STATE OF CONNECTICUT
Auditors of Public Accounts

AUDIT SUMMARY

Office of the Chief Medical Examiner

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Fiscal Years Ended June 30, 2022 and 2023

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 the Office of the Chief Medical Examiner 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, 2022 and 2023. 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

4 Findings

0 Repeat Findings

Our audit identified internal control deficiencies and instances of noncompliance with laws, regulations, or policies.

NOTEWORTHY FINDINGS

	Findings	Recommendations
1	We reviewed 20 vouchers related to 16 purchase orders, totaling $326,128 and noted the Office of the Chief Medical Examiner (OCME) did not promptly commit funds for four purchases, totaling $78,149. We also noted an additional 83 vouchers, totaling $1,029,610, charged to the tested purchase orders without sufficient funds available. OCME delayed committing the funds between one and 66 days.	OCME should strengthen internal controls to ensure it issues purchase orders in compliance with Section 4-98 of the General Statutes.
2	OCME did not perform cremation certificate fee accountability and reconciliation procedures for March 2023 through June 2023.	OCME should follow its accountability and reconciliation procedures to ensure that cremation certificate fees are properly processed, monitored, and reported.
3	OCME incurred contractual obligations of $1,241,840, but did not complete GAAP Form 5.	OCME should strengthen internal controls over the accounting and reporting of its contractual obligations to ensure the completeness and accuracy of its GAAP forms.
4	Our examination of 20 cremation fee revenue transactions with invoices totaling $36,000 noted that OCME deposited four of 11 check receipts between one and nine business days late. These late deposits totaled $6,450.	OCME should strengthen internal controls over deposits to ensure compliance with Section 4-32 of the General Statutes or apply for a waiver from the State Treasurer.