



AUDIT SUMMARY

Office of the Chief Medical Examiner

www.cga.ct.gov/apa

Fiscal Years Ended June 30, 2020 and 2021

ABOUT THE AGENCY



The Office of the Chief Medical Examiner (OCME) is statutorily responsible to investigate all human deaths occurring in the State of Connecticut in the following categories:

- Violent deaths, whether apparently homicidal, suicidal or accidental, including but not limited to those due to thermal, chemical, electrical or radiational injury and criminal abortion, whether apparently self-induced or not
- Sudden or unexpected deaths not caused by readily recognizable disease
- Deaths under suspicious circumstances
- Deaths of persons whose bodies are to be cremated, buried at sea, or otherwise disposed of that will subsequently be unavailable for examination
- Deaths related to disease resulting from employment or to job related accident
- Deaths related to disease which might constitute a threat to public health, and
- Any other death, not clearly the result of natural causes, that occurs while the deceased person is in the custody of a peace officer, law enforcement agency, or the Commissioner of Correction.

ABOUT THE AUDIT

We have audited certain operations of OCME in fulfillment of our duties under Section 2-90 of the Connecticut General Statutes. The scope of our audit included, but was not necessarily limited to, the fiscal years ended June 30, 2020 and 2021. The objectives of our audit were to evaluate the:

1. Office's internal controls over significant management and financial functions;
2. Office's compliance with policies and procedures internal to the office or promulgated by other state agencies, as well as certain legal provisions; and
3. Effectiveness, economy, and efficiency of certain management practices and operations, including certain financial transactions.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[Link to full report](#)



Our audit identified internal control deficiencies and instances of noncompliance with laws, regulations, or policies that warrant the attention of management.

NOTEWORTHY FINDING



Finding

1

OCME did not maintain a receipts journal for cremation certificate receipts.



Recommendation

OCME should establish a receipts journal to record all cremation certificate revenue in accordance with the State Accounting Manual.

<p>2 prior audit RECOMMENDATIONS have been resolved</p>	<p>The Office of the Chief Medical Examiner should strengthen controls over cremation certificate receipts by reconciling the number of cremation certificates issued to its invoices and collections. OCME should sequentially number cremation certificates and require approvals of fee waivers in its Case Manager system.</p>	
	<p>The Office of the Chief Medical Examiner should strengthen its purchasing controls by obtaining multiple quotations from contractors and vendors on the Department of Administrative Services approved list.</p>	