeguards	Achieved

• The area of water and physical obstacles each lifeguard supervises (E.G glare, dead water)	Achieved
• Supervision techniques and supervision of different activities	Achieved
• How lifeguards communicate	Achieved
• Leaving poolside procedures **Comments:**	Achieved
• After-hours groups must be lifeguarded within supervision ratios by a facility employed PLPC lifeguard	Achieved
A facility schematic/s should be included detailing:	
• Recommended Static Positions	Achieved
• Patrolling routes	Achieved
The NOP should give poolside lifeguards as much information as they need to make informed minute-by-minute decisions on supervising the pool without being over prescriptive and too lengthy. The following are some useful headings:	
• Personal appearance and conduct of lifeguards (talking, grooming, uniform etc)	Achieved
• Identification of hazards/risks	Achieved
• Poolside first aid	Achieved
Customer behaviour	
1. Acceptable behaviour	Achieved
2. Unacceptable behaviour	Achieved
• Supervision of different customer groups, (children, youth, special needs etc)	Achieved
• Supervision of different activities, (lane swimming, diving boards etc)	Achieved
It is desirable that the normal operating procedures be cross referenced to any other similar procedures, EG:	
1. EAP	Achieved
2. Health and Safety policies	Achieved

NOTE: Evidence will be required to back up the written policies in the NOP – eg training schedule showing induction. How the pool determines its supervision policies and sets out its plan are the domain of that particular pool. The assessors' task is to verify that the essential components are present. Some pools do not publish detailed supervision policies. If this is the case an oral description backed up with poolside observations and lifeguard questioning will suffice.	
Facilities with dedicated Learn to Swim Pools, Private Pools and/or Spa pools, Saunas and steam rooms	
• Learn to Swim Pools, Private pools must have signage clearly visible to say the area of water is not supervised by a lifeguard	Achieved
• NOP must clearly state procedures for dealing with the private pools/spa and sauna/steam rooms relative to the facility, for example (but not limited to)	Not applicable
• Time restriction	Not applicable
• Hydration advice	Not applicable
• How these are monitored (eg, alarms, regular checks)	Not applicable
• Minimum age for use (i applicable)	Not applicable
• Minimum number of people	Not applicable
• Who is in charge in an emergency	Not applicable
• How staff communicate with each other (E.G Teachers from the LTS pool communicate to the lifeguards in the main pool	Achieved
The above list is a guide only – the detail is the domain of that particular pool.	

Dedicated Learn to Swim Facility	
Dedicated stand-alone Learn to Swim Facility (ie not within a complex that has other aquatic activities and is ONLY open for structured lessons)	
• NOP must clearly state either qualified lifeguards are on pool deck OR LTS instructors are qualified lifeguards, in the water teaching but within the supervision ratios	Not applicable
• Signage to say the area is not actively supervised by a lifeguard	Not applicable
• Clear documented procedures covering (but not limited to):	Not applicable
• What happens if an instructor has to leave the water	Not applicable

• Who is in charge of an emergency situation	Not applicable
• How staff communicate with each other	Not applicable

Emergency Action Plan	
CRITERIA: Existence of an Emergency Action Plan **HOW: Evidence of the EAP is clearly apparent**	
ESSENTIAL COMPONENTS	
• All lifeguards must have easy access to a current EAP	Achieved
• EAP must be in manual format with poolside emergency signage to compliment procedures	Achieved
EAP must succinctly specify the actions to be taken in every reasonably foreseeable emergency. In most cases this will be limited to pool and facility emergencies. It should include reference to the following:	
• Who is in charge	Achieved
• Nature and location of emergency equipment	Achieved
• Key steps in dealing with an emergency	Achieved
• Pool rescue	Achieved
• Medical alert, (choking, asthma, angina/heart attack, serious cuts, fractures and dislocations etc)	Achieved
• Building evacuation	Achieved
• Major first aid	Achieved
• Spinals	Achieved
• Aftercare for victims and staff	Achieved
• A flowchart summary of the key steps in dealing with an emergency should be available to lifeguards	Achieved
• A pool manual cross referencing health and safety policies, pool supervision policies, Normal Operating Procedures and Emergency Action Plan should be available to lifeguards giving them one-stop-shop access to the "big picture"	Achieved

• Evidence that regular (minimum quarterly) staff training occurs including staff training plans and signed staff training records	Achieved

Pool Alone	
CRITERIA: Existence of a policy relating to child supervision **HOW: Review facility NOPs relating to child supervision**	
ESSENTIAL COMPONENTS:	
• NOP must set an age below which a child may not swim unaccompanied and thus becomes a pool alone. Minimum age is under 8 years	Achieved
• NOP must detail supervision of under 5's in the pool and include provision for ratios of adult to child(ren) **Comments:**	Achieved
• NOP must give some guidelines on effective enforcement	Achieved

Risk Management Plan	
CRITERIA: Existence of a pool water risk management plan. **HOW: Evidence of a pool water quality risk management plan (RMP) is clearly apparent**	
ESSENTIAL COMPONENTS:	
• PRMP is onsite, easily accessible has been reviewed annually (review report completed) and updated where necessary	Achieved
• PRMP identifies all of the significant risks for each element of the pool system.	Achieved
• PRMP identifies the critical points of the pool system.	Achieved
• PRMP identifies the barriers to contamination (including staff training and/or qualifications, staffing levels, sampling programmes, calibration of analysers).	Achieved
• PRMP quantifies the risks.	Achieved
• PRMP identifies measures to prevent, reduce or eliminate the risks.	Achieved
• PRMP identifies necessary improvements to the pool to manage the risk. Improvements are prioritised & there is a timetable for implementing the improvements.	Achieved

Health and Safety	
CRITERIA: Confirm the operation of a health and safety management process **HOW: Review facility NOPs relating to health and safety**	
ESSENTIAL COMPONENTS:	
• Documented process whereby hazards/risks are identified and recorded, they are managed by being minimised or eliminated	Achieved
• Documented process for recording and investigating employee accidents and notifiable death, injury, illness and incident	Achieved
• Documented process for recording customer accidents	Achieved
• Documented process for recording customer notifiable death, injury, illness and incident	Achieved
• Documented process for wet and dry rescues	Achieved
• A record is kept of all customer accidents requiring further medical attention	Achieved
• There is documented evidence that the information gathered from the above reporting procedures is scrutinised and used to make changes (if necessary) designed to improve safety, for example Health & Safety Meeting minutes. Evidence sighted of last four meetings **Comments:**	Achieved
• Provide chemical inventory for all chemicals on site as per Health & Safety at Work Act (Hazardous Substance Regulation 2017) **Comments:**	Achieved
NOTE: This section is not designed to supersede any more thorough HEALTH AND SAFETY PROCESS a pool may have. It is not designed to fulfil legislative or contractual obligations under the HSE Act or OSH. It is a few fundamental pointers to assist the pool manager in providing a safe environment for employees and customers.	

Water Quality	
CRITERIA: Water testing programme compliant with NZS 5826:2010. **HOW: Review facility NOPs relating to water quality.**	
ESSENTIAL COMPONENTS: **NOP must specify:**	
• Lowest and highest values for the relevant chemical constituents within the parameters contained in NZS 5826:2010	Achieved

• A frequency of testing that meets the minimum set in NZS 5826:2010	Achieved
• The detail and frequency of microbiological tests	Achieved
1. Tests must be scheduled a minimum of monthly	Achieved
2. Tests must include: • Faecal Coliforms or E. coli • Staphylococcus aureus • Pseuduomonas aeruginosa • Standard plate count	Achieved
• Four weeks water chemical value tests as specified by the assessor must confirm the presence of chemicals between the lowest and highest values set in NZS 5826:2010	Achieved
• Four separate sets of microbiological tests as specified by the assessor must confirm the absence of pathogens of the time above the highest value set in NZS 5826:2010	Achieved
• Visual check of records, testing procedures and pool laboratory to confirm that written evidence does correspond to what actually occurs at the facility.	Achieved
• Must detail the water treatment qualifications held by the relevant staff. **Comments:**	Achieved
• Procedure must cover actions in response to – faecal solids, vomit, diarrhoea, blood and an incident in a confirmed cryptosporidium outbreak and notifiable disease outbreak and reporting requirements.. **Comments:**	Achieved
• Procedure must specify – type of contamination and response, removal of solids and semi-solids (Vacuuming), filtration and turnover, evacuation times, disinfection for each pool. **Comments:**	Achieved

• That faecal accident, especially those involving diarrhoea, are recorded. **Comments:**	Achieved

Water Quality (On site)	
Water Quality Including Pool Contamination **CRITERIA: Confirmation that staff understand and apply the faecal accident procedure.** **HOW: Questioning to verify that staff understand the faecal accident procedure.**	
ESSENTIAL COMPONENTS: • A visual check of records and equipment. • Questioning of frontline staff to determine that if a faecal accident occurred it would be dealt with in accordance with the procedure • Visual check of records, testing procedures and pool laboratory to confirm that written evidence does correspond to what actually does occur at the facility.	Achieved
NOTE: Every lifeguard is not expected to know the entire procedure. They must be able to perform the first response to avoid contamination of pool customers and then know where to access further information or advice.	

Supervision (On site)
CRITERIA: Confirmation that all pools are supervised according to NOP. **HOW: Visual check and questioning to verify that staff understand and apply pool supervision policy.**

ESSENTIAL COMPONENTS: • All water open for use is supervised by a lifeguard • Any closed water is closed with a barrier or its access is supervised by a lifeguard • Lifeguards must have an understanding of the rationale behind the individual pools procedures and a grasp of the information contained in the procedures; at a level whereby they are able to make sound decisions on how they supervise the pool on a minute by minute, second by second basis • Lifeguards are not required to know or even recognise the technical terms or even names of procedures • Lifeguards should be asked to quote actual examples of the application of pool supervision procedure (unless they just do not happen) • Lifeguards should be given hypothetical situations and asked for their response. The response should mirror the rationale behind procedures • Lifeguard in charge must have an understanding of the rationale behind the procedures and a grasp of the information contained in the procedures • Lifeguard in charge should be asked to quote pool supervision ratios • PLSA Lifeguards will be asked to confirm a PLPC staff member is always rostered on with them • Lifeguards should be asked about after-hours bookings and who is rostered on.	Achieved
Facilities with Learn to Swim Pools, Private Pools/Spas	
• Private pools/spas must have signage clearly visible to say the area of water is not supervised • Lifeguards should be familiar with the guidelines of use as per the NOP	Achieved
Dedicated stand-alone Learn to Swim Facility	Achieved
• Lifeguards and/or instructors should be familiar with the guidelines of use as per the NOP • Signage clearly visible to say that the facility is not supervised by a lifeguard	Achieved

Emergency Action Plan (On site)

CRITERIA: Confirmation that staff understand and apply the pools EAP. HOW: Visual check and questioning to verify that staff understand EAP.	
ESSENTIAL COMPONENTS: • Lifeguards must be able to outline the essential elements of the appropriate response to every reasonably foreseeable emergency. • That the assessor is satisfied a victim would receive care expected from an entry level lifeguard using Pool Lifeguard Practising Certificate as the benchmark. • Lifeguards are not required to know or even recognise the technical terms or even names of procedures. • Lifeguards should be asked to quote actual examples of the application of the pool EAP (unless they just do not happen). • Lifeguards should be given hypothetical situations and asked for their response. The response should mirror the rationale behind procedures. • Senior lifeguards should know the plan backwards and be able to adapt it to cater to the more unlikely situations, e.g. multiple casualties. • Formal EAP training is given regularly.	Achieved

Pool Alone (On site)
CRITERIA: Confirmation that staff understand and apply the pools child supervision policy. **HOW: Visual check and questioning to verify that staff understand child supervision policy.**

ESSENTIAL COMPONENTS:	Achieved
• Any signage must be clear and visible. • Any signage must not contradict pool policy • All signage be professionally written from quality materials to allow maximum visibility and efficiency. **Front counter staff** must be expert at the enforcement of pool alone as they are the primary enforcer • Front counter staff should be asked to quote actual examples of pool alone instances (unless they just do not happen) • Front counter staff should be given hypothetical situations and asked for their response. The response should mirror policy • Front counter staff should be asked how they would respond to a child below the minimum age being "dumped" at the pool front gates **Poolside staff** must be expert at the identification of, and corrective action relating to, unsupervised children under minimum age • Poolside staff should be asked to quote actual examples of pool alone instances (unless they just do not happen or the staff member has not dealt with any) • Poolside staff should be given hypothetical situations and asked for their response. The response should mirror policy	

Health and Safety (On site)

CRITERIA: Confirmation that staff understand and apply the pools health and safety policy.
HOW: Visual check and questioning to verify that staff understand health and safety policy.

ESSENTIAL COMPONENTS:	Achieved
• A visual check of records and question poolside staff to confirm that the specified recording of near misses, accidents, notifiable death, injury, illness and incidents and review processes (H&S minutes) occur. • Annual Incident Review has been returned to NZRA Quality Programme Coordinator. • A visual check of signage, spills kits, Personal Protection Equipment (PPE) and MSDS for all chemicals on site in accordance with the Health & Safety at Work Act 2015 (Hazardous Substance Regulation 2017). • A visual check that staff members have induction and training on chemical storage, use and disposal. **Comments:**	

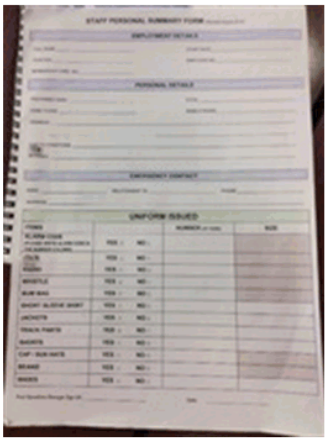
Field manager's signature

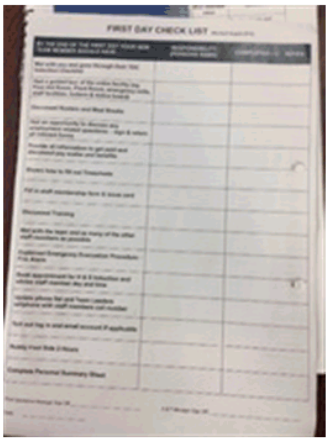
Appendix - Photos

Section: Supervision

Question:

- Evidence that all lifeguards have completed an induction PRIOR to working on Poolside

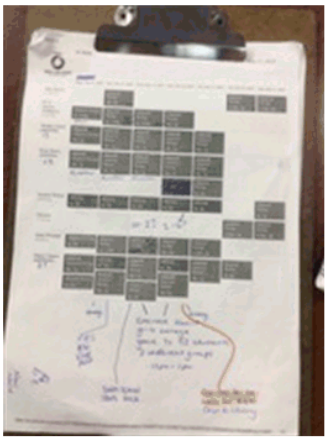




Section: Supervision

Question:

- Evidence that all staff have undergone PLSA or PLPC training and assessment



Section: Supervision

Question:

- Learn to Swim Pools, Private pools must have signage clearly visible to say the area of water is not supervised by a lifeguard

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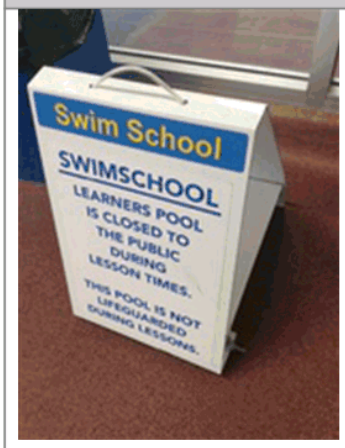

Section: Water Quality

Question:

- Visual check of records, testing procedures and pool laboratory to confirm that written evidence does correspond to what actually occurs at the facility.

Section: Water Quality (On site)

Question: **ESSENTIAL COMPONENTS:**

- A visual check of records and equipment.
- Questioning of frontline staff to determine that if a faecal accident occurred it would be dealt with in accordance with the procedure
- Visual check of records, testing procedures and pool laboratory to confirm that written evidence does correspond to what actually does occur at the facility.

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Section: Supervision (On site)

Question: **Dedicated stand-alone Learn to Swim Facility**

Section: Supervision (On site)

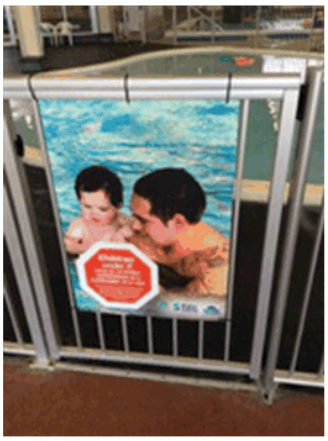
Question: **ESSENTIAL COMPONENTS:**

- All water open for use is supervised by a lifeguard
- Any closed water is closed with a barrier or its access is supervised by a lifeguard
- Lifeguards must have an understanding of the rationale behind the individual pools procedures and a grasp of the information contained in the procedures; at a level whereby they are able to make sound decisions on how they supervise the pool on a minute by minute, second by second basis
- Lifeguards are not required to know or even recognise the technical terms or even names of procedures
- Lifeguards should be asked to quote actual examples of the application of pool supervision procedure

Appendix - Photos

(unless they just do not happen)

- Lifeguards should be given hypothetical situations and asked for their response. The response should mirror the rationale behind procedures
- Lifeguard in charge must have an understanding of the rationale behind the procedures and a grasp of the information contained in the procedures
- Lifeguard in charge should be asked to quote pool supervision ratios
- PLSA Lifeguards will be asked to confirm a PLPC staff member is always rostered on with them
- Lifeguards should be asked about after-hours bookings and who is rostered on.



Section: Supervision (On site)

Question:

- Private pools/spas must have signage clearly visible to say the area of water is not supervised
- Lifeguards should be familiar with the guidelines of use as per the NOP

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Section: Emergency Action Plan (On site)	
Question: **ESSENTIAL COMPONENTS:** • Lifeguards must be able to outline the essential elements of the appropriate response to every reasonably foreseeable emergency. • That the assessor is satisfied a victim would receive care expected from an entry level lifeguard using Pool Lifeguard Practising Certificate as the benchmark. • Lifeguards are not required to know or even recognise the technical terms or even names of procedures. • Lifeguards should be asked to quote actual examples of the application of the pool EAP (unless they just do not happen). • Lifeguards should be given hypothetical situations and asked for their response. The response should mirror the rationale behind procedures. • Senior lifeguards should know the plan backwards and be able to adapt it to cater to the more unlikely situations, e.g. multiple casualties. • Formal EAP training is given regularly.	

Appendix - Photos

Section: Pool Alone (On site)

Question: **ESSENTIAL COMPONENTS:**

- Any signage must be clear and visible.
- Any signage must not contradict pool policy
- All signage be professionally written from quality materials to allow maximum visibility and efficiency.

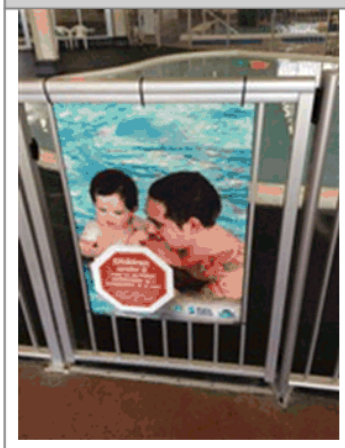
Front counter staff must be expert at the enforcement of pool alone as they are the primary enforcer

- Front counter staff should be asked to quote actual examples of pool alone instances (unless they just do not happen)
- Front counter staff should be given hypothetical situations and asked for their response. The response should mirror policy
- Front counter staff should be asked how they would respond to a child below the minimum age being "dumped" at the pool front gates

Poolside staff must be expert at the identification of, and corrective action relating to, unsupervised children under minimum age

- Poolside staff should be asked to quote actual examples of pool alone instances (unless they just do not happen or the staff member has not dealt with any)
- Poolside staff should be given hypothetical situations and asked for their response. The response should mirror policy

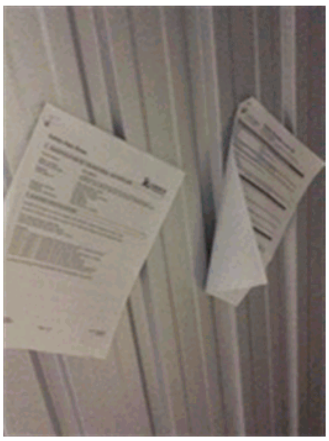
Appendix - Photos



Section: Health and Safety (On site)

Question: **ESSENTIAL COMPONENTS:**

- A visual check of records and question poolside staff to confirm that the specified recording of near misses, accidents, notifiable death, injury, illness and incidents and review processes (H&S minutes) occur.
- Annual Incident Review has been returned to NZRA Quality Programme Coordinator.
- A visual check of signage, spills kits, Personal Protection Equipment (PPE) and MSDS for all chemicals on site in accordance with the Health & Safety at Work Act 2015 (Hazardous Substance Regulation 2017).
- A visual check that staff members have induction and training on chemical storage, use and disposal.



