REPORT OF THE
TEXAS FORENSIC SCIENCE COMMISSION

EL PASO POLICE DEPARTMENT
CRIME LABORATORY INVESTIGATION

JULY 27, 2012

I. BACKGROUND

A. History and Mission of the Texas Forensic Science Commission

In May 2005, the Texas Legislature created the Texas Forensic Science Commission ("TFSC" or "Commission") by passing House Bill 1068 (the "Act"). The Act amended the Code of Criminal Procedure to add Article 38.01, which describes the composition and authority of the TFSC. *See* Act of May 30, 2005, 79th Leg., R.S., ch. 1224, § 1, 2005. The Act took effect on September 1, 2005. *Id.* at § 23.

The Act provides that the TFSC "shall investigate, in a timely manner, any allegation of professional negligence or misconduct that would substantially affect the integrity of the results of a forensic analysis conducted by an accredited laboratory, facility or entity." TEX. CODE CRIM. PROC. art. 38.01 § 4(a)(3).

The term "forensic analysis" is defined as a medical, chemical, toxicological, ballistic, or other examination or test performed on physical evidence, including DNA evidence, for the purpose of determining the connection of the evidence to a criminal action. *Id.* at art. 38.35(4). The statute excludes certain types of analyses from the "forensic analysis" definition, such as latent fingerprint analysis, a breath test specimen, and the portion of an autopsy conducted by a medical examiner or licensed physician.[1]

The FSC has nine members—four appointed by the Governor, three by the Lieutenant Governor and two by the Attorney General. *Id.* at art. 38.01 § 3. Seven of the nine commissioners are scientists and two are attorneys (one prosecutor and one criminal defense attorney). *Id.* The TFSC's presiding officer is designated by the Governor. *Id.* at § 3(c).

---

[1] For complete list of statutory exclusions, *see* TEX. CODE CRIM. PROC. art. 38.35(a)(4)(A)-(F) & (f).

The TFSC's policies and procedures set forth the process by which it determines whether to accept a complaint, as well as the process used to conduct an investigation once a complaint is accepted. (*See* TFSC Policies & Procedures at § 3.0, 4.0.) The ultimate result of an investigation is the issuance of a final report.

B. Attorney General Opinion No. GA-0866

On January 28, 2011, the Commission asked Texas Attorney General Greg Abbott to respond to three questions regarding the scope of its jurisdiction under its enabling statute (TEX. CODE CRIM. PROC., art. 38.01). Interested parties submitted briefs on the legal issues contained in the opinion request. On July 29, 2011, the Attorney General issued the following legal guidance:

1. The TFSC lacks authority to take any action with respect to evidence tested or offered into evidence before September 1, 2005. Though the TFSC has general authority to investigate allegations arising from incidents that occurred prior to September 1, 2005, it is prohibited, in the course of any such investigation, from considering or evaluating evidence that was tested or offered into evidence before that date.

2. The TFSC's investigative authority is limited to laboratories, facilities, or entities that were accredited by the Texas Department of Public Safety ("DPS") at the time the analysis took place.

3. The Commission may investigate a field of forensic science that is neither expressly included nor expressly excluded on DPS' list of accredited forensic disciplines, as long as the forensic field meets the statute's definition of "forensic analysis" (*See* Article 38.35 of the Act) and the other statutory requirements are satisfied.

The Commission's investigation of the El Paso Police Department Crime Laboratory ("EPPDCL") falls within its statutory jurisdiction as set forth in the Opinion for the following reasons: (1) the alleged negligence or misconduct occurred after the effective date of the Act; (2) EPPDCL is accredited by DPS; and (3) controlled substance analysis is a DPS-accredited forensic discipline.

C. Limitations of this Report

No finding contained herein constitutes a comment upon the guilt or innocence of any individual. A final report by the TFSC is not prima facie evidence of the information or findings contained in the report. TEX. CODE CRIM. PROC. art. 38.01 § 4 (e); FSC Policies and Procedures § 4.0 (d). The Commission does not currently have enforcement or rulemaking authority under its statute. The information it receives during the course of any investigation is dependent upon the willingness of concerned parties to submit relevant documents and respond to questions posed. The information gathered has not been subjected to the standards for admission of evidence in a courtroom. For example, no individual testified under oath, was limited by either the Texas or Federal Rules of Evidence (*e.g.,* against the admission of hearsay) or was subjected to formal cross-examination under the supervision of a judge. The primary purpose of this report is to encourage the development of forensic science in Texas.

II. SUMMARY OF COMPLAINT AND KEY FACTS

A. Complaint History

On September 2, 2011, the national Innocence Project ("IP") filed a complaint alleging "serious scientific negligence or misconduct" substantially affecting controlled substance analyses and reporting by the EPPDCL. (*See* **Exhibit A**.) The complaint followed on the heels of a letter and report issued by ASCLD-LAB in June 2011, in which the accrediting agency expressed serious concerns regarding EPPDCL's work and placed the laboratory on probation. In its complaint, IP asked the Commission to identify whether serious negligence or misconduct occurred, and if so to take the following steps:

(1) determine the impact; and (2) identify any corrective policies, actions, or forms of support.

On September 8, 2011, the Commission voted unanimously to investigate the complaint. Soon thereafter, the Commission began working with the EPPDCL, the American Association of Crime Laboratory Directors—Laboratory Accreditation Board ("ASCLD-LAB"), DPS, and the El Paso District Attorney's Office regarding the allegations contained in the complaint.

B. EPPDCL Accreditation History

The EPPDCL provides forensic services in breath alcohol testing and controlled substance testing. When the complaint was filed in this case, the laboratory employed three forensic examiners (one of whom served as quality manager) and one police sergeant who served as the laboratory director. Currently, the laboratory employs one forensic examiner who also serves as the quality manager, and one scientifically qualified, interim laboratory director.

EPPDCL was first accredited under the ASCLD-LAB Legacy program on March 3, 2006 for the five-year term through March 2011. In February 2011, the lab was granted a six-month extension to its Legacy accreditation to allow it to transition to accreditation under the ASCLD-LAB-*International*, or ISO program.

The ASCLD-LAB ISO-accreditation program incorporates internationally recognized conformity standards for testing and calibration, based on ISO/IEC 17025:2005. The ISO-accreditation program is generally regarded as more rigorous than the Legacy program. One of the most significant differences between the two programs for purposes of this investigation is the Legacy program only requires one on-site

assessment by ASCLD-LAB every five years, while the ISO program requires an on-site assessment every year. All laboratories accredited by ASCLD-LAB currently will move to ISO accreditation when their Legacy accreditations expire. All new accreditations are performed under the ISO program exclusively.

In preparation for the lab's transition to ISO, ASCLD-LAB conducted an on-site assessment from May 24-26, 2011. On June 27, 2011, ASCLD-LAB issued a full assessment report containing 18 corrective actions, 15 of which were classified as Level 1 corrective actions, and 3 of which were classified as Level 2 corrective actions. (*See* Assessment Reports at **Exhibit B**.) As the Commission noted throughout the investigation, it is not the number of corrective actions but rather the nature of the corrective actions that is important in determining the quality of a laboratory's work.

Some of the most significant corrective actions identified by the ASCLD-LAB lead assessor may be summarized as follows: (1) insufficient detail in spectral data to allow for independent reviewer to evaluate/interpret data; (2) criteria for identification were not acceptable for the analysis of solid dosage drugs; (3) insufficient mass spectral data raised concerns about the analytical competency of the examiners; (4) lab management failed to demonstrate that technical responsibility in the drug section has been delegated to an individual with appropriate technical training or experience; and (5) discrepancies in one analyst's proficiency test raised concerns about the competency of that analyst and the efficacy of the technical review process.

On June 27, 2011, ASCLD-LAB sent a letter to the laboratory highlighting the lead assessor's concerns and placing the laboratory on probation under the Legacy program until September 2, 2011. (*See* **Exhibit C**.) The letter required the suspension of

all instrumental analysis of casework until examiner competence could be demonstrated. It also required the external review of six months worth of casework by competent personnel from an ASCLD-LAB accredited laboratory. Finally, the laboratory was required to submit a corrective action plan to ASCLD-LAB within fourteen days. (*See* **Exhibit D**.)

In July 2011, Integrated Forensics Laboratories ("IFL") of Euless, Texas was retained to assist the laboratory in fulfilling its conditions of probation. IFL conducted technical review for six months worth of previous casework (122 cases). The technical review included examination of electronic records for administrative and quality errors, but not re-testing of the evidence. In a report issued on August 16, 2011, IFL noted numerous data and documentation problems but did not observe any false positive findings. (*See* **Exhibit E**.) For example, IFL observed poor technical review and overly complicated case notes in many files, making it difficult for an independent examiner to conduct a review of the files. Reviewers also observed a lack of consistent policy and reporting of subsampling, and the incorrect "unconfirmed" de facto identification of non-controlled substances in exhibits.

On September 2, 2011, ASCLD-LAB extended EPPDCL's probation until December 31, 2011. (*See* **Exhibit F**.) ASCLD-LAB allowed EPPDCL to resume instrumental analysis, subject to 100% external review (by a controlled substance proficiency tested examiner from an ASCLD-LAB accredited facility). From September-November 2011, IFL conducted technical review for all cases generated by the laboratory. ASCLD-LAB requested a report on the results of that review by December 5, 2011.

In August 2011, EPPDCL submitted an appeal for five of the corrective actions issued by the ASCLD-LAB lead assessor in his June 2011 report. On October 19, 2011, ASCLD-LAB sustained two of the appeals and denied three. The Board also added one additional corrective action. (*See* **Exhibit G**.)

On December 4, 2011, IFL management issued a report summarizing the results of a 10-day site visit and technical review for the period from September-November, 2011. (*See* **Exhibit H**.) In addition to extensive on-site training of examiners, IFL reviewed 79 cases, revised EPPDCL's standard operating procedures, removed one instrument from use, recommended the removal of an examiner from casework, recommended hiring a "technically qualified" laboratory director, encouraged management to expose analysts to other laboratories and training programs, and recommended re-testing of cases worked by the removed analyst. IFL also recommended the casework of the remaining two examiners be subject to 100% technical review while the laboratory searched for a technically competent laboratory director.

On December 23, 2011, ASCLD-LAB sent a letter to EPPDCL extending the lab's Legacy accreditation until April 6, 2012 and lifting the sanction of probation. (*See* **Exhibit I**.) On March 26, 2012, ASCLD-LAB granted ISO accreditation to EPPDCL. (*See* **Exhibit J**.)

III. TFSC INVESTIGATION

A. Statutory Requirement for Written Report

An investigation under the TFSC's enabling statute "must include the preparation of a written report that identifies and also describes the methods and procedures used to identify: (A) the alleged negligence or misconduct; (B) whether the negligence or

misconduct occurred; and (C) any corrective action required of the laboratory, facility, or entity." *Id.* at 4(a)(3)(b)(1). A TFSC investigation may include one or more: (A) retrospective reexaminations of other forensic analyses conducted by the laboratory, facility, or entity that may involve the same kind of negligence or misconduct; and (B) follow-up evaluations of the laboratory, facility, or entity to review: (i) the implementation of any corrective action required . . . . ; or (ii) the conclusion of any retrospective reexamination under paragraph (A). *Id.* at 4(a)(3)(b)(2).

B. TFSC Investigative Methods and Procedures

The TFSC's initial investigation consisted of three main phases: (1) document collection; (2) document review; and (3) interviews of laboratory personnel and management. Commission staff also consulted extensively with the Executive Director of ASCLD-LAB and the Deputy Assistant Director of DPS, and maintained ongoing contact with the El Paso County District Attorney's Office and the complainant. As a result of the initial investigation, the Commission made numerous recommendations at its January 13, 2012 meeting. (*See* **Section D** below).

1. Document Review

Commission staff began collecting and reviewing documents in September 2011. The EPPDCL was extremely responsive and provided all requested documents quickly. From September 2011 to the writing of this report, Commission staff reviewed thousands of pages of documents provided by EPPDCL, and made numerous follow-up inquiries to documents received. A list of documents provided to the Commission as part of the initial collection and review phase may be found at **Exhibit K**.

2. Interviews of EPPDCL Analysts and Management

On December 13, 2011, Dr. Sarah Kerrigan (Chair of the EPPDCL Investigative Panel) and Lynn Robitaille (Commission General Counsel) traveled to El Paso to conduct interviews of laboratory management and forensic analysts. Dr. Kerrigan and Ms. Robitaille also met with District Attorney Jaime Esparza and his staff. Commissioner Richard Alpert joined the meeting with the District Attorney via teleconference. The EPPDCL Investigative Panel (Kerrigan, Alpert, Eisenberg) also held non-deliberative telephone conferences periodically for the purpose of ensuring necessary information was gathered from EPPDCL, ASCLD-LAB and DPS in a timely manner.

C. Observations

The Commission's interviews at EPPDCL yielded numerous observations, which may be divided roughly into the following subjects: (a) August 2010 proficiency exam; (b) scientific leadership and authority of quality manager; and (c) sufficiency of spectral data, technical review process and analyst competence.

As a threshold matter, the on-site visit indicated that examiners were committed to good science and extremely eager to improve their work. Management also expressed a strong desire to take the corrective action needed to remedy the situation in the laboratory. The Commission commends the laboratory and EPPD management for their openness and willingness to respond to the various corrective actions suggested by ASCLD-LAB and the Commission. The Commission also commends EPPD leadership for their decision to alert the public regarding the laboratory's probation by posting the June ASCLD-LAB letter and assessment report on their website. The Commission

encourages all crime laboratories in Texas to embrace a similar commitment to transparency.

1. August 2010 Proficiency Exam

In August 2010, one of the EPPDCL analysts completed a standard proficiency examination. The proficiency examination was *not* a blind examination; the examiner was aware she was completing a proficiency test. The analyst performed 44 injections of a white powder sample into the GC/MS instrument, and 43 of the 44 results were negative. However, she reported the result as positive for cocaine, relying on the single positive run. The original sample was re-tested by another examiner—the same examiner who performed the technical review in the case. His result was negative.

The three EPPDCL examiners discussed the discrepant findings, and the quality manager expressed concern to the laboratory director that the sole positive GC/MS run was likely attributable to a switched sample or contamination from a previously run case. Nevertheless, the lab director instructed the technical reviewer to re-run what remained of the sample used by the analyst to reach the positive finding, which of course tested positive. The director then decided to report the result as positive, which was incorrect. This decision overrode the initial negative finding by the technical reviewer as well as concerns expressed by the quality manager regarding the possibility of contamination and/or switched sample in the single positive run, thus raising serious concerns about lack of scientific leadership in the laboratory. In addition, the test itself raised fundamental concerns regarding the competency of the analyst who performed it.

2. Scientific Leadership and Authority of Quality Manager

When ASCLD-LAB first accredited the laboratory in March 2006, the inspection report indicated that "responsibilities and authority [for the quality manager] were not clearly defined or understood. . . ." This dynamic was still evident to a large degree during the Commission's interviews in December 2011, though analysts expressed optimism regarding positive changes implemented by IFL, including much greater authority for the quality manager.

Until January 2012, EPPDCL was directed by a police sergeant with little scientific education or training. The sergeant had ultimate decision-making authority in all matters affecting the laboratory. As ASCLD-LAB Executive Director Ralph Keaton explained during the Commission's January 2012 meeting, accreditation standards do not require that a laboratory director have scientific education or training. However, in the absence of a scientifically qualified director, there must be a scientifically competent technical lead to provide guidance and make decisions when necessary. This role is often filled by the quality manager. Under such a scenario, the quality manager must have the authority to make technical determinations when questions arise. One of the most obvious deficiencies in the laboratory during the five-year period from 2006 to 2011 was a lack of authority on the part of the quality manager. The laboratory director was unable to adequately discern key analytical information needed for decision-making in challenging situations like the proficiency test example, and did not always defer to the quality manager in those situations.

In addition, the Commission learned during interviews that before failing her August 2010 proficiency test, the analyst in question was: (1) signed off to perform independent casework; (2) authorized to perform technical review; and (3) assumed the

role of quality manager, all within a relatively short time period. Though there appears to have been some confusion regarding who served in the quality manager role during that period, the analyst believed she served as quality manager shortly after being authorized to perform independent casework. This dynamic is inconsistent with the process used in most accredited crime laboratories to clearly identify an appropriately qualified individual to perform the role of quality manager, and provides another example of a lack of scientific leadership and lack of exposure to commonly accepted principles and practices.

3. Sufficiency of Spectral Data, Technical Review and Analyst Competence

Another concern expressed in EPPDCL's March 2006 inspection report (**Exhibit O**) was that spectra in the case file was insufficient to support the identification made by the examiners. Further, the report noted the laboratory did not have a system of technical review for instrumental casework to ensure the conclusions of its examiners were reasonable and within the constraints of scientific knowledge. Finally, the report noted the controlled substance examiners did not have a firm understanding of the instruments, methods and procedures used, or the interpretation of data for samples other than marijuana. *During the June 2011 ASCLD-LAB assessment, the most critical corrective actions involved precisely the same issues.*

Based on the similarities between the 2006 and 2011 assessments, the Commission was concerned that systemic deficiencies had persisted in the laboratory over a five-year period. Because ASCLD-LAB only conducted on-site assessments every five years under the Legacy program, it was easy for these issues to go undetected. Moreover, in response to the original assessment in 2006, laboratory management hired a

consultant from the University of Texas at El Paso to advise the laboratory on addressing the corrective actions. In retrospect, it appears the consultant made recommendations that may have been better suited to university research than a crime laboratory setting. For example, the consultant recommended EPPDCL purchase an alternate (ion trap) GC/MS with notably different features, over the existing (quadrupole) system. As IFL noted in its December report, the differences between the two GC/MS systems created significant operational difficulties in the laboratory. IFL recommended the alternate (ion trap) GC/MS be taken out of commission in December 2011. This issue was also addressed in the subsequent DPS Audit, which commented specifically on the use of an instrument that did not facilitate inter-laboratory comparisons, collections/libraries, and comparison of results from other forensic laboratories (*See* **Exhibit M**). Though other forensic laboratories use the ion trap, it is not used as frequently as other types of GC/MS instruments and it was not the best instrument choice for the EPPDCL staff.

In addition, the training modules and standard operating procedures created in 2006 did not provide sufficient clarity regarding the quality of spectral data needed in the file to support drug identifications, the reporting of sub-sampling or the confirmation of non-controlled substances in exhibits. These shortcomings have been a main focus of ongoing corrective work in the laboratory. Additional recommendations regarding quality of the spectral data were also made by DPS during its audit of the laboratory, as discussed below.

Because the laboratory is relatively small and none of the examiners had forensic experience before working at the EPPDCL, they were unable to recognize needed improvements in the areas described above. Though they attended occasional training

outside the laboratory, they deferred to the standard operating procedures and established training modules developed by the consultant at the University of Texas at El Paso, and approved by the EPPDCL. As further discussed below, the laboratory has since made measurable improvements with respect to analyst understanding of the instruments, methods and procedures used, and the interpretation of data.

D. Initial TFSC Recommendations

At its January 13, 2012 meeting, the Commission made five recommendations to EPPDCL to address the concerns cited above. (*See* **Exhibit L**). They included the following:

1. By February 7, 2012, the Texas Department of Public Safety ("DPS") will conduct an audit of the EPPDCL, including but not limited to: (a) technical and administrative review of every controlled substance case processed by EPPDCL since November 1, 2011; (b) interviews with each laboratory employee, ensuring new policies and procedures have been implemented and are understood by the examiners; and (c) any other applicable audit standards DPS would typically utilize when conducting an internal audit of a DPS system laboratory.

2. By April 6, 2012, DPS will re-test every controlled substance analysis performed by analyst Sifuentes, giving priority to the 60 cases on the DPS list with the greatest possible impact.