BUILDING CONSENT AUTHORITY ACCREDITATION ASSESSMENT REPORT

TAUPO DISTRICT COUNCIL

International Accreditation New Zealand, Private Bag 28908 Remuera Auckland 1541, Ph. (09) 525 6655, Fax (09) 525 2266

CONTENTS

INTRODUCTION

This report relates to the accreditation assessment of the Taupo District Council Building Consent Authority (BCA) which took place 6-9 March 2019 to determine compliance with the requirements of the *Building (Accreditation of Building Consent Authorities) Regulations 2006* (the Regulations).

This report is based on the document review, witnessing of activities and interviews with the BCA's employees and contractors undertaken during the accreditation assessment.

A copy of this report, and subsequent information regarding progress towards clearance of non-compliance/s, will be provided to the Ministry of Business, Innovation and Employment (MBIE) in accordance with International Accreditation New Zealand's (IANZ) contractual obligations. This report may also be made publicly available by the BCA as long as this is not done in a way that mispresents the content within. It may also be released under the Local Government Meetings and Official Information Act 1987 consistent with any ground for withholding that might be applicable.

ACCREDITATION FEEDBACK AND CONTINUING ACCREDITATION

Accreditation is a statement, by IANZ, that your organisation complies with the Regulations and MBIE BCA accreditation scheme guidance documents (as relevant). Where non-compliance with the Regulations has been identified, the Act requires that it must be addressed. This report will also highlight examples of good practice and performance.

This accreditation assessment found that the BCA was non-compliant with a number of accreditation requirements as detailed below. The non-compliances identified must be addressed before accreditation is continued.

Summary of the non-compliances identified during the assessment

Your non-compliances with the Regulations have been summarised and recorded in detail in this report. Please complete the Record of Non-compliance table/s detailing your proposed corrective actions and forward a copy to IANZ. This plan of action must be provided to IANZ by 25/04/2019.

All non-compliances must be finally addressed and cleared by 25/06/2019. To maintain accreditation you must provide evidence of the actions taken to clear non-compliance to IANZ within the required timeframe. If you do not agree with the non-compliances identified, please contact the Lead Assessor as soon as possible. If you need further time to address non-compliances, please contact the Lead Assessor as soon as possible.

Where you are seeking an extension to an agreed timeframe to address a non-compliance, your Chief Executive is required to make a formal request for an extension of the timeframe.

If you have a complaint about the assessment process, please refer to the MBIE accreditation guidance.

NEXT ACCREDITATION ASSESSMENT

Unless your BCA undergoes a significant change, requiring some form of interim assessment, or the BCA is unable to clear the identified non-compliances within the agreed timeframe, the next assessment of the BCA is planned for March 2021. You will be formally notified of your next assessment six weeks prior to its planned date.

ASSESSMENT SUMMARY

ORGANISATION DETAILS		
Organisation:	Taupo District Council	
Address for service:	72 Lake Terrace Taupo 3330 New Zealand	
Client Number:	7419	
Accreditation Number:	14	
Chief Executive:	Gareth Green	
Chief Executive contact details:	ggreen@taupo.govt.nz	
BCA Authorised Representative:	Kelvin Short	
BCA Authorised Representative contact details:	kshort@taupo.govt.nz	
BCA Quality Manager:	Alix Lattey	
Number of BCA FTE's	Technical - 4 Administration – 1 FTE Vacancies - 1	
ASSESSMENT TEAM		
Lead Assessor:	Carolyn Osborne	
Lead Assessor contact details:	cosborne@ianz.govt.nz	
Technical Expert/s:	Colin Pickering	
MBIE observer/s:	Mike Reedy	
IANZ REPORT PREPARATION		
Prepared by:	Carolyn Osborne	
Signature:	*C Osborne*	
Checked by:	P Wakefield	
Signature:	P Wakefield.	
Date:	26/03/2019	
ASSESSMENT FINDINGS		
	This assessment:	**Last assessment:**
Total # of "serious" non-compliances:	1	NA
Total # of "general" non-compliances:	32	NA
Total # of non-compliances outstanding:	32	NA
Number of recommendations:	0	NA
Number of advisory notes:	4	NA
Date clearance plan required from BCA:	25/04/2019	
Date all non-compliances must be finally cleared:	25/06/2019	
Accreditation to continue with non-compliance clearance?	Yes	
NEXT ASSESSMENT		
Recommended next assessment type:	Full assessment	
Recommended next assessment date:	March 2021	
COMMENTS		

ASSESSMENT OBSERVATIONS

REGULATION 6A NOTIFICATION REQUIREMENTS

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**SNC 1 To be resolved**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

- **Procedures** did not address the requirement to notify MBIE and IANZ according to the situations discussed in the MBIE Guidance. **Implementation** may have been needed since July 2017 but this was unclear.

SNC 1. To be resolved.

REGULATION 7 PERFORMING BUILDING CONTROL FUNCTIONS

Regulation 7(2)(a): providing consumer information

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 1. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

Procedures (Public Information) addressed most requirements except the following:

- Did not discuss the need for the applicant to submit proposed Inspection Maintenance and Reporting information for any proposed Specified Systems.
- Did not discuss access for Inspectors when performing site inspections.
- When discussing the issuing of Code Compliance Certificates did not clarify sufficiently Compliance Schedule matters.

GNC 1. To be resolved.

Regulation 7(2)(b)-(c), and 7(2)(d)(i): receiving, checking and recording applications

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 2. To be resolved.**
Opportunities for improvement? Y/N	**Yes**
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	**1**
Advisory note number/s:	**A1**

Observations and comments, including good practice and performance

7(2)(b) Receiving

- **Procedures** (Form 2 template) did not ensure buildings in consent applications were classified according to the A1 Classifications in the 1992 Building Regulations. **Implementation** of this requirement was not demonstrated.

GNC 2. To be resolved.

Comment, in one application reviewed the building had not been classified correctly according to the A1 Classifications in the 1992 Building Regulations..

The BCA is advised **(A1)** to consider including (in their procedures for receiving) a cut off time for receiving at the end of a working day.

7(2)(c) Checking applications for completeness.

Procedures addressed requirements and were effectively implemented.

7(2)(d)(i) Recording applications in the processing system.

Procedures addressed requirements and were effectively implemented.

Regulations 7(2)(d)(ii): assessing applications (Categorisation)

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 3. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
• **Procedures** (Goget with respect to Categorisation), were not consistent with the Competency Assessments and the Skills Matrix. **GNC 3. To be resolved.** Current procedures (for the most part) were effectively implemented. **Comment.** In one instance, in the records reviewed, there had been a miss-categorisation of a building.	

Regulations 7(2)(d)(iii): allocating applications

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 4. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
• **Procedures** (Goget with respect to Allocation), were not consistent with the Competency Assessments and the Skills Matrix. **GNC 4. To be resolved.** Current procedures (for the most part) were effectively implemented. **Comment.** In one instance, in the records reviewed, allocation had not been according to competencies recorded in the Competency Assessment and Skills Matrix for that individual.	

Regulation 7(2)(d)(iv): processing building consent applications

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 5. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

- **Procedures** did not address the requirement to consider decisions under s112(2) of the Act.
- **Implementation** of procedures (with respect to Specified Systems) had not been effective in that there was not a sufficient level of detail for some Specified Systems and Performance Standards.
- **Procedures** did not prompt the review of swimming pools.
- **Procedures** did not prompt the review of the collection of relevant Building Levies.
- **Procedures** did not prompt the review of earthquake prone buildings(s133 AT)
- **Implementation** of procedures for reviewing and recording access and facilities for people with disabilities had not been effective in the following way. The decisions, reasons for decisions and outcome of decisions were recorded in an incorrect location in the processing checklist.
- **Implementation** of procedures for compiling and amending Compliance Schedules was not effective with respect to Performance Standards for some Specified Systems.
- **Implementation** of processing procedures was not effective with respect to recording of decisions reasons for decisions and the outcome of decisions 6(b)(c) and (d) of these regulations.

GNC 5. To be resolved

Regulation 7(2)(d)(v): granting and issuing consents

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 6. To be resolved**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

- **Procedures** for granting and issuing consents did not prompt the BCA to consider levies with respect to s53 (2)(b), s54 and s58 of the Act.
- **Procedures** did not prompt the BCA to send the applicant any Territorial Authority documents or information if/when received.
- **Implementation** of procedures was not effective when ensuring that the building consent states the Specified Systems that must be covered by the Compliance Schedules.
- **Implementation** of procedures was not effective at ensuring the building consent states the Performance Standards covered by the Compliance Schedules.
- **Implementation** of procedures was not effective at ensuring the building consent states the Specified Systems that must be covered by the Compliance Schedules when Compliance Schedules required amendment.
- **Implementation** of procedures was not effective at ensuring the building consent states the Performance Standards that must be covered by the Compliance Schedules when Compliance Schedules required amendment.

GNC 6. To be resolved.

Other than the previous findings current procedures were otherwise effectively implemented.

The BCA had been fully compliant with the statutory clock in 21 of the previous 22 months.

Regulation 7(2)(e): planning, performing and managing inspections

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 7. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

- **Procedures** did not clarify to the Inspector how to manage work that varies from the consent.
- **Procedures** did not clarify to the Inspector how to manage work that does not comply with the Building Code.
- **Procedures** did not prompt the Site Inspector to manage work that needs to be checked for any warnings or bans issued by MBIE. **Implementation** of this requirement was not demonstrated by the BCA.

GNC 7. To be resolved.

Other than the previous findings current procedures were effectively implemented.

Regulation 7(2)(f): code compliance certificates, compliance schedules and notices to fix

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 8. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

Application for a code compliance certificate

- **Procedures** did not ensure that the BCA collected information to demonstrate that Specified Systems were capable of performing to Performance Standards identified on an issued building consent. **Implementation** of this requirement was not demonstrated by the BCA.

Code compliance certificates

- **Procedures** for considering whether to issue a CCC did not clarify that Specified Systems must be capable of performing to Performance Standards identified on an issued building consent. **Implementation** of this requirement was not demonstrated by the BCA.
- **Procedures** for considering whether to issue a CCC did not prompt the BCA to consider whether there were any applicable warnings or bans related to any building method or product that may have been used. **Implementation** of this requirement was not demonstrated by the BCA.
- **Procedures** for issuing Code Compliance Certificates did not address requirements in that CCC's were being issued with classifications other than those required in A1 of the 92 Regulations. **Implementation** of this requirement was not demonstrated by the BCA.
- **Procedures** for issuing CCC's did not discuss meeting the requirement to issue CCC's within 20 working days.

The BCA had been fully compliant with issuing CCC's within 20 working days in all of the previous 24 months.

The BCA was effectively managing CCC decisions at 24 months were there had been no application for a CCC.

Compliance Schedules

- **Implementation** was not effective with respect to Performance Standards on Compliance Schedules.

Notices to fix

- **Procedures** did not prompt the BCA to notify another responsible authority of the need to issue a Notice to Fix.
- **Procedures** did not prompt the BCA to consider s165 of the Act when issuing a Notice to Fix.
- **Procedures** did not prompt the BCA to consider s166 of the Act when issuing a Notice to Fix.

GNC 8. To be resolved.

Regulation 7(2)(g): customer inquiries

Non-compliance? Y/N	No
Non-compliance number/s:	-
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
Procedures addressed requirements and were effectively implemented.	

Regulation 7(2)(h): customer complaints

Non-compliance? Y/N	No
Non-compliance number/s:	-
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
Procedures addressed requirements and were effectively implemented.	

REGULATION 8 ENSURING ENOUGH EMPLOYEES AND CONTRACTORS

Regulation 8(1): forecasting workflow

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 9. To be resolved**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

- **Procedures** did not prompt the BCA to review/record the volume of work performed by the BCA in the previous two years when planning forward workflow. **Implementation** of this requirement was not demonstrated by the BCA.
- **Procedures** did not prompt the BCA to review/record limitations on Technical Leadership or Specialist Technical knowledge when planning forward workflow. **Implementation** of this requirement was not demonstrated by the BCA.
- **Procedures** did not prompt the BCA to review/record known external factors that might influence the volume of building work e.g. new sub-divisions, changes in interest rates. **Implementation** of this requirement was not demonstrated by the BCA.
- **Procedures** did not prompt the BCA to review/record the number of Full Time Equivalent (FTE) required at each level of competency for consenting, inspecting and certifying. **Implementation** was not demonstrated by the BCA.

GNC 9. To be resolved.

Regulation 8(2): identifying and addressing capacity and capability needs

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 10. To be resolved**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
• **Procedures** did not prompt the BCA to record the number of Full Time Equivalent (FTE) required at each level of competency for consenting inspecting and certifying. **Implementation** was not demonstrated by the BCA. • **Procedures** did not prompt the BCA to record the number of Technical Leadership and Specialist Technical knowledge required. **Implementation** of this requirement was not demonstrated by the BCA. • **Implementation** of the requirement to calculate numbers of FTE required had been effective in part. The BCA had completed an exercise to calculate the number of FTE required using a resource calculator. To date the BCA did not have the number of FTE required. **GNC 10. To be resolved.**	

REGULATION 9 ALLOCATING WORK

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 11.To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
• **Procedures** (Goget System) did not ensure consistency between Competency Assessments, the Skills Matrix and Goget. **GNC 11. To be resolved.**	

REGULATION 10 ESTABLISHING AND ASSESSING COMPETENCY OF EMPLOYEES

Regulation 10(1) and (3): assessing prospective employees

Non-compliance? Y/N	No
Non-compliance number/s:	-
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
Procedures addressed requirements. They had not been implemented in the previous two years.	

Regulation 10(2) and (3): assessing employees performing building control functions

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 12. To be resolved** **GNC's 13, 14, 15, 16, 17, 18. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	

10(2) Competency Assessment System

- **Procedures** did not require the BCA to maintain records of competency of Assessors according to Appendix 2 of the National Competency Assessment System (The BCA's recorded Competency Assessment System)

GNC 12. To be resolved.

13(3)(a-f) Assessment against requirements 10(3)(a-f)

- **Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for each of parts 10(3)(a-f) of these regulations.

GNC's 13, 14, 15, 16, 17, 18. To be resolved.

Competency Assessments had been performed annually.

REGULATION 11 TRAINING EMPLOYEES DOING A TECHNICAL JOB

Regulation 11(1) and (2)(a)-(d),(f) and (g): the training system

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 19. To be resolved** **GNC 20. To be resolved**
Opportunities for improvement? Y/N	**Yes**
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	**1**
Advisory note number/s:	**A2**

Observations and comments, including good practice and performance

11(1) Training System

- **Procedures** did not specify that the BCA would perform Training Needs Assessments annually.

GNC 19. To be resolved.

11(2)(b) Training Plans

- **Procedures** did not require the BCA to specify how implementation of training shall be reviewed. **Implementation** of this requirement was not demonstrated by the BCA
- **Procedures** did not require the BCA to record the reason for any training that was missed. **Implementation** was not demonstrated by the BCA.

GNC 20. To be resolved

The BCA is advised **(A2)** to ensure (wherever possible) to review application of training by reviewing the application of training in relevant consents and record the consent numbers as evidence.

Regulation 11(2)(e): supervising employees doing a technical job under training

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 21. To be resolved**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
Procedures addressed requirements • **Implementation** of procedures had not been effective as the BCA was not reviewing all work performed by individuals in training up until the point they were deemed to be fully competent by the BCA. • **Implementation** was also not effective in that the BCA was not recording sufficient observations for each piece of work performed by any trainee. This is intended to meet regulations 6(b)(c) and (d) of the regulations. **GNC 21. To be resolved.**	

REGULATION 12 CHOOSING AND USING CONTRACTORS

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 22. To be resolved.** **GNC 23. To be resolved.** **GNC 24. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

12 (1) System

- **Procedures** did not address the requirement to record the qualification of any prospective contractor.

GNC 22. To be resolved.

12 (2) (c) Contracts.

Procedures (contracts) did not require the following:

- Contractor to comply with a Quality Assurance System.
- Contract to specify selected staff within an organisation where relevant.
- Contract to specify powers and authorities to be granted to any contracted staff.
- Contract to discuss managing internal and external communications specifically with respect to engagement with the media.
- Contract to specify that staff will be required to have annual Competency Assessments.
- Contract to require contractor to adhere to the BCA's policies procedures and systems (or their own).

GNC 23. To be resolved.

12(2)(e) Performance monitoring.

- **Procedures** did not require the BCA to monitor contactor performance against the defined standards documented in their contract.

GNC 24. To be resolved.

REGULATION 13 ENSURING TECHNICAL LEADERSHIP

Non-compliance? Y/N	No
Non-compliance number/s:	-
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
Procedures addressed requirements and were effectively implemented.	

REGULATION 14 ENSURING NECESSARY (TECHNICAL) RESOURCES

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 25. To be resolved.**
Opportunities for improvement? Y/N	**Yes**
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	**1**
Advisory note number/s:	**A3**
Observations and comments, including good practice and performance	

- **Procedures** did not address the requirement to determine/record the information and equipment that any contractor may be required to provide.

GNC 25. To be resolved.

Other than the previous finding current procedures were effectively implemented.

The BCA is advised **(A3)** to consider revising their moisture meter calibration procedure to specify that the meter shall be sent for servicing if it reads outside the parameters specified on the moisture block. In this case outside 17-19 % moisture.

REGULATION 15 KEEPING ORGANISATIONAL RECORDS

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 26. To be resolved**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

Procedures did not address the following:

- The organisations chart did not specify the number of technical staff performing building control functions in Full Time Equivalence.
- Did not specify authorities to address s133AT and s90 requirements.

GNC 26. To be resolved.

Other than the previous findings current procedures were effectively implemented.

REGULATION 16 FILING APPLICATIONS FOR BUILDING CONSENT

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 27. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

- **Procedures** did not specify fourteen document types specified in the MBIE Guidance.

GNC 27. To be resolved.

Despite the previous findings files reviewed held appropriate content.

REGULATION 17 ASSURING QUALITY

Regulations 17(1) and (2)(a): A quality assurance system that covers management and operations

Non-compliance? Y/N	No
Non-compliance number/s:	-
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
Procedures addressed requirements. Where omissions were found they are addressed under their relevant regulation.	

Regulation 17(2)(b) and (3): A policy on quality and a quality manager

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 28. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
17(2)(b) Quality Policy • **Procedures** (Quality Policy) did not specify a commitment to Continuous Improvement. **GNC 28. To be resolved.** Other than the previous finding procedures were appropriate. **17(3) Quality Manager** The BCA had recorded a Quality Manager	

Regulation 17(2)(d) and 17(5): Management reporting and review, including of the quality system

Non-compliance? Y/N	No
Non-compliance number/s:	-
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
Procedures addressed requirements and were effectively implemented.	

Regulation 17(4): Compliance with a quality assurance system

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 29. To be resolved**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	

- **Procedures** (Induction) did not require the BCA to include training in Quality System procedures during induction. Implementation of this requirement had not been needed to be demonstrated since July 2017.
- **Procedures** (Training) did not require the BCA to include training in Quality System Procedures as part of any relevant training event. **This was resolved during the assessment**. However i**mplementation** of this requirement was not demonstrated.
- **Procedures** (Management Review and Internal Audit) did not require the BCA to ensure staff refreshed their familiarity with and relevant Quality System procedures as a result of any relevant findings made during Management Review or Internal Audit. **This was resolved during the assessment.** However **implementation** of this requirement was not demonstrated.
- **Procedures** (Continuous Improvement) did not require the BCA to ensure staff refreshed their familiarity with relevant Quality System procedures as a result of any relevant findings made in the Continuous Improvement process **This was resolved during the assessment**. However i**mplementation** of this requirement was not demonstrated.
- **Procedures** (Contractor) did not require the contractors performing building control functions (if any) using their own (the contractors) processes (not the BCA's) to comply with a Quality Assurance System. Implementation of this requirement had not needed to be demonstrated since July 2017.

GNC 29. To be resolved.

Regulation 17(2)(c): Ensuring operation within any scope of accreditation

Non-compliance? Y/N	NA
Non-compliance number/s:	
Opportunities for improvement? Y/N	
Number of recommendations:	
Recommendation number/s:	
Number of advisory notes:	
Advisory note number/s:	
Observations and comments, including good practice and performance	
NA	

Regulation 17(2)(e) Supporting continuous improvement

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 30. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

- **Procedures** did not prompt the BCA to accept and consider feedback from customers, employees and contractors. **This was resolved during the assessment.**
- **Procedures** did not prompt the BCA to identify issues and opportunities within its policies procedures and systems. **This was resolved during the assessment.**
- **Procedures** did not prompt the BCA to respond to issues identified in its performance of building control functions. **This was resolved during the assessment.**
- **Procedures** did not prompt the BCA to respond to any non-compliances identified with accreditation requirements in an assessment. **This was resolved during the assessment.**
- **Procedures** did not require the BCA to monitor and evaluate any action implemented in response to a Continuous Improvement. **Implementation** of this requirement was not demonstrated.

GNC 30. To be resolved.

Current procedures were implemented.

Regulation 17(2) (h): Undertaking annual audits

Non-compliance? Y/N	**Yes**
Non-compliance number/s:	**GNC 31. Resolved during assessment.**
Opportunities for improvement? Y/N	**Yes**
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	**1**
Advisory note number/s:	**A4**
Observations and comments, including good practice and performance	
• **Procedures** did not give guidance on sample size when performing internal audits. **This was resolved during the assessment.** The BCA is advised **(A4)** to ensure their sample size is always fit for purpose. At present the BCA was selecting five consent when reviewing technical functions and this may/may not capture enough information to look for trends. Current procedures were effectively implemented.	

Regulation 17(2)(i): Identifying and managing conflicts of interest

Non-compliance? Y/N	No
Non-compliance number/s:	-
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
Procedures addressed requirements and were effectively implemented.	

Regulation 17(2)(j): Communicating with internal and external persons

Non-compliance? Y/N	No
Non-compliance number/s:	-
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
Procedures addressed requirements and were effectively implemented.	

Regulation 17(3A): Complaints about building practitioners

Non-compliance? Y/N	No
Non-compliance number/s:	-
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-
Observations and comments, including good practice and performance	
Procedures addressed requirements. There had been no need to implement them since July 2017.	

REGULATION 18 TECHNICAL QUALIFICATIONS

Non-compliance? Y/N	**Yes - See Record of Non-compliance for details**
Non-compliance number/s:	**GNC 32. To be resolved.**
Opportunities for improvement? Y/N	No
Number of recommendations:	0
Recommendation number/s:	-
Number of advisory notes:	0
Advisory note number/s:	-

Observations and comments, including good practice and performance

- **Procedures** (list of appropriate qualifications) included trade qualifications and these are not specified as appropriate by MBIE.
- **Procedures** did not specify that staff would be working towards an appropriate qualification within 12 months. **Implementation** of this requirement was not demonstrated in that a BCA staff member had been employed for 19 months and was not yet underway with an appropriate qualification.

GNC 32. To be resolved.

RECORD OF NON-COMPLIANCE

Non-compliance number:	**SNC 1**	
Breach of regulatory requirement:	Regulation 6A	
Finding:	Serious Non-compliance	
Finding details:	• **Procedures** did not address the requirement to notify MBIE and IANZ according to the situations discussed in the MBIE Guidance. **Implementation** may have been needed since July 2017 but this was unclear.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2019	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 1**	
Breach of regulatory requirement:	**Regulation 7(2)(a)**	
Finding:	General Non-compliance	
Finding details:	**Procedures** did not address the following: • Did not discuss the need for the applicant to submit proposed Inspection Maintenance and Reporting information for any proposed Specified Systems. • Did not discuss access for Inspectors when performing site inspections. • When discussing the issuing of Code Compliance Certificates did not clarify sufficiently Compliance Schedule matters.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 2**	
Breach of regulatory requirement:	Regulation 7(2)(b)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** (Form 2 template) did not ensure buildings in consent applications were classified according to A1 of the 1992 Building Regulations. **Implementation** of this requirement was not demonstrated.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 3**	
Breach of regulatory requirement:	Regulation 7(2)(d)(ii)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** (Goget with respect to Categorisation), were not consistent with the Competency Assessments and the Skills Matrix.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 4**	
Breach of regulatory requirement:	Regulation 7(2)(d)(iii)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** (Goget with respect to Allocation), were not consistent with the Competency Assessments and the Skills Matrix.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 5**	
Breach of regulatory requirement:	Regulation 7(2)(d)(iv)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not address the requirement to consider decisions under s112(2) of the Act. • **Implementation** of procedures (with respect to Specified Systems) had not been effective in that there was not a good level of detail for some Specified Systems and Performance Standards. • **Procedures** did not prompt the review of swimming pools. • **Procedures** did not prompt the review of the collection of relevant Building Levies. • **Procedures** did not prompt the review of earthquake prone buildings(s133 AT) • **Implementation** of procedures for reviewing and recording access and facilities for people with disabilities had not been effective in the following way. The decisions, reasons for decisions and outcome of decisions were recorded in an incorrect location in the processing checklist. • **Implementation** of procedures for compiling and amending Compliance Schedules was not effective with respect to Performance Standards for some Specified Systems. • **Implementation** of processing procedures was not effective with respect to recording of decisions reasons for decisions and the outcome of decisions 6(b)(c) and (d) of these regulations.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		

Plan of action: *To be provided by BCA*	
Evidence of implementation: *To be provided by BCA*	
Non-compliance cleared? Y/N	Choose an item.
Signed:	
Date:	Click here to enter a date.

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 6**	
Breach of regulatory requirement:	Regulation 7(2)(d)(v)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** for granting and issuing consents did not prompt the BCA to consider levies with respect to s53 (2)(b), s54 and s58 of the Act. • **Procedures** did not prompt the BCA to send the applicant any Territorial Authority documents or information if/when received. • **Implementation** of procedures was not effective at ensuring the building consents states the Specified Systems that must be covered by the Compliance Schedules. • **Implementation** of procedures was not effective at ensuring the building consent states the Performance Standards covered by the Compliance Schedules. • **Implementation** of procedures was not effective at ensuring the building consent states the Specified Systems that must be covered by the Compliance Schedules when Compliance Schedules required amendment. • **Implementation** of procedures was not effective at ensuring the building consent states the Performance Standards that must be covered by the Compliance Schedules when Compliance Schedules required amendment.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		

Plan of action: *To be provided by BCA*	
Evidence of implementation: *To be provided by BCA*	
Non-compliance cleared? Y/N	Choose an item.
Signed:	
Date:	Click here to enter a date.

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 7**	
Breach of regulatory requirement:	Regulation 7(2)(e)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not clarify to the Inspector how to manage work that varies from the consent. • **Procedures** did not clarify to the Inspector how to manage work that does not comply with the Building Code. • **Procedures** did not prompt the Site Inspector to manage work that needs to be checked for any warnings or bans issued by MBIE. **Implementation** of this requirement was not demonstrated by the BCA.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 8**
Breach of regulatory requirement:	Regulation 7(2)(f)
Finding:	General Non-compliance
Finding details:	**Application for a code compliance certificate** • **Procedures** did not ensure that the BCA collected information to demonstrate that Specified Systems were capable of performing to Performance Standards identified on an issued building consent. **Implementation** of this requirement was not demonstrated by the BCA. **Code compliance certificates** • **Procedures** for considering whether to issue a CCC did not clarify that Specified Systems must be capable of performing to Performance Standards identified on an issued building consent. **Implementation** of this requirement was not demonstrated by the BCA. • **Procedures** for considering whether to issue a CCC did not prompt the BCA to consider whether there were any applicable warnings or bans related to any building method or product that may have been used. **Implementation** of this requirement was not demonstrated by the BCA. • **Procedures** for issuing Code Compliance Certificates did not address requirements in that CCC's were being issued with classifications other than those required in A1 of the 92 Regulations. **Implementation** of this requirement was not demonstrated by the BCA. • **Procedures** for issuing CCC's did not discuss meeting the requirement to issue CCC's within 20 working days. **Compliance Schedules** • **Implementation** was not effective with respect to Performance Standards on Compliance Schedules. **Notices to fix** • **Procedures** did not prompt the BCA to notify another responsible authority of the need to issue a Notice to Fix. • **Procedures** did not prompt the BCA to consider s165 of the Act when issuing a Notice to Fix. • **Procedures** did not prompt the BCA to consider s166 of the Act when issuing a Notice to Fix.
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective.

	Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 9**
Breach of regulatory requirement:	Regulation 8(1)
Finding:	General Non-compliance
Finding details:	• **Procedures** did not prompt the BCA to review/record the volume of work performed by the BCA in the previous two years when planning forward workflow. **Implementation** of this requirement was not demonstrated by the BCA. • **Procedures** did not prompt the BCA to review/record limitations on Technical Leadership or Specialist Technical knowledge when planning forward workflow. **Implementation** of this requirement was not demonstrated by the BCA. • **Procedures** did not prompt the BCA to review/record known external factors that might influence the volume of building work e.g. new sub-divisions, changes in interest rates. **Implementation** of this requirement was not demonstrated by the BCA. • **Procedures** did not prompt the BCA to review/record the number of Full Time Equivalent (FTE) required at each level of competency for consenting, inspecting and certifying. **Implementation** was not demonstrated by the BCA.
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.

IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.

EVIDENCE	
Plan of action: *To be provided by BCA*	

Evidence of implementation: *To be provided by BCA*	
Non-compliance cleared? Y/N	Choose an item.
Signed:	
Date:	Click here to enter a date.

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 10**	
Breach of regulatory requirement:	Regulation 8(2)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not prompt the BCA to record the number of Full Time Equivalent (FTE) required at each level of competency for consenting inspecting and certifying. **Implementation** was not demonstrated by the BCA. • **Procedures** did not prompt the BCA to record the number of Technical Leadership and Specialist Technical knowledge required. **Implementation** of this requirement was not demonstrated by the BCA. • **Implementation** of the requirement to calculate numbers of FTE required had been effective in part. The BCA had completed an exercise to calculate the number of FTE required using a resource calculator. To date the BCA did not have the number of FTE required.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		

Non-compliance cleared? Y/N	Choose an item.
Signed:	
Date:	Click here to enter a date.

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 11**	
Breach of regulatory requirement:	Regulation 9	
Finding:	General Non-compliance	
Finding details:	• Procedures (Goget System) did not ensure consistency between Competency Assessments, the Skills Matrix and Goget.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 12**	
Breach of regulatory requirement:	Regulation 10(1)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not require the BCA to maintain records of competency of Assessors according to Appendix 2 of the National Competency Assessment System (The BCA's recorded Competency Assessment System)	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 13**	
Breach of regulatory requirement:	Regulation 10(3)(a)	
Finding:	General Non-compliance	
Finding details:	• **Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for 10(3)(a) of these regulations.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 14**	
Breach of regulatory requirement:	Regulation 10(3)(b)	
Finding:	General Non-compliance	
Finding details:	• **Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for each of 10(3)(b) of these regulations.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 15**	
Breach of regulatory requirement:	Regulation 10(3)(c)	
Finding:	General Non-compliance	
Finding details:	• **Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for each of 10(3)(c) of these regulations.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 16**	
Breach of regulatory requirement:	Regulation 10(3)(d)	
Finding:	General Non-compliance	
Finding details:	• **Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for each of 10(3)(d) of these regulations.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 17**	
Breach of regulatory requirement:	Regulation 10(3)(e)	
Finding:	General Non-compliance	
Finding details:	• **Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for each of 10(3)(e) of these regulations.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 18**	
Breach of regulatory requirement:	Regulation 10(3)(f)	
Finding:	General Non-compliance	
Finding details:	• **Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for each of 10(3)(f) of these regulations.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 19**	
Breach of regulatory requirement:	Regulation 11(1)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not specify that the BCA would perform Training Needs Assessments annually.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 20**	
Breach of regulatory requirement:	Regulation 11(2)(b)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not require the BCA to specify how implementation of training shall be reviewed. **Implementation** of this requirement was not demonstrated by the BCA • **Procedures** did not require the BCA to record the reason for any training that was missed. **Implementation** was not demonstrated	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 21**	
Breach of regulatory requirement:	Regulation 11(2)(e)	
Finding:	General Non-compliance	
Finding details:	• **Implementation** of procedures had not been effective in the BCA was not reviewing all work performed by individuals in training up until the point they were deemed to be fully competent by the BCA. • **Implementation** was also not effective in that the BCA was not recording sufficient observations for each piece of work performed by any trainee. This is intended to meet regulations 6(b)(c) and (d) of these regulations.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 22**	
Breach of regulatory requirement:	Regulation 12(1)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not address the requirement to record the qualification of any prospective contractor.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 23**	
Breach of regulatory requirement:	Regulation 12(2)(c)	
Finding:	General Non-compliance	
Finding details:	**Procedures** (contracts) did not require the following: • Contractor to comply with a Quality Assurance System. • Contract to specify selected staff within an organisation where relevant. • Contract to specify powers and authorities to be granted to any contracted staff. • Contract to discuss managing internal and external communications specifically with respect to engagement with the media. • Contract to specify that staff will be required to have annual Competency Assessments. • Contract to require contractor to adhere to the BCA's policies procedures and systems (or their own).	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		

Date:	Click here to enter a date.

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 24**	
Breach of regulatory requirement:	Regulation 12(2)(e)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not require the BCA to monitor contactor performance against the defined standards documented in their contract.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 25**	
Breach of regulatory requirement:	Regulation 14	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not address the requirement to determine/record the information and equipment that any contractor may be required to provide.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 26**	
Breach of regulatory requirement:	Regulation 15	
Finding:	General Non-compliance	
Finding details:	**Procedures** did not address the following: • The organisations chart did not specify the number of technical staff performing building control functions in Full Time Equivalence. • Did not specify authorities to address s133AT and s90 requirements.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 27**	
Breach of regulatory requirement:	Regulation 16	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not specify fourteen document types specified in the MBIE Guidance.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 28**	
Breach of regulatory requirement:	Regulation 17(2)(b)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** (Quality Policy) did not specify a commitment to Continuous Improvement.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 29**	
Breach of regulatory requirement:	Regulation 17(4)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** (Induction) did not require the BCA to include training in Quality System procedures during induction. Implementation of this requirement had not been needed to be demonstrated since July 2017. • **Procedures** (Training) did not require the BCA to include training in Quality System Procedures as part of any relevant training event. **This was resolved during the assessment**. However **implementation** of this requirement was not demonstrated. • **Procedures** (Management Review and Internal Audit) did not require the BCA to ensure staff refreshed their familiarity with and relevant Quality System procedures as a result of any relevant findings made during Management Review or Internal Audit. **This was resolved during the assessment.** However **implementation** of this requirement was not demonstrated. • **Procedures** (Continuous Improvement) did not require the BCA to ensure staff refreshed their familiarity with relevant Quality System procedures as a result of any relevant findings made in the Continuous Improvement process **This was resolved during the assessment**. However **implementation** of this requirement was not demonstrated. • **Procedures** (Contractor) did not require the contractors performing building control functions (if any) using their own (the contractors) processes (not the BCA's) to comply with a Quality Assurance System. Implementation of this requirement had not needed to be demonstrated since July 2017.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		

Plan of action: *To be provided by BCA*	
Evidence of implementation: *To be provided by BCA*	
Non-compliance cleared? Y/N	Choose an item.
Signed:	
Date:	Click here to enter a date.

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 30**	
Breach of regulatory requirement:	Regulation 17(2)(e)	
Finding:	General Non-compliance	
Finding details:	• **Procedures** did not require the BCA to monitor and evaluate any action implemented in response to a Continuous Improvement. **Implementation** of this requirement was not demonstrated.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

RECORD OF NON-COMPLIANCE

Non-compliance number:	**GNC 32**	
Breach of regulatory requirement:	Regulation 18	
Finding:	General Non-compliance	
Finding details:	• **Procedures** (list of appropriate qualifications) included trade qualifications and these are not specified as appropriate by MBIE. • **Procedures** did not specify that staff would be working towards an appropriate qualification within 12 months. **Implementation** of this requirement was not demonstrated in that a BCA staff member had been employed for 19 months and was not yet underway with an appropriate qualification.	
BCA Actions required:	Please develop a Plan to address the above finding/s. Please include in the Plan the types of evidence you will submit at a later date to demonstrate the Plan has been effective. Please send the evidence that demonstrates the Plan has been effective.	
IMPORTANT DATES		
Non-compliance to be cleared by:	**25/06/2019**	
	Due by:	**Accepted by IANZ:**
Plan of action from BCA:	25/04/2018	Click here to enter a date.
Evidence of implementation from BCA:	14/06/2019	Click here to enter a date.
EVIDENCE		
Plan of action: *To be provided by BCA*		
Evidence of implementation: *To be provided by BCA*		
Non-compliance cleared? Y/N	Choose an item.	
Signed:		
Date:	Click here to enter a date.	

SUMMARY OF RECOMMENDATIONS

Recommendations are intended to assist your BCA to maintain compliance with the Regulations. They are **not** conditions for accreditation but a failure to make changes may result in non-compliance with the Regulations in the future.

No recommendations were made.

SUMMARY OF ADVISORY NOTES

Advisory notes are intended to assist your BCA to improve compliance with accreditation requirements based on IANZ's experience. They are **not** conditions for accreditation and do not have to be implemented to maintain accreditation.

IANZ advises that:

A1 The BCA consider including (in their procedures for receiving) a cut off time for receiving at the end of a working day.

A2 The BCA ensure (wherever possible) to review application of training by reviewing the application of training in relevant consents and record the consent numbers as evidence.

A3 The BCA consider revising their moisture meter calibration procedure to specify that the meter shall be sent for servicing if it reads outside the parameters specified on the moisture block. In this case outside 17-19 % moisture.

A4 The BCA ensure their sample size for internal audit is always fit for purpose. At present the BCA was selecting five consent when reviewing technical functions and this may/may not capture enough information to look for trends.

SUMMARY TABLE OF NON-COMPLIANCE

The following table summarises the non-compliance identified with the accreditation requirements in your BCA's accreditation assessment. Where a non-compliance has been identified, a Record of Non-compliance template has been prepared detailing the issue, and to enable you to detail your proposed corrective actions to IANZ. You must update and return a template for each non-compliance identified.