3. Within seven days, the City of El Paso will retain a qualified full-time interim laboratory director for EPPDCL until a permanent qualified laboratory director is hired. The hiring of a permanent qualified laboratory director shall be accomplished by April 6, 2012 (the expiration date for EPPDCL's ASCLD-LAB Legacy accreditation).

4. The interim laboratory director will conduct technical and administrative review of all casework performed during his or her tenure.

5. The EPPDCL will provide periodic progress reports to the Commission regarding the hiring of the permanent qualified laboratory director.

The EPPDCL responded proactively to all recommendations made by the Commission. First, the laboratory contracted with IFL to retain Ron Fazio as its interim, full-time laboratory director. Mr. Fazio has worked diligently with the remaining EPPDCL examiners to make significant improvements in the laboratory's policies and procedures and to address the other issues of concern raised by ASCLD-LAB and the Commission. The City of El Paso posted an opening for the laboratory director position, though the department has yet to identify a qualified director to fill the position. Mr. Fazio will remain as full-time, interim director until the position is filled permanently or until the City identifies another cost–effective alternative, such as outsourcing the testing to another ASCLD-LAB accredited laboratory in Texas. The interim director continues to conduct all technical and administrative review of casework, and EPPD management has provided periodic updates to the Commission regarding the laboratory's status.

E. Retrospective Re-Analysis of Cases and DPS Audit

Two of the recommendations listed in the Commission's January 18, 2012 letter involved the assistance of DPS, as follows:

1. Retrospective Re-Analysis of Cases

The DPS laboratories in El Paso and Midland performed re-testing on 100 cases in which instrumental analysis was performed. This group represented all non-marijuana drug cases worked by the analyst who failed the proficiency test discussed above. DPS did not observe any incorrect drug identifications for any of the analyst's cases. While issues regarding evidence labeling and weights were identified and addressed by the interim director, there was no indication that the analyst misidentified any of the drugs in the cases reviewed.

2. DPS Audit

DPS conducted an on-site audit of EPPDCL from January 30, 2012 to February 2, 2012. (*See* **Exhibit M**.) During the visit, DPS conducted technical and administrative review of every controlled substance case processed by EPPDCL since November 1, 2011. DPS also conducted interviews with each laboratory employee, ensuring new policies and procedures were implemented and understood by the examiners. Emphasis was concentrated in the following areas: case documentation; quality assurance/quality control; and evidence handling. At the time of the DPS audit, the laboratory was already in the process of remediating several findings from the June 2012 ASCLD-LAB ISO assessment, and Mr. Fazio was serving as interim laboratory director.

The DPS audit report yielded six findings. Two of the findings involved minor issues in evidence handling practice that did not comply with the lab's new procedures. The laboratory addressed those issues promptly. The remaining three findings involved casework documentation issues. One involved documentation of the use of abbreviations in case notes. The auditors also noted a lack of documentation regarding extraneous and/or missing ions, and insufficient information in the case record for cases in which an FTIR instrument was used for confirmation. DPS also cited a number of cases in which the laboratory report did not reference the sampling plan/method used as required in the new procedures.

DPS concluded the remaining EPPDCL analysts had good technical skills, but would benefit from additional training in the areas of instrument troubleshooting, critical evaluation of results, and awareness/exchange of practices and processes with other forensic laboratories as well as the forensic community in general. EPPDCL addressed

each of these issues with additional training and revisions to the case documentation and procedures as appropriate. All samples identified as having poor FTIR spectra were re-analyzed via GC/MS. None produced conflicting identifications.

In the weeks following the DPS audit, DPS and the Commission requested additional case files at random from EPPDCL, to ensure issues identified regarding the quality of the data in the file had been resolved. The Commission and DPS were satisfied the issues were remedied based on the review of case folders. (*See* DPS Addendum Report at **Exhibit M**.) Moreover, during the April 2012 TFSC meeting, the lead DPS auditor expressed the opinion that the EPPDCL was currently operating within the minimum standards recommended by SWGDRUG (the Scientific Working Group for the Analysis of Seized Drugs).

F. Negligence/Misconduct Determination

The Commission's enabling statute requires it to investigate, in a timely manner, any allegation of professional negligence or misconduct that would substantially affect the integrity of the results of a forensic analysis conducted by an accredited laboratory, facility, or entity. TEX. CODE CRIM. PROC. art. 38.01 § 4(a)(3). The term "forensic analysis" means a "medical, chemical, toxicologic, ballistic, or other expert examination or test performed on physical evidence, including DNA evidence, for the purpose of determining the connection of the evidence to a criminal action. *Id.* at 38.35 (a)(4).

While the terms "professional negligence" and "professional misconduct" are not defined in the statute, the Commission has defined these terms in its policies and procedures, as follows:

> "Professional Misconduct" means, after considering all of the circumstances from the actor's standpoint, the actor, through a material act

> or omission, deliberately failed to follow the standard of practice generally accepted at the time of the forensic analysis that an ordinary forensic professional or entity would have exercised, and the deliberate act or omission substantially affected the integrity of the results of a forensic analysis. An act or omission was deliberate if the actor was aware of and consciously disregarded an accepted standard of practice required for a forensic analysis." (TFSC Policies & Procedures at 1.2.)
>
> "Professional Negligence" means, after considering all of the circumstances from the actor's standpoint, the actor, through a material act or omission, negligently failed to follow the standard of practice generally accepted at the time of the forensic analysis that an ordinary forensic professional or entity would have exercised, and the negligent act or omission substantially affected the integrity of the results of a forensic analysis. An act or omission was negligent if the actor should have been but was not aware of an accepted standard of practice required for a forensic analysis." (TFSC Policies & Procedures at 1.2.)

1. "Professional Misconduct"

At its April 13, 2012 meeting, the Commission voted unanimously that no evidence of "professional misconduct" was found during the course of the EPPDCL investigation. This conclusion was based on the following investigative components: (1) the Commission's review of thousands of pages of documents; (2) the Commission's on-site interviews of laboratory management and personnel; (3) hundreds pages of follow-up information and responses to Commission questions provided by the laboratory; (4) results of DPS re-testing of evidence; (5) results of the DPS audit; and (6) communications with ASCLD-LAB throughout the course of the investigation.

2. "Professional Negligence"

At its April 13, 2012 meeting, the Commission voted unanimously that no evidence of "professional negligence" was found during the course of the EPPDCL investigation. This conclusion was based on the following investigative components: (1) the Commission's review of thousands of pages of documents; (2) the Commission's on-

site interviews of laboratory management and personnel; (3) hundreds pages of follow-up information and responses to Commission questions provided by the laboratory; (4) results of DPS re-testing of evidence; (5) results of the DPS audit; and (6) communications with ASCLD-LAB throughout the course of the investigation.

Nevertheless, the Commission expressed significant concern regarding the lack of scientific leadership in the laboratory from 2006-2011, failure of the laboratory director to exercise judgment in deferring to the quality manager during the August 2010 proficiency exam, and a hierarchical culture that prioritized police department chain of command over scientific expertise in decision-making. These issues were most acutely demonstrated by the August 2010 proficiency test example. However, the proficiency exam did not "substantially affected the integrity of the results of a forensic analysis" as defined by the Commission's enabling statute and policies and procedures and thus does not satisfy the TFSC's current definition of "professional negligence."

Concerns regarding scientific leadership and laboratory culture have been remedied by EPPD leadership's agreement that any laboratory director (interim or permanent) will possess the scientific training and education necessary to ensure the integrity and reliability of the laboratory's work. The quality manager has also been granted the appropriate level of decision-making authority to ensure any issues are identified and addressed in a timely manner. In addition, EPPDCL has worked diligently to correct concerns regarding quality of spectral data and other quality issues raised by the June 2011 ASCLD-LAB assessment and the January 2012 DPS audit. EPPDCL also cooperated fully in adopting the recommendations made by the Commission at its January 13, 2012 meeting. For all these reasons, EPPDCL has made significant

improvements to ensure the integrity and reliability of the forensic analysis performed by the laboratory.

The Commission provides a few final recommendations to EPPDCL in Section IV below. They are designed to ensure ongoing vigilance as the laboratory moves forward.

G. Action Taken by El Paso District Attorney Jaime Esparza

The Commission commends District Attorney Jaime Esparza for his office's handling of the issues raised by the EPPDCL investigation. Prosecutors affected by challenges to the integrity and reliability of crime laboratory analysis play a critical role in ensuring appropriate stakeholders are informed of the potential scope and significance of issues raised. The Commission encourages other prosecutors facing similar factual scenarios to respond as proactively as District Attorney Esparza did in this case.

The EPPDCL informed the District Attorney that ASCLD-LAB had placed the laboratory on probation shortly after the probation letter was issued in late June 2011. On July 1, 2011, District Attorney Esparza received a list of cases worked by the EPPDCL from March 2006 (when the laboratory was first accredited) through July 2011. That list contained a law enforcement agency case number. The District Attorney immediately sent the list to the El Paso County Information Technology Department to run each law enforcement case number through the County's Justice Information Management System ("JIMS"). This process generated a report with key identification information for each case.

After receiving the information from JIMS, the District Attorney's Office researched the addresses for each defendant or defense attorney who represented a

defendant on the list. The office then drafted and mailed individual notices informing each defendant or defense attorney of the probationary status of the laboratory. The notice included a link to ASCLD-LAB's full assessment report, which was posted on the District Attorney's website.

In addition, the District Attorney's office participated actively in the Commission's site visit in December 2011, as well as Commission meetings in Austin in January and April 2012. The District Attorney also fully supported the re-testing of cases by DPS, and was extremely responsive to inquiries from the Commission throughout the course of the investigation.

IV. ADDITIONAL RECOMMENDATIONS

The Commission makes the following additional recommendations:

1. The Commission's strong preference is to have a full-time *and* 100% on-site scientifically qualified laboratory director at EPPDCL. While the City continues its search for a permanent director, EPPDCL should continue to retain a scientifically qualified interim director. The current interim director spends 50% of his time on-site in the laboratory; the Commission believes any subsequently retained interim or permanent director should be on-site 100% of the time. The Commission recognizes this recommendation may be rendered moot if the City decides to outsource to an ASCLD-LAB accredited laboratory instead of continuing in-house testing.

2. Before a laboratory report is issued in any case, the scientifically qualified laboratory director must perform technical review of the case. This process is already documented in the laboratory's operating procedures and should not be changed.

3. The Commission strongly supports an enhanced surveillance visit to be conducted by ASCLD-LAB within one year of the date on which ISO accreditation was granted in March 2012. EPPDCL should send a copy of any report generated by ASCLD-LAB to the Commission.

4. EPPDCL should continue communicating any changes in personnel, actions by ASCLD-LAB, or other material status changes to the Commission as they occur.

EL PASO POLICE DEPARTMENT CRIME LAB REPORT
TABLE OF EXHIBITS

1. *Exhibit A* – Innocence Project's complaint

2. *Exhibit B* – ASCLD-LAB Assessment report issued November 9, 2011

3. *Exhibit C* – June 27, 2011 letter from Keaton to Hernandez placing lab on probation

4. *Exhibit D* – Latest version of Corrective Action Report with Lead Assessor comments

5. *Exhibit E* – August 16, 2011 Integrated Forensics report

6. *Exhibit F* – September 2, 2011 letter from Keaton to Hernandez explaining extension of accreditation and changes to probation

7. *Exhibit G* – October 19, 2011 letter from Keaton to Hernandez with results of laboratory's appeal

8. *Exhibit H* – December 4, 2011 Integrated Forensics report

9. *Exhibit I* – December 23, 2011 ASCLD-LAB letter lifting the laboratory's probation

10. *Exhibit J* – March 26, 2011 ASCLD-LAB letter granting ISO accreditation

11. *Exhibit K* – Copies of the table of contents from FSC EPPD document volumes I, II, III, and IV.

12. *Exhibit L* – Commission January 18, 2012 letter to lab with recommendations

13. *Exhibit M* – DPS audit reports

14. *Exhibit N* – Copy of sample notice from District Attorney Esparza to defense counsel notifying them of the laboratory's probation

15. *Exhibit O* – March 2006 ASCLD-LAB Inspection Report

EXHIBIT A

TEXAS FORENSIC SCIENCE COMMISSION
COMPLAINT FORM
-INDIVIDUAL-

Please complete this form and return to:

Texas Forensic Science Commission - Sam Houston State University
College of Criminal Justice
816 17th Street, Box 2296
Huntsville, TX 77341-2296
Phone: 1(888) 296-4232
Fax: 1(888) 305-2432

The Texas Forensic Science Commission ("FSC") investigates complaints that allege professional negligence or misconduct by a laboratory, facility or entity that has been accredited by the Director of the Texas Department of Public Safety that would substantially affect the integrity of the results of a forensic analysis.

Please keep in mind that the FSC investigates cases subject to its statutory authority. The term "forensic analysis" includes any medical, chemical, toxicological, ballistic, or other examination or test performed on physical evidence, including DNA evidence, for the purpose of determining the connection of the evidence to a criminal action. The term does not include latent fingerprint examinations, a breath test specimen or the portion of an autopsy conducted by a medical examiner or licensed physician and any allegation involving these forensic fields is expressly excluded from the FSC's statutory authority to investigate.

The FSC will examine the details of your complaint to determine what level of investigation to perform. All complaints are taken seriously. Because of the complex nature and number of complaints received by the FSC, we cannot give you any specific date by which that review may be completed.

If the criteria for an investigation are met, the FSC will send a letter to the complainant, laboratory/facility and/or individual(s) named in the complaint indicating that the FSC has received the complaint. The FSC will then request a response from the entity and/or individual who is the subject of the complaint. We may also need to obtain additional information from you.

If the criteria for an investigation are not met or the FSC declines to investigate further, you will receive a letter from the FSC.

All information and complaints are subject to the Texas Public Information Act (Texas Government Code Chapter 552).

Your cooperation, patience and understanding are appreciated.

1. PERSON COMPLETING THIS FORM

Name: Stephen Saloom

Address: 40 Worth Street, Suite 701

City: New York State: NY

Zip Code: 10075

Home Phone: Work Phone: 212-364-5394

Email Address (if any): ssaloom@innocenceproject.org

2. SUBJECT OF COMPLAINT

List the full name, address of the laboratory, facility or individual that is the subject of this complaint (if known):

Individual/Laboratory: El Paso Police Department Crime Laboratory

Address: 911 N. Raynor Street

City: El Paso State: TX

Date of Examination, Analysis, or Report: June 27, 2011

Type of forensic analysis: Controlled Substances

Laboratory Case Number (if known):

Is the forensic analysis associated with any law enforcement investigation, prosecution or criminal litigation? Yes ☐ No ☑

*If you answered "Yes" above, provide the following information (if possible):

*Name of Defendant:

*Case Number/Cause Number:
(if unknown, leave blank)

*Nature of Case:
(e.g burglary, murder, etc.)

*The county where case was investigated, prosecuted or filed:

*The court:

*The outcome of case:

*Names of attorneys in case (if known):

*Your relationship with the defendant:

☐ Self ☐ Family Member ☐ Parent

☐ Friend ☐ Attorney ☑ None

Other (please specify):

*If you are not the defendant, please provide us with the following information regarding the defendant:

Name:

Address (if known):

Home phone number: Work phone number:

3. WITNESSES

Provide the following about any person with factual knowledge or expertise regarding the alleged professional negligence or misconduct which is the subject of this complaint. Attach separate sheet(s), if necessary.

First witness (if any):

Name: Ralph Keaton

Address: 139J Technology Drive, Garner, NC 27529

Daytime phone: 919-773-2600 Evening phone:

Fax : 919-773-2602 Email Address: rkeaton@ascld-lab.org

Second witness (if any):

Name: Sergeant David Hernandez

Address: 911 N. Raynor Street, El Paso, TX

Daytime phone: 915-564-7221 Evening phone:

Fax : Email Address: 2138@elpasotexas.gov

4. DESCRIPTION OF COMPLAINT

Please write a *brief* statement of event(s), acts or omissions you believe show that an accredited laboratory, facility or other entity committed professional negligence or misconduct that substantially affected the integrity of the results of a forensic analysis. You may use additional paper, if necessary.

Please see attached letter and documents.

5. EXHIBITS AND ATTACHMENT(S)

Whenever possible, complaints should be accompanied by readable copies (NO ORIGINALS) of any laboratory reports, relevant witness testimony, affidavits of experts about the forensic analysis, or other documents related to your complaint. Please list and attach any documents that might assist the Commission to evaluate your complaint.

Documents provided will NOT be returned.

List of attachments:

(1) Letter to Texas Forensic Science Commission detailing description of complaint. (2) ASCLD/L

6. YOUR SIGNATURE AND VERIFICATION

You must sign below:
By signing below, I certify that the statements made by me in this complaint are true. I also certify that any documents or exhibits attached are true and correct copies, to the best of my knowledge.

Signature:

Date signed: 9/2/11

INNOCENCE PROJECT

Barry C. Scheck, Esq.
Peter J. Neufeld, Esq.
Directors

Maddy deLone, Esq.
Executive Director

Innocence Project
40 Worth Street, Suite 701
New York, NY 10013

Tel 212.364.5340
Fax 212.364.5341

www.innocenceproject.org

September 1, 2011

Texas Forensic Science Commission
Sam Houston State University
College of Criminal Justice - CL17
PO Box 2296
816 17th Street
Huntsville, TX 77341-2296

Dear Commissioners:

I submit this letter to detail my attached allegation of serious scientific negligence or misconduct substantially affecting the controlled substances analyses and reporting at the El Paso Police Department Crime Laboratory (EPPDCL).

This allegation follows from the June 27, 2011 letter from American Society of Crime Laboratory Directors Laboratory Accreditation Board (ASCLD/LAB) to Sergeant David Hernandez at EPPDCL.[1] The issues raised by the letter indicate that the integrity of the results of the forensic analyses conducted at the EPPDCL was undermined in various ways, and likely in numerous cases, by virtue of the laboratory's many failures to follow appropriate procedures. We believe that an investigation, and the recommendations that would follow, pursuant to your authority under Texas Code of Criminal Procedure 38.01(4)(a)(3), will provide an opportunity to improve the quality of justice and the quality of forensic analyses in Texas. Your expert and independent review and recommendations will certainly also enhance public – and thus juror – faith in the integrity of evidence analyzed by the EPPDCL in the wake of these serious problems.

ASCLD/LAB, the body that accredits the EPPDCL, recently placed the latter on probation after its assessment team made several findings that raised serious concerns about the preparedness of personnel in the laboratory to conduct forensic controlled substances analyses. These findings depict a laboratory with many staff that lacked the requisite scientific training for their work,

[1] Keaton, Ralph. Letter to Sergeant David Hernandez, El Paso Police Department Crime Laboratory, El Paso, TX, and ASCLD/LAB-*International* Full Assessment Report, 27 June 2011, available at http://www.co.el-paso.tx.us/documents/EPPD%20Controlled%20Substance%20Lab%20Report.pdf (last accessed, 8/18/2011). (Hereafter, ASCLD/LAB report)

insufficient instrumentation, and an overall inattention to quality and protocol necessary for the quality of forensic laboratory work that Texas relies upon to provide justice.

We allege that the findings of ASCLD/LAB regarding incomplete or incorrect analyses of controlled substances; failure to follow laboratory protocols and the use of incorrect protocols for analyses; the use of instruments that were not functioning properly or were not calibrated properly; incomplete laboratory reports or conclusions offered in reports were not supported by data; and laboratory responsibilities assigned to unqualified or unauthorized personnel at the EPPDCL indicate negligence or misconduct that would affect the integrity of forensic results.[2] The EPPDCL was and continues to be a Department of Public Safety accredited "laboratory, facility or entity that conducts forensic analysis of physical evidence for use in a criminal proceeding…that has been recognized for accreditation by the Director of the Department of Public Safety under Section 411.0205(c), Government Code and 37 Texas Administrative Code §§28.131 et seq."[3] The Texas Forensic Science Commission has jurisdiction to investigate pursuant to Texas Code of Criminal Procedure 38.01, et seq.