Regulatory requirement	Non-compliance (Serious / General)	Non-compliance identification number	Breach of regulation 5/6? (Enter Yes where applicable)						Resolved On-site? Yes/No	Date Non-compliance to be cleared by (DD/MM/YYYY) N/A where NC is resolved on-site	Date Non-compliance cleared (DD/MM/YYYY)	Number of		Brief comment (to get to the heart of the issue)
			5(a)	5(b)	5(c)	6(b)	6(c)	6(d)				Recommendations	Advisory notes	
6(A)(1)	Serious	SNC1	x	x					No	25/06/2019				**Procedures** did not address the requirement to notify MBIE and IANZ according to the situations discussed in the MBIE Guidance. **Implementation** may have been needed since July 2017 but this was unclear.
6(A)(2)	Choose an item.													
Regulation 7														
7(1)	Choose an item.													
7(2)(a)	General	GNC 1	x	x					No	25/06/2019				**Procedures** did not address the following: Did not discuss the need for the applicant to submit proposed Inspection Maintenance and Reporting information for any proposed Specified Systems. Did not discuss access for Inspectors when performing site inspections. When discussing the issuing of Code Compliance Certificates did not clarify sufficiently Compliance Schedule matters
7(2)(b)	General	GNC 2	x	x					No	25/06/2019			x	**Procedures** (Form 2 template) did not ensure buildings in consent applications were given classified uses according to A1 of the 1992 Building Regulations. **Implementation** of this requirement was not demonstrated.
7(2)(c)	Choose an item.													
7(2)(d)(i)														
7(2)(d)(ii)	General	GNC 3	x	x					No	25/06/2019				**Procedures** (Goget with respect to Categorisation), were not consistent with the Competency Assessments and the Skills Matrix.
7(2)(d)(iii)	General	GNC 4	x	x					No	25/06/2019				**Procedures** (Goget with respect to Allocation), were not consistent with the Competency Assessments and the Skills Matrix.
7(2)(d)(iv)	General	GNC 5	x	x	x	x	x	x	No	25/06/2019				**Procedures** did not address the requirement to consider decisions under s112 (2) of the Act. **Implementation** of procedures (with respect to Specified Systems) had not been effective in that

Regulatory requirement	Non-compliance (Serious / General)	Non-compliance identification number	Breach of regulation 5/6? (Enter Yes where applicable)						Resolved On-site? Yes/No	Date Non-compliance to be cleared by (DD/MM/YYYY) N/A where NC is resolved on-site	Date Non-compliance cleared (DD/MM/YYYY)	Number of		Brief comment (to get to the heart of the issue)
			5(a)	5(b)	5(c)	6(b)	6(c)	6(d)				Recommendations	Advisory notes	
														there was not a good level of detail for some Specified Systems and Performance Standards. **Procedures** did not prompt the review of swimming pools. **Procedures** did not prompt the review of the collection of relevant Building Levies. **Procedures** did not prompt the review of earthquake prone buildings(s133 AT) **Implementation** of procedures for reviewing and recording access and facilities for people with disabilities had not been effective in the following way. The decisions, reasons for decisions and outcome of decisions were recorded in an incorrect location in the processing checklist. **Implementation** of procedures for compiling and amending Compliance Schedules was not effective with respect to Performance Standards for some Specified Systems. **Implementation** of processing procedures was not effective with respect to recording of decisions reasons for decisions and the outcome of decisions 6(b)(c) and (d) of these regulations.
7(2)(d)(v)	General	GNC 6	x	x	x				No	25/06/2019				**Procedures** for granting and issuing consents did not prompt the BCA to consider levies with respect to s53 (2)(b), s54 and s58 of the Act. **Procedures** did not prompt the BCA to send the applicant any Territorial Authority documents or information if/when received. **Implementation** of procedures was not effective at ensuring the building consents states the Specified Systems that must be covered by the Compliance Schedules. **Implementation** of procedures was not effective at ensuring the building consent states the Performance Standards covered by the Compliance Schedules. **Implementation** of procedures was not effective at ensuring the building consent states the Specified Systems that must be covered by the Compliance Schedules when Compliance Schedules required amendment. **Implementation** of procedures was not effective at

Regulatory requirement	Non-compliance (Serious / General)	Non-compliance identification number	Breach of regulation 5/6? (Enter Yes where applicable) 5(a)	5(b)	5(c)	6(b)	6(c)	6(d)	Resolved On-site? Yes/No	Date Non-compliance to be cleared by (DD/MM/YYYY) N/A where NC is resolved on-site	Date Non-compliance cleared (DD/MM/YYYY)	Number of Recommendations	Number of Advisory notes	Brief comment (to get to the heart of the issue)
														ensuring the building consent states the Performance Standards that must be covered by the Compliance Schedules when Compliance Schedules required amendment.
7(2)(e)	General	GNC 7	x	x	x				No	25/06/2019				**Procedures** did not clarify to the Inspector how to manage work that varies from the consent. **Procedures** did not clarify to the Inspector how to manage work that does not comply with the Building Code. **Procedures** did not prompt the Site Inspector to manage work that needs to be checked for any warnings or bans issued by MBIE. **Implementation** of this requirement was not demonstrated by the BCA.
7(2)(f)	General	GNC 8	x	x	x				No	25/06/2019				**Application for a code compliance certificate** **Procedures** did not ensure that the BCA collected information to demonstrate that Specified Systems were capable of performing to Performance Standards identified on an issued building consent. **Implementation** of this requirement was not demonstrated by the BCA. **Code compliance certificates** **Procedures** for considering whether to issue a CCC did not clarify that Specified Systems must be capable of performing to Performance Standards identified on an issued building consent. **Implementation** of this requirement was not demonstrated by the BCA. **Procedures** for considering whether to issue a CCC did not prompt the BCA to consider whether there were any applicable warnings or bans related to any building method or product that may have been used. **Implementation** of this requirement was not demonstrated by the BCA. **Procedures** for issuing Code Compliance Certificates did not address requirements in that CCC's were being issued with building use classifications other than those specified in A1 of the 1992 Building Regulations. **Implementation** of this requirement was not demonstrated by the BCA. **Procedures** for issuing CCC's did not discuss meeting the requirement to issue CCC's within 20

Regulatory requirement	Non-compliance (Serious / General)	Non-compliance identification number	Breach of regulation 5/6? (Enter Yes where applicable) 5(a)	5(b)	5(c)	6(b)	6(c)	6(d)	Resolved On-site? Yes/No	Date Non-compliance to be cleared by (DD/MM/YYYY) N/A where NC is resolved on-site	Date Non-compliance cleared (DD/MM/YYYY)	Number of Recommendations	Number of Advisory notes	Brief comment (to get to the heart of the issue)
														working days. **Compliance Schedules** **Implementation** was not effective with respect to Performance Standards on Compliance Schedules. **Notices to fix** **Procedures** did not prompt the BCA to notify another responsible authority of the need to issue a Notice to Fix. **Procedures** did not prompt the BCA to consider s165 of the Act when issuing a Notice to Fix. **Procedures** did not prompt the BCA to consider s166 of the Act when issuing a Notice to Fix.
7(2)(g)	Choose an item.													
7(2)(h)	Choose an item.													
Regulation 8														
8(1)	General	GNC 9	x	x	x				No	25/06/2019				**Procedures** did not prompt the BCA to review/record the volume of work performed by the BCA in the previous two years when planning forward workflow. **Implementation** of this requirement was not demonstrated by the BCA. **Procedures** did not prompt the BCA to review/record limitations on Technical Leadership or Specialist Technical knowledge when planning forward workflow. **Implementation** of this requirement was not demonstrated by the BCA. **Procedures** did not prompt the BCA to review/record known external factors that might influence the volume of building work e.g. new sub-divisions, changes in interest rates. I**mplementation** of this requirement was not demonstrated by the BCA. **Procedures** did not prompt the BCA to review/record the number of Full Time Equivalent (FTE) required at each level of competency for consenting, inspecting and certifying. **Implementation** was not demonstrated by the BCA
8(2)	General	GNC 10	x	x	x				No	25/06/2019				**Procedures** did not prompt the BCA to record the number of Full Time Equivalent (FTE) required at each level of competency for consenting inspecting and certifying. **Implementation** was not demonstrated by the BCA.

Regulatory requirement	Non-compliance (Serious / General)	Non-compliance identification number	Breach of regulation 5/6? (Enter Yes where applicable)						Resolved On-site? Yes/No	Date Non-compliance to be cleared by (DD/MM/YYYY) N/A where NC is resolved on-site	Date Non-compliance cleared (DD/MM/YYYY)	Number of		Brief comment (to get to the heart of the issue)
			5(a)	5(b)	5(c)	6(b)	6(c)	6(d)				Recommendations	Advisory notes	
														Procedures did not prompt the BCA to record the number of Technical Leadership and Specialist Technical knowledge required. **Implementation** of this requirement was not demonstrated by the BCA. **Implementation** of the requirement to calculate numbers of FTE required had been effective in part. The BCA had completed an exercise to calculate the number of FTE required using a resource calculator. To date the BCA did not have the number of FTE required.
Regulation 9														
9	General	GNC 11	x	x					No	25/06/2019				**Procedures** (Goget System) did not ensure consistency between Competency Assessments, the Skills Matrix and Goget.
Regulation 10														
10(1)	General	GNC 12	x	x	x				No	25/06/2019				**Procedures** did not require the BCA to maintain records of competency of Assessors according to Appendix 2 of the National Competency Assessment System (The BCA's recorded Competency Assessment System)
10(2)	Choose an item.													
10(3)(a)	General	GNC 13			x	x	x	x	No	25/06/2019				**Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for 10(3)(a) of these regulations.
10(3)(b)	General	GNC 14			x	x	x	x	No	25/06/2019				**Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for 10(3)(b) of these regulations.
10(3)(c)	General	GNC 15			x	x	x	x	No	25/06/2019				**Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for 10(3)(c) of these regulations.
10(3)(d)	General	GNC 16			x	x	x	x	No	25/06/2019				**Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for 10(3)(d) of these regulations.
10(3)(e)	General	GNC 17			x	x	x	x	No	25/06/2019				**Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of

Regulatory requirement	Non-compliance (Serious / General)	Non-compliance identification number	Breach of regulation 5/6? (Enter Yes where applicable)						Resolved On-site? Yes/No	Date Non-compliance to be cleared by (DD/MM/YYYY) N/A where NC is resolved on-site	Date Non-compliance cleared (DD/MM/YYYY)	Number of		Brief comment (to get to the heart of the issue)
			5(a)	5(b)	5(c)	6(b)	6(c)	6(d)				Recommendations	Advisory notes	
														these regulations) for 10(3)(e) of these regulations.
10(3)(f)	General	GNC 18			x	x	x	x	No	25/06/2019				**Implementation** of procedures was not effective in that there were not adequate decisions, reasons for decisions or outcomes of decisions (6(b)(c)(d) of these regulations) for 10(3)(f) of these regulations.
Regulation 11														
11(1)	General	GNC 19	x	x					No	25/06/2019				**Procedures** did not specify that the BCA would perform Training Needs Assessments annually.
11(2)(a)	Choose an item.													
11(2)(b)	General	GNC 20	x	x	x				No	25/06/2019			x	**Procedures** did not require the BCA to specify how implementation of training shall be reviewed. **Implementation** of this requirement was not demonstrated by the BCA **Procedures** did not require the BCA to record the reason for any training that was missed. **Implementation** was not demonstrated
11(2)(c)	Choose an item.													
11(2)(d)	Choose an item.													
11(2)(e)	General	GNC 21			x	x	x	x	No	25/06/2019				**Implementation** of procedures had not been effective in the BCA was not reviewing all work performed by individuals in training up until the point they were deemed to be fully competent by the BCA. **Implementation** was also not effective in that the BCA was not recording sufficient observations for each piece of work performed by any trainee. This is intended to meet regulations 6(b)(c) and (d) of these regulations.
11(2)(f)	Choose an item.													
11(2)(g)	Choose an item.													
Regulation 12														
12(1)	General	GNC 22	x	x					No	25/06/2019				**Procedures** did not address the requirement to record the qualification of any prospective contractor
12(2)(a)	Choose an item.													
12(2)(b)	Choose an item.													
12(2)(c)	General	GNC 23	x	x					No	25/06/2019				**Procedures** (contracts) did not require the following: Contractor to comply with a Quality Assurance System. Contract to specify selected staff within an

Regulatory requirement	Non-compliance (Serious / General)	Non-compliance identification number	Breach of regulation 5/6? (Enter Yes where applicable)						Resolved On-site? Yes/No	Date Non-compliance to be cleared by (DD/MM/YYYY) N/A where NC is resolved on-site	Date Non-compliance cleared (DD/MM/YYYY)	Number of		Brief comment (to get to the heart of the issue)
			5(a)	5(b)	5(c)	6(b)	6(c)	6(d)				Recommendations	Advisory notes	
														organisation where relevant. Contract to specify powers and authorities to be granted to any contracted staff. Contract to discuss managing internal and external communications specifically with respect to engagement with the media. Contract to specify that staff will be required to have annual Competency Assessments. Contract to require contractor to adhere to the BCA's
12(2)(d)	Choose an item.													
12(2)(e)	General	GNC 24	x	x					No	25/06/2019				**Procedures** did not require the BCA to monitor contactor performance against the defined standards documented in their contract.
12(2)(f)	Choose an item.													
Regulation 13														
13(a)	Choose an item.													
13(b)	Choose an item.													
Regulation 14														
14	General	GNC 25	x	x					No	25/06/2019			x	**Procedures** did not address the requirement to determine/record the information and equipment that any contractor may be required to provide.
Regulation 15														
15(1)(a)	General	GNC 26	x	x					No	25/06/2019				**Procedures** (The organisations chart) did not specify the number of technical staff performing building control functions in Full Time Equivalence. Procedures (The organisation Authorities) did not specify authorities to address s133AT and s90 requirements.
15(1)(b)	Choose an item.													
15(2)	Choose an item.													
Regulation 16														
16(1)	Choose an item.													
16(2)(a)	General	GNC 27	x	x					No	25/06/2019				**Procedures** did not specify fourteen document types specified in the MBIE Guidance.
16(2)(b)	Choose an item.													
16(2)(c)	Choose an item.													
Regulation 17														
17(1)	Choose an item.													

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Regulatory requirement	Non-compliance (Serious / General)	Non-compliance identification number	Breach of regulation 5/6? (Enter Yes where applicable)						Resolved On-site? Yes/No	Date Non-compliance to be cleared by (DD/MM/YYYY) N/A where NC is resolved on-site	Date Non-compliance cleared (DD/MM/YYYY)	Number of		Brief comment (to get to the heart of the issue)
			5(a)	5(b)	5(c)	6(b)	6(c)	6(d)				Recommendations	Advisory notes	
17(2)(a)	Choose an item.													
17(2)(b)	General	GNC 28	x	x					No	25/06/2019				**Procedures** (Quality Policy) did not specify a commitment to Continuous Improvement.
17(2)(c)	Choose an item.													
17(2)(d)	Choose an item.													
17(2)(e)	General	GNC 30	x	x					No	25/06/2019				**Procedures d**id not require the BCA to monitor and evaluate any action implemented in response to a Continuous Improvement. **Implementation** of this requirement was not demonstrated.
17(2)(h)	General	GNC 31	x	x					Yes				x	**Procedures** did not give guidance on sample size when performing internal audits.
17(2)(i)	Choose an item.													
17(2)(j)	Choose an item.													
17(3)	Choose an item.													
17(3A)(a)	Choose an item.													
17(3A)(b)	Choose an item.													
17(3A)(c)	Choose an item.													
17(4)(a)	General	GNC 29	x	x	x				Part	25/06/2019				**Procedures** (Induction) did not require the BCA to include training in Quality System procedures during induction. I**mplementation** of the requirement to include training in procedures during induction was not demonstrated. **Procedures** (Training) did not require staff to learn their procedures as part of any training event. **Implementation** of the requirement to include training in Quality System Procedures as part of any relevant training event was not demonstrated. **Procedures** (Management Review and Internal Audit) did not require staff to refresh their familiarity with their procedures as part of any Management Review or Internal Audit finding. **Implementation** was not demonstrated of the requirement to include quality procedures training in response to any relevant finding made during Management Review and Internal Audits. **Procedures** did not require the BCA staff to refresh their familiarity with procedures in response to any relevant Continuous Improvement. **Implementation** was not demonstrated of the requirement to ensure staff refreshed their familiarity with and relevant Quality System procedures as a result of any relevant findings made in the Continuous Improvement

Regulatory requirement	Non-compliance (Serious / General)	Non-compliance identification number	Breach of regulation 5/6? (Enter Yes where applicable) 5(a)	5(b)	5(c)	6(b)	6(c)	6(d)	Resolved On-site? Yes/No	Date Non-compliance to be cleared by (DD/MM/YYYY) N/A where NC is resolved on-site	Date Non-compliance cleared (DD/MM/YYYY)	Number of Recommendations	Number of Advisory notes	Brief comment (to get to the heart of the issue)
														process. **Procedures** (Contractor) did not require the contractors performing building control functions (if any) using their own (the contractors) processes (not the BCA's) to comply with a Quality Assurance System.
17(4)(b)	Choose an item.													
17(5)(a)	Choose an item.													
17(5)(b)	Choose an item.													
Regulation 18														
18(1)(a)	General	GNC 32	x	x	x				No	25/06/2019				**Procedures** (list of appropriate qualifications) included trade qualifications and these are not specified as appropriate by MBIE. **Procedures** did not specify that staff would be working towards an appropriate qualification within 12 months. **Implementation** of this requirement was not demonstrated in that a BCA staff member had been employed for 19 months and was not yet underway with an appropriate qualification.
18(1)(b)	Choose an item.													
18(1)(c)	Choose an item.													
18(3)(a)	Choose an item.													
18(3)(b)	Choose an item.													

Our ref: R803 SA6

AUDIT NEW ZEALAND
Mana Arotake Aotearoa

Level 2, 100 Molesworth Street
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15 February 2019

Brian Fox
Head of Risk and Regulatory
Taupo District Council
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Taupo Mail Centre 3352

Dear Brian

Second Report on the Administrative Headquarters Building Project for Taupo District Council

On 10 October 2017 Taupo District Council (TDC) confirmed its wish to engage Audit New Zealand to provide assurance services over its Headquarters Building Project (the Project). We had proposed review services on a three part segmental basis covering the early planning, the procurement and the delivery of the Project. We provided an interim report on 19 December 2017 which presented our findings and recommendations on the initial planning that had been completed up to that time. This report presents our findings and recommendations on the further planning work that has been undertaken between December 2017 and early February 2018.

Audit New Zealand is a business unit of the Controller and Auditor-General. Our assurance services have been provided in accordance with Section 17 of the Public Audit Act 2001 and the Auditor-General's Standard AG-5.

Background

Since 2016 TDC has been investigating options for a replacement Headquarters Building. There were two principal issues with the old building – its seismic resilience and the presence of asbestos in the building. The replacement options included refurbishing the old building, leasing a building or building a new building on one of several potential sites. In December 2017 the Council resolved to demolish the old building so the refurbishment option ceased to exist.

During 2018 TDC progressed its investigations into potential sites for a new building. A consultant was engaged to investigate and report on development options for the Great Lake Centre (GLC) with a view to constructing a new administrative headquarters alongside a cultural centre. Because of the complexity of the GLC option a specific master planning exercise was necessary. The other sites being considered by the Council were comparatively more straightforward. Another consultant was engaged to progress a business case assessment for all the options under consideration.

The Council had originally hoped to make a decision on a replacement building as part of the 2018 LTP process. However, the further investigations that were required precluded this. The Council is now planning to make its decision as part of a 2019 LTP amendment process.

This report is intended to inform Council about the appropriateness of its planning processes up to early February 2019. As the last step in this review we considered a draft business case document prepared by TDC's consultant and provided to us on 5 February 2019 and some updated planning documents provided to us on 8 February 2019.

Our reference to "Project" in this report is a reference to a building project to provide a new administrative headquarters wherever it is located. We note that TDC is also using "Project" as a specific reference to the GLC site (the Cultural Precinct Project = CPP). This report needs to be interpreted in the context of a project for an Administrative Headquarters Building wherever that is located.

Scope and approach

TDC is seeking an independent review of the Administrative Headquarters Building Project to confirm that:

- sound and prudent management processes are being applied to the planning; and
- key expectations for major projects undertaken in the public sector are being met.

In undertaking the review work we have considered:

- compliance with recognised good practice in the public sector;
- compliance with the applicable policies and planning for the development; and
- whether the objectives for the Project are likely to be met from the process point of view.

For this second report we reviewed documentation relevant to the matters being considered that was provided to us between November 2018 and early February. We also visited TDC on 17 and 18 January and met with staff who are responsible for the Project including the Chief Executive. We also met with the Acting Mayor and the Chair of the Audit and Risk Committee.

Standards and guidance

The primary good practice guidance that we have used for our services is:

- "Better Business Cases" guidance for projects produced by the Treasury, 2015;
- our internally developed methodologies for review of project management and governance; and
- we have also developed an extensive knowledge and experience base for project management from our work across the public sector.

Limitations

We have not assessed the specific merits of the options being considered by TDC for a new Administrative Headquarters Building. It is TDC's responsibility to determine which building option it prefers and ultimately adopts.