El Paso Police Department Crime Lab Accreditation on Probation

On July 7, 2011, El Paso Police Chief Greg Allen held a news conference to announce that on June 27, 2011, the EPPDCL's accreditation status was placed on probation by its accrediting body, ASCLD/LAB. The EPPDCL received its initial accreditation through the ASCLD/LAB Legacy accreditation program on March 3, 2006. The accreditation certificate was valid through March 2, 2011, at which time the EPPDCL was to transition to the ASCLD/LAB-*International* accreditation program. Beginning March 2009, ASCLD/LAB required that all crime laboratories initiating a new accreditation certification or renewing its accreditation certification must be accredited to the ASCLD/LAB-*International* program. The ASCLD/LAB-*International* program adheres to an internationally recognized set of conformity standards based on ISO/IEC 17025:2005 and is more rigorous than the Legacy program. On February 18, 2011, EPPDCL received permission from ASCLD/LAB for a six month extension of its accreditation to "provide sufficient time for a successful transition from the ASCLD/LAB Legacy program to the ASCLD/LAB-*International* program." [4]

On May 24-26, 2011, ASCLD/LAB conducted an on-site inspection to determine if the EPPDCLwas in compliance with *ASCLD/LAB-International* program requirements. At the time of the assessment, Sgt. David Hernandez was the laboratory director supervising three proficiency tested and two non-proficiency tested personnel. At the closing meeting, EPPDCL officials were notified of all non-conformities cited by the assessment team in a *Preliminary Assessment Report* at its on-site closing meeting.[5] The EPPDCL has 30 calendar days from the

---

[2] Please see page 3, *infra*, for a full explication of this allegation.

[3] List of DPS Accredited Labs from Texas, http://www.txdps.state.tx.us/CrimeLaboratory/documents/List_Texas_LabsAccredited.pdf (last visited August 15, 2011).

[4] February 18, 2011 letter from Ralph Keaton (ASCLD/LAB) to Sergeant David Hernandez of the El Paso Police Department. Available athttp://www.elpasotexas.gov/police/ASD.asp#11 (last accessed, 8/1/2011).

[5] ASCLD/LAB Report, *supra* note 1, at 2 of 23.

release of the *Full Assessment Report* (FAR) to provide the Lead Assessor with a proposed corrective action plan for each *Corrective Action Request* (CAR) indicated in the FAR. The EPPDCL must address 15 Level 1 CARs (the most severe level of non-compliance) which must be corrected and proof of correction must be provided to the Lead Assessor 180 days from the FAR release date (by December 26, 2011) and three Level 2 CARs which may be corrected before the next surveillance visit.[6] The corrective action plan should be issued to the Lead Assessor by September 2, 2011.

Findings Demonstrate A Collapse of Laboratory's Scientific Framework

The findings of the Full Assessment Report which could affect the integrity of the results of forensic analyses fall into the following categories:

- Controlled substances analyses were not complete or were incorrect[7,8]
- Protocols for analyses were not followed or protocols for analyses were incorrect[9, 10,11,12]
- Instruments were not functioning properly or were not calibrated properly[13,14,15]
- Laboratory reports were incomplete or conclusions offered in reports were not supported by data[16,17,18]
- Laboratory responsibilities assigned to unqualified or unauthorized personnel[19,20,21,22,23]

---

[6] Id. at 4 of 23.

[7] CAR#1: In eight of the 16 controlled substances reports reviewed, there was no indication that a sampling plan was used. In one case where 129 tablets were submitted as evidence, only one tablet was confirmed through an instrumental analysis.

[8] CAR#2: One of the laboratory's mass spectrometers could not detect isomers that differentiate common drugs in 6 of the 16 cases reviewed. Within a class of compounds, specific drugs cannot be distinguished at the instrument's level of function. In two of the 16 cases reviewed, the mass spectral data did not support the conclusions. Retention time data was also not taken into account when samples were compared to standards.

[9] CAR#1, *supra* note 8.

[10] CAR#3: The laboratory procedure employed a toxicology procedure to analyze solid dosage form substances and does not define acceptable ranges for retention time comparisons with known standards.

[11] CAR#13: All controlled substances testing uses approximate volumes to measure liquids using a graduated cylinder. Investigation into one case revealed the laboratory practice was not in line with its documented procedure and analysts do not reference volumes as "approximate."

[12] CAR#14: In one controlled substances case, the analyst measured the volume of a liquid substance contained in a bottle and used the manufacturer's dosage (or concentration) on the label to calculate the quantity of the substance rather than conducting an analysis through laboratory testing.

[13] CAR#2, *supra* note 9.

[14] CAR#7: The calibration certificate for the balance used to weigh controlled substances evidence with a mass of 50 pounds or more did not include measurement uncertainty nor was it in compliance with a metrological specification. This is important because Texas sentencing statues are based on quantity with 50 pounds as a cut-off point.

[15] CAR#16: Mass spectrometers were regularly tuned, but the key values for the standard of an acceptable tune were not documented.

[16] CAR#2, *supra* note 9.

[17] CAR#4: In two of the 16 cases reviewed, mass spectral data was not sufficient to support the identification of the substance in question, leading the assessors to raise concerns about the competence of the analysts.

[18] CAR#5: 15 of the 16 controlled substances reports do not describe the items to be analyzed.

[19] CAR#8: The laboratory designated technical responsibility for Drug Chemistry to an individual without the qualified training and experience.

These findings appear to demonstrate that the problems at the EPPDCL were systemic, and describe a laboratory environment that lacked the scientific approach fundamental to any forensic scientists' work. For example, the fact that a laboratory protocol for one state of matter was approved for the analysis of substances in a different state of matter - particularly when paired with the fact that the analysts conducting the tests were unable recognize this scientifically improper protocol - highlights the need for the Commission's intervention in order to ensure the integrity of the results of forensic analyses performed by this laboratory.

Strengthening the EPPDCL and Providing a Path Forward

Addressing the issues identified at the EPPDCL has special importance to the Texas criminal justice system. There are many forensic units across the state of Texas that are not staffed by persons with post-secondary science education. Without traditional laboratory or research experience, these forensic analysts look to their supervisors or peers for scientific training and guidance. The EPPDCL recognized this problem; it had planned a leadership transition because the laboratory director was not a trained chemist. Additionally, in order to satisfy the terms of the ASCLD/LAB-*International* accreditation program, the EPPDCL needed to recruit a candidate with a chemistry or biology degree to lead the laboratory.[24] The forensic breakdown at the EPPD is demonstrative of what can happen to forensic analyses in the absence of that guiding scientific hand.

We therefore ask, pursuant to your authority under Texas Code of Criminal Procedure 38.01(4)(a)(3), that the Commission conduct an investigation into the seemingly clear negligence or misconduct at the EPPDCL that clearly undermined the integrity of the results of forensic analyses it performed. Specifically, we request that the Commission (1) identify whether serious negligence or misconduct existed; if negligence or misconduct is found (2) determine its impact; and (3) identify any corrective policies, actions, or forms of support that can ensure that: A) this experience allows the EPPDCL to emerge a stronger and more scientifically rigorous crime laboratory, in order to help ensure the integrity of the forensic analyses that it performs; and B) that any convictions which may have been affected by these problems receive proper review.

Determine Impact of Negligence or Misconduct.

---

[20] CAR#9: Two of the three personnel using laboratory instruments for controlled substances testing were not authorized to operate the instruments.

[21] CAR#12: No evidence that two of the three personnel performing controlled substances were given authorization to conduct testing, operate laboratory equipment, issue reports, or provide opinions and interpretations.

[22] CAR#17: One examiner was unable to provide a reasonable analytical conclusion in a proficiency test where the analyst sampled and tested the substance 45 times yielding one positive result and 44 negative results on a confirmatory test for cocaine. The root cause analysis indicated the analyst's "flawed analytical deduction" as one root cause for the failed proficiency test.

[23] CAR#18: The test file indicated a second root cause for the aforementioned analyst who performed 45 confirmatory tests as "switched samples." This could not have been the root cause because the analyst obtained the correct negative result 44 of 45 attempts at testing, yet reported the positive result despite the fact that it was achieved only once in 45 attempts.

[24] Schladen, M, "On probation: El Paso Police Department Crime Lab told to fix issues," El Paso Times, July 8, 2011, available at http://www.elpasotimes.com/news/ci_18437256 (last accessed, 8/18/2011).

Should the Commission find evidence of negligence or misconduct in the course of its investigation, it will be important to determine how long the negligence or misconduct persisted by determining the approximate "start date" and assessing the specific or cumulative effects of that negligence or misconduct. While ASCLD/LAB only requires that the EPPDCL look six months back from the June 27th date of the letter, that time period is arbitrary relative to the existence of problems and does not appear to be associated with time at which the documented non-conformities began. This determination could be done by assessing how long the EPPDCL has been conducting non-marijuana testing and sampling laboratory reports and calibration reports going back to that date or March 3, 2006 (when EPPDCL was first accredited), whichever is appropriate. Reports should be reviewed to determine whether the non-conformities were confined to specific analysts or if they were present across the EPPDCL's work. It will also be important to understand how long the lab personnel have practiced in the controlled substances unit, whether laboratory procedures changed during that span of time, and why the on-site inspection that granted EPPDCL its initial accreditation didn't detect these issues if they have existed since the laboratory was accredited.

Corrective Actions, Policies, or Support

Texas Code of Criminal Procedure 38.01(4)(a)(3) provides the Commission the ability to identify "any corrective action required of the laboratory, facility, or entity." In the case of the EPPDCL, we urge you to consider identifying best practices, policies, or resources that will support the laboratory's scientific development. Potential remedies may include:

- **Training in the Scientific Method.** The omissions in laboratory reports, incomplete or incorrect analyses, and lack of attention to the performance of the laboratory's instruments demonstrate a lack of understanding of the scientific method. Training on proper laboratory procedures and the importance of careful, deliberate attention to detail could advance the EPPDCL analysts' understanding of laboratory procedures and the consequences for taking or not taking specific actions.
- **Best Practices or Resources for Controlled Substances Analyses.** The EPPDCL did not have the scientific foundation that would have equipped its leadership and staff to identify and implement the best practices and protocols for controlled substance analyses and the interpretation of information from the data generated by the analyses. Given the expertise of the Commission, best practices or specific resources could be recommended that would bolster not only the EPPDCL, but all other crime laboratories performing controlled substances analyses.
- **Establishing a Model Laboratory Report.** The findings of the ASCLD/LAB assessment demonstrated that the EPPDCL analysts did not include the necessary items in laboratory reports. Developing criteria for an exemplary laboratory report and developing a model laboratory report for controlled substances analyses would provide practical assistance to the EPPDCL analysts.
- **Ensure Review of Tainted Convictions.** Many classes of problematic forensic analyses were highlighted in the accreditation report. More may be uncovered as EPPDCL pursues the six month review required by ASCLD/LAB, however, and the Commission's investigation may identify yet additional problematic analyses. In the course of the

Commission's investigation, any and all cases in which inadequate forensic analyses call into question a past conviction must be given a thorough and proper review.

- **Policies for Transparency.** We commend the EPPDCL for posting the ASCLD/LAB letter and report on its website. This action demonstrates that the EPPDCL is an organization that wants to learn from the situation in which it finds itself. The Commission has a history of pursuing open and transparent discussion and deliberation of the charges that are brought before it, and that itself has spurred attention to and action on some of the matters it has considered. At the present time, laboratory accreditation assessment reports, reviews, and audits are considered confidential and are not regularly released to the public. The amount of information shared with the public was an important first step toward the greater transparency that will further foster faith in the forensic analyses performed by the EPPDCL in the future.
- **Proper Support for the Laboratory to Handle the Work Expected of it.** The El Paso Police Department Crime Laboratory surely wanted to be able to properly handle all of the work expected of it. In order to that, however, that laboratory needs to be properly supported in light of the demands placed upon it. Unfortunately, those needs often get lost in the focus on overall state, county and local budget demands, and are not the concern of the police officers trying to simply address all of the crimes about which it is aware. The Texas Forensic Science Commission would provide an important service to the EPPDCL - and crime laboratories throughout the state - if it examined the role of the disconnect between demand placed upon the EPPDCL and its ability to meet that demand within the resources available to it as part of the overall problem alleged.

Commission's Statutory Duties Require Investigation Beyond ASCLD/LAB Audit
While ASCLD/LAB's accreditation process and audit brought these issues to light, it must be noted that the Commission's statutory duty to investigate[25] requires the Commission to itself investigate meritorious complaints. Reliance upon ASCLD/LAB accreditation and audit procedures would be patently insufficient for that purpose.

Specifically, it is the Commission's responsibility to:

- Determine if the actions rise to negligence or misconduct that would substantially affect the integrity of the results of a forensic analysis;
- Identify corrective action that the Commission deems necessary to both justice and public confidence in the forensic evidence that will be presented by this laboratory in the future;
- Consider whether retrospective re-examinations of other forensic analyses performed by this laboratory should be conducted in the interests of justice.

Further, as the Commission was created in large part to enable the public to understand the forensic problems that may have existed, as well as to ensure that appropriate corrective actions are taken to ensure justice in cases past, present and future which might otherwise be affected by the identified negligence or misconduct, its responsibility is different from that of ASCLD/LAB.

[25] Texas Code of Criminal Procedure 38.01, Sec. 4, Duties.

ASCLD/LAB is an organization that serves its crime laboratory customers,[26] in this case the EPPDCL. Its specific job is not to serve the citizens of Texas. While in this instance the EPPDCL has (commendably) decided to make public the ASCLD/LAB accreditation report of its Crime Laboratory, *full* public disclosure of the investigative and corrective work to be done is not required by ASCLD/LAB, and tends not to occur in the manner envisioned by the Commission's enabling statute. Thus, reliance upon ASCLD/LAB for such public release of information would be both inappropriate and contrary to past experience.

Because the purpose of an ASCLD/LAB audit is different than that of a Texas Forensic Science Commission investigation, and because the Commission has a specific duty to inform Texans of their work and findings, the Commission would fail to meet its duty if it wholly relies upon the ASCLD/LAB accreditation and audit processes to serve the function intended by a Texas Forensic Science Commission investigation and report.

Conclusion

Professional negligence or misconduct of the nature discovered at the EPPDCL undermine justice, public safety, and the public's faith in their criminal justice system. Specifically, they can seriously harm juror faith in the evidence necessary to prove guilt beyond a reasonable doubt. Texas specifically counts on its Forensic Science Commission to provide the independent, expert, and transparent review and recommendations in the wake of such problems that can restore justice, safety, and public confidence in forensic evidence.

Discovery of the EPPDCL breakdown is terrifying realization of how criminal justice can be tainted. But it is also an opportunity to learn, and improve the quality of justice provided not just by the EPPDCL, but by extension, throughout forensic practice in Texas. The Commission's response to this situation will surely be followed by forensic practitioners throughout the state, and possibly the nation. Through policy recommendations that can provide a supportive framework for a scientific revival at EPPDCL, the expertise of the Commission can be transformative in creating resources for laboratories state-wide and encouraging a higher standard of best practices. We look forward to your decision and thank you for your consideration of this matter.

Respectfully submitted,

Stephen Saloom
Policy Director

Sarah Chu
Forensic Policy Advocate

---

[26] ASCLD/LAB.org, QUALITY POLICY STATEMENT OF THE AMERICAN SOCIETY OF CRIME LABORATORY DIRECTORS LABORATORY ACCREDITATION BOARD (ASCLD/LAB), available at http://www.ascld-lab.org/about_us/qualitypolicy.html (last accessed, 8/30/2011).

EXHIBIT B

ASCLD/LAB-*International*

Full Assessment Report

El Paso Police Department
Crime Laboratory
El Paso, Texas

PART 1 – GENERAL INFORMATION

INTRODUCTION

This is the ASCLD/LAB-*International Full Assessment Report* of the El Paso Police Department Crime Laboratory. The on-site assessment was conducted during the period May 24-26, 2011.

The ASCLD/LAB-*International* assessment team consisted of the following members:

Lead Assessor:

Harry A. Fox, III - Staff Inspector, ASCLD/LAB / Annville, Pennsylvania

Technical Assessors:

Chris Bryant – Virginia Department of Forensic Science / Roanoke, Virginia

Observer:

Glen Johnson - Staff Inspector, ASCLD/LAB / Round Rock, Texas

OBJECTIVES OF ASSESSMENT

The assessment was conducted to assess the management and technical operations of the laboratory in accordance with the accreditation requirements specified below, and to report the findings of the assessment in a fair and impartial manner to the laboratory and to the ASCLD/LAB Board of Directors for the purpose of accreditation in accordance with the scope of the assessment.

ACCREDITATION REQUIREMENTS

The assessment was performed using the requirements of ISO/IEC 17025:2005; the *ASCLD/LAB-International Supplemental Requirements for Testing Laboratories* (2011) and the laboratory's own documented management system.

SCOPE OF ASSESSMENT

The laboratory is seeking accreditation in and was assessed in the following areas:

Field	
Forensic Science Testing	
Discipline(s)	Categories of Testing
Drug Chemistry	Controlled Substances

LABORATORY OVERVIEW

The El Paso Police Department Crime Laboratory is a local government laboratory and provides services and assistance to law enforcement agencies in and around El Paso, Texas. The laboratory is located at 911 N. Raynor Street, El Paso, Texas. Sergeant David Hernandez is the laboratory director and, at the time of the assessment, the laboratory had a staff of 3 proficiency tested personnel and 2 non-proficiency tested personnel.

ASSESSMENT TEAM FINDINGS

The laboratory was found to be in conformance with all ASCLD/LAB-*International* accreditation requirements except for those requirements cited in Part 2 of this report, or the assessment team found that the requirement was not applicable to the operations of this program.

Each requirement for which the assessment team found the laboratory to not be in total conformance was marked "No." A *Preliminary Assessment Report,* listing specific nonconformities cited by the assessment team, was provided at the on-site, closing meeting.

COMMENTS

Comments include recommendations, suggestions, or other observations documented by the assessment team that are not supported by sufficient objective evidence of non-compliance. The laboratory is not required to respond to comments. The following comment(s) were documented by the assessment team during the on-site assessment:

- None

RIGHT TO APPEAL

The laboratory director has the right to appeal at any time during the accreditation process. Further information about the appeals process may be obtained by contacting the ASCLD/LAB Executive Director at 919-773-2600.

STATUS OF REPORT

This *Full Assessment Report* and the findings and corrective action requests are provided for pre-decisional purposes only.

REPORT AUTHORIZATION

This *Full Assessment Report* of the El Paso Police Department Crime Laboratory is issued by Lead Assessor Harry Fox. As Lead Assessor, Mr. Fox has reviewed the contents of this report and affirms that the report represents a true and accurate accounting of the findings of the ASCLD/LAB-*International* assessment team.

Lead Assessor Harry A. Fox, III

Harry A. Fox III

Signature

June 17, 2011

Date

DISTRIBUTION LIST

Sergeant David Hernandez, Laboratory Director

Mr. Ralph M. Keaton, ASCLD/LAB Executive Director

Mr. John K. Neuner, ASCLD/LAB-*International* Program Manager

Ms. Tracy Cheaney-Plummer, ASCLD/LAB Program Manager

PART 2 – CORRECTIVE ACTION REQUESTS

A quality review of the nonconformities cited by the assessment team at the on-site closing meeting was conducted by an ASCLD/LAB Quality Review Panel. The purposes of the ASCLD/LAB quality review included considering consistency of interpretations, appropriate relationships between findings and the clause(s) to which those findings are assigned, and to consider the recommended level assigned to each finding by the assessment team.

Following the completion of the quality review, formal *Corrective Action Requests* were prepared by the Lead Assessor and are issued to the El Paso Police Department Crime Laboratory in this *Full Assessment Report*.