Our expectations

To enable us to undertake our work we expect that TDC has:

- provided us with all information that we have requested or that is in the possession of the parties involved in the Project and is relevant to our engagement; and
- advised of any circumstances that have arisen during the course of our work that may be material to and significant in relation to our work.

Assurance reviews of this kind can help an entity understand the risks it faces and assist it to manage those risks, but it does not remove the responsibility of the entity itself for ensuring that its actions comply with all relevant legal and other standards.

Findings and conclusions

In undertaking this review we considered whether TDC had met reasonable expectations for a local authority in managing the Project in respect of:

- planning;
- project management;
- consultation with the community; and
- governance and decision making.

We record below our observations and findings on these matters:

Planning – investigation of options

At a workshop on 18 October 2017 the Council considered site options for a new Headquarters Building. Three sites remained under consideration at that time:

- GLC
- Lake Terrace (the site of the old headquarters building)
- Tuwharetoa St car park

Council concluded that its preference was for a new building on the GLC site. Council also concluded that the option of leasing a building had been discounted "for now". These conclusions were reported publicly in a media statement on 24 October 2017.

Consideration of the leasing option that led to the 24 October media statement occurred at a Council workshop. A workshop is not a formal decision making forum. It does not appear that Council has ever formally resolved to set aside the leasing option. Consequently this option should probably be taken forward into the 2019 LTP Amendment process for a final decision by Council having taken account of submissions.

During 2018 TDC progressed its investigations into the GLC site. A consultant was engaged (Warren and Mahoney) to undertake a master planning exercise into the options for a multi-purpose development of the GLC site to include both administrative and cultural facilities. The output from this master planning was reported to Council at a workshop on 12 November 2018. The Council indicated a preference for "Option B".

During 2017 and 2018 TDC has used a range of forums to progress the consideration of the Project. These forums included formal meetings of Council, Council workshops both open and closed and public consultation. Many of these sessions resulted in indications and preferences as to options rather than firm unqualified decisions. The 2019 LTP Amendment process is an ideal opportunity to make the final decisions.

In the latter stages of our review we learned that the Council decided on 11 February 2019 to select Tuwharetoa Street as its preferred option for the administration building.

We understand that three site options (as noted above) will be taken forward to the 2019 LTP Amendment process with the GLC site having a further refinement of that option in respect of the "Option B" development at that site. We understand that Tuwharetoa Street will now be indicated as the preferred site. As noted above the leasing option should probably be a fourth option.

We expect that the Council will confirm a site through the LTP process. However, the Council may also wish to consider confirming an alternative site option should its first ranked option become unachievable. Identifying an alternative may minimise delay should a show stopping situation eventuate with the first ranked option.

Planning – business case development

In our first review in December 2017 we did not identify a business case assessment for the Project. However, we did locate substantial information that addressed some of the key elements of a business case assessment.

Since our first report TDC has progressed the development of its business case. A consultant (Howard Davies Group) has been engaged to progress the development. We understand that The Treasury's Better Business Case guidance has been used. The Consultant's report was provided to Council in early February 2019 and we received a copy on 5 February 2019. We reviewed the report to confirm its scope and conclusion but we did not review it in detail. We noted its recommendation to select the GLC site as the preferred option. However, we understand that the Council has not accepted this recommendation and has instead selected the Tuwharetoa St site as its preferred option.

We discussed the business case with staff during interviews in January. We noted at that time the need for a balanced assessment of all site and development options including the leasing option. However, we found that the draft business case report has substantial information in relation to the

GLC site but somewhat less information for the other sites. We do not see this as an issue but we note that a precis of the business case information will need to go into the Consultation Document for the 2019 LTP Amendment process and that the information will need to be balanced for all options to avoid perceptions of pre determination.

Project management - general

Following our last review and recommendation TDC appointed a Project Manager in February 2018. We commend TDC for taking this step. We believe it has already been useful in ensuring a focus for the management of the Project.

We assume that the Project Manager's role is sufficiently broad to encompass a project for a headquarters building at any site and that his role is not limited to the CPP option. TDC may need to consider whether this requires any clarification of role.

Our review found that TDC had engaged a Consultant to undertake an initial project management review (health check) that was reported on 22 August 2018. This was a good initiative. Consideration should be given to having further formal reviews at regular intervals through the Project. The Consultant's report was largely favourable. However, some opportunities for improvement were noted in respect of cost estimating, risk management, record keeping and programming.

Where there are matters for improvement we suggest that an action plan and reporting be implemented to keep a track of progress with the various actions. The Status Reports currently being issued may be useful in this regard.

The Project will require a fully developed framework in which it is intended to operate. A draft Project Plan was provided to us on 8 February. In the interests of avoiding delay with our reporting for this review we have not reviewed the Project Plan in detail. However, we observe that it has good structure and content and that TDC intends to further develop and update it over time. It will be important to have a comprehensive plan in place when the final site selection has been made. The scope of a project plan is usually quite broad but it should be a foundation document for the Project. The plan should address all the key areas associated with project management including scope, governance, management structure, resourcing and individual responsibilities, delegations, risk management, reporting and quality management, a timeline, a procurement strategy and cost management. Much of this content already exists. We noted that Terms of Reference (TOR) for the Steering and Advisory Groups have been agreed. The TOR are included in the Project Plan.

The Headquarters Building is a major project initiative for the Council. It has all the conventional project attributes of scope, time, cost and quality as well as having a high political and public profile. For this reason further development of a comprehensive risk assessment should be considered.

Management of quality is an important element of project management. This area will require further planning.

Project management – resourcing

We noted above the appointment of a Project Manager. Additional resourcing will be required for the Project as it enters its final planning and delivery stages. The resourcing may need to be sourced both internally and externally. As examples of the additional resourcing we are referring to we note the need to manage a large construction contract, the need for periodic and formal project reviews, the need for a good level of regular reporting and external communications, and the need to manage quality. Legal and building/resource consent processes will also be necessary. This additional resourcing should be identified in the Project Plan and budgeted for.

Project management - procurement

A procurement strategy and plan for the design and construction phases of the Project exists in draft form. We were provided with a copy on 8 February. As noted above and in the interests of time with this reporting we have not reviewed the plan in detail. However, we observe that the plan has some good content but also describes a procurement approach that in part we do not think reflects good practice. We discussed the procurement strategy and plan with staff during interviews in January. We understand that separate design and construction contracts are being considered. However, there are many options available for the structure, scope and form of the contracts and the approaches available for the market enquiries. It is important that TDC confirms its approach to this as soon as possible. We discussed the need for some external expertise to be brought in to assist TDC to identify a preferred option for the contracting arrangements. We understand that this is proposed. There is an urgent need to finalise the strategy and plan if TDC wishes to avoid delay once Council has confirmed a direction for the Project.

We reviewed the approach that TDC took for the engagement in 2018 of a consultant for the master planning work. A two stage procurement process was followed involving a first stage Registration of Interest (ROI) process and a second stage Request for Proposal (RFP) process. A staff team evaluated the ROI responses and Council endorsed a recommendation for a shortlist of tenderers for the second (RFP) stage. We were surprised to find that the evaluation of the RFP responses was undertaken by Council itself i.e by the elected members. This is unusual and not necessarily good practice as it compromises the governance and management accountabilities and responsibilities. We acknowledge that Council will have a strong interest in the procurement arrangements for the Project but there are ways of accommodating that interest without the Council itself (elected members) undertaking the evaluation.

We do not hold any concerns about the decision that was made for the selection of a master planning consultant. However, for the design and construction contracts there will be a significant technical element to the evaluation and it is essential that the evaluation teams be resourced with people who have appropriate technical expertise. That may require both internal and external resourcing. TDC may wish to consider an opportunity for a shortlist of tenderers to provide a presentation jointly to the evaluation teams and Council following the initial evaluation of tenders. The evaluation team could then consider any feedback that the Council may wish to provide before the evaluation team determines its recommendations for award of the contracts.

We note that each of these major procurements should be supported by a procurement plan which amongst other things describes the proposed process and sets out the evaluation team and criteria and weightings to be used in the evaluation.

We also noted that in the procurement of the master planning consultant only two respondents were shortlisted for the RFP stage. There were good reasons for this. However, for the future procurements for the Project we would suggest a minimum of three respondents be taken forward to a second stage. This approach is suggested as a risk mitigation measure to ensure that there is good competition in the second and most critical stage.

Project management – financial management

We discussed with staff the capability of TDC's financial system to manage the demands of a major project. We were advised that TDC had managed the Taupo Roading Bypass project and that no issues with the financial system were evident. We note the need for the system to be able to record and report with appropriate categorisation of cost on multiple contracts for a single project. We did not identify any obvious cause for concern with the financial system.

Consultation with the community

A communications plan was prepared for the Project in June 2018. This was a good initiative. It will need periodic updating as each new phase of the Project commences.

We understand that TDC has a number of communications channels with its community including a weekly page in the Taupo Times newspaper, a webpage and periodic e newsletters. These avenues for public information should serve TDC well for the Project.

We noted that over the last two years there has been extensive consultation with the community about the Project. During 2017 the consultation, and particularly that related to the 2017 Annual Planning process, was quite broad involving a number of site and development options including leasing. However, during 2018 much of the consultation related to the GLC option only. There was extensive consultation about the GLC option between May and November 2018 including a public meeting on 3 October and an "open" Council workshop on 12 November.

The Council signalled in October 2017 and in February 2018 that GLC was its preferred option and we have already noted above that this option is complex. We understand that this preference has now changed. However, it is important that the single focus of the 2018 consultation now be broadened again through the 2019 LTP Amendment process to incorporate all options still under consideration.

Specific consultation has been undertaken with Iwi such as hui on 19 July, 20 August and 15 October 2018 as well as an invitation to Iwi to join the community workshops.

We note that if the GLC site is selected by Council following the 2019 LTP Amendment process then there may be a partnership option with Iwi that could be progressed. Obviously that would involve a much closer relationship.

We believe that the Council's obligations to consult have been progressed quite well through the processes it has followed. However, the 2019 LTP process will be an essential opportunity to complete the consultation process in respect of the three site options still being considered as well as the leasing option.

Governance and decision making

Over the last two years there has been an extensive series of Council workshops and formal meetings to discuss and consider building options. We summarise the more important events as follows:

- 13 April 2017 Extraordinary Meeting of Council: Considered issues with the existing building. Council indicated a preference for a new building at Lake Terrace and agreed to progress this matter through the annual planning process.
- 26 April 2017 Council Meeting: Considered the consultation document for the 2017/18 Annual Plan (AP). The document confirmed the preferred option but also described alternative options including leasing.
- 7, 15 June 2017 Council Meeting: Hearing and deliberations session for AP submissions. A preference for a new building was reconfirmed but staff were directed to further investigate site and leasing options.
- 31 July 2017 Council workshop: Considered new build options at four sites.
- 22 Aug 2017 Council workshop: Considered EOI responses to a market enquiry for site and building lease options.
- 18 Oct 2017 Council workshop: Considered building site options and determined a preference for the GLC site.
- 12 Dec 2017 Council Meeting: Resolved to demolish the old building.
- 1 Feb 2018 Council Meeting: Confirmed GLC as the preferred location for a new administrative building and confirmed the need for a master plan for development at that site.
- 24 April 2018 Council Meeting: Council agree to proceed with master planning and procure a consultant to do this work.
- 30 Apr/15 May 2018 Council Meetings: LTP hearing and deliberations session. Council approved a budget for the master planning and a business case assessment.
- 6 June, 6 July, 19 July, 19 Sept, 12 Nov, 5 Dec 2018 Council workshops: a series of six workshops associated with the master planning work and community consultation.

We note from the above the significant reliance on Council workshops to progress consideration of the Project and in particular the options for development at the GLC. Some of the workshops were "open" sessions at which members of the community were present. We note two matters for consideration by TDC:

- Given the Council's obligations to consult and the significance of the Project for TDC the Council needs to ensure that workshops are not a de facto decision making forum. In this regard we note the media release of 24 October 2017 in which it was announced that the Council would not be progressing the leasing option at that time. This Council position arose from a Council workshop on 18 October 2017 and not from a formal Council meeting and resolution.

- The 2019 LTP Amendment process offers an excellent opportunity to close out the process for selection of a site for a new administrative headquarters building. However, for this decision to be robust it is essential that the Consultation Document contains a balanced description of each of the options under consideration including a narrative on significant risks and pros and cons for each option. There are some known issues or risks with some of the options and it is important that Council be transparent about them. Council can signal its site preference but must be prepared to be open minded when assessing the submissions that are made.

Overall conclusion and recommendations

Taupo District Council's Administrative Headquarters Building Project is a significant project. During 2018 TDC made good progress with the development of options for a replacement building. One of the options was the GLC site with a multi-purpose development. The complexity of the GLC site has necessitated considerable work through a master planning exercise to develop some building options. The other potential sites are less complex. However, all sites have some issues.

The 2019 LTP Amendment process is an ideal opportunity to confirm a site selection and to lock in the direction for the Project. There are a number of matters that TDC should take into account. We recommend as follows:

1 The option to lease a building does not appear to have been formally closed out by Council. To ensure a robust building option process TDC should consider taking the leasing option forward into the 2019 LTP Amendment process for a final decision by Council having taken account of submissions.

2 It is important that the single focus of the 2018 consultation (GLC) now be broadened again through the 2019 LTP Amendment process to incorporate all options still under consideration.

3 For the decision on a site to be robust it is essential that the LTP Consultation Document contains a balanced description of each of the options under consideration including a narrative on the significant risks and pros and cons for each option. It is important to be transparent about these matters.

4 During the 2019 LTP Amendment process the Council may wish to consider confirming an alternative site option should its first ranked option become unachievable because of an unresolvable risk or cost or some other reason. Identifying an alternative site option may assist in avoiding a future delay.

5 When a final decision on a site has been made a Project Plan should be finalised. A substantial draft of this plan already exists. Further development of the Project Schedule and risk, quality and costings will be required. We suggest that the Project Plan is formally reviewed by an expert.

6 Consideration should be given to undertaking further formal project management reviews at regular intervals throughout the Project.

7 Where the project management reviews note a need for improvement then an action plan and reporting should be implemented to keep a track of progress with the various actions. The Status Reports currently being issued may be useful in this regard.

8 The Project is likely to require additional resourcing both internal and external as it progresses. This additional resourcing should be identified in the Project Plan and budgeted for.

9 A procurement strategy and plan needs to be further developed for the major procurement that lies ahead. Some external expertise may have to be brought in to assist TDC to identify a preferred option for the tendering approach and contracting arrangements. There is an urgent need to finalise the strategy and plan if TDC wishes to avoid delay once Council has confirmed a direction for the Project.

10 For the design and construction contracts there will be a significant technical element to the evaluation. It is essential that the evaluation teams be resourced with people who have good technical expertise. That may require both internal and external resourcing.

11 A communications plan has been prepared for the Project. It will need periodic updating as each new phase of the Project commences.

We are pleased to submit this report which represents a review up to 8 February 2019. We are available to clarify any matters arising from this report.

Yours sincerely

Peter Davies
Director, Specialist Audit and Assurance Services

Cc Audit Director


AUDIT NEW ZEALAND
Mana Arotake Aotearoa
Report to the Council on the audit of
Taupō District Council's
Consultation Document to amend the Long Term Plan for the period 1 July 2018 to 30 June 2028

Contents

Key messages

We have completed the audit of Taupō District Council's (the Council's) Consultation Document to amend the Long Term Plan for the period 1 July 2018 to 30 June 2028. This report sets out our findings from the audit and draws attention to our detailed findings, and where appropriate makes recommendations for improvement.

Audit opinion

We completed the audit of the Council's Consultation Document (CD) to amend the Long Term Plan for the period 2018-28 and issued an unmodified opinion on 19 March 2019.

The amendment of the Long-Term Plan (LTP) is a significant undertaking and management worked very well with us throughout the audit process.

We concluded that Council has produced a CD that fulfils its primary purpose of providing an effective basis for public participation in decision making related to the proposed amendment. The CD included all the major matters that we expected, provided preferred and alternative options to address these issues and encouraged the community to provide feedback.

Future focus

As well as the opinion issued on the CD we will also issue an opinion on the final amended LTP that will be adopted before 1 July 2019.

The Council needs to ensure there are systems in place to monitor its actual performance against budgets and levels of service included in the amended LTP from 1 July 2019. These systems will assist with annual reporting, and also internal monitoring and reporting to the Council.

Thank you

We would like to thank the Council, management, and staff for their assistance during the audit.

Clarence Susan
Audit Director
26 March 2019

1 Our audit opinion

1.1 We issued an unmodified audit opinion

We issued an unmodified audit opinion on the Council's CD on 19 March 2019.

This means we are satisfied the Council's CD meets the statutory purpose and provides an effective basis for public participation in the Council's decision making in relation to the matters covered by the proposed amendment.

We found the underlying information and assumptions used to prepare the CD provided a reasonable and supportable basis for the preparation of the document.

1.1 Unadjusted misstatements

The CD is free from material misstatements, including omissions. However, in the course of the audit, we found certain misstatements that are individually and collectively not material to the CD.

We have discussed any misstatements that we found with management. All misstatements were amended prior to the Council adopting the CD.

2 Audit scope and objective

The scope of our audit engagement and our respective responsibilities are contained in our audit engagement letter dated 1 March 2019.

In summary, the Council is proposing to amend its LTP for the 10 years 2018–28 by including a Council Administration Building in the town centre, on Tūwharetoa Street (previously a car park), with in-berm parking to replace the number of parks impacted by the proposed new Council Administration Building.

Also included in the consultation document for the proposed long term plan amendment are options in relation to a proposed museum. Council's preferred option is to not build a new museum, and therefore the proposed long term plan amendment is not impacted by this option in the consultation document.

3 Control environment

Our approach to the audit was to identify, confirm, and assess the Council's key processes and controls over the underlying information and ultimate production of both the CD and the amended LTP. The purpose of this assessment was to enable us to plan the most effective and efficient approach to the audit work needed to provide our two audit opinions.

Our assessment was based on our findings gathered during the 2018-28 Long term plan audit, client knowledge and discussions with senior management. The conclusion of our assessment is as follows:

- the overall control environment is effective;
- the planning and budgeting function is operating throughout Council;
- despite not being able to controls test the financial model, through substantive testing we confirmed the financial model is operating appropriately and as described; and
- overall, no significant control deficiencies have been identified.

4 Areas of audit emphasis

During the planning stage of the audit, and our review of the content of the CD, we identified the following areas of emphasis during our audit. In this section of the report, we comment on our findings on those matters.

4.1 Content of the CD

We were satisfied that the CD included appropriate information to enable consultation with the public on the key issue.

Based on our work on the underlying information and over the CD, we concluded that the CD provides an effective basis for public participation in the Council's decision-making processes relating to the content of the LTP amendment.

4.2 Adopting and auditing the underlying information

The Council prepared and adopted the underlying information necessary to support the CD. The Council achieved this by producing a draft supporting information pack consisting of only the changes required to the LTP.

We have documented our conclusions of those aspects of audited underlying information considered below:

4.2.1 Financial Strategy

The financial strategy has not significantly changed since adoption of the original 2018-2028 strategy. We reviewed the minimal changes proposed and concluded that Council remain prudent in their approach to funding and debt.

We reviewed the proposed changes to the Financial Strategy and concluded that these were consistent with underlying information, the financial model and accurately informs the CD.

We also concluded that the Strategy meets the purpose as set out in the Act and is appropriate for inclusion in the CD.

4.2.2 Infrastructure Strategy

The Infrastructure Strategy has not significantly changed from the 2018-28 LTP.

We have reviewed the proposed changes to the infrastructure strategy and ensured that these are consistent with underlying information and disclosures, where applicable, in the consultation document.

4.2.3 Significant forecasting assumptions

There have been no changes to the significant financial forecasting assumptions applied from the 2018-28 LTP.

The assumptions included in the Council's underlying information are in line with our expectations and have been allocated an appropriate level of uncertainty.

We tested the key assumptions relating to the proposed amendment and concluded the assumptions have been appropriately reflected in the financial modelling and the underlying information.