Also, please be aware that in accordance with ASCLD/LAB-*International* policy, no specific *Corrective Action Request* (CAR) will be issued against 4.1.2 of ISO/IEC 17025:2005; however, the response to this clause will be marked "No" until appropriate corrective actions have been completed and accepted by the Lead Assessor for each Level 1 CAR.

The laboratory has thirty (30) calendar days from the date of release of this *Full Assessment Report* to provide the Lead Assessor with a proposed corrective action plan for each CAR issued with the report. The laboratory should refrain from implementing proposed corrective actions until the Lead Assessor's acceptance of the proposed corrective actions.

For any Level 1 CAR contained in this *Full Assessment Report*, the laboratory will have 180 calendar days from the release date of the *Full Assessment Report* to complete corrective actions (including the initial 30 calendar days to submit a corrective action plan), provide the Lead Assessor with objective evidence of completed corrective actions, and to have the Lead Assessor accept the action as complete. The 180 calendar day completion date is December 26, 2011.

For any Level 2 CAR contained in this *Full Assessment Report*, the El Paso Police Department Crime Laboratory may elect to complete corrective actions prior to the next surveillance visit. However, should the laboratory choose that option, the laboratory will still have thirty (30) calendar days from the release date of the *Full Assessment Report* to provide the Lead Assessor with a proposed corrective action plan for each Level 2 CAR issued with the report.

Alternatively, for any Level 2 CAR, the laboratory may elect to respond to the request in accordance with the provisions for a Level 1 CAR as indicated above.

Continued on Next Page

CORRECTIVE ACTION REQUEST (CAR) Number 1 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	5.10.1 Paragraph 3.19	Source:	ISO 17025:2005 EPPD Crime Lab ISO Controlled Substance Analysis Manual (Effective 2/14/11)	Level:	1
Requirement:	5.10.1 - The results of each test, calibration, or series of tests or calibrations carried out by the laboratory shall be reported accurately, clearly, unambiguously and objectively, and in accordance with any specific instructions in the test. 3.19 - When sampling is used, the language in the report must make it clear to the reader that the results are based on a sampling plan. Details about the sampling plan are not required in the report, but must be clearly recorded in the examination.				
Finding:	Controlled substance reports do not state that a sampling plan was used to arrive at the result that was reported in 8 of the 16 reports reviewed. For example: The laboratory examined a case that contained 129 tablets. The controlled substance in only one of the tablets was confirmed by instrumental analysis. The report was not clear that only one of the 129 tablets was tested.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 2 of 18

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	4.2.1 4.13.2.5 6.6.64	Source:	ISO 17025:2005 2011 Supplemental - Testing EPPD Crime Lab ISO Controlled Substance Analysis Manual – Results of Analysis (Effective 2/14/11)	Level:	1
Requirement:	4.2.1 - The laboratory shall establish, implement and maintain a management system appropriate to the scope of its activities. The laboratory shall document its policies, systems, programmes, procedures and instructions to the extent necessary to assure the quality of the test and/or calibration results. The system's documentation shall be communicated to, understood by, available to, and implemented by the appropriate personnel. 4.13.2.5 - Records to support conclusions shall be such that in the absence of the analyst (however named), another competent reviewer could evaluate what was done and interpret the data. 6.6.64 - Compare mass spectrum and retention time of analyte(s) to mass spectrum and retention times of standards stored in the compound table and to Standard (positive control) analyzed on the same day (24hrs) and under the same analytical conditions. In order to positively identify an analyte using GC/MS, it is widely accepted that the full scan spectrum have a minimum of three characteristic ions whose ratios are within 20% of the same ion ratios run on standards on the same instrument. A recommendation of a three kilocount, minimum or more, peak is suitable for comparison. [*The Handbook of Forensic Drug Analysis*, pg 113.]				
Finding:	The peak intensity displayed in library spectra used for comparison on one of the laboratory's mass spectrometers was so limited in detail that it was not possible to differentiate positional isomers of common drugs reported in 6 of the 16 cases reviewed. For example: Methamphetamine identification was made based on the three ions of greatest abundance. Many compounds in the same class (phenethylamines) are indistinguishable when compared using these three ions.				

	Mass spectral sample data reviewed in the case files had insufficient peak intensity to support the identification of the substance reported in 2 of the 16 cases reviewed. For example: An Alprazolam mass spectral identification was based on the three ions of greatest abundance that matched to the standard. The sample spectrum had additional significant ions not attributable to the compound identified. Review of case records and interviews revealed that retention time data was not taken into account when comparing sample and standard data, as required by laboratory policy.
Corrective Action Due By:	On or before December 26, 2011

CORRECTIVE ACTION REQUEST (CAR) Number 3 of 18

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	5.4.1 6.6.64	Source:	ISO 17025:2005 EPPD Crime Lab ISO Controlled Substance Analysis Manual – Results of Analysis (Effective 2/14/11)	Level:	1
Requirement:	5.4.1 - The laboratory shall use appropriate methods and procedures for all tests and/or calibrations within its scope. These include sampling, handling, transport, storage and preparation of items to be tested and/or calibrated, and, where appropriate, an estimation of the measurement uncertainty as well as statistical techniques for analysis of test and/or calibration data. 6.6.64 - Compare mass spectrum and retention time of analyte(s) to mass spectrum and retention times of standards stored in the compound table and to Standard (positive control) analyzed on the same day (24hrs) and under the same analytical conditions. In order to positively identify an analyte using GC/MS, it is widely accepted that the full scan spectrum have a minimum of three characteristic ions whose ratios are within 20% of the same ion ratios run on standards on the same instrument. A recommendation of a three kilocount, minimum or more, peak is suitable for comparison. [*The Handbook of Forensic Drug Analysis*, pg 113.]				
Finding:	The laboratory procedure states "In order to positively identify an analyte using GC/MS, it is widely accepted that the full scan spectrum have a minimum of three characteristic ions whose ratios are within 20% of the same ion ratios run on standards on the same instrument. A recommendation of a three kilocount, minimum or more, peak is suitable for comparison. [*The Handbook of Forensic Drug Analysis*, pg 113.]". These criteria for identification are not acceptable for the analysis of solid dosage form drug substances. The procedure the laboratory employs has been taken from a procedure for analysis for toxicology samples. The laboratory procedure does not define acceptable ranges for retention time comparisons with known standards.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 4 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	5.2.1 5.2.5	Source:	ISO 17025:2005	Level:	1
Requirement:	5.2.1 - The laboratory management shall ensure the competence of all who operate specific equipment, perform tests and/or calibrations, evaluate results, and sign test reports and calibration certificates. When using staff who are undergoing training, appropriate supervision shall be provided. Personnel performing specific tasks shall be qualified on the basis of appropriate education, training, experience and/or demonstrated skills, as required. 5.2.5 - The management shall authorize specific personnel to perform particular types of sampling, test and/or calibration, to issue test reports and calibration certificates, to give opinions and interpretations and to operate particular types of equipment. The laboratory shall maintain records of the relevant authorization(s), competence, educational and professional qualifications, training, skills and experience of all technical personnel, including contracted personnel. This information shall be readily available and shall include the date on which authorization and/or competence is confirmed.				
Finding:	In two of 16 controlled substances cases reviewed, mass spectral data from samples was insufficient in detail to support making an identification of the substance present. Review of this work raises concerns about the competency of the analysts.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 5 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	5.10.1 Section 7.c.	Source:	ISO 17025:2005 EPPD Crime Lab Operations Manual (Reporting Guidelines)	Level:	1
Requirement:	5.10.1 - The results of each test, calibration, or series of tests or calibrations carried out by the laboratory shall be reported accurately, clearly, unambiguously and objectively, and in accordance with any specific instructions in the test or calibration methods. 7. Each test report will include the following information: c. The name and address of the customer; identification of the method used (sampling plan); a description of, the condition of, and unambiguous identification of the item(s) tested (comments in footnote or in controlled substance worksheet); the date of receipt of the test where this is critical to the validity and application of the results, and the date(s) of performance of the test or; reference to the sampling plan or procedures used by the laboratory or other bodies where these are relevant to the validity or application of the results (standards and samples are run within a 24-hour clock and recorded in the instrument retention time log (Binders C and F found in the laboratory) and the 2011 Analysis Primary Standard Binder (G); the type of test, where appropriate, the units of measurement; the name(s), function(s) and signature(s) or equivalent identification of person(s) authorizing the test report (technical review signatures); and where relevant, a statement to the effect that the results relate only to the items tested or calibrated. (Revised 04/25/2011).				
Finding:	Controlled substance reports do not contain a description of the items tested in 15 of the 16 cases reviewed.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 6 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	4.2.1 5.3.4 Section 3.1	Source:	ISO 17025:2005 EPPD Crime Lab Operations Manual	Level:	1
Requirement:	4.2.1 - The laboratory shall establish, implement and maintain a management system appropriate to the scope of its activities. The laboratory shall document its policies, systems, programmes, procedures and instructions to the extent necessary to assure the quality of the test and/or calibration results. The system's documentation shall be communicated to, understood by, available to, and implemented by the appropriate personnel. 5.3.4 - Access to and use of areas affecting the quality of the tests and/or calibrations shall be controlled. The laboratory shall determine the extent of control based on its particular circumstances. 3.1 - Access to the crime laboratory is restricted. This is in effect to protect the integrity of the evidence, the confidentiality of case reports and to avoid exposing untrained persons to hazardous substances used in the laboratory. Doors to the crime laboratory will remain closed when authorized personnel are not present in the lab.				
Finding:	The entrance to the Controlled Substance laboratory is accessed through the Crime Scene laboratory which is secured with an electronic lock system that was malfunctioning during the assessment. If the door to the Controlled Substance laboratory is open, Crime Scene and other police department personnel have access both to the laboratory and the evidence/report storage room located in the laboratory. During the assessment both the laboratory and evidence/storage room doors were observed to be opened when no personnel authorized by the laboratory director were present.				
Corrective Action Due By:	On or before December 26, 2011				

CORRECTIVE ACTION REQUEST (CAR) Number 7 of 18

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	5.6.2.1.1	Source:	ISO 17025:2005	Level:	1
Requirement:	"….. When using external calibration services, traceability of measurement shall be assured by the use of calibration services from laboratories that can demonstrate competence, measurement capability and traceability. The calibration certificates issued by these laboratories shall contain the measurement results, including the measurement uncertainty and/or a statement of compliance with an identified metrological specification (see also 5.10.4.2)."				
Finding:	Texas sentencing statutes for controlled substances include escalating penalties for quantities of controlled substances from 50 to 250 pounds and above 250 pounds. A balance used for weighing controlled substance evidence in quantities of 50 pounds or more was found to have a calibration traceability certificate that stated the following: "This certificate is NOT ISO 17025 compliant and should not be used as a substitute for an ISO 17025 certificate." The measurement results on the certificate did not include measurement uncertainty or a statement of compliance with an identified metrological specification.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 8 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	4.1.5 (g, h) 4.1.5.h.1	Source:	ISO 17025:2005 2011 Supplemental - Testing	Level:	1
Requirement:	4.1.5 - The laboratory shall: g) provide adequate supervision of testing and calibration staff, including trainees, by persons familiar with methods and procedures, purpose of each test and/or calibration, and with the assessment of the test or calibration results; h) have technical management which has overall responsibility for the technical operations and the provision of the resources needed to ensure the required quality of laboratory operations; 4.1.5.h.1 - The laboratory shall designate technical responsibility for each discipline. Each designee shall have appropriate technical training and technical experience in the discipline.				
Finding:	Laboratory management has failed to provide objective evidence that technical responsibility in the Drug Chemistry discipline has been delegated to an individual with the appropriate technical training and technical experience.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 9 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	5.5.3	Source:	2011 Supplemental - Testing	Level:	1
Requirement:	Equipment shall be operated by authorized personnel.				
Finding:	For two of three personnel utilizing laboratory equipment for Controlled Substance testing, there is no objective evidence to demonstrate that authorization has been given to these individuals to utilize laboratory equipment.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 10 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	4.2.4	Source:	ISO 17025:2005	Level:	2
Requirement:	Top management shall communicate to the organization the importance of meeting customer requirements as well as statutory and regulatory requirements.				
Finding:	The laboratory provided no objective evidence to demonstrate that top management has communicated the importance of meeting customer requirements to the laboratory organization.				
Corrective Action Due By:			On or before first surveillance visit		

CORRECTIVE ACTION REQUEST (CAR) Number 11 of 18

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	4.2.7 Section 4.8	Source:	ISO 17025:2005 Operations Manual – Document Implementation	Level:	1
Requirement:	4.2.7 - Top management shall ensure that the integrity of the management system is maintained when changes to the management system are planned and implemented. 4.8 - Document Implementation a. Upon approval to changes to a controlled document(s), staff will be provided with a copy of the revised controlled document, outlining the changes. Employees will sign a acknowledge receipt in writing. b. Permanent changes to a controlled document will be done at the time the annual review is conducted and a revised controlled document will be issued. c. Implementation of new or revised documents will be in accordance with the revision issue or approval date on the document. d. The laboratory's director will ensure that approved versions of documents are available to lab personnel and in use by the effective date.				
Finding:	Two dates are identified on each management system document; the issue date and the effective date. Based on laboratory procedures, it is unclear when a new or revised document is authorized for usage.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 12 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	5.2.5	Source:	ISO 17025:2005	Level:	2
Requirement:	The management shall authorize specific personnel to perform particular types of sampling, test and/or calibration, to issue test reports and calibration certificates, to give opinions and interpretations and to operate particular types of equipment.				
Finding:	For two of three personnel performing Controlled Substances testing, there is no objective evidence that demonstrates authorization has been given to these individuals to perform sampling, testing, issuing test reports, giving opinions and interpretations and operating laboratory equipment.				
Corrective Action Due By:	On or before first surveillance visit				

CORRECTIVE ACTION REQUEST (CAR) Number 13 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	5.10.1 Section 2.7.D	Source:	ISO 17025:2005 EPPD Crime Lab ISO Controlled Substance Analysis Manual (Effective 2/14/11)	Level:	1
Requirement:	5.10.1 - The results of each test, calibration, or series of tests or calibrations carried out by the laboratory shall be reported accurately, clearly, unambiguously and objectively, and in accordance with any specific instructions in the test or calibration methods. 2.7.D - Volumes: liquids greater than one milliliter shall be approximated using a graduated cylinder or appropriate measuring device.				
Finding:	For Controlled Substances testing, liquids are recorded in approximate volumes using graduated cylinders; however, in one case that was reviewed, the volume reported was not referenced as an approximate volume. Subsequent interview of the analyst revealed that the laboratory practice when reporting the volume of a liquid is not to state the volume as "approximate".				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 14 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	5.4.1 Section II.1	Source:	ISO 17025:2005 Operations Manual – Service Overview	Level:	1
Requirement:	5.4.1 - The laboratory shall use appropriate methods and procedures for all tests and/or calibrations within its scope. These include sampling, handling, transport, storage and preparation of items to be tested and/or calibrated, and, where appropriate, an estimation of the measurement uncertainty as well as statistical techniques for analysis of test and/or calibration data. II.1 - At this time, the El Paso Police Department Crime Laboratory does NOT provide quantitative analysis of controlled substance or trace samples less than 0.1 milligrams.				
Finding:	In one Controlled Substances case where a volume measurement was made, the analyst used the volume of liquid found in the evidence (a bottle) to calculate the quantity of the controlled substance present. The quantity of controlled substance reported was calculated using the manufacturer's dosage (milligrams/milliliter) listed on the bottle and the volume of liquid measured by the analyst. The analyst did not use accepted quantitative analysis methods nor did the analyst take into account the possibility that the liquid in the bottle was a dilution of the original preparation identified on the label of the bottle. Furthermore, the analyst did not follow the laboratory's quantitative analysis of controlled substances policy.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 15 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	5.2.6.2.2	Source:	2011 Supplemental - Testing	Level:	2
Requirement:	For any laboratory personnel whose job responsibility includes test report writing, a competency test shall include, at a minimum: A written test report to demonstrate the individual's ability to properly convey results and/or conclusions and the significance of those results/conclusions.				
Finding:	The laboratory's Controlled Substances training manual does not require a written test report as part of the final test to determine competency.				
Corrective Action Due By:			On or before first surveillance visit		

CORRECTIVE ACTION REQUEST (CAR) Number 16 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	5.5.6	Source:	ISO 17025:2005	Level:	1
Requirement:	The laboratory shall have procedures for safe handling, transport, storage, use and planned maintenance of measuring equipment to ensure proper functioning and in order to prevent contamination or deterioration.				
Finding:	Mass spectrometers used for Controlled Substances testing are tuned regularly but key values that define the criteria for an acceptable tune have not been documented.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 17 of 18

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	4.11.3	Source:	ISO 17025:2005	Level:	1
Requirement:	Where corrective action is needed, the laboratory shall identify potential corrective actions. It shall select and implement the action(s) most likely to eliminate the problem and to prevent recurrence. Corrective actions shall be to a degree appropriate to the magnitude and the risk of the problem. The laboratory shall document and implement any required changes resulting from corrective action investigations.				
Finding:	A cause analysis conducted by the laboratory determined one root cause for an incorrect proficiency test result. Review of the same proficiency test file and an interview of the analyst revealed that flawed analytical deduction was another root cause. The examiner was unable to come to a reasonable analytical conclusion based a series of tests that included one presumptive (color) test and one confirmatory (gas chromatograph/mass spectrum) test yielding a positive result for Cocaine and 44 negative confirmatory (gas chromatograph/mass spectrum) tests from a re-sampling of the same item.				
Corrective Action Due By:	On or before December 26, 2011				

CORRECTIVE ACTION REQUEST (CAR) Number 18 of 18

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	5.2.1	Source:	ISO 17025:2005	Level:	1
Requirement:	The laboratory management shall ensure the competence of all who operate specific equipment, perform tests and/or calibrations, evaluate results, and sign test reports and calibration certificates. When using staff who are undergoing training, appropriate supervision shall be provided. Personnel performing specific tasks shall be qualified on the basis of appropriate education, training, experience and/or demonstrated skills, as required.				
Finding:	Review of a proficiency test file in which the analyst failed to report the expected and consensus value (No Controlled Substance) and subsequent interview of the analyst revealed that the root cause determination by laboratory management of "switched samples" by the analyst was not the root cause for the failed proficiency. The assessment team found that the analyst was incapable of coming to a reasonable analytical conclusion after performing one presumptive and 45 confirmatory tests on the same substance. Forty-four of 45 confirmatory tests yielded the correct "No Controlled Substance" result yet the analyst reported the presence of Cocaine based on single positive presumptive and confirmatory tests. The root cause for this proficiency was clearly the analyst's significantly flawed deductive reasoning capabilities. Furthermore, corrective action taken by laboratory management to address the failed proficiency did not include suspension from performing casework, retraining or competency testing. Case file review by laboratory management did reveal one additional instance of "switched sample".				
Corrective Action Due By:			On or before December 26, 2011		

ASCLD/LAB-*International*

Full Assessment Report

El Paso Police Department
Crime Laboratory
El Paso, Texas

PART 1 – GENERAL INFORMATION

INTRODUCTION

This is the ASCLD/LAB-*International Full Assessment Report* of the El Paso Police Department Crime Laboratory. The on-site assessment was conducted during the period May 24-26, 2011.

The ASCLD/LAB-*International* assessment team consisted of the following members:

Lead Assessor:

Harry A. Fox, III - Staff Inspector, ASCLD/LAB / Annville, Pennsylvania

Technical Assessors:

Chris Bryant – Virginia Department of Forensic Science / Roanoke, Virginia

Observer:

Glen Johnson - Staff Inspector, ASCLD/LAB / Round Rock, Texas

OBJECTIVES OF ASSESSMENT

The assessment was conducted to assess the management and technical operations of the laboratory in accordance with the accreditation requirements specified below, and to report the findings of the assessment in a fair and impartial manner to the laboratory and to the ASCLD/LAB Board of Directors for the purpose of accreditation in accordance with the scope of the assessment.