4.2.4 Forecast performance report

Our review of the underlying information confirmed that no changes were made to the forecast performance disclosures and measures adopted in the 2018-28 LTP.

4.2.5 Financial model and forecasted financial statements

Our review and testing of the financial model concluded that assumptions and formulas were applied consistently and in line with our expectations. This gave us reasonable assurance over the basis of the financial forecasts.

We also performed a high level analytical review over the key forecasted financial statements. We concluded that the forecast financial statements are in line with our understanding of the underlying information and our knowledge of the proposed amendment.

Overall, we consider the forecasted financials remain in alignment with the Council's Financial Strategy and represent a prudent approach.

4.2.6 Quality of asset-related forecasting information

Our review of the asset related forecasting information confirmed there have been no significant changes to the asset related information in the original 2018-28 LTP.

The proposed changes within the transportation and investment activities are consistent with the underlying information and the consultation document.

5 Other matters arising from our audit

We completed our planned work in accordance with our Engagement Letter and we identified the following matter for your attention:

5.1 Quality control of the underlying information

Our review of the underlying documentation yielded misstatements. We note that most of the errors were not significant to the audit, and all suggested changes were made by management in a prompt manner.

6 Publication of the CD on the Council's website

As the Council intends publishing the CD electronically, please allow time for us to examine the final electronic file version of the audit report before its inclusion on your web site.

We need to ensure consistency with the paper-based documents that have been subject to audit. Changes may also be needed to parts of the audit opinion, for example page number references and the inclusion of additional information to readers of the electronic report.

7 Audit of the final amended LTP

The next step in the amended LTP audit process will be the audit of the final LTP. This is scheduled to start in the week commencing 10 June 2019 and be completed by 24 June 2019.

To ensure our audit of the final LTP is efficient we expect the Council to prepare a schedule of changes to the financial forecasts and draft LTP that were the basis of the CD. This will enable us to assess the extent of changes as a result of community consultation and tailor our audit work accordingly.

Under section 94(1) of the Act, our audit report on the final LTP forms part of the amended LTP, which the Council is required to adopt before 1 July 2019 (section 93(3)). Our agreed timeframes will enable us to issue our audit report in time for the Council meeting on 25 June 2019, at which time the amended LTP will be formally adopted.

We are responsible for reporting on whether the LTP meets the statutory purpose and provides a reasonable basis for integrated decision making by the Council and accountability to the community. We considered the quality of the underlying information and assumptions as part of the audit of the CD. So for the audit of the LTP, we will focus on how these are reflected in the LTP. We will consider the effect of the decisions that come out of the consultation process and review the LTP to gain assurance that appropriate, material, consequential changes and disclosures have been made.

At the conclusion of the LTP audit, we will ask the Council to provide us with a signed management representation letter on the LTP. The audit team will provide the letter template during the LTP audit.

Appendix 1: Mandatory disclosures

Area	Key messages
Our responsibilities in conducting the audit.	We carried out this audit on behalf of the Controller and Auditor-General. We are responsible for expressing an independent opinion on the Consultation Document to amend the 2018-28 Long Term Plan (CD) and reporting that opinion to you. This responsibility arises from section 93C(4) of the Local Government Act 2002. The audit of the CD does not relieve management or the Council of their responsibilities. Our audit engagement letter dated 1 March 2019 contains a detailed explanation of the respective responsibilities of the auditor and the Council.
Auditing standards	We carry out our audit in accordance with the International Standard on Assurance Engagements (New Zealand) 3000 (revised): *Assurance Engagements Other Than Audits or Reviews of Historical Financial Information*, the International Standard on Assurance Engagements 3400: *The Examination of Prospective Financial Information,* and the Auditor-General's Auditing Standards.
Auditor independence	We confirm that, for the audit of the Taupō District Council's CD for the period 1 July 2018 to 30 June 2028, we have maintained our independence in accordance with the requirements of the Auditor-General, which incorporate the independence requirements of the External Reporting Board. In addition to our work carrying out all legally required external audits, we have provided assurance reports on certain matters in respect of the Council's Debenture Trust Deed and the Planning and Procurement Processes for a new Headquarters Building. These assignments are compatible with those independence requirements. Other than these assignments, we have no relationship with or interests in the Council or any of its subsidiaries.
Other relationships	We are not aware of any situations where a spouse or close relative of a staff member involved in the audit occupies a position with the Council that is significant to the audit. We are not aware of any situations where a staff member of Audit New Zealand has accepted a position of employment with the Council during or since the end of the financial year.
Unresolved disagreements	We have no unresolved disagreements with management about matters that individually or in aggregate could be significant to the CD. Management has not sought to influence our views on matters relevant to our audit opinion.

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Terms of Reference

Grants and Partnerships Policy 2015

DRAFT

Taupo District Council

May 2019

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1. Terms of Reference

Background

As part of the Internal Risk Programme for 2019/2020, and in accordance with our engagement letter dated 8 October 2018, we will undertake Internal Audit procedures, consistent with the Risk Management framework of Taupo District Council ('TDC').

This will assist the Audit and Risk Committee to exercise oversight of Management's compliance with the Grants and Partnerships Policy and respond to any risks associated with this Policy.

Our Internal Audit methodology is designed to complement the Internal Audit process of Council. These engagements are designed to specifically address areas where the identified risk is higher or where management and/or Council require additional procedures over and above what is provided in the ordinary course of business.

Objective and scope

The objective of this engagement is to assess compliance with the Grants and Partnerships Policy 2015 (including the amendment on 26 June 2018), by TDC.

The period to be covered will be 1 July 2018 to 30 June 2019.

The specific procedures and our approach which will form our engagement are recorded in **Appendix A.**

Sponsor

The sponsor of this engagement will be Brian Fox (Group Manager Corporate and Community).

Staffing

This engagement will be performed by the following:

John Dixon	Engagement Partner responsible for the overall engagement.
Natasha Eastwood	Engagement Manager responsible for overseeing the delivery of the engagement.

Other staff, including specialists, will be used as required.

Timeframe

The timeframes for this assessment will be agreed as required.

Planning of Engagement	TBC
Commence fieldwork (subject to availability of data)	TBC
Expected date for completion of fieldwork	TBC
Issue draft findings / workshop results	TBC
Management Comments received	TBC
Final results issued	TBC

Deliverables

At the end of this engagement we will meet with relevant staff/management to discuss our findings and agree upon a practical approach to implementing any recommendations for improvement. Individual written reports will be used as the basis for this discussion.

To ensure a 'no surprises' approach we will regularly communicate progress updates to you during fieldwork.

As noted above, we will issue individual reports which will be produced within 10 business days of the completion of the fieldwork.

Our oral reports and any draft reports which you might receive will not constitute our definitive findings and recommendations. These findings and recommendations, if any, will be contained solely in our final written report.

These reports are provided solely for the Council for the purpose for which the services are provided. Unless required by law you shall not provide this report to any third party, publish it on a website or refer to us or the services without our prior written consent. In no event, regardless of whether consent has been provided, shall we assume any responsibility to any third party to whom our report is disclosed or otherwise made available. No copy, extract or quote from our report may be made available to any other person without our prior written consent to the form and content of the disclosure.

The engagement will not constitute an agreed upon procedure, review or audit in terms of standards issued by the New Zealand Institute of Chartered Accountants. Accordingly, this engagement is not intended to, and will not, result in the expression of an audit opinion nor the fulfilling of any statutory audit or other requirements.

Fees

We estimate that this assignment will take approximately 3 days onsite in Taupo with 3 days planning and reporting time from our Hawke's Bay office. This will have an estimated total fee range for this engagement will be $9,500 - $10,500 exclusive of GST and disbursements.

This fee excludes a service fee of 5% to cover our office support costs in respect of photocopying, postage, tolls and faxes, stationery, couriers and mileage. In addition to our fee, any other significant direct out of pocket expenses incurred would be charged at cost (e.g. travel and accommodation).

Achieving the timetable and budget, are dependent upon Council staff members being available to work with our team as required during that course of this evaluation and the availability of required documentation. Should the nature and extent of work required differ from that anticipated we will discuss with you and agree a revised timeframe and budget.

2. Acceptance

Please contact me if you have any questions in respect of this Terms of Reference.

If you are in agreement with this Terms of Reference, please sign where indicated below and return to us.

John Dixon
Partner
PwC
Napier
24 May 2019

I accept the above terms of reference for the Internal Audit Procedures on behalf of Taupo District Council.

_____ _____

Brian Fox
Group Manager Corporate and Community
Taupo District Council

Date

Appendix A

Engagement	*Procedures*
Grants and Partnerships Policy 2015*	1. Read the Grants and Partnerships Policy to gain an understanding of policy and processes. 2. Interview key staff to gain an understanding of the processes in place for the management of the Grants and Partnerships policy. 3. For a sample of 5 grants and 5 partnerships we will confirm that the policy has been complied with and highlight departures from policy (if any). 4. Assess the above policies, procedures and processes against good practice and make recommendations to address any gaps or weaknesses.

* Note: there was an amendment to the GPP on 26 June 2018

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Taupo District Council

Procurement Policy Review

25 February 2019

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Brian Fox
Head of Risk & Regulatory
Taupo District Council
72 Lake Terrace
Taupo

25 February 2019

Report for Services In Relation To Procurement Policy Review for Taupo District Council

Dear Brian

We are pleased to provide you our report that provides a summary of our key findings from our internal audit covering a review of your Procurement Policy.

This report was prepared in accordance with the terms and conditions set in our engagement letter dated 20th September 2018 and should be read in conjunction with the key terms of business, restrictions and disclaimers included in this report.

Thank you for the opportunity to support you in this piece of work. We would also like to express our appreciation for the assistance provided to us by your team during this project.

Please do not hesitate to contact me if you have any questions or require further assistance.

Yours sincerely

John Dixon
Partner
john.j.dixon@nz.pwc.com
P: 06 833 3733

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Section 1

Executive Summary

Executive Summary

PwC was engaged by Taupo District Council to assess the compliance of 2014 Procurement Policy. We have reviewed the compliance with the Policy for the period 1 July 2017 to 30 June 2018.

We note that a new version of the policy is in the process of being finalised, and we have therefore also reviewed compliance with the draft policy where it differs from the 2014 version.

We set out below the Objective and Approach for this engagement.

Objective

1. Ensure compliance with the Procurement Policy 2014 and 2018. Specifically focussing on:
   - Compliance with the tender process guidelines.
   - Compliance with the quote process guidelines.

Approach

Our approach was as follows:

- Gain an understanding of the procurement process through discussion with relevant staff.
- Select a sample of tender transactions to test whether procedures and processes are in compliance with the policy.
- Select a sample of transactions that meet the threshold for requiring quotes and test whether procedures and processes are in compliance with policy.
- Assess the policy, procedures and processes against good practice to identify any gaps or weaknesses.

Section 2

Our findings

Process Testing – Tender Process
Our findings

1. Tender Opening Process	Priority Rating	**High**

Observation

In our testing of compliance with the tender opening guidelines as per section 3.4.3 of Part 3 of the Procurement Operational Guidelines, we noted the following:

- 4 of the samples tested did not conform to the guidelines. The tenders were not opened by the required people as outlined in the operational guidelines.
- 2 of the samples tested did not have the appropriate tender opening form in the database.

Recommendation

We recommend that:

1. The council review this process and ensure that controls are put in place to ensure compliance.
2. The above section be reviewed on a regular basis in order to ensure that it is still relevant and updated as necessary.
3. A control is put in place to ensure that all relevant and mandatory documents are scanned into the database and held on file, such as a checklist for all documents required to be on file. At completion of a project this checklist can be used to ensure that all required documents are uploaded into the database and are on file. This will ensure all mandatory documentation is maintained.

Management comment

Management accept the findings and recommendations of the report as it is written.

Implementation date and management responsible	Immediately – Risk Manager

Process Testing – Tender Process
Our findings (cont)

2. Tender Recommendation Summary Report	Priority Rating	**High**

Observation

From our testing of compliance with the tender evaluation process as per section 3.4.18 of part 3 of the Procurement Operations Guidelines we noted:

- 4 instances where there was no tender recommendation summary report in the database.
- 2 instances where the report on file was not completed or signed.

When testing our sample and the relevant supporting documentation we noted the existence of multiple versions of the tender evaluation summary reports.

Recommendation

We recommend:

1. That the Council ensure that the tender recommendation summary report is completed, signed and saved in the database for all projects that have gone through the tender process. The use of a checklist as documented in finding number 1 above will be useful in ensuring that all documents are held on file.
2. That the Council review these forms and implement the use of one comprehensive form in order to maintain consistency throughout the operations of Council. We also recommend that the older versions be removed from the document library and other storage locations.

Management comment

Management accept the findings and recommendations of the report as it is written.

Implementation date and management responsible	Immediately – Risk Manager

Process Testing – Quote Process
Our findings (cont)

3. Quotes Not Obtained As Per Policy Guidelines	Priority Rating	**High**

Observation

During our testing over the compliance with the quote guidelines we noted 7 instances where quotes were not obtained for expenses in accordance with the threshold defined by the Procurement Operational Guidelines.

Recommendation

We recommend a review of the policy guidelines around the quote process and ensure that these guidelines are still relevant, and are practical and economical. For example, where expenses that are standard and have the same provider, these would not need the quotes every month but maybe on an annual or biannual cycle obtaining three quotes would be more practical.

To ensure that the policy is complied with appropriately we recommend that the guidelines (once updated) are communicated to all relevant staff.

Management comment

Management accept the findings and recommendations of the report as it is written.

Implementation date and management responsible	Immediately – Risk Manager

General Observations and Recommendations

Observation

During our review of the Procurement Policy 2014 and 2018 versions we noted that the Procurement Operational Guidelines were not included under the section "Other Relevant Policies". These guidelines outline the detail behind the procurement policy and therefore would be expected to be include in this list.

During our review of the Procurement Operational Guidelines we noted a reference on page 51 for the location of the tender recommendation summary report. However, during our discussions with management we noted that this document is actually stored in multiple locations which increases the risk of staff using the incorrect version of the template.

Recommendation

We recommend:

1. That the 'Procurement Operational Guidelines' be included in the "Other Relevant Policies" list in the Procurement Policy document.
2. That the correct location is included on page 51 for the tender recommendation summary report. Once this is updated all staff should be notified of this location to ensure that they are using only the approved template.

Section 3

Appendices

Appendix 1 - Documents Sighted and Glossary

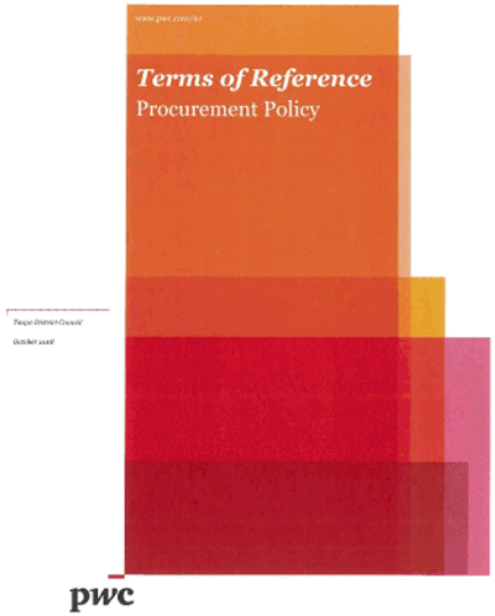
The following documents have been reviewed by PwC in assessing TDC's compliance with the Procurement Policy

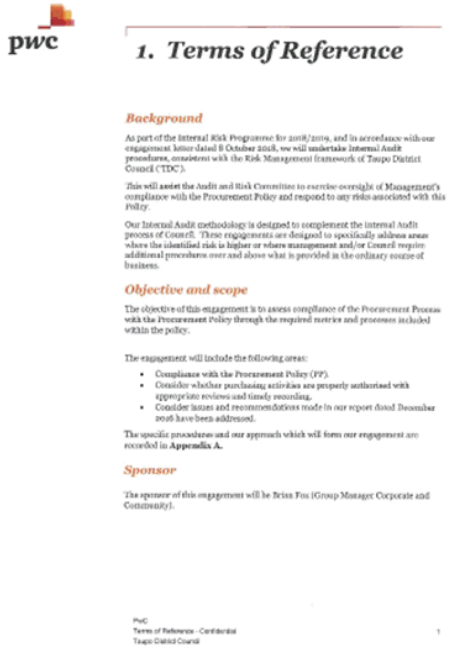
- Procurement Policy 2014
- Procurement Policy 2018 draft
- Procurement Operational Guidelines February 2015
- Tender documentation filed in objective for the sample of projects that were selected for testing compliance with the tender process.
- Purchase orders, Invoices and Quotes for the sample of transactions selected for testing compliance with the quote process.

Glossary

- TDC – Taupo District Council
- PwC – PricewaterhouseCoopers

Appendix 2 - Terms of Reference





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1. Terms of Reference

Background

As part of the Internal Risk Programme for 2018/2019, and in accordance with our engagement letter dated 8 October 2018, we will undertake Internal Audit procedures, consistent with the Risk Management framework of Taupo District Council (TDC).

This will assist the Audit and Risk Committee to exercise oversight of Management's compliance with the Procurement Policy and respond to any risks associated with this Policy.

Our Internal Audit methodology is designed to complement the internal Audit process of Council. These engagements are designed to specifically address areas where the identified risk is higher or where management and/or Council require additional procedures over and above what is provided in the ordinary course of business.

Objective and scope

The objective of this engagement is to assess compliance of the Procurement Process with the Procurement Policy through the required metrics and processes included within the policy.

The engagement will include the following areas:

- Compliance with the Procurement Policy (PP).
- Consider whether purchasing activities are properly authorised with appropriate reviews and timely recording.
- Consider issues and recommendations made in our report dated December 2016 have been addressed.

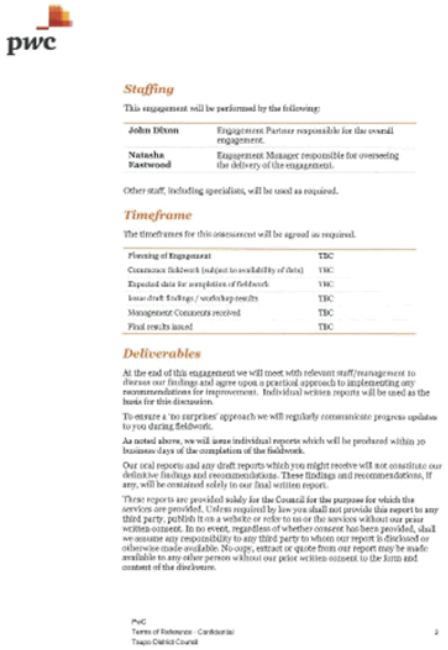
The specific procedures and our approach which will form our engagement are recorded in **Appendix A.**

Sponsor

The sponsor of this engagement will be Brian Fox (Group Manager Corporate and Community).

PwC
Terms of Reference - Confidential
Taupo District Council 1

Appendix 2 - Terms of Reference (cont)



Staffing

This engagement will be performed by the following:

John Dixon	Engagement Partner responsible for the overall engagement.
Natasha Eastwood	Engagement Manager responsible for overseeing the delivery of the engagement.

Other staff, including specialists, will be used as required.

Timeframe

The timeframes for this assessment will be agreed as required.

Planning of Engagement	TBC
Commence fieldwork (subject to availability of data)	TBC
Expected date for completion of fieldwork	TBC
Issue draft findings / workshop results	TBC
Management Comments received	TBC
Final results issued	TBC

Deliverables

At the end of this engagement we will meet with relevant staff/management to discuss our findings and agree upon a practical approach to implementing any recommendations for improvement. Individual written reports will be used as the basis for this discussion.

To ensure a 'no surprises' approach we will regularly communicate progress updates to you during fieldwork.

As noted above, we will issue individual reports which will be produced within 10 business days of the completion of the fieldwork.

Our oral reports and any draft reports which you might receive will not constitute our definitive findings and recommendations. These findings and recommendations, if any, will be contained solely in our final written report.

These reports are provided solely for the Council for the purpose for which the services are provided. Unless required by law you shall not provide this report to any third party, publish it on a website or refer to us or the services without our prior written consent. In no event, regardless of whether consent has been provided, shall we assume any responsibility to any third party to whom our report is disclosed or otherwise made available. No copy, extract or quote from our report may be made available to any other person without our prior written consent to the form and content of the disclosure.