ACCREDITATION REQUIREMENTS

The assessment was performed using the requirements of ISO/IEC 17025:2005; the *ASCLD/LAB-International Supplemental Requirements for Testing Laboratories* (2011) and the laboratory's own documented management system.

REPORT AUTHORIZATION

This *Full Assessment Report* of the El Paso Police Department Crime Laboratory is issued by Lead Assessor Harry Fox. As Lead Assessor, Mr. Fox has reviewed the contents of this report and affirms that the report represents a true and accurate accounting of the findings of the ASCLD/LAB-*International* assessment team.

Lead Assessor Harry A. Fox, III

Signature

November 9, 2011 – Revised Report
Date

DISTRIBUTION LIST

Sergeant David Hernandez, Laboratory Director

Mr. Ralph M. Keaton, ASCLD/LAB Executive Director

Mr. John K. Neuner, ASCLD/LAB-*International* Program Manager

Ms. Tracy Cheaney-Plummer, ASCLD/LAB Program Manager

CORRECTIVE ACTION REQUEST (CAR) Number 1 of 16

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	5.10.1 Paragraph 3.19	Source:	ISO 17025:2005 EPPD Crime Lab ISO Controlled Substance Analysis Manual (Effective 2/14/11)	Level:	1
Requirement:	5.10.1 - The results of each test, calibration, or series of tests or calibrations carried out by the laboratory shall be reported accurately, clearly, unambiguously and objectively, and in accordance with any specific instructions in the test. 3.19 - When sampling is used, the language in the report must make it clear to the reader that the results are based on a sampling plan. Details about the sampling plan are not required in the report, but must be clearly recorded in the examination.				
Finding:	Controlled substance reports do not state that a sampling plan was used to arrive at the result that was reported in 8 of the 16 reports reviewed. For example: The laboratory examined a case that contained 129 tablets. The controlled substance in only one of the tablets was confirmed by instrumental analysis. The report was not clear that only one of the 129 tablets was tested.				
Corrective Action Due By:			On or before December 26, 2011		

	Mass spectral sample data reviewed in the case files had insufficient peak intensity to support the identification of the substance reported in 2 of the 16 cases reviewed. For example: An Alprazolam mass spectral identification was based on the three ions of greatest abundance that matched to the standard. The sample spectrum had additional significant ions not attributable to the compound identified. Review of case records and interviews revealed that retention time data was not taken into account when comparing sample and standard data, as required by laboratory policy.
Corrective Action Due By:	On or before December 26, 2011

CORRECTIVE ACTION REQUEST (CAR) Number 4 of 16

Laboratory Name: El Paso Police Department Crime Laboratory
Laboratory Location: El Paso, TX
Laboratory Contact Name: Sgt. David Hernandez
Contact Number: (915) 564-7202
Summation Conference Date: May 26, 2011

FINDING

Clause No.:	5.2.1	Source:	ISO 17025:2005	Level:	1
Requirement:	5.2.1 - The laboratory management shall ensure the competence of all who operate specific equipment, perform tests and/or calibrations, evaluate results, and sign test reports and calibration certificates. When using staff who are undergoing training, appropriate supervision shall be provided. Personnel performing specific tasks shall be qualified on the basis of appropriate education, training, experience and/or demonstrated skills, as required.				
Finding:	In two of 16 controlled substances cases reviewed, mass spectral data from samples was insufficient in detail to support making an identification of the substance present. Review of this work raises concerns about the competency of the analysts. Analysts were unable to demonstrate in interviews that they had an understanding of the basis for making interpretations of the mass spectral data used to reach the reported conclusions.				
Corrective Action Due By:			On or before March 19, 2012		

CORRECTIVE ACTION REQUEST (CAR) Number 6 of 16

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	4.2.1 5.3.4 Section 3.1	Source:	ISO 17025:2005 EPPD Crime Lab Operations Manual	Level:	1
Requirement:	4.2.1 - The laboratory shall establish, implement and maintain a management system appropriate to the scope of its activities. The laboratory shall document its policies, systems, programmes, procedures and instructions to the extent necessary to assure the quality of the test and/or calibration results. The system's documentation shall be communicated to, understood by, available to, and implemented by the appropriate personnel. 5.3.4 - Access to and use of areas affecting the quality of the tests and/or calibrations shall be controlled. The laboratory shall determine the extent of control based on its particular circumstances. 3.1 - Access to the crime laboratory is restricted. This is in effect to protect the integrity of the evidence, the confidentiality of case reports and to avoid exposing untrained persons to hazardous substances used in the laboratory. Doors to the crime laboratory will remain closed when authorized personnel are not present in the lab.				
Finding:	The entrance to the Controlled Substance laboratory is accessed through the Crime Scene laboratory which is secured with an electronic lock system that was malfunctioning during the assessment. If the door to the Controlled Substance laboratory is open, Crime Scene and other police department personnel have access both to the laboratory and the evidence/report storage room located in the laboratory. During the assessment both the laboratory and evidence/storage room doors were observed to be opened when no personnel authorized by the laboratory director were present.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 8 of 16

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	4.1.5 (g, h) 4.1.5.h.1	Source:	ISO 17025:2005 2011 Supplemental - Testing	Level:	1
Requirement:	4.1.5 - The laboratory shall: g) provide adequate supervision of testing and calibration staff, including trainees, by persons familiar with methods and procedures, purpose of each test and/or calibration, and with the assessment of the test or calibration results; h) have technical management which has overall responsibility for the technical operations and the provision of the resources needed to ensure the required quality of laboratory operations; 4.1.5.h.1 - The laboratory shall designate technical responsibility for each discipline. Each designee shall have appropriate technical training and technical experience in the discipline.				
Finding:	Laboratory management has failed to provide objective evidence that technical responsibility in the Drug Chemistry discipline has been delegated to an individual with the appropriate technical training and technical experience.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 10 of 16

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	4.2.4	Source:	ISO 17025:2005	Level:	2
Requirement:	Top management shall communicate to the organization the importance of meeting customer requirements as well as statutory and regulatory requirements.				
Finding:	The laboratory provided no objective evidence to demonstrate that top management has communicated the importance of meeting customer requirements to the laboratory organization.				
Corrective Action Due By:			On or before first surveillance visit		

CORRECTIVE ACTION REQUEST (CAR) Number 12 of 16

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	5.2.5	Source:	ISO 17025:2005	Level:	2
Requirement:	The management shall authorize specific personnel to perform particular types of sampling, test and/or calibration, to issue test reports and calibration certificates, to give opinions and interpretations and to operate particular types of equipment.				
Finding:	For two of three personnel performing Controlled Substances testing, there is no objective evidence that demonstrates authorization has been given to these individuals to perform sampling, testing, issuing test reports, giving opinions and interpretations and operating laboratory equipment.				
Corrective Action Due By:			On or before first surveillance visit		

CORRECTIVE ACTION REQUEST (CAR) Number 14 of 16

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	5.4.1 Section II.1	Source:	ISO 17025:2005 Operations Manual – Service Overview	Level:	1
Requirement:	5.4.1 - The laboratory shall use appropriate methods and procedures for all tests and/or calibrations within its scope. These include sampling, handling, transport, storage and preparation of items to be tested and/or calibrated, and, where appropriate, an estimation of the measurement uncertainty as well as statistical techniques for analysis of test and/or calibration data. II.1 - At this time, the El Paso Police Department Crime Laboratory does NOT provide quantitative analysis of controlled substance or trace samples less than 0.1 milligrams.				
Finding:	In one Controlled Substances case where a volume measurement was made, the analyst used the volume of liquid found in the evidence (a bottle) to calculate the quantity of the controlled substance present. The quantity of controlled substance reported was calculated using the manufacturer's dosage (milligrams/milliliter) listed on the bottle and the volume of liquid measured by the analyst. The analyst did not use accepted quantitative analysis methods nor did the analyst take into account the possibility that the liquid in the bottle was a dilution of the original preparation identified on the label of the bottle. Furthermore, the analyst did not follow the laboratory's quantitative analysis of controlled substances policy.				
Corrective Action Due By:			On or before December 26, 2011		

CORRECTIVE ACTION REQUEST (CAR) Number 16 of 16

Laboratory Name:	El Paso Police Department Crime Laboratory
Laboratory Location:	El Paso, TX
Laboratory Contact Name:	Sgt. David Hernandez
Contact Number:	(915) 564-7202
Summation Conference Date:	May 26, 2011

FINDING

Clause No.:	5.2.1	Source:	ISO 17025:2005	Level:	1
Requirement:	The laboratory management shall ensure the competence of all who operate specific equipment, perform tests and/or calibrations, evaluate results, and sign test reports and calibration certificates. When using staff who are undergoing training, appropriate supervision shall be provided. Personnel performing specific tasks shall be qualified on the basis of appropriate education, training, experience and/or demonstrated skills, as required.				
Finding:	During a proficiency test, an analyst failed to report the expected and consensus value (No Controlled Substance) after performing multiple and repeated tests (one presumptive and 45 confirmatory). 44 of 45 confirmatory tests yielded the correct result, yet the analyst reported the presence of a drug based on single positive presumptive and confirmatory tests. During the review and corrective action process, the laboratory management did not consider the ability of the analyst to reach the appropriate conclusion after the numerous and repeated tests conducted. During an interview, the analyst could not demonstrate knowledge regarding how she reached the conclusion after several re-samplings and multiple retests resulted in a different result, other than to say she switched samples.				
Corrective Action Due By:			On or before March 19, 2012		

EXHIBIT C

AMERICAN SOCIETY OF CRIME LABORATORY DIRECTORS
LABORATORY ACCREDITATION BOARD

June 27, 2011

2011 JUL -1 PM 3:44
COUNTY ATTORNEY
JO ANNE BERNAL

Sergeant David Hernandez
El Paso Police Department
Crime Laboratory
911 N. Raynor Street
El Paso, Texas 79903

Dear Sgt. Hernandez:

During a June 24, 2011 meeting of the ASCLD/LAB Board of Directors, the findings issued during the recent assessment of the El Paso Police Department Crime Laboratory were considered. Several of the findings of the assessment team raised serious concerns about the preparedness of personnel in your laboratory to conduct the full gamut of forensic controlled substances analyses.

As a result of the Board's concern resulting from the findings of the assessment team, the El Paso Police Department Crime Laboratory's accreditation was placed on probation until September 2, 2011, with the condition that the laboratory suspend all casework involving instrumental analysis until such time that the laboratory demonstrates, to ASCLD/LAB, that all personnel performing drug chemistry are competent in extraction theory, instrumental analysis, and data interpretation and that they are competent in the methods used by the laboratory.

As a second condition, the laboratory must have an external review of the past six (6) months of casework involving instrumental analysis by competent personnel from an ASCLD/LAB accredited laboratory.

As a third condition, within 14 calendar days of this notification, the lab must provide the ASCLD/LAB Executive Director with a plan of action to address the concerns related to the work in the laboratory.

Failure to meet any of the stated conditions may result in suspension or revocation of accreditation. Please be assured that the Board wishes to assist the El Paso Police Department Crime Laboratory in maintaining a quality forensic program and to continue the accreditation of your laboratory.

If you wish to appeal the decision of the Board, you must do so in writing to me and clearly state the basis for the appeal.

If you have any questions or concerns, please feel free to contact us.

Sincerely,

Ralph M. Keaton

Ralph M. Keaton
Executive Director

cc: ASCLD/LAB Board of Directors
ASCLD/LAB Office
Harry Fox, ASCLD/LAB Lead Assessor

Ralph Keaton, Executive Director • 139 J Technology Drive, Garner, NC 27529 • Phone (919) 773-2600 • FAX (919) 773-2602 • E-mail rkeaton@ascld-lab.org

EXHIBIT D

2ND SUBMISSION OF PROPOSED CORRECTIVE ACTIONS – RECEIVED 9/1/11 VIA FED/EX.

Note: **All Lead Assessor comments inserted after 7/27/11 but before 9/1/11 are in this color.**
All Lead Assessor comments inserted after 9/1/11 are in this color.
All Lab comments inserted after 10/11/11 are in this color.
All Lead Assessor comments inserted after 11/6/11 are in this color.

CORRECTIVE ACTION REQUEST (CAR) **Number** 1 **of** 18

Clause No.:	5.10.1 Paragraph 3.19	Source:	ISO 17025:2005 EPPD Crime Lab ISO Controlled Substance Analysis Manual (Effective 2/14/11)	Level:	1

Requirement: 5.10.1 The results of each test, calibration, or series of tests or calibrations carried out by the laboratory shall be reported accurately, clearly, unambiguously and objectively, and in accordance with any specific instructions in the test.

3.19 When sampling is used the language in the report must make it clear to the reader that the results are based on a sampling plan. Details about the sampling plan are not required in the report, but must be clearly recorded in the examination.

Finding: Controlled substance reports do not state that a sampling plan was used to arrive at the result that was reported in 8 of the 16 reports reviewed. For example: The Laboratory examined a case that contained 129 tablets. The controlled substance in only one of the tablets was confirmed by instrumental analysis. The report was not clear that only one of the 129 tablets was tested.

Proposed Corrective Action 1: The Controlled Substance Analysis Manual (CAM) has been edited to include the requirement to include clear language when a sampling/sub-sampling plan has been employed. **(I am unable to find where in the CAM you make it a requirement to include "language in the report must make it clear to the reader that the results are based on a sampling plan"?**
As of 10/25/11, the laboratory reporting criteria is found in our LOM Chapter 20, Section 7 (HYPERLYNK 1) and the CAM refers to reporting guidelines in the LOM; sampling/sub-sampling requirements are now also listed in the CAM (HYPERLYNK 2)

Changes include suggested reporting language. **("Suggested" reporting language" implies the analyst has no restrictions on reporting language.)**
The word "Suggested" has been removed and the language is now as of 10/25/11 referred to Reporting Guidelines in both the LOM and CAM. (HYPERLYNK 2) This corrective action is approved.
With this approval, it will be necessary to demonstrate 90 days of compliance, effective immediately. To ensure records are in compliance, a sampling of objective evidence in the form of case notes and laboratory reports must be provided to the lead assessor for review and approval at thirty (30) day increments. If the objective evidence provided does not meet compliance requirements, the clock is reset for another 90 days.)

The CAM has also been edited to address visual examinations of pharmaceutical identifiers, conducted on part or whole of the exhibit. The requirement has been added to use clear reporting language "Visual Identification Only" when visual examinations of pharmaceutical identifiers were conducted on an exhibit, whether conducted on part or whole of the exhibit. **(This change is not relevant to this finding.)**

The finding states that the report was not clear and that only one tablet was tested and not 129 tablets. The revised reporting criteria in the LOM and CAM reflects that a visual identification is the sum of all presumptive testing and allowing the description of one or more confirmed tablet(s) will now be a requirement and will be written on lab report; as of 10/25/2011. CAM page 9 of 10 (HYPERLYNK 5).

This change will become effective once you concur. If we may proceed the revisions to the Controlled Substance manual will take effect on or about September 2, 2011. On August 17, 2011 amended language to CAM Draft Section 3, page 12 titled Sampling Technique **(The amended language in this section clearly spells out your sampling procedures but does not address the finding; i.e., failure to include language in the report that makes it clear to the reader that the results are based on a sampling plan.) As of 10/25/2011, Please refer to CAM, pg 6 of 10, definition of Tested Weight (HYPERLYNK 4)** and Section 2.2, page 8 titled Suggested Reporting Guidelines **(In the Suggested Reporting Guidelines under "Marihuana", your example shows a net weight of 1.62 grams and a "Tested Weight" of 1.62 grams. Does this mean all of the material, 1.62 grams, was consumed in testing? That is how I interpret your definition of tested weight.) (These "suggested" reporting guidelines provide very good examples but the language does not set minimum reporting requirements nor does it appear to address the finding. With the exception of the first example under "Statistical Sampling", the sample reports do not clearly state how many units were tested. Additionally, using the term "Tested Weight" appears to imply the quantity of material consumed in testing.) On 10/25/2011, Please refer CAM Scope: Reporting Guidelines page 5 of 10 (HYPERLYNK 3) page 5of 10 to definition of Tested Weight in CAM page 6 of 10 (HYPERLYNK 4) (Note my response above. If the tested weight is actually the weight of material consumed in testing, I am satisfied with this procedure and it is approved. IF THIS IS NOT THE CASE, PLEASE CLARIFY!**

With this approval, it will be necessary to demonstrate 90 days of compliance, effective immediately. To ensure records are in compliance, a sampling of objective evidence in the form of case notes and laboratory reports must be provided to the lead assessor for review and approval at thirty (30) day increments. If the objective evidence provided does not meet compliance requirements, the clock is reset for another 90 days.)

Proposed Corrective Action 2: Members of this laboratory will undergo a training session covering the following sections of the Laboratory Operations Manual.
Reporting Guidelines → Lab Operations Manual page 88 of 109 letters a, b, c, p, q, and r in their entirety.
Controlled Substance Manual pg 10 Summarized below.
A training session, provided by instructor IFL President Mr. Ron Fazio. **(Objective evidence has been provided that documents how the referenced training was conducted, who attended and who provided the training.) Please refer to HYPERLYNK 9 which outlines the training and the certificates of completion by each analyst. (As stated previously, this proposed corrective action is approved. No further action on the part of the laboratory is necessary.)**
Laboratory Operations Manual: Pages 89 and 90.
p.
On August 17, 2011 amended language to CAM Draft Section 2.2 page 8 Suggested Reporting Guidelines.
("Suggested Reporting Guidelines" is the problem. As of 10/25/2011 removed "Suggested" HYPERLYNK 2 It appears no minimum reporting requirements have been established. If stated as a requirement, the example for "Pharmaceutical Identification Only" reports would be satisfactory and approved.) Please refer to CAM pharmaceutical identifiers on page 9 of 10 (HYPERLYNK 5) (The information displayed in Section K. Phamaceutical Identifiers on page 9 of 10 of the CAM does not address minimum reporting requirements. The only change is the addition of : "refer to CAM section entitled "Analysis of Tablets, Capsules, and other Pharmaceuticals". The "Analysis of Tablets, Capsules and other Pharmceuticals" section of the CAM sets no minimum reporting requirements. To further clarify: There's nothing in the laboratory's "Reporting Guidelines" that sets a minimum of what must be reported.)
(I am troubled by the last sentence in Section 9.1, Paragraph B. It states: "If confirmatory analysis is omitted, analyst shall adhere to reporting procedure in reporting procedures." Why no confirmatory analysis? What does this sentence mean?)

q. All test reports under results will have documentation in case record regarding the positive result in one presumptive and one confirmative result. Only one instrument offers a qualified confirmative result at this time (GC/MS). Revised 04/25/2011.