The engagement will not constitute an agreed upon procedure, review or audit in terms of standards issued by the New Zealand Institute of Chartered Accountants. Accordingly, this engagement is not intended to, and will not, result in the expression of an audit opinion nor the fulfilling of any statutory audit or other requirements.

Fees

We estimate that this assignment will take approximately 2 days onsite in Taupo with 3 days planning and reporting time from our Hawke's Bay office. This will have an estimated total fee range for this engagement will be $9,000 - $9,500 exclusive of GST and disbursements.

This fee excludes a service fee of $N to cover our office support costs in respect of photocopying, postage, tolls and faxes, stationery, couriers and mileage. In addition to our fee, any other significant direct out of pocket expenses incurred would be charged at cost (e.g. travel and accommodation).

Achieving the timetable and budget, are dependent upon Council staff members being available to work with our team as required during that course of this evaluation and the availability of required documentation. Should the nature and extent of work required differ from that anticipated we will discuss with you and agree a revised timeframe and budget.

Appendix 2 - Terms of Reference (cont)

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2. Acceptance

Please contact me if you have any questions in respect of this Terms of Reference.

If you are in agreement with this Terms of Reference, please sign where indicated below and return to us.

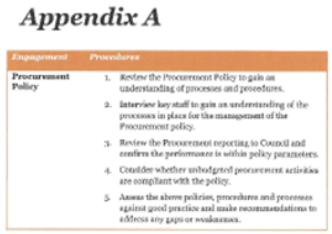
John Dixon
Partner
PwC
Napier
[date]

I accept the above terms of reference for the Internal Audit Procedures on behalf of Taupo District Council.

Brida Fox
Group Manager Corporate and Community
Taupo District Council

12/11/18
Date

PwC
Terms of Reference - Confidential
Taupo District Council



Appendix A

Engagement	Procedures
Procurement Policy	1. Review the Procurement Policy to gain an understanding of processes and procedures. 2. Interview key staff to gain an understanding of the processes in place for the management of the Procurement policy. 3. Review the Procurement reporting to Council and confirm the performance is within policy parameters. 4. Consider whether unbudgeted procurement activities are compliant with the policy. 5. Assess the above policies, procedures and processes against good practice and make recommendations to address any gaps or weaknesses.

Disclaimer

This document has been prepared solely for the purposes stated herein and should not be relied upon for any other purpose.

In preparing this document and providing our recommendations, we have relied upon, and assumed the accuracy and completeness of, all information available to us from public sources and furnished to us by Taupo District Council staff.

It should not be construed that we have conducted an audit of the information we have used.

This document has been prepared solely for use by Taupo District Council.

Our engagement did not constitute a statutory audit (the objective of which is the expression of an opinion on financial statements) or an examination (the objective of which is the expression of an opinion on management's assertions).

To the fullest extent permitted by law, PwC accepts no duty of care to any third party in connection with the provision of this document and/or any related information or explanation (together, the "Information").

Accordingly, regardless of the form of action, whether in contract, tort (including without limitation, negligence) or otherwise, and to the extent permitted by applicable law, PwC accepts no liability of any kind to any third party and disclaims all responsibility for the consequences of any third party acting or refraining to act in reliance on the Information.

This document has been prepared with care and diligence and the statements and opinions within it are given in good faith and in the belief on reasonable grounds that such statements and opinions are not false or misleading. No responsibility arising in any way for errors or omissions (including responsibility to any person for negligence) is assumed by us or any of our partners or employees for the preparation of the document to the extent that such errors or omissions result from our reasonable reliance on information provided by others or assumptions disclosed in the document or assumptions reasonably taken as implicit.

We reserve the right, but are under no obligation, to revise or amend the document if any additional information (particularly as regards the assumptions we have relied upon) which exists at the date of this document, but was not drawn to our attention during its preparation, subsequently comes to light.

This document is issued pursuant to the terms and conditions set out in our letter of engagement with by Taupo District Council.

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Taupo District Council

Treasury Management Policy

25 February 2019

Confidential

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Brian Fox
Head of Risk and Regulatory
Taupo District Council
72 Lake Terrace
Taupo

25 February 2019

Report for Services In Relation To Treasury Management Policy for Taupo District Council

Dear Brian

We are pleased to provide you our report that provides a summary of our key findings from our internal audit covering a review of your key financial controls and policy in relation to Treasury Management.

This report was prepared in accordance with the terms and conditions set in our engagement letter dated 20th September 2018 and should be read in conjunction with the key terms of business, restrictions and disclaimers included in this report.

Thank you for the opportunity to support you in this piece of work. We would also like to express our appreciation for the assistance provided to us by your team during this project.

Please do not hesitate to contact me if you have any questions or require further assistance.

Yours sincerely

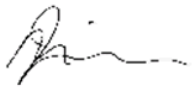

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Table of contents

Section 1

Executive Summary

Executive Summary

PwC has been engaged by Taupo District Council to assess compliance of the Treasury Portfolio with the Treasury Management Policy through the required metrics and processes included within the policy. We have assessed this for the period 1 July 2017 to 30 June 2018.

The engagement included the following areas:
- Compliance with the Treasury Management Policy (TMP).
- Consider whether investing activities are properly authorised with appropriate reviews and timely recording.
- Consider the specific requirements of the TEL Investment (TEL) Portfolio.
- Consider whether issues and recommendations made in our report dated February 2018 have been addressed.

We set out below the Objectives and Approach for this engagement.

Objective

1. Ensure compliance with the Treasury Management Policy (TMP). Specifically focussing on:
   - Investments
   - Borrowing
   - Risk
   - Cash and Working Capital
   - Management
   - Reviews

2. Ensure investing activities are properly authorised with appropriate reviews and timely recording, for example:
   - Pre Deal Activities
   - Execution of Deals
   - Confirmation
   - Investment Risk

Approach

Our approach was as follows:

- Gain an understanding of the processes in place for Treasury Management through discussion with relevant staff.
- Select a sample of investments across three months to test procedures and processes are in compliance with the policy.
- Assess the policy, procedures and processes against good practice to identify any gaps or weaknesses.
- Review the Treasury Management Policy reporting to Council and confirm the performance is within the policy parameters.
- Ensure the specific requirements of the TEL portfolio are met.
- Ensure issues and recommendations made in our report dated February 2018 have been addressed.

Section 2

Our findings

Process Testing – Investment Procedures
Our findings

1. Deals Supporting Documentation	Priority Rating	**Low**

Observation

During our testing over the deal tickets and supporting documentation we noted the following exceptions:

- 4 instances where there was no deal ticket available for a call transaction.
- 2 instances where no term deposit confirmation or other documentation was attached to the deal ticket.
- 1 instance where the term deposit confirmation was not attached to the deal ticket but could be located attached to the monthly reconciliation.

Recommendation

As best practice all deals have the appropriate documentation attached to the deal ticket. This will ensure all deals are being appropriately considered, reviewed and checked for accuracy. This will also ensure the transactions comply with the TMP.

Management comment

We acknowledge those instances mentioned where some paperwork was not attached or available for review. We do note however that all transactions have been considered, reviewed and appropriately authorised. Subsequent to this audit we have also established a new treasury transaction register to record all transaction information including deal tickets and confirmations.

Implementation date and management responsible	Immediately – Finance Manager

Process Testing – Investment Procedures

In its financial investment activity, Council's primary objective when investing is the protection of its investment capital and that a prudent approach to risk/return is always applied within the confines of the Policy. Therefore Council has implemented specific policy parameters to effectively and manage its investments, including:

- Borrowing Limits
- Interest Rate Maturity
- Credit rating requirements
- Portfolio mix requirements
- Liquidity limits

Under section 4.2 of the TMP, debt is to be managed within required limits. We obtained borrowing limit data from the Treasury reports for September 2017, February 2018 and May 2018 to test to ensure that the limits are in line with the policy. No instances of non-compliance were noted.

The Council has established a unique asset allocation strategy. We note that the policy allows for a variance from the Policy by +/- 25% before the breach is required to be reported. We noted no exceptions outside of the 25% allowance as noted on the following page.

We have obtained the reconciliations for the General Fund and TEL for the months of September 17, February 18 and May 18 and assessed the credit ratings of each counterparty. Based on this we have noted no exceptions.

Consistent with the sample within Borrowing Limits, no instances were noted where the Interest Rate per the Borrowing Spreadsheet was outside the accepted parameters.

Investment Portfolio Mix

TEL Investment Portfolio

The Council has established a unique asset allocation strategy. We have assessed this by obtaining the information from the monthly treasury reports for September 17, February 18 and May 18. We note that the policy allows for a variance of the allocation by +/- 25% before the breach is required to be reported.

	Asset Classes	$	Actual Allocation	Breach - prior to 25% Allowance?	Within 25% Allowance	Breach noted in Monthly Report
Sep-17	Cash - Actual 12%, Policy limits 0 - 35%	6,599,000	12%	No	N/A	N/A
	Diversified Fixed Interest - Actual 74%, Policy limits 25 - 75%	42,000,000	74%	No	N/A	N/A
	Australasian Equities - Actual 11%, Policy limits 0 - 35%	6,497,000	11%	No	N/A	N/A
	International Equities - Actual 1%, Policy limits 0 - 40%	799,000	1%	No	N/A	N/A
	Property - Actual 25%, Policy limits 0 - 40%	1,169,000	2%	No	N/A	N/A
		57,064,000				
Feb-18	Cash - Actual 14%, Policy limits 0 - 35%	11,629,000	20%	No	N/A	N/A
	Diversified Fixed Interest - Actual 73%, Policy limits 25 - 75%	38,000,000	65%	No	N/A	N/A
	Australasian Equities - Actual 10%, Policy limits 0 - 35%	6,539,000	11%	No	N/A	N/A
	International Equities - Actual 1%, Policy limits 0 - 40%	932,000	2%	No	N/A	N/A
	Property - Actual 2%, Policy limits 0 - 40%	1,169,000	2%	No	N/A	N/A
		58,269,000				
May-18	Cash - Actual 12%, Policy limits 0 - 35%	6,904,000	12%	No	N/A	N/A
	Diversified Fixed Interest - Actual 72%, Policy limits 25 - 75%	43,000,000	72%	No	N/A	N/A
	Australasian Equities - Actual 13%, Policy limits 0 - 35%	7,492,000	13%	No	N/A	N/A
	International Equities - Actual 1%, Policy limits 0 - 40%	812,000	1%	No	N/A	N/A
	Property - Actual 2%, Policy limits 0 - 40%	1,169,000	2%	No	N/A	N/A
		59,377,000				

Our Findings

Based on the work performed above no breaches were noted, therefore no control weakness has been noted.

Prior Year Reported Findings
Follow up actions

	Finding	Follow Up
Monthly Reconciliation	During our testing over the reconciliations performed each month we identified one month (August 2016), which was not signed off.	Based on testing performed in the current year no exceptions have been identified.
Deal Ticket Documentation	During our testing over deal tickets, we noted instances where there was no supporting documentation attached to the deal ticket.	Refer to the control point raised on page 7 for 2018 findings.
Unplanned Overdrafts	We noted that there was an unplanned overdraft at the end of December 2016/ beginning Jan 2017.	Based on testing performed in the current year, there were no such instances noted.

Section 3

Appendices

Appendix 1 - Documents Sighted and Glossary

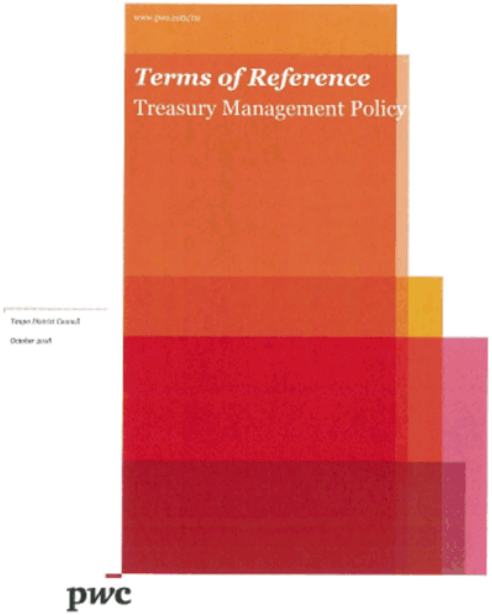
The following documents have been reviewed by PwC in assessing TDC's compliance with the TMP

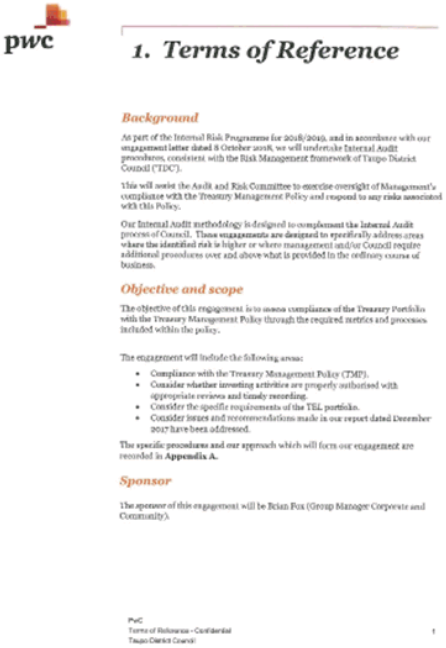
- Treasury Management reports for September 2017, February 2018 and May 2018.
- Treasury spreadsheets & information for September 2017, February 2018 and May 2018.
- Deal Tickets for September 2017, February 2018 and May 2018.
- Treasury monthly reconciliation folder for September 2017, February 2018 and May 2018.
- Public Council minutes from Taupo District Council website.

Glossary

- TDC – Taupo District Council
- TMP – Treasury Management Policy
- TMG – Treasury Management Group
- TEL – Investment Portfolio
- GF – General Fund
- PwC – PricewaterhouseCoopers

Appendix 2 - Terms of Reference





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1. Terms of Reference

Background

As part of the Internal Risk Programme for 2018/2019, and in accordance with our engagement letter dated 8 October 2018, we will undertake Internal Audit procedures, consistent with the Risk Management framework of Taupo District Council (TDC).

This will assist the Audit and Risk Committee to exercise oversight of Management's compliance with the Treasury Management Policy and respond to any risks associated with this Policy.

Our Internal Audit methodology is designed to complement the Internal Audit process of Council. These engagements are designed to specifically address areas where the identified risk is higher or where management and/or Council require additional procedures over and above what is provided in the ordinary course of business.

Objective and scope

The objective of this engagement is to assess compliance of the Treasury Portfolio with the Treasury Management Policy through the required metrics and processes included within the policy.

The engagement will include the following areas:

- Compliance with the Treasury Management Policy (TMP).
- Consider whether investing activities are properly authorised with appropriate reviews and timely recording.
- Consider the specific requirements of the TEL portfolio.
- Consider issues and recommendations made in our report dated December 2017 have been addressed.

The specific procedures and our approach which will form our engagement are recorded in **Appendix A.**

Sponsor

The sponsor of this engagement will be Brian Fox (Group Manager Corporate and Community).

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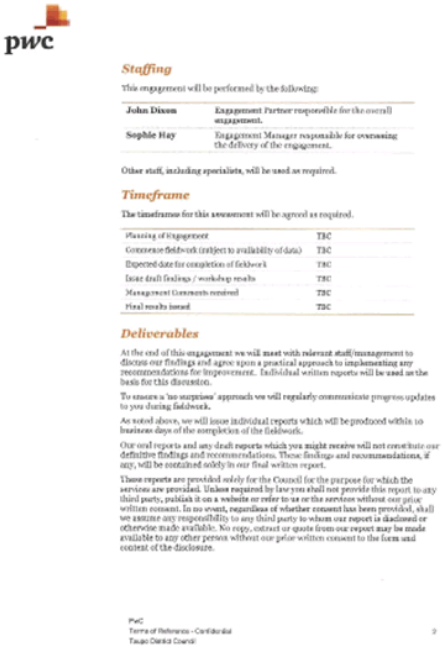
Taupo District Council 1

Appendix 2 - Terms of Reference (cont)



Staffing

This engagement will be performed by the following:

John Dixon	Engagement Partner responsible for the overall engagement.
Sophie Hay	Engagement Manager responsible for overseeing the delivery of the engagement.

Other staff, including specialists, will be used as required.

Timeframe

The timeframe for this assessment will be agreed as required.

Planning of Engagement	TBC
Commence fieldwork (subject to availability of data)	TBC
Expected date for completion of fieldwork	TBC
Issue draft findings / workshop results	TBC
Management Comments received	TBC
Final results issued	TBC

Deliverables

At the end of this engagement we will meet with relevant staff/management to discuss our findings and agree upon a practical approach to implementing any recommendations for improvement. Individual written reports will be used as the basis for this discussion.

To ensure a 'no surprises' approach we will regularly communicate progress updates to you during fieldwork.

As noted above, we will issue individual reports which will be produced within 10 business days of the completion of the fieldwork.

Our oral reports and any draft reports which you might receive will not constitute our definitive findings and recommendations. These findings and recommendations, if any, will be contained solely in our final written report.

These reports are provided solely for the Council for the purpose for which the services are provided. Unless required by law you shall not provide this report to any third party, publish it on a website or refer to us or the services without our prior written consent. In no event, regardless of whether consent has been provided, shall we assume any responsibility to any third party to whom our report is disclosed or otherwise made available. No copy, extract or quote from our report may be made available to any other person without our prior written consent to the form and content of the disclosure.

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The engagement will not constitute an agreed upon procedure, review or audit in terms of standards issued by the New Zealand Institute of Chartered Accountants. Accordingly, this engagement is not intended to, and will not, result in the expression of an audit opinion nor the fulfilling of any statutory audit or other requirements.

Fees

We estimate that this assignment will take approximately 2 days onsite in Taupo with 3 days planning and reporting time from our Hawke's Bay office. This will have an estimated total fee range for this engagement will be $9,000 - $9,500 exclusive of GST and disbursements.

This fee excludes a service fee of 5% to cover our office support costs in respect of photocopying, postage, tolls and fares, stationery, couriers and mileage. In addition to our fee, any other significant direct out of pocket expenses incurred would be charged at cost (e.g. travel and accommodation).

Achieving the timetable and budget, are dependent upon Council staff members being available to work with our team as required during the course of this evaluation and the availability of required documentation. Should the nature and extent of work required differ from that anticipated we will discuss with you and agree a revised timeframe and budget.

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Appendix 2 - Terms of Reference (cont)

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2. Acceptance

Please contact me if you have any questions in respect of this Terms of Reference.

If you are in agreement with this Terms of Reference, please sign where indicated below and return to us.

John Dixon
Partner
PwC
Napier
17 August 2018

I accept the above terms of reference for the Internal Audit Procedures on behalf of Taupo District Council.

Brian Fox
Group Manager Corporate and Community
Taupo District Council

Date 12/4/18

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Taupo District Council

Appendix A

Engagement	Procedures
Treasury Management Policy	1. Review the TMP to gain an understanding of processes and procedures. 2. Obtain confirmations from financial institutions to confirm information contained in the TKI and ISY spreadsheets. 3. Interview key staff to gain an understanding of the processes in place for the management of the Treasury policy. 4. Review the Treasury Management reporting to Council and confirm the performance is within policy parameters. 5. Assess the above policies, procedures and processes against good practice and make recommendations to address any gaps or weaknesses. 6. Follow-up on the status of issues reported in our review dated December 2017 and by the external auditors.

Disclaimer

This document has been prepared solely for the purposes stated herein and should not be relied upon for any other purpose.

In preparing this document and providing our recommendations, we have relied upon, and assumed the accuracy and completeness of, all information available to us from public sources and furnished to us by Taupo District Council staff.

It should not be construed that we have conducted an audit of the information we have used.

This document has been prepared solely for use by Taupo District Council.

Our engagement did not constitute a statutory audit (the objective of which is the expression of an opinion on financial statements) or an examination (the objective of which is the expression of an opinion on management's assertions).

To the fullest extent permitted by law, PwC accepts no duty of care to any third party in connection with the provision of this document and/or any related information or explanation (together, the "Information").