"**When"** analysis by GC/MS is unable to provide positive identification in some instances, another technique (FTIR, derivatization, etc.) must be utilized to provide positive identification. For example, certain stereo- and geometric isomers give identical or very similar results. Other scenario, may involve thermo-liable compounds where simple solvent extractions into the GC/MS will not work. After the training session, provided by instructor IFL President Mr. Ron Fazio, the Quality Manager completed a document change form adding this new language. **(The LOM continues to be in conflict with your draft statement above. On page 91 of 113, paragraph q. of the LOM, it clearly states "Only one instrument offers a qualified confirmative result at this time (GC/MS)." A language change to make both statements compatible should satisfy the assessment team.) The LOM statement "Only one instrument offers a qualified confirmative result at this time (GC/MS)." has been deleted on 10/25/2011 HYPERLYNK 7 (This hyperlink doesn't point to a document relating to this issue.) (The deletion of text referenced in your response above was verified upon review of page 94 of 117 of the updated LOM, Revision # 10-25-11-00. The corrected language in the LOM is approved.)**

To further assist you, please note the following when continuing to prepare objective evidence of compliance:
All relevant Laboratory Management System Documentation must have been issued and in effect when objective evidence is collected and provided for review to confirm compliance.
Laboratory Director Sgt. D.Hernandez has consulted with Mr. Fox and advised that all amendments/revisions/additions to any laboratory document and/or manual will take effect immediately upon approval by Mr. Fox (Limitations while under Probation). **(So that it is absolutely clear, in my discussions with Sgt. Hernandez, I made no stipulation that amendments/revisions/additions to any laboratory document required my approval prior to implementation. That is a responsibility that rests solely with the El Paso Police Department Crime Laboratory Director.)** Once proposed correction actions are approved, by Mr. Fox, the Quality Manager will issue out a memorandum describing the "effective" date and the authorized use of the documents/manuals. On August 25, 2011 the Quality Manger added language to the LOM Draft Chapter XVI Section 4.8 Document Implementation pg 68. **[The second sentence of paragraph a) of Section 4.8 Document Implementation is unclear. There appears to be something missing in the sentence. It states: "The memorandum will address where the staff members my find the authorized use of the controlled document and effective date will mirror the acceptance date of the Quality Manager".] The portion of the second sentence has been deleted, "and the effective date will mirror the acceptance date of the Quality Manager." HYPERLYNK 7. (The proposed change remains unclear. Is it your intent to say the following:**

> *Upon approval of changes to a controlled document(s), the Quality Manager will issue a memorandum to appropriate staff members outlining the changes/revisions to the controlled document. The memorandum will address where the staff members may find the authorized controlled document and its effective date. All appropriate staff members will acknowledge the new document and its effective date by signing the original memorandum issued by the Quality Manager.*

The above is merely an attempt on my part to understand the intent of your proposed corrective action. It is not intended as a recommended change to your language.)

- The version of the pertinent Management System Documentation in effect when objective evidence is collected must be provided.
- Objective evidence for this CAR must include a sampling of case work reports that clearly demonstrate conformance with the laboratory's reporting requirements.
- Documentation must be provided that confirms the proposed training has been developed, approved, implemented and completed.
- References to specific documents or portions of documents that are objective evidence of compliance should be a part of the proposed corrective action statement.

- If appropriate, the supporting documentation should clearly show what has been added, changed or deleted. A legend with examples of the font used to display additions, changes, or deletions of verbiage is recommended.

The "Case Folder Checklist" (the technical review checklist) has been modified to include verification that the technical reviewer confirmed clear language was used when a sampling/sub-sampling plan was employed. The new Case Folder Checklist will become effective on or about August 20, 2011. **(I am unable to find the stated modification in the document that is HYPERLYNKed to this paragraph.) On 10/25/2011, the phrasing in the Case Folder Checklist "clear language was used when a sampling/sub-sampling plan was employed in the laboratory report." HYPERLYNK 8 (The updated language was found and is approved.)**

Proposed Corrective Action 3: EPPD QM, Arturo Herrera, gave lab analysts Candice Sifuentes and Nahum Najera a training session on August 19, 2011. The training session covered the changes outlined I Proposed Corrective Actions 1, 2, and 3. Please refer to the outline of the training session, provided by instructor IFL President Mr. Ron Fazio.

Proposed Corrective Action 4: EPPD analysts Arturo Herrera, Candice Sifuentes, and Nahum Najera will issue corrected reports on 8 reports identified in the finding. The corrected reports will reflect the new reporting requirements. Copies of the corrected reports will be made available on or about September 23, 2011. **(Because the finding did not state the specific cases in question, please ensure the corrected reports you plan to make available are those identified by the technical assessor. If you are not certain, please notify me. Also, please be aware that you will be required to provide objective evidence of compliance for a period of not less than 90 days after approval of your plan.) HYPERLYNK 22 includes 16 amended reports The amending of sixteen laboratory reports and original reports will be scanned into HYPERLYNK 22. (The amended laboratory reports provided are consistent in content and format with the updated laboratory reporting guidelines. This corrective action is approved.**
With this approval, it will be necessary to demonstrate 90 days of compliance, effective immediately. To ensure records are in compliance, a sampling of objective evidence in the form of case notes and laboratory reports must be provided to the lead assessor for review and approval at thirty (30) day increments. If the objective evidence provided does not meet compliance requirements, the clock is reset for another 90 days.)

CORRECTIVE ACTION REQUEST (CAR) **Number** 2 **of** 18

Clause No.:	4.2.1 4.13.2.5 6.6.64	Source:	ISO 17025:2005 2011 Supplemental-testing EPPD Crime Lab ISO Controlled Substance Manual-results of analysis (effective 2/14/11)	Level:	1

Requirement: 4.2.1 The laboratory shall establish, implement and maintain a management system appropriate to the scope of its activities. The laboratory shall document its policies, systems, programmes, procedures and instructions to the extent necessary to assure the quality of the test and/or calibration results. The system's documentation shall be communicated to, understood by, available to, and implemented by the appropriate personnel.

4.13.2.5 Records to support conclusions shall be such that in the absence of the analyst (however named), another competent reviewer could evaluate what was done and interpret the data.

6.6.64 Compare mass spectrum and retention time of analyte(s) to mass spectrum and retention times of standards stored in the compound table and to Standard (positive control) analyzed on the same day (24hrs) and under the same analytical conditions. In order to positively identify an analyte using GC/MS, it is widely accepted that the full scan spectrum have a minimum of three characteristic ions whose ratios are within 20% of the same ion ratios run on standards on the same instrument. A recommendation of a three kilocount, minimum or more, peak is suitable for comparison**.** *[The Handbook of Forensic Drug Analysis, pg 113.]*

Finding: The peak intensity displayed in library spectra used for comparison on one of the laboratory's mass spectrometers was so limited in detail that it was not possible to differentiate positional isomers of common drugs reported in 6 of 16 cases reviewed. For example: Methamphetamine identification was made based on the three ions of greatest abundance. Many compounds in the same class (Phenethylamines) are indistinguishable when compared using these three ions.
Mass spectral sample data reviewed in the case files had insufficient peak intensity to support the identification of the substance reported in 2 of the 16 cases reviewed. For example: An Alprazolam mass spectral identification was based on the three ions of greatest abundance that matched to the standard. The sample spectrum had additional significant ions not attributable to the compound identified.
Review of the case records and interviews revealed that retention time data was not taken into account when comparing sample and standard data, as required by the laboratory policy.

Proposed Corrective Action 1:
Limited mass spectral information has been identified as an issue during our independent audit of 122 cases. Therefore, EPPD has implemented a two-fold approach; training and policy. Training by IFL will include the analysis and evaluation of problem mass spectra, including those from both an over-abundance and under-abundance of analyte. Training Description IFL-for a full description of the proposed training. Demonstration of the training will be provided and completed on or about 8/30/11. [IFL graded competency test (s) and proficiencies of tests will be available on or about August 31, 2011]. **(Please provide documentation showing what specific**

training was provided as well as competency and proficiency test results.) IFL competency and proficiency test results are in PDF scan and include certificates of completion (HYPERLYNK 9) In addition, all EPPD analysts will undergo an online, 31 hour, Forensic Mass Spectroscopy class, as part of continuing education, offered by the **West Virginia University Forensic Science Initiative for Public Lab Employees** is expected to be completed by on or about Oct 31, 2011. All analysts have registered and are enrolled West Virginia University Course. This class covers ionization sources, mass analyzers, detectors; rules and aspects of mass spectra; elemental composition and molecular ions assist in interpretation; and interpretation of mass spectra.]. **(Please provide documentation showing what specific training was provided as well as competency and proficiency test results.) Please refer to HYPERLYNK 9 (The information provide satisfies the assessment team's requirements) and HYPERLYNK 10 (Competency and Proficiency test results from the WVU course are not provided. Provide test results for each employee.) to see the IFL and West Virginia University certificates of completion.**

The policy changes include the establishment of minimum criteria of a ion spectral match. These changes can be referenced in the CAM, Section 11 titled Cautionary Guide lines page 75; effective 8/31/11 once approved by Mr. Fox. The Policy changes in the CAM include the information listed below;

Analyzing the Data

1. Perform a confirmatory analysis of the exhibit. Use an appropriate instrument and method based, if possible, on information gathered from presumptive testing or visual identifiers. If not possible, refer to the "Unknown Substances" SOP (Chapter 12).

2. "Confirmatory analysis" must conform to the recommendations currently published by SWGDRUG (www.swgdrug.org).

2a. When analyzing an exhibit on a GC/MS, the identification must be based on positive color test(s), retention time of the GC, and mass spectrum from the MS.

2b. The retention time of an exhibit must be within the acceptance criteria of the retention time of a known primary standard. The acceptance criteria are established in the Controlled Substance Analysis Manual, Section 7 pages 33-36 and 40-43. The reference standard must be run within 24 hrs of the sample.

2c. The mass spectrum of an exhibit must be within the acceptance criteria of a known library spectrum. The acceptance criteria are established in the Controlled Substance Analysis Manual, Section 7 page 33-36 for the Varian and 40-43 for the Thermo. **(The Varian and Thermo procedural guidelines are acceptable with the exception of Paragraph C. under "Interpretation" See comments under 5. below. The removal of the formula and the insertion of +/- 0.15 minutes was amended to both the Varian (LOM pages 8 to 11 of 19) and Thermo GC/MS Interpretation sections (LOM pages 12 to 19 of 19) regarding retention times. HYPERLYNK 11 (How was a retention time difference of ± 0.15 minutes arrived at? Threshold values are generally supported by statistical data that demonstrates the accuracy and precision of the measurement. Do you have supporting data such as this for your retention time threshold?).** A list of legitimate known spectral libraries may be referenced in this section as well. Under Cautionary Guide lines page 75 also advises on acceptance criteria. **(These guidelines are acceptable. It is, however, suggested that "rejection" criteria be included. Will consider the language and consult with Integrated Forensic Laboratory.**

2d. When analyzing an exhibit on a FTIR, the identification must be based on positive color tests and the spectrogram **(spectrum)** from the FTIR.

3. Print and retain the sample chromatogram(s) and spectra/spectrum and of all relevant samples, blanks, and standards in the case folder. These chromatograms and spectra/spectrum will be labeled with laboratory number, Submitting Agency Case Number, corresponding exhibit number, date, examiner's initials, and method of sample preparation (if not shown on the worksheet) and retained in the case file. Standard chromatograms and spectra/spectrum must also contain a traceable lot number of the standard. Instrument operating conditions will be retained in the case folder or available in a retrievable format.

4. Library searches can be used to provide useful information pertaining to the identity of a compound, but should not be used as a replacement for verifying positive identification, due to the abridged nature of the ion spectra found in search libraries. Results from library searches need not be printed. Use of the word 'spectra" implies something other than a chromatogram. Please clarify what you referring to? The laboratory is referring to "Ion" spectra..

5. The difference between retention times of the known and unknown samples must be less than three percent. How was the threshold of "less than three percent" arrived at? The Quality Manager sought advice from Texas Department of Public Safety Crime Laboratory Director (Ms. Ann Falknor) and was provided with their policy addressing retention time guidelines. What references are you using to support this procedure? Texas DPS Controlled Substance Manual SOP. Using this formula, the shorter the retention time, the greater the relative window of acceptance. At 3%, for example a standard elutes at 5.00 min and a sample elutes at 4.85 minutes. **Using the formula below the acceptance criteria can not be more than 0.15 minutes or 3 %. (That is incorrect. For example: if the standard elutes at 10.00 minutes and the sample elutes at 9.70 minutes, the retention time difference is 0.30 minutes or 3%. Threshold values are generally supported by statistical data that demonstrates the accuracy and precision of the measurement). You may want to reconsider your threshold parameters.** Quality control factors would advise the analyst to update the internal libraries and/or possible perform maintenance on the GC/MS. Results would be documented appropriately in Instrument maintenance logs and in case work if applicable.

$$\%\text{Difference} = \left| \frac{\text{retention time of std} - \text{retention time of sample}}{\text{Retention time of std}} \right| \times 100$$

As of 10/25/2011, see HYPERLYNK 11, the removal of the formula and the insertion of +/- 0.15 minutes was amended to both the Varian and Thermo GC/MS Interpretation sections regarding retention times. (See Lead Assessor response in paragraph 2c above.)

Lead Assessor Response:
Please clarify how and where the content of this proposed corrective action fits into the Lab Management System documentation? The proposed amendments referenced in the paragraphs 1 through 4 above, don't appear to address what are acceptable criteria for the identification of controlled substances. Without supporting documentation, the parameters stated in paragraph 5 could not be defended. Please refer to CAM Draft pages 33-43, and 75. Documentation will be found within case record, preferably in Controlled Substance Worksheet and/or on instrument generated reports

Proposed Corrective Action 2:
EPPD has always used the comparison of the retention time of an exhibit to a known standard. However, we have altered our retention time acceptance criteria. Please refer to CAM Draft Section 7 on Varian Saturn 2000 and Section 7 on Thermo Focus/DSQ II to Cautionary Guidelines to view our new acceptance criteria and **(See comments in Proposed Corrective Action 1 regarding retention time). Please refer to HYPERLYNK 11 addressing new language on retention time. (See Lead Assessor response in paragraph 2c above.)**
Current case worksheets will include confirmation that retention time of the exhibit was compared to a known standard, once approved by Mr. Fox. **(The HYPERLYNKed worksheet shows a completion date of April 28, 2011. Other than handwritten notes, there appears to be no inclusion of the proposed "confirmation that the retention time of the exhibit was compared to a known standard" as part of the form itself. How do you intend to ensure retention time confirmation is done?) New checklist criteria for retention time and sampling on lab report was added to case folder checklist HYPERLYNK 8 (Accept for the ± 0.15 minute retention time acceptance criteria, the update to the checklist is satisfactory.) and New language was added to Confirmatory Tests in CAM regarding keeping a copy of the primary standard in the case folder HYPERLYNK 12 (The update to Confirmatory Tests is satisfactory.)**

Proposed Corrective Action 3:
A document change form was completed for the purpose of removing the toxicology reference in its entirety and all comments relating to the practice of highlighting three ions from all quality documents. This can be referenced the CAM Draft, page 32 and Technical Checklist removal of highlighting three ions. **(This statement appears to apply to the original Lead Assessor Response under "Proposed Corrective Action 4"). Please refer to HYPERLYNK 11 (CAM p. 9) outlining revised procedural GC/MS guidelines as of 10/25/2011. In addition to HYPERLYNK 11, a new "Case Folder Check list" outlines new check box criteria for Retention time and sampling on lab report HYPERLYNK 8 (As stated previously, these updates are satisfactory accept for the retention time acceptance criteria.)**

Proposed Corrective Action 4:
Language was adopted and two amendments were created titled Procedural Guidelines for the "GC/MS Varian Ion Trap Saturn 2000 and the GC/MS Thermo Focus DSQ II Quadrupole." On or about August 17, 2011, added language to the CAM Draft Varian pages 33 and 40 and CAM Draft Thermo pages 40-43. **(See Lead Assessor comments in the current Proposed Corrective Action 1 above. See laboratory's response in Proposed Corrective Action 1 and Corrective Action 2's proposal 1 through 3) (See responses above.)**

Proposed Corrective Action 5: On or about August 17, 2011, added language to **CAM Draft** Section 11, page 75 titled Cautionary Guide lines outlining acceptance criteria for GC/MS interpretation(s). **(See Lead Assessor comments in the current Proposed Corrective Action 1 above.) (See laboratory's response in Corrective Action 1 and Corrective Action 2's proposal 1 through 3) (See responses above.)**

A document change form is an approved internal form that addresses the
need to modify/change language on any form or manual. Incorrect reference, please reference LOM Draft Section XVI entitled Document Management pg 63-66. **(I am still unclear about this form. When looking at the form, how is this form distinguished from the final document? Is there a control number or a title; e.g. "Document Change Form 2011-16"?) As of 10/25/2011, new language was added to the LOM (Document Approval), letter b "After the form has been approved by quality Manager the laboratory director will assign a revision number." HYPERLYNK 13 (LOM p.66) displays removal of effective date and insertion of Document ID Number and Revision Number. As of 10/25/ 2011, new language describing the revision number will be the effective final working document approved by the laboratory director and will be ready for distribution and/or use was added to the footer of the document change form. HYPERLYNK 13. (The updated language in the Document Management section of the LOM is satisfactory. Objective evidence that this and all other changes made in the LOM and CAM must be provided for a period of 90 days. To ensure implementation is consistent with policy/procedure statements in these manuals, submissions of objective evidence to the Lead Assess must occur at 30 day intervals.)**

CORRECTIVE ACTION REQUEST (CAR) **Number** 3 **of** 18

Clause No.:	5.4.1 6.6.64	Source:	ISO 17025:2005 EPPD Crime Lab ISO Controlled Substance Manual-results of analysis (effective 2/14/11)	Level:	1

Requirement: 5.4.1 -The laboratory shall use appropriate methods and procedures for all tests and/or calibrations within its scope. These include sampling, handling, transport, storage and preparation of items to be tested and/or calibrated, and, where appropriate, an estimation of the measurement uncertainty as well as statistical techniques for analysis of test and/or calibration data.

6.6.64-Compare mass spectrum and retention time of analyte(s) to mass spectrum and retention times of standards stored in the compound table and to Standard (positive control) analyzed on the same day (24hrs) and under the same analytical conditions. In order to positively identify an analyte using GC/MS, it is widely accepted that the full scan spectrum have a minimum of three characteristic ions whose ratios are within 20% of the same ion ratios run on standards on the same instrument. A recommendation of a three kilocount, minimum or more, peak is suitable for comparison. [*The Handbook of Forensic Drug Analysis*, pg 113.]

Finding: The laboratory procedures states "In order to positively identify an analyte using GC/MS, it is widely accepted that the full scan spectrum have a minimum of three characteristics ions whose ratios are within 20 % of the same ion ratios run on standards on the same instrument. A recommendation of a three kilo count, minimum or more, peak is suitable for comparison. [*The Handbook of Forensic Drug Analysis*, pg 113.]" These criteria for identification are not acceptable for the analysis of solid dosage form drug substances. The procedure the laboratory employs has been taken from a procedure for analysis for toxicology samples. The laboratory procedure does not define acceptable ranges for retention time comparisons with known standards.

PLEASE NOTE: The Controlled Substance Analysis Manual provided with the corrective action plan documents received on September 1, 2011 contains materials that duplicate those proposed or actually included in the manual. The numbering system employed in this document is inconsistent and very confusing. If changes are made to the manual, the text that has been removed, changed or added should be present and clearly identifiable. The numbering system should be clear and consistent. It has been difficult to understand what has been or will be removed, added or changed. To adequately understand the context and relevance of the change or addition to the specific section of the manual, the above stated issues with the manual should be corrected.

For the finding stated above please refer to CAR 2 discussing the removal of the formula and its comparison limitation to +/- 0.15 min. HYPERLYNK 11 **(Refer the Lead Assessor response in paragraph 2c of CAR 2.)**

The active manuals were left intact and the draft manuals sent to you with the new language in red "once approved" would have been implemented in the intact versions.

As of 10/25/2011, we have addressed the formatting concerns and have final active manual(s) with appropriate revision numbers (For CAM and LOM please refer to header's revision number 10-25-2011-00; manuals included in the response folder as attachments). **(The updated language**

in the LOM and CAM appears to be satisfactory. Objective evidence that these changes to the LOM and CAM have been implemented must be provided for a period of 90 days. To ensure implementation is consistent with policy/procedure statements in these manuals, submissions of objective evidence to the Lead Assess must occur at 30 day intervals.)