Accordingly, regardless of the form of action, whether in contract, tort (including without limitation, negligence) or otherwise, and to the extent permitted by applicable law, PwC accepts no liability of any kind to any third party and disclaims all responsibility for the consequences of any third party acting or refraining to act in reliance on the Information.

This document has been prepared with care and diligence and the statements and opinions within it are given in good faith and in the belief on reasonable grounds that such statements and opinions are not false or misleading. No responsibility arising in any way for errors or omissions (including responsibility to any person for negligence) is assumed by us or any of our partners or employees for the preparation of the document to the extent that such errors or omissions result from our reasonable reliance on information provided by others or assumptions disclosed in the document or assumptions reasonably taken as implicit.

We reserve the right, but are under no obligation, to revise or amend the document if any additional information (particularly as regards the assumptions we have relied upon) which exists at the date of this document, but was not drawn to our attention during its preparation, subsequently comes to light.

This document is issued pursuant to the terms and conditions set out in our letter of engagement with by Taupo District Council.

TAUPO DISTRICT COUNCIL RISK MANAGEMENT CHARTER 2019/21

1. CONTEXT

Taupō District Council is a local authority which operates in a highly visible and accountable political and statutory environment and is committed to good corporate governance through risk management. Council's high level goals and objectives are established through Statute and consultation with the community and are principally documented in Council's Long Term Plan and Annual Plan. Council's performance relative to those goals and objectives is assessed and reported on through the preparation of an Annual Report.

The management of risk is integral to achieving Council's ~~mission~~ vision to be the most prosperous and liveable district in the North Island by 2022 as outlined in its Long Term Plan:

- It enables the incorporation of contemporary risk management initiatives across all levels of the Council;
- It facilitates and initiates innovation, co-operation and sharing of resources; and
- It enhances the Council's ~~programs of economic development, environmental management, urban enhancement, community well-being, quality management and customer service.~~ 10 groups of activities to deliver the required community outcomes.

Many ~~of the Council's Key values have relevance to the Risk Management~~ Charter:

- ~~Concern for citizens;~~
- ~~Respect for the rights of others; and~~
- ~~Responsiveness to customer needs.~~

Commented [JD1]: Vision stated in 2018 -2028 LTP

Commented [JD2]: LTP does not refer to specific programs but identifies 10 activities and community outcomes.

Commented [JD3]: Remove as new values not related to risk management.

Commented [JD4]: Update to current values or remove from Charter

2. DEFINITIONS

2.1 Risk

~~AS/NZS~~ ISO 31000:~~2009~~2018 defines risk as the effect of uncertainty on objectives. ~~An effect is a positive or negative deviation from what is expected.~~ An effect is a deviation from the expected. It can be positive negative or both, and can address, create or result in opportunities and threats. Objectives can have different aspects and categories, and can be applied at different levels.

Commented [JD5]: Update reference to AS/NZS ISO 31000:2018. Check current definition

This definition of risk recognises that we all operate in an uncertain world. Whenever we try to achieve an objective, there's always the chance that things will not go according to plan. Every step has an element of risk that needs to be managed and every outcome is uncertain. Whenever we try to achieve an objective, we don't always get the results we expect. Sometimes we get positive results and sometimes we get negative results and occasionally we get both. Because of this, we need to reduce uncertainty as much as possible.

Uncertainty (or lack of certainty) is a state or condition that involves a deficiency of information that leads to inadequate or incomplete knowledge or understanding. Because of this, we need to reduce uncertainty where appropriate.

2.2 Risk Management

Risk management consists of coordinated activities to direct and control an organisation with regard to risk.

To truly effective risk management requires these elements in to be in place

a) Risk management is an integral part of all Council activities.
b) A structured and comprehensive approach to risk management is used to ensure consistent results.
c) The risk management framework and process are customised and proportionate to the Council's external and internal context related to its objectives.
d) Involves appropriate and timely involvement of stakeholders to enables their knowledge, views and perceptions to be considered that results in improved awareness and informed risk management.
e) Be dynamic and anticipate, detect, acknowledge and respond to changes and events in an appropriate and timely manner.
f) Uses the best available information ensuring that the inputs to risk management are based on historical and current information, as well as on future expectations. Risk management explicitly takes into account any limitations and uncertainties associated with such information and expectations. Information should be timely, clear and available to relevant stakeholders.
g) Recognise that human behaviour and culture significantly influence all aspects of risk management at each level and stage.
h) Risk management is continually improved through learning and experience.

Commented [JD6]: Include comments from ISO 3100 to ensure TDCs risk management is consistent with best practice.

~~Risk management covers the whole spectrum of risks and not just those associated with finance, health and safety and insurance. It also includes risks associated with public image (reputation), the environment, technology, contracts/partnerships, projects etc.~~

2.3 Gross, Inherent or Untreated Risk
The risk that an activity or an event would pose if no treatments (controls or other mitigating factors) were in place.

2.4 Risk Treatments or Controls
Risk treatments or controls are ~~actions~~ measures that ~~are taken to manage risks~~ maintain or modify risks. Treatments or controls include, but are not limited to, any process, policy, device, practice, or other conditions and/or actions which maintain and/or modify risk.

Commented [JD7]: New wording consistent with ISO 3100

Modification of risks generally involve one or a combination of the following actions ~~Controls~~There ~~are generally 5 actions you can take to manage risks.~~

Commented [JD8]: 'Controls' replaced with 'modification' as ISO 3100 uses this terminology

1. Avoidance of the risk
2. Reduction of the risk
3. Transferring the risk
4. Acceptance or retention of the risk
5. Sharing the risk

2.5 Residual or Treated Risk
Residual or treated risk is the threat that remains after all efforts to identify and treat the risk have been made. Since residual risk is unknown, many organisations choose to either accept residual risk or transfer it for example, by purchasing insurance to transfer the risk to an insurance company

2.6 Risk Tolerance
Risk tolerance can be defined as 'the amount and type of risk that an organisation can take in order to meet their strategic objectives.

2.7 Risk Appetite
Risk appetite can be defined as 'the amount and type of risk that an organisation is willing to take in order to meet their strategic objectives.

3. RISK MANAGEMENT AIMS AND OBJECTIVES

The purpose of risk management is the creation and protection of value. It improves performance, encourages innovation and supports the achievement of objectives.

Commented [JD9]: Updated to be consistent with ISO 3100: 2018

The purpose of the risk management framework is to assist the organisation in integrating risk management into significant activities and functions. The effectiveness of risk management will depend on its integration into the governance of the Council including decision-making. This requires support from stakeholders, particularly top management.

3.1 The aim of risk management is to ensure that the Council has ~~an~~ effective processes to support better decision making in the planning and delivery of products and services to the community through its integration into governance and decision making of the Council and good understanding of risks and their likely impacts. It is Council's intention ~~policy~~ to implement and maintain a Risk Management system that reflects best practice and ensure that sound risk management practices are incorporated into Council's planning and decision making processes.

Commented [JD10]: Minor wording change

3.2 The objectives of the Council's risk management strategy are to:-

- Align risk management with the Council's objectives, strategies and culture.
- Establish the amount and type of risk that may or may not be taken and ensure that this is communicated to the organisation and stakeholders.
- Communicate value of risk management to the organisation and its stakeholders
- Promote systematic monitoring of risks
- Ensure that the risk management framework remains appropriate to the context of the organisation.
- ~~Raise awareness of the need for risk management.~~
- ~~Minimise loss, disruption, damage and injury and reduce the cost of risk, thereby maximising resources.~~
- ~~Inform policy and decision making by identifying risks and their likely impact.~~

Commented [JD11]: New objectives consistent with ISO 3100 : 2018

Commented [JD12]: Removed as covered by new objective statements

3.3 These objectives will be achieved by:-

- Emphasising that risk management is a core responsibility by establishing and communicating clear roles, responsibilities and reporting lines within the Council for risk management.

Commented [JD13]: Detail on how objectives will be achieved

- Allocating appropriate resources for risk management.
- Ensuring effective and timely communication with, and the active involvement of all staff that directly contribute to and shape the decisions and activities of the Council.
- Consistent identification, analysis, evaluation, treatment and recording of risks.
- Maintaining a Risk Register of all known risks affecting Council, grouped as a minimum into Strategic and Operational. All risks will be analysed and classified into Extreme, High, Moderate and Low;
- Ongoing monitoring and evaluation of outcomes and ongoing improvement of risk management processes Monitoring progress in delivering the strategy and reviewing the risk management arrangements on an on-going basis by reviewing strategic risks, which have broad organisational wide impact on a quarterly basis by the Executive Management Team and twice annually by the Audit Committee, including what actions Council is undertaking to moderate these risks

Commented [JD14]: Updated to reflect guidance from ISO 3100: 2018

4. RISK MANAGEMENT METHODOLOGY

4.1 The Council recognises that to be effective, risk management must become part of the Council's culture, integrated into the Council's corporate and business plans and everyday activities, rather than being viewed or run as a separate program. Further, risk management must become the responsibility of every employee, contractor, volunteer and elected member of the Council.

4.2 Overarching strategies for managing risk within Council are:

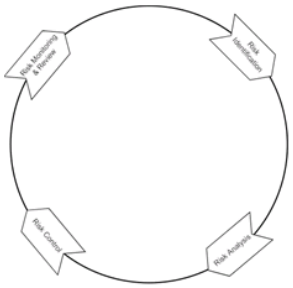
- Council's Chief Executive will establish and implement a relevant Risk Management system that ensures a systematic method is used to identify, analyse, evaluate, treat, monitor and communicate key risks associated with Council responsibilities in order to manage risk in according to the Council's risk appetite as outlined in 5.3.
- Ensuring that the concept of risk management becomes fundamental to the organisational culture through the philosophy of risk minimisation by doing everything possible to reduce the probability and/or impact of a risk towards zero for each and every activity undertaken by the Council.
- Ensuring the risk management system is consistent with recognised industry standards in particular ISO 3100:2018. This Standard for Risk Management provides a 'ready-made' strategy that enables a consistent and comprehensive approach to risk management across the Council, and we generally follow the approach in this standard.

Commented [JD15]: Expand by identifying risk minimisation as 'a process of doing everything possible to reduce the probability and/or impact of a risk towards zero'. Not to be confused with risk management that allows for risk acceptance and partial treatment of risk.

Commented [JD16]: Superfluous to requirements

4.3 The Taupo District Council will use a 4 stage risk management cycle as illustrated in the diagram below:-

Commented [JD17]: Updated image



The 4 stages of risk management are part of a cycle. Risk management is dynamic and so the identification/detection stage needs to be carried out continuously

Commented [JD18]: Included detection of risks.

5. COUNCIL'S RISK APPETITE

Commented [JD19]: Updated to expand on factors that contribute to the risk appetite. These include How much risk can the Council can support in achieving its objective (risk capacity), How much variation the Council accepts in achieving its objectives (risk tolerance), Attitudes within Council towards growth, risk and return (Risk attitude). Include new clause to cover this information.

5.1 The establishment of Council's statement on risk appetite is intended to guide employees in their actions and ability to accept and manage risks. The Council is periodically updated on the effectiveness of the management of key Council potential risk exposures, through reports to the Audit Committee. The risk appetite of Council is Defined as how much risk the Council is prepared to accept on achieving its objectives ~~reflected by the combination of the severity ratings within the Consequence table and the Likelihood table, which provides an inherent risk rating.~~

5.2 The key determinants of risk appetite include, but are not limited to:

- The Council's existing risk profile
- The Council's risk capacity and tolerance or how much risk the Council can support and how much variation it will accept in achieving its objectives
- The risk attitude within Council towards growth, risk and return
- The Council's and communities expectations and its legal and statutory obligations,
- ~~The income potential from accepting risks relative to income from risk-free activities (the risk/reward trade off);~~
- ~~Capital availability; and~~
- The adequacy of risk management systems and the Council's existing risk profile

5.3 To meet its objectives the Taupo District Council will generally operate within a low overall risk range. The Taupo District Council's lowest risk appetite will relate to financial, environmental, safety and compliance objectives, including employee health and safety, with a marginally higher risk appetite towards its strategic, reporting, and operations objectives. More specifically its appetite for risk is as follows:

No Appetite	• For actions or decisions that have a significant impact on Council's long term financial sustainability • For anything that has an adverse effect on the natural environment, in particular the districts water resources. • For anything that unreasonably compromises peoples safety and welfare • For internal fraud, collusion, theft and associated reputational risk. • For non-compliance with Legal and Regulatory obligations. • For unauthorised release of confidential information
Low Appetite	• For system failures or information and data security breaches • For third party (contractors) failure. • For risks arising from failure to meet customer & ratepayer commitments. • For risks arising from breaches of internal policies and standing orders

Commented [JD20]: Taken from current LTP. Water quality is a key challenge.

Medium Appetite	• For risks associated with the implementation of change and key strategic plans. • For risks associated with implementing business improvements and the Council's vision.
High (considerable) Appetite	• For developing and implementing improvements to service delivery • For seeking improved efficiency of Council operations

6. ROLES AND RESPONSIBILITIES FOR RISK MANAGEMENT

Audit & Risk Committee	• ~~Ensuring that the Council has an effective risk management process in place~~ • Approve the Council's risk management charter and risk management guides • Overseeing the risk management process across Council ~~The Audit and Risk Committee Charter~~ and sets out the details for levels of monitoring required by the Committee. • Receiving reports on the approved internal Audit Strategy/Plan.
Chief Executive and Senior Leadership Group	• Ensuring that the Council has an effective risk management process in place • Establishing and maintaining a climate of risk awareness and intelligence; • Developing and maintaining governance mechanisms that effectively monitor risks and their management; and • ~~Set requirements for risk management based on ISO 31000:2018.~~
Group Managers	• Ensuring compliance of their groups with the ~~Risk Management Strategy and the~~ Risk Management Charter and the promotion of a positive risk and compliance culture • Identifying, evaluating, assessing, treating and monitoring the key risks that might potentially prevent them from achieving their objectives; • ~~Integrating risk management aspects of their business; and into all~~ • ~~Ensuring that risk management practices and treatments are:~~ ~~- Consistent with Council requirements;~~ ~~- Monitored to ensure that management strategies remain effective; and~~ ~~- Commensurate with the level of risk exposure.~~
Managers/Supervisors & Team Leaders	• ~~To support Group Managers in the identification and management of Key Risks~~ • To manage operational risks effectively in their particular service areas • To monitor and review risks at appropriate intervals • ~~Ensuring that any time a health or safety risk is identified, a risk assessment should be updated and if necessary, a mitigating risk treatment plan enacted.~~

Commented [JD21]: CEOs role.

Commented [JD22]: As per TOR

Commented [JD23]: Removed. Requirements for risk management specified in Charter

Commented [JD24]: Removed as there is no strategy referred to

Commented [JD25]: Removed. Not required, covered elsewhere

Commented [JD26]: Removed. Covered elsewhere.

All Staff	• Observing and informing Managers or Team Leaders of any specific public risk; • Maintaining an awareness of risks (current and potential) that relate to their area of responsibility; • Actively support and contribute to risk management initiatives; • Using a documented risk management process to eliminate or minimise health and safety risks where appropriate; • Complying with all health and safety instructions, policies and procedures; • Using and maintaining safety devices and personal protective equipment correctly; • Being familiar with emergency and evacuation procedures and complying with the instructions given by emergency response personnel such as fire wardens and first aiders; and • Report all accidents, incidents and near misses.
Staff who Engage or Manage Contractors	• The prequalification process is completed prior to awarding the contract; • The primary contractor completes the Council's contractor induction; • The primary contractor provides an Health and Safety plan for contracts over $250,000; • A comprehensive Job Safety Analysis (JSA) is completed by contractors; • The equipment and materials used by contractors are safe and used in a manner that does not pose a risk to the contractors or to Council staff, volunteers and the public; • Contact is maintained with the contractor, providing job supervision and inspection of the quality of the work; and • Contractors have statutory compensation and liability insurance.
Contractors	• They are competent to do the job asked of them; • They have the qualifications, training, experience and certificates of competency that will be needed for the job; • They have the Health & Safety knowledge required for the job; • They have statutory compensation and liability insurance; • They maintain the premises/area in which they work in a safe and healthy manner for themselves and for the staff, volunteers and the public; • They employ safe tools and systems of work to do the work; • Electrical power tools are regularly inspected and tagged • Material Safety Data Sheets (MSDS) are provided for all chemicals; • Instructions and supervision from the contracting company are adequate; • Close supervision is required particularly in the case of young or inexperienced workers; and • They communicate regularly with their Council contract supervisor: - Methods of work are approved by the contract supervisor; and - They raise any issue that is or may become a health, safety or core business concern.
Risk Manager	• To develop and review the risk management charter and processes in accordance with best practice • To provide advice and support to Leadership Team and Service Managers on the identification, analysis and prioritisation of risks • To report on the identification and progress of strategic risks to the Audit & Accounts Committee • To provide risk management training as required to Officers and Members

Commented [JD27]: Removed all parts covered elsewhere in documents such as the H&S Policy

Commented [JD28]: Remove. Covered by H&S

Commented [JD29]: Remove. Covered by H&S

7. RESOURCING

Annual resourcing will be established through the annual estimates process.

Commented [JD30]: Annual budgeting process. Expand to reinforce requirement for budget managers to resource their team adequately for risk management activities that they are required to complete.

8. MONITORING AND REVIEW

8.1 To ensure that informed decisions are made, it is essential to identify key strategic risks. These risks will be separated into operational and governance risks. The operational risks will be identified and monitored by the Senior Leadership Team ~~level as part of the Corporate Planning process~~ and the governance risks identified and monitored by the by the Audit & Risk Committee. All strategic risks will be documented on Strategic Risk Registers which will be maintained by the Risk Manager ~~on behalf of the Leadership Team~~.

Commented [JD31]: Reflects current practice

8.2 Progress in managing strategic risks will be monitored and reported on to ensure that intended actions are delivered and risks managed.

8.3 The Strategic Risk Registers will form the basis of half yearly risk management reports to the Audit & Risk Committee.

8.4 ~~Internal audits will be carried out periodically to review the Council's risk management arrangements to review their effectiveness.~~

Commented [JD32]: Removed. Progress on risks is to be reviewed so audits serve no purpose if reviews done correctly.

8.5 ~~Internal audits will also:~~

- ~~Identify and report weaknesses in the controls established by management to manage/monitor risks;~~
- ~~Provide advice on the design/operation of the controls established by management to manage/monitor risk.~~

Commented [JD33]: Removed as risks are to monitored and reported on as per ISO 3100: 2018

8.6 ~~The Risk Manager will review the strategic risk register on an annual basis and incorporate strategic risk areas into the internal audit planning process as appropriate.~~

Commented [JD34]: Monitoring & testing programme rather than audit.

8.7 Service Managers ~~should~~ shall maintain a record of key operational risks within their service areas. ~~relating to service change, projects and significant procurement. Progress in managing these risks should be monitored on a regular basis.~~

Commented [JD35]: Change should to shall to make it a requirement rather than recommendation. Cannot review unless people create records and record decisions regarding risks.

9. AUTHORITY

All areas of the organisation will be open to Risk Management initiatives and in carrying out their functions all Risk Management and/or Internal Audit staff will have access to all other Council staff, information, records, documents, reports and property. Risk Management and/or Internal Audit staff have direct access to non-Executive appointees or co-opted to any established Audit and Risk Committee or other appropriate Committee as determined by Council.

10. REVIEW OF RISK MANAGEMENT STRATEGY

This ~~strategy~~ charter will be reviewed every 2 years by the Council's Audit and Risk Committee.

Commented [JD36]: Change to include regular reviews not exceeding 2 years.

Taupō District Council

Audit & Risk Committee
Schedule of Policies

Policy	Date of last review	Date of next review
Fraud Policy	May 2018	May 2021
Risk Management Charter	October 2018	June 2019
Protected Disclosures Policy	July 2017	July 2020
Conflict of Interest Guidelines – Staff	July 2017	July 2020
Procurement Policy	July 2014	July 2017 **(commenced)**
Sensitive Expenditure Policy	October 2017	October 2020
Audit & Risk Committee Terms of Reference	November 2016	TBA

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