Proposed Corrective Action 1:
The laboratory will initiate a document change form to add ISO 17025:2005 Clause 5.4.1 to "Reporting Guidelines" page 89 of the Laboratory Operations Manual
As of August 23, 2011, our laboratory has added language to amend reporting guidelines in our LOM draft Reporting Guidelines pg 91 letter S **(adding this language to "Reporting Guidelines" in the Laboratory Operations Manual does not appear to address this finding. This addition wouldn't fit because the other language in your "Reporting Guidelines" is directly related to the requirements stated in ISO 17025 Clause 5.10 "Reporting of Results". This finding relates to "appropriate methods and procedures" in ISO 17025 Clause 5.4.1.) The laboratory did not have Requirement 5.4.1 in either of the manuals and decided to include it. Action 1 is to merely add the language to our SOPs. (That may be the case; however, anything designated as a "corrective action", must appropriate address the finding in question. I don't believe it does in this case.)**

, by adding suggested reporting language in CAM Draft Suggested Reporting Guidelines Section 2.2 pg 8 **(Again, this does not appear to address this finding); Refer to CAR 1 HYPERLYNK 2 (Refer to Lead Assessor response in CAR 1) addressing reporting guidelines, CAR 2 retention time language HYPERLYNK 11, and CAM's Cautionary Guidelines criteria for chromatographic and spectral critique HYPERLYNK 14**, removal of the 20% rule CAM Draft pg 32 **(Removal of the section is appropriate and approved)**, adding the Varian and Thermo **(These procedural guidelines are acceptable and approved with the exception of what is noted in CAR 2) See Laboratory's corrections to retention time in CAR1 (Refer to Lead Assessor response in CAR 1) HYPERLYNK 2.** Procedural Guidelines CAM Draft, and adding Cautionary Guidelines CAM Draft **(Refer to CAR 1)**. See Laboratory response to CAR1. The combination of the aforementioned policy changes and amending the sixteen reports reviewed by the assessment team will address the clause. The laboratory cannot amend the reports until Mr. Fox approves the proposed corrective action 1.

The full assessment was shared with Integrated Forensic Laboratories and together with the syllabus provided to ASCLD/LAB Board of Directors, Mr. Ron Fazio, President of IFL, is also providing recommendations to meet the individual CAR's as well inclusive in the training. The recommendation to strike the above Proposed Corrective Action 2 and re-address it below will address the clause and remediate the finding. As part of the IFL training on August 17, 2011, Quality Manger issued a training memorandum outlining discussion on several topics including but not limited to the Suggested Reporting Guidelines" found in our CAM Draft Section 2.2 page 8.
(Discussion on topics including "Reporting Guidelines" in the CAM does not appear to address this finding. It doesn't fit because "Reporting Guidelines" is directly related to the requirements stated in ISO 17025 Clause 5.10 "Reporting of Results". This finding relates to "appropriate methods and procedures" in ISO 17025 Clause 5.4.1.) The word "Suggested" was removed. Please refer to CAR 1. The procedures for the Varian and Thermo in CAR2 address the removal of the formula and comparison limitations of +/- 0.15 minutes Retention time was added language. **(Refer to Lead Assessor responses in both CARs 1 and 2.)**

The topics were not limited to Reporting Guidelines; however, discussion on Cautionary Guidelines was discussed as well and added to the CAM manual. The Cautionary Guidelines discusses minimum acceptance criteria **(HYPERLYNK 14** CAM Cautionary Guidelines**).** The combination of the Varian Procedure and the Thermo GC/MS procedure and Cautionary Guidelines relates back to the finding, "the laboratory procedure does not define acceptable ranges for retention time comparisons with known

standards." We have simplified the RT acceptance criteria to simply be +/- 0.15 minutes in the SOPs. Please refer to CAR 2. **(Refer to the Lead Assessor response in paragraph 2c in CAR 2.)**
The laboratory has also added language to the Case Record Review Sheet/Admin/Tech Review **CAR 1 HYPERLYNK 8** and illustrates, "Retention time matches primary standard +/- 0.15 minutes". Integrated Forensic Labs reviewed 122 cases and RT is included in the review for all cases. The laboratory also is including language in the CAM regarding placement of a copy of the primary standard controls to include the blank and primary standard RT and spectrum. Language was added to the CAM, under confirmatory tests, see CAR2 **HYPERLYNK 12**. **(Refer to Lead Assessor responses in both CARs 1 and 2.)**

Proposed Corrective Action 2:
On August 18, 2011 added language to LOM draft Section XX page 90- 92 letter s , CAM Draft Manual Section 2 "Minimum Criteria for Reporting the Presence of a Controlled Substance and Suggested Reporting Guidelines." Pg 8, Varian and Thermo Procedural Guidelines and the CAM Draft Cautionary Guidelines are together considered the EPPD's *Minimum Criteria for Identification* of a controlled substance. The manuals now includes language for the documentation of the presumptive tests, the retention time (and acceptable ranges), and conducting ion spectra comparisons using the entire spectra. **(See comments in Proposed Corrective Action 1 above.) Please refer to lab responses in Proposed Corrective Action 1 (Refer to Lead Assessor responses in both CARs 1 and 2.)**

Proposed Corrective Action 3
The proposed changes to the Minimum Criteria were covered in detail in a collaborative meeting with lab staff and IFL on August 18, 2011. A copy of the memo documenting the meeting can be referenced here. The Procedural Guidelines for GC/MS Varian Ion Trap Saturn 2000 pgs 33-36, Procedural Guidelines for GC/MS Thermo Focus DSQ II Quadrupole pgs 40-43 , and "Cautionary Guidelines" pg 75, all outline peak identification (selection), selection of appropriate drug reference standard for comparison, guideline for Retention Time Analysis, Data Interpretation indicating legitimate library references, and a minimum acceptance criteria of the retention time. At 3%, for example a standard elutes at 5.00 min and a sample elutes at 4.85 minutes. Using the formula below the acceptance criteria can not be more than 0.15 minutes (3%). **(See comments in Proposed Corrective Action 1 above.) Please refer to lab responses in Proposed Corrective action 1 and CAR2 (language of +/- 0.15 minutes and removal of formula). (Refer to Lead Assessor responses in both CARs 1 and 2.)**

Proposed Corrective Action 4:
Analyzing the Data
Mr. Fox the earlier responses provided did not address where in our laboratory system we would address concerns about 5.4.1 into policy. Controlled Substance Manual Section 11 entitled "Cautionary Guidelines 1-12", pages 75 thru 76, outlines the policy addressing acceptable criteria for the identification of controlled substances. **(These guidelines are acceptable. It is, however, suggested that "rejection" criteria be included.** Also see proposed Corrective Action 1, 2 and 3. **Rejection Criteria is noted and the laboratory will consult with Integrated Forensic Laboratories and local peer-laboratories and will in the future include sections on rejection criteria**.

CORRECTIVE ACTION REQUEST (CAR) **Number** 5 **of** 18

Clause No.:	5.10.1 Section 7.c	Source:	ISO 17025:2005 EPPD Crime Laboratory Operations Manual (Reporting Guidelines)	Level:	1

Requirement: 5.10.1 The results of each test, calibration, or series of tests or calibrations carried out by the laboratory shall be reported accurately, clearly, unambiguously and objectively, and in accordance with any specific instructions in the test or calibration methods.

7. Each test report will include the following information:
c. The name and address of the customer; identification of the method used (sampling plan); a description of, the condition of, and unambiguous identification of the item(s) tested (comments in footnote or in controlled substance worksheet); the date of receipt of the test where this is critical to the validity and application of the results, and the date(s) of performance of the test or; reference to the sampling plan or procedures used by the laboratory or other bodies where these are relevant to the validity or application of the results (standards and samples are run within a 24-hour clock and recorded in the instrument retention time log (Binders C and F found in the laboratory) and the 2011 Analysis Primary Standard Binder (G); the type of test, where appropriate, the units of measurement; the name(s), function(s) and signature(s) or equivalent identification of person(s) authorizing the test report (technical review signatures); and where relevant, a statement to the effect that the results relate only to the items tested or calibrated. (Revised 04/25/2011).

Finding: Controlled substance reports do not contain a description of the items tested in 15 of 16 cases reviewed.

Proposed Corrective Action 1:
The supplemental criteria will be re-addressed and documented during open forum during the weekly laboratory staff meeting.

Lead Assessor Response:
Please clarify. I am unsure what "supplemental criteria" are you referring to?
The full assessment was shared with Integrated Forensic Laboratories and in conjunction with the training (described in the syllabus provided to ASCLD/LAB Board of Directors), IFL has also provided recommendations concerning most of the individual CAR's . EPPD laboratory reports will now include clear and unambiguous language concerning exhibit description(s), weight(s), and sampling plan(s). **(Please reference here where these requirements are enumerated in the EPPD Crime Lab management system documents. As of 10/25/2011, the CAMs' reporting and cautionary guidelines were recommended by IFL (describing minimum acceptance criteria) and were implemented. HYPERLYNK 14** In addition EPPD will issue 'Amended' reports on the 15 cases reviewed by the assessment team; by September 23, 2011. **Objective evidence must be provided to demonstrated compliance. The amending of sixteen laboratory reports and original reports will be scanned into HYPERLYNK 22. (The amended laboratory reports provided are consistent in content and format with the updated laboratory reporting guidelines. This corrective action is approved.**
With this approval, it will be necessary to demonstrate 90 days of compliance, effective immediately. To ensure records are in compliance, a sampling of objective evidence in the form of case notes and laboratory reports must be provided to the lead assessor for review and approval at thirty (30) day increments. If the objective evidence provided does not meet compliance requirements, the clock is reset for another 90 days.)

Proposed Corrective Action 2:

The laboratory will initiate a document change to provide a statement on the lab report that explains that the lab report reflects the results that relate only to the items tested. The new laboratory report will be used when the correction is approved.

Lead Assessor Response:

The finding states "controlled substances reports do not contain a description of the items tested". The proposed statement does not appear to provide a clear and unambiguous description of the items (evidence) tested.

On August 23, 2011, Quality Manager documented in an e-mail an outline describing the importance of the new CAM Draft pg 8 "Suggested Reporting Guidelines" and CAM Draft Cautionary Guidelines pg 75 addressing minimum acceptance criteria found within our Controlled Substance Draft Manual. Quality Manager, Art Herrera, mentioned not until Mr. Fox approves of the amendments can one demonstrate objective proof. The training memorandum meeting held on August 17, 2011 was conducted by the Quality Manager, Art Herrera, and IFL President Mr. Ron Fazio. Memo displays analyst(s) signatures.

(Although the examples in the "Suggested Reporting Guidelines" provide clear descriptions of the items tested, "Suggested" reporting language" implies the analyst has no restrictions or minimum requirements on reporting language. For this reason, there appears to be no requirements. Please clarify what is actually required.) New language addresses the removal of "Suggested" (HYPERLYNK 2) and are now reporting guideline requirements. This corrective action is approved.

With this approval, it will be necessary to demonstrate 90 days of compliance, effective immediately. To ensure records are in compliance, a sampling of objective evidence in the form of case notes and laboratory reports must be provided to the lead assessor for review and approval at thirty (30) day increments. If the objective evidence provided does not meet compliance requirements, the clock is reset for another 90 days.)

CORRECTIVE ACTION REQUEST (CAR) **Number** 6 **of** 18

Clause No.:	4.2.1 5.3.4 Section 3.1	Source:	ISO 17025 :2005 EPPD Crime Lab Operations Manual	Level:	1

Requirement: 4.2.1 -The laboratory shall establish, implement and maintain a management system appropriate to the scope of its activities. The laboratory shall document its policies, systems, programs, procedures and instructions to the extent necessary to assure the quality of the test and/or calibration results. The system's documentation shall be communicated to, understood by, available to, and implemented by the appropriate personnel.

5.3.4-Access to and use of areas affecting the quality of the tests and/or calibrations shall be controlled. The laboratory shall determine the extent of control based on its particular circumstances.

3.1-Access to the crime laboratory is restricted. This is in effect to protect the integrity of the evidence, the confidentiality of case reports and to avoid exposing untrained persons to hazardous substances used in the laboratory. Doors to the crime laboratory will remain closed when authorized personnel are not present in the lab.

Finding: The entrance to the Controlled Substance laboratory is accessed through the Crime Scene laboratory which is secured with an electronic lock system that was malfunctioning during the assessment. If the door to the Controlled Substance laboratory is open, Crime Scene and other police department personnel have access both to the laboratory and the evidence/report storage room located in the laboratory. During the assessment both the laboratory and evidence/storage room doors were observed to be opened when no personnel authorized by the laboratory director were present.

The below detail does not reflect a proposed corrective action response sent on 08/26/2011. Please send comment on the requested action. Laboratory response is in this font color green. **(Please see correct response below. I copied and pasted the wrong information.)**

Proposed Corrective Action 1:
The laboratory director will provide a training session dedicated to this topic solely as outlined in the quality documents will be administered to all members of the laboratory staff. Any additional instances of nonconformance in relation to these training components will be disciplined with a written reprimand.

Lead Assessor Response:
The proposed corrective action is accepted. Upon completion of the training, please provide objective evidence that includes the training content, who attended the training and a signed or initialed acknowledgement by the attendees that states the attendee received and understood the training.

- Is this a onetime training session or is the topic a part of a regular management system review process?

On 8/26/2011, the laboratory director issued a Director's Memorandum reflecting the training event. The training event will either be a monthly, quarterly, or yearly reminder regarding laboratory security to all staff members. This documentation was entered into the LOM Draft Chapter IV Laboratory Security pages 20-22 **(The referenced documents in this corrective action plan provide satisfactory objective evidence to demonstrate compliance with the requirements stated in this finding.)**

Proposed Corrective Action 2:

All repair detail on these access points will be made available to laboratory staff, so they make special effort to attend to any malfunctioning units.

Lead Assessor Response:

I am unclear what this statement means. Please explain in more detail. Do you intend to incorporate the security cameras into your Laboratory Security policy/procedures? If so, please include details concerning their function and what monitoring protocols will be in place to ensure your Laboratory Security procedures are adhered to. Security Cameras were installed on May 27, 2011 and are maintained by Homeland Security Office. In the event the door is left open….written reprimand on personnel file. If system is malfunctioning either Homeland security office, building manager Mr. Harry Sommers, lab director Sgt. D. Hernandez and/or lab directors designee would notify analysts via e-mail, telephone, or in person. All analysts will cease analysis until security malfunction is corrected. All evidence must remain locked, in locked drawers or assigned lockers, until malfunction is corrected. Lab director will keep record of all malfunctioning events. This documentation was entered into the LOM Draft Chapter IV Laboratory Security pages 20-22. **(This is useful information but it doesn't explain what the cameras are monitoring or the protocols that are in place to ensure that the laboratory space has not been accessed by unauthorized personnel. What do the personnel in the Homeland Security Office do to ensure the laboratory is secure?)**

CORRECTIVE ACTION REQUEST (CAR) **Number** 7 **of** 18

Clause No.: 5.6.2.1.1 Source: ISO 17025:205 Level: 1

Requirement: "….. When using external calibration services, traceability of measurement shall be assured by the use of calibration services from laboratories that can demonstrate competence, measurement capability and traceability. The calibration certificates issued by these laboratories shall contain the measurement results, including the measurement uncertainty and/or a statement of compliance with an identified metrological specification (see also 5.10.4.2)."

Finding: Texas sentencing statutes for controlled substances include escalating penalties for quantities of controlled of controlled substances from 50 to 250 pounds and above 250 pounds. A balance used for weighing controlled substance evidence in quantities of 50 pounds or more was found to have a calibration traceability certificate that stated the following; "This certificate is NOT ISO 17025 compliant and should not be used as a substitute for an ISO 17025 certificate." The measurement results on the certificate did not include measurement uncertainty or a statement of compliance with an identified metrological specification.

Corrective Action:
The Mettler Toledo Hawk Serial # 0008010-6EB has been replaced by a new lab-bench scale.
Lead Assessor Response:
This corrective action is accepted. Objective evidence must be provided that shows the original balance was taken out of service. Objective evidence must be provided that documents the new balance referenced above is in compliance with the clause referenced in this finding.

Proposed Corrective Action 1:
All required documentation for use, care, and maintenance of the replacement unit will follow the prescribed detail as outlined in the El Paso Police Department Crime Laboratory's Quality documents (LOM draft, pg 110). The external calibration service will provide the following information in compliance with ISO 17025:2005 Clauses 5.6.2.1.1 and 5.10.4.2 specifically identifying against which specification the measurements have been compared by giving an unambiguous reference to the specification. The complete measurement process including the effects of the instruments capability, human factors in conducting the test or calibration, and environmental factors. This uncertainty represents an expanded uncertainty expressed at approximately 95% confidence level using a coverage factor of k = 2.
Lead Assessor Response:
This corrective action is accepted. Objective evidence must be provided that all requirements detailed in your corrective action plan have been and are being followed.

On August 26, 2011, memorandum stating Mettler Toledo Hawk Serial # 0008010-6EB was removed from use. Laboratory will verify to NIST traceable standard(s) and Vendor's forms will address ISO 9000 and ISO 17025 vendor compliance. **(Based on the language in the body of the reference memorandum, the laboratory director has been informed the balance has been removed from service. Is there objective evidence that laboratory staff have been so informed and has a sign be placed on the balance stating it is out of service? The balance was removed for work on authorized case work.** Toledo Hawk Serial # 0008010-6EB **was removed from the laboratory and sent to "Narcotics Division" HYPERLYNK 16. A photograph of the balance with the appropriate signage will suffice as objective evidence.) Please see Memo 9/15/2011 (HYPERLYNK 16) stating its objective acknowledgment by laboratory staff. (Is the balance still located in the laboratory? If so, is there a sign indicating it is out of service? Please email me a photograph if this is**

the case. If the balance is no longer located in the laboratory, what is its disposition? Has it been scraped, surplused, sold, etc.? If so, please provide appropriate documentation.)

CORRECTIVE ACTION REQUEST (CAR) **Number** 8 **of** 18

Clause No.: 4.1.5 (G H) Source: ISO 170525:2005 Level: 1

4.1.5. h.1 2011 Supplemental testing

Requirement: The laboratory shall
g) provide adequate supervision of testing and calibration staff, including trainees, by persons familiar with methods and procedures, purpose of each test and/or calibration, and with the assessment of the test or calibration results;

h) have technical management which has overall responsibility for the technical operations and the provision of the resources needed to ensure the required quality of laboratory operations;

4.1.5.h.1 The laboratory shall designate technical responsibility for each discipline. Each designee shall have appropriate technical training and technical experience in the discipline.

Finding: Laboratory management has failed to provide objective evidence that technical responsibility in the Drug Chemistry discipline has been delegated to an individual with the appropriate technical training and technical experience.

Proposed Corrective Action 1:
Major revision for Laboratory Operations Manual Organizational chart
Lead Assessor Response:
The proposed organizational chart does not denote technical responsibility to an individual with the appropriate background. The Quality Manager position as defined in your proposed revision to the Laboratory Operations Manual does not indicate the individual is the technical leader for a particular discipline.

On May 27, 2011, language was added to the LOM draft Section 5 page 7-10 entitled Organizational Chart and Delegation of Authority defines Arturo A. Herrera as Quality Manager for the El Paso Police Department Crime Laboratory's Drug testing section.
The Memorandum dated January 04, 2011 from the Laboratory Director to all staff members identifies Arturo A. Herrera as Quality Manger. (Quality Manager assignment memo).

On August 24, 2011, language was added/amended/revised to LOM Draft Chapter II Section 5.1 Delegation and 5.2 Organization pg 8-10 addressing the qualifications, duties, and responsibilities of Quality Manger (technical) vs. Laboratory Director (non-technical). **(The amended language in the referenced document satisfactorily meets the requirements of the ISO 17025 Clauses stated in this finding. Objective evidence of its inclusion in a laboratory management approved management system document is required for acceptance.) The training records, meetings, PARs/CARs, and document change forms initiated by the Quality Manager will be shown via Crime Laboratory Management Review Binder. As of 10/25/2011, final and approved versions of the LOM and CAM are saved in the response folder; for acknowledgement by staff please refer to HYPERLYNK 24. (Objective evidence of the inclusion of the amended LOM Draft Chapter II Delegation and 5.2 Organization pg 8-10 simply requires providing an electronic copy of the approved and current version of the LOM with these changes in it.) Please note under "Top Management", the sentence beginning with "The Quality Manager will advise….is repeated below the strikethrough). Language regarding second sentence was removed on 10/25/2011; please refer to HYPERLYNK 17.** A review of the entire LOM Draft was conducted by the Quality Manager to remove all technical responsibilities and duties that were technical in

nature from the Laboratory Director, who at this time has no technical qualifications. These duties and responsibilities will be permanently assigned to the Quality Manager once Mr. Fox approves of the changes to the LOM Draft. (Mr. Fox we will send you a copy of the LOM and CS Manual Drafts that the amendments are outlined in red). **(Send me electronic copies of all current approved manuals that include all of the changes/additions that have been implemented.)**

Proposed Corrective Action 2:

The LOM draft Section 5.1 page 8 (HYPERLYNK) entitled Delegation defines Top Management to include the Quality Manager which will be the "formal scientific authority" of Top Management.

Revised definition (In red) for Top Management and Quality Manager

Definition

- Top Management is the Laboratory Director as noted in the Laboratory Operations Manual Organizational Chart has the responsibility and authority to manage, provide supervision, perform first level supervisory for laboratory functions including those of an operational or administrative nature as required and authorized. ~~Perform or verify (administrative) work affecting the quality of the tests and/or calibrations performed in this laboratory setting. He or she will ensure that the integrity of the management system is maintained when changes to the management system are planned and implemented~~. (Revised during GAP response on 04/25/2011). If Top Management lacks a scientific background to effectively review scientific-related ~~responsibility~~ (Please clarify) The wrong wording was entered; refer to document change form and LOM Draft Chapter II Section 5.1 Delegation and 5.2 Organization which will address the qualifications, duties, and responsibilities of Quality Manger (technical) vs. Laboratory Director (non-technical). Also LOM Draft Section V pg 21-25 entitled "Quality System" addresses new language identifying the Quality Manager as the authority of the Quality System. The Quality Manager with the appropriate scientific background will be the formal scientific authority. (What if the Quality Manager doesn't have the appropriate scientific background?) New LOM Draft Chapter II section 5.2 pg 8 lists the qualifications of the Quality Manager. Arturo A. Herrera has the enlisted qualifications. The laboratory has asked Mr. Ron Fazio to submit a proposal to the laboratory for consultation services through-out the fiscal year. The consulting will include assistance in technically related management issues and continuing education are some topics discussed with Mr. Fazio. ~~The Quality Manager will advise and assure that those planned and systematic actions necessary to provide sufficient confidence that a laboratory's product or service will satisfy given requirements for quality~~. This language has been removed and in its place "The Quality Manager will advise and assure that those technically planned and systematic laboratory actions are scientifically referenced and accepted with in the scientific community. (I am uncertain from this statement exactly what authority the Quality Manager has. Please clarify.) Please refer to refer to document change form and LOM Draft Chapter II Section 5.1 Delegation and 5.2 Organization **(The amended language in the referenced documents satisfactorily meets the requirements of the ISO 17025 Clauses stated in this finding. Objective evidence of its inclusion in a laboratory management approved management system document is required for acceptance.)** **HYPERLYNK 17 LOM 5.1 Delegation page 8 and/or refer to Laboratory Operations Manual attachment. Acknowledgement by staff see HYPERLYNK 24. (See Lead Assessor in Corrective Action #1 above.**
-

Lead Assessor Response: The "Top Management" definition above is not the same as that provided in the proposed revision of the Laboratory Operations Manual that accompanied this corrective action plan. Please confirm which should be considered.

Note: The term "Quality Manager" found in this and other parts of the Operations Manual is not consistent with the statements under "key managerial personnel" found on Page 8 of the proposed Laboratory Operations Manual. The key managerial personnel statements refer to "Quality Assurance Manager".

- Mr. Fox we have been diligently working on the concerns you have mentioned and rest assured my thoughts as Quality Manager have hopefully addressed these concerns in LOM Draft Chapter II Section 5.1 Delegation and 5.2 Organization. These changes will take effect once you approve the LOM and CS

Manual Drafts. **(The amended language in the referenced documents satisfactorily meets the requirements of the ISO 17025 Clauses stated in this finding. Objective evidence of its inclusion in a laboratory management approved management system document is required for acceptance.) HYPERLYNK 17 LOM 5.1 Delegation page 8 and/or refer to Laboratory Operations Manual attachment. Acknowledgement by staff see HYPERLYNK 24. (See Lead Assessor in Corrective Action #1 above.**

- Quality Manager: An individual is not designated; however, is appointed has been changed and new language describes the qualifications as well LOM Draft Chapter II Section 5.2 pages 8 and 9 ~~designated~~ (appointed?) by top management who, irrespective of other responsibilities, has the defined authority and obligation to ensure that the quality requirements of the management system are implemented and maintained. The Quality Manager qualifications have been amended **see HYPERLYNK above** (please clarify) ~~have a minimum of a baccalaureate in a natural science, criminalistics or a closely related field and at least two years of forensic science experience performing casework in one of the ASCLD/LAB-International accredited disciplines.~~

Lead Assessor Response:
Using this definition and the proposed organizational chart, could the Quality Manager could be a crime scene specialist and technical leader of the Drug Analysis discipline?

- No sir, we have added new language, revised, deleted, and/or amended the LOM Draft for the purposes of delineating Arturo A. Herrera as Quality Manager in the Organizational chart (accompanying memo dated January 4, 2011) and the description of the Quality Manager which now lists new language addressing qualifications. (see above HYPERLYNK regarding Section 5.2) Aside from education we have addressed that this person must have demonstrated several years of proficiency in controlled substances from an accredited ASCLD/LAB laboratory. We are also recommending that this individual become a member of AFQAM (Association of Forensic Quality Assurance Mangers). On August 16, 2011, I applied and submitted my credentials to the Membership Committee (AFQAM application) and submitted a training request to attend the 2011 AFQAM Conference in Albuquerque, New Mexico on September 26 – 30, 2011(AFQAM Training Request Memo). **(The amended language in the referenced documents satisfactorily meets the requirements of the ISO 17025 Clauses stated in this finding. Objective evidence of its inclusion in a laboratory management approved management system document is required for acceptance.) As of 10/25/2011, HYPERLYNK 17 LOM 5.1 Delegation page 8 and/or refer to Laboratory Operations Manual attachment. Acknowledgement by staff see HYPERLYNK 24. (See Lead Assessor in Corrective Action #1 above.**
-

Mr. Fox the red font will become permanent once you approve of the changes.

- **CRIMINALISTICS SERGEANT/LABORATORY DIRECTOR – SERGEANT (Managerial Support):** The Criminalistics Laboratory Director is responsible for the ~~entire enterprise~~ overall operation of the drug laboratory. ~~The Laboratory Director with the scientific and technical expertise to evaluate and perform technical work can reviews goals, objectives, and strategies, and projects a shared-vision of the future~~. Top management makes decisions that affect ~~everyone~~ laboratory staff members in the organization and is held entirely responsible for the success or failure of the Crime Laboratory. This top management role will ensure that the ASCLD-Lab Guiding Principles of Professional Responsibility for Crime Laboratories and Forensic Scientists are reviewed annually with laboratory staff; provide evidence of commitment to the development and implementation of the management system and to continually improve its effectiveness; shall communicate to the organization the importance of meeting customer requirements as well as statutory and regulatory requirements. (Revised 04/25/2011). ~~In the event the Laboratory Director lacks the~~

~~aforementioned education and technical experience to perform, evaluate technical work, in cooperation with a Quality Manager with those requirements, the Laboratory Director will ensure the duties and responsibilities are still meet. The Laboratory Director should have a minimum of a baccalaureate degree in a natural/physical science, criminal justice, or a closely related field. The Laboratory Director should have at least five years of forensic science.~~ The Laboratory Director and Quality Manager/Technical Lead are considered top management and must effectively communicate throughout the year to satisfactory meet the ASCLD/LAB annual audits. **(The amended language satisfactorily meets the requirements of the ISO 17025 Clauses stated in this finding. Objective evidence of its inclusion in a laboratory management approved management system document is required for acceptance.)**

HYPERLYNK 17 LOM 5.1 Delegation page 8 and/or refer to Laboratory Operations Manual attachment. Acknowledgement by staff see HYPERLYNK 24. (See Lead Assessor in Corrective Action #1 above.
The section further delineates the description for Quality Manger/Technical Lead and the necessary qualifications.

The Laboratory Director should have a minimum of a baccalaureate degree in a natural/physical science, criminal justice, or a closely related field. The Laboratory Director should have at least five years of forensic science. (What does this mean?) (LOM Chapter II Section 5.1 Delegation page 8) or see above this language has been removed as of 8/24/2011.

A new amended manual will be distributed with new duties and responsibilities for the Quality Manager; the following pages have been amended. (Not provided.)

- On August 24, 2011, language was added/amended/revised to LOM Draft Chapter II Section 5.1 Delegation and 5.2 Organization addressing the qualifications, duties, and responsibilities of Quality Manger (technical) vs. Laboratory Director (non-technical). **A review of the entire LOM Draft was conducted by the Quality Manager** to remove all technical responsibilities and duties that were technical in nature from the Laboratory Director, who at this time has no technical qualifications. These duties and responsibilities will be permanently assigned to the Quality Manager once Mr. Fox approves of the changes to the LOM Draft. (Mr. Fox we will send you a copy of the LOM and CS Manual Drafts that the amendments are outlined in red). **(The amended language in the referenced documents satisfactorily meets the requirements of the ISO 17025 Clauses stated in this finding. Objective evidence of its inclusion in a laboratory management approved management system document is required for acceptance.) HYPERLYNK 17 LOM 5.1 Delegation page 8 and/or refer to Laboratory Operations Manual attachment. Acknowledgement by staff see HYPERLYNK 24. (See Lead Assessor in Corrective Action #1 above.)**

CORRECTIVE ACTION REQUEST (CAR) **Number** 9 **of** 18

Clause No.: 5.5.3 Source: 2011 supplemental testing Level: 1

Requirement: Equipment shall be operated by authorized personnel.

Finding: For two of three personnel utilizing laboratory equipment for controlled substance testing there is no objective evidence to demonstrate that authorization has been given to these individuals to utilize laboratory equipment.

Proposed Corrective Action 1:

On August 25, 2011, Quality Manager Arturo A. Herrera issued a memorandum entitled "Authorization of Equipment". The memorandum outlines all the equipment located in the laboratory. A document change form entitled "8/25/2011 B" added language to the LOM Draft Chapter XXIV Employee Training and Development Section 4 page 103 outlining the authorization of equipment, etc… . (The Authorization of Equipment memorandum and the amended language in the referenced document satisfactorily meets the requirements of the ISO 17025 Clause stated in this finding. Objective evidence of its inclusion in a laboratory management approved management system document is required for acceptance.) Please refer to HYPERLYNK 25, the request to place in management review binder. . (The authorization memorandum addressed the finding. Objective evidence of the inclusion of the amended LOM Draft Chapter Chapter XXIV simply requires providing an electronic copy of the approved and current version of the LOM with these changes in it.)

CORRECTIVE ACTION REQUEST (CAR) **Number** 10 **of** 18

Clause No.: 4.2.4 Source: ISO 17025:2005 Level: 2

Requirement: Top management shall communicate to the organization the importance of meeting customer requirements as well as statutory and regulatory requirements.

Finding: The laboratory provided no objective evidence to demonstrate that top management has communicated the importance of meeting customer requirements to the laboratory organization.

Proposed Corrective Action 1:
Top management will communicate the importance of meeting the customer requirements to the laboratory organization in a formal shift meeting and the corresponding documentation will be provided.

Lead Assessor Response:
The proposed corrective action is accepted. Will communication of this importance be a regular part of the laboratory management system process? To satisfy remediation of this finding, objective evidence must be provided to demonstrate compliance.

(Please respond to the question posed in my earlier response above.)

Yes, it will be a regular part of the laboratory management system process. Please see the memorandum issued on 01/04/2011 HYPERLYNK 20. By being aware of the importance of their activities, the laboratory personnel will perform their duties with the customers' needs in mind, thus providing a better service. Also, from time to time, our Police Department, DEA Microgram, Texas Health Department, or other peer – laboratories will send out intelligence regarding new drug trends. The Quality Manager has printed out the e-mails and has had each of the analyst sign the document acknowledging the discussion of the topics covered. By being aware of the new trends the chemists will be better prepared to meet the requirements of the customers. See example HYPERLYNK 18. (This statement and the hyperlinked documents satisfy this requirement.)

As a result of an audit on case folders the quality manager documented via "Management Review Meeting Check list addressing corrective actions and training issues on case folders inventoried (HYPERLYNK 18). (This appears to be the wrong hyperlink.)

Also, HYPERLYNK 18 (This too appears to be the wrong hyperlink.) includes LOM Sections XX Evidence handling and documentation (page 82 of 117), XX1 Control of Laboratory Records (page 97 of 117), and Case File Removal (page 99 of 117).

CORRECTIVE ACTION REQUEST (CAR) **Number** 11 **of** 18

Clause No.: 4.27 Source: ISO 17025:2005 Level: 1

Section 4.8 Operational Manual
Document Implementation

Requirement: 4.2.7
Top management shall ensure that the integrity of the management system is maintained when changes to the management system are planned and implemented.

4.8

a. Upon approval to changes to a controlled document(s), staff will be provided with a copy of the revised controlled document, outlining the changes. Employees will sign a acknowledge receipt in writing.

b. Permanent changes to a controlled document will be done at the time the annual review is conducted and a revised controlled document will be issued.

c. Implementation of new or revised documents will be in accordance with the revision issue or approval date on the document.

d. The laboratory's director will ensure that approved versions of documents are available to lab personnel and in use by the effective date.

Finding: Two dates are defined on each management system document; the issue date and the effective date. Based on laboratory procedures it is unclear when a new or revised document is authorized for usage.

Proposed Corrective Action 1:
Amended policy and procedure to include definition of effective date. The definition of "effective date" found on page 63 of the proposed Laboratory Operations Manual is clear and concise.

4.2.7 Top management shall review and document the understanding and importance of the Lab Operations Manual "VI Quality System ~~Laboratory Director~~ shall ensure that the integrity of the management system is maintained when changes to the management system are planned and implemented all changes will adhere to XVI Document Management policy" and "4.8 Document Implementation".

On August 25, 2011 the Quality Manger added language to the LOM Draft Chapter XVI Section 4.8 Document Implementation pg 68.

a. ~~Upon approval to changes to a controlled document(s), staff will be provided with a copy of the revised controlled document, outlining the changes. Employees will sign a acknowledge receipt in writing~~; Upon approval to changes to a controlled document(s) the Quality Manager will issue out to appropriate staff members a memorandum outlining the changes/revisions to the controlled document. The memorandum will address where the staff members my find the authorized use of the controlled document and effective date will mirror the acceptance date of the Quality Manager. All appropriate staff members will acknowledge the new document by signing the original memorandum issued by the Quality Manager. Does this mean the staff will receive an approved revised controlled document prior to its effective date? If

so, how will management ensure the revision/s are not implemented by staff prior to the effective date? See above language; receipt will be in the form of a memorandum issued by the Quality Manager. **(The revised language in the Documentation Implementation section is generally satisfactory. However, I don't see anything that prevents staff from using older versions of the controlled document or the new version prior to the effective date. Can you clarify?) Older versions are marked archived (HYPERLYNK 26), Administrative/Technical reviews, and/or audits may be conducted to insure that staff is using current manuals and/or forms with correction revision numbers. (This appears to be appropriate for older versions. My concern is also with the availability of new versions and their potential use prior to the effective date. Are new versions unavailable to staff prior to the effective date? How do you handle that?)**

On August 17, 2011 a memorandum from the Quality Manager outlined the changes to the LOM Draft and Controlled Substance Manual Draft. Memo states as a result of signed aforementioned training addressing the responses; nine items were added, amended, and/or revised in our Controlled Substance Manual (pending approval from Mr. Fox). The manual in this example would list "effective" date on the header once approved by Mr. Fox and the Quality Manager Memorandum addressing the new Document Implementation.

b. ~~Permanent changes to a controlled document will be done at the time the annual review is conducted and a revised controlled document will be issued.~~ The revisions occurring throughout the fiscal year will be addressed as mentioned in "a"; however, at the time of the annual review conducted by the Quality Manager he/she will remove all "strike-throughs" and revised or amended dates. At the conclusion of the annual review the Quality Manager will issue the final controlled document. However, **there will be no** temporary changes as each scenario will be handled by the Quality Manager when the individual requests are made. Revised 8/25/2011
How will temporary changes to controlled documents be handled? There will be no temporary changes.

c. ~~Implementation~~ Distribution of new or revised documents will be in accordance with the ~~revision issue or approval date~~ effective date on the document; How does this related to paragraph "a." above? New language was amended to paragraph a outlining this concern. **(See comment in paragraph "a".) Older versions are marked archived (HYPERLYNK 26), Administrative/Technical reviews, and/or audits may be conducted to insure that staff is using current manuals and/or forms with correction revision numbers. . (This appears to be appropriate for older versions. My concern is also with the availability of new versions and their potential use prior to the effective date. Are new versions unavailable to staff prior to the effective date? How do you handle that?)**

d. The ~~laboratory's director~~ Quality Manager will ensure that approved versions of documents are available to lab personnel and in use by the effective date. Please clarify. This seems to imply that approved versions of controlled documents will be available and in use prior to the effective date? Is that correct? "Approval date" will no longer be used; please refer to above amendments to the LOM. Currently the Quality Manager has address the changes in the form of "DRAFT" and upon Mr. Fox's approval the changes will take effect once the Quality Manager issues out the memorandum outlined in paragraph "a". **(See comment in paragraph "a".) Older versions are marked archived (HYPERLYNK 26), Administrative/Technical reviews, and/or audits may be conducted to insure that staff is using current manuals and/or forms with correction revision numbers. . (This appears to be appropriate for older versions. My concern is also with the availability of new versions and their potential use prior to the effective date. Are new versions unavailable to staff prior to the effective date? How do you handle that?)**

e.

~~The laboratory shall be removing "Approval Date" from all forms to meet the new definition documented by the laboratory. The approval date will now be documented on "Document Change Form" by the Quality Manager section only portion of the form.~~

On July 26, 2011 Document Change form B approves that all Crime Laboratory Forms and Manuals remove from the header the "Approval Date". **(This proposed change is accepted. Objective evidence demonstrating the change has been implemented must be provided.) See LOM 10/25/2011; manual will be attached for your review and HYPERLYNK 19 displays table of contents only. Please refer to header displaying revision number 10-25-11-00.**

Lead Assessor Response: See comments above. The statements above will need to be clear, concise and consistent before this corrective action can be approved.

CORRECTIVE ACTION REQUEST (CAR) **Number** 12 **of** 18

Clause No.: 5.2.5 Source: ISO 17025:2005 Level: 2

Requirement: 5.2.5

The management shall authorize specific personnel to perform particular types of sampling, test and/or calibration, to issue test reports and calibration certificates, to give opinions and interpretations and to operate particular types of equipment.

Finding:

For two of the three personnel performing Controlled Substances testing, there is no objective evidence that demonstrates authorization has been given to these individuals to perform sampling, testing, issuing test reports, giving opinions and interpretations and operating laboratory equipment.

Proposed Corrective Action:

On August 25, 2011, Quality Manager Arturo A. Herrera issued a memorandum entitled "Authorization of Equipment". The memorandum outlines all the equipment located in the laboratory and specific authorized personnel. A document change form entitled "8/25/2011 B" added language to the LOM Draft Chapter XXIV Employee Training and Development Section 4 page 103 outlining the authorization of equipment, etc… (The Authorization of Equipment memorandum satisfactorily meets the requirements of the ISO 17025 Clause stated in this finding.)

Personnel performing controlled substances testing will have written authorization via interoffice memorandum to perform sampling, testing, issuing laboratory reports, give opinions and interpretations once the complete the required training.

Lead Assessor Response:

The proposed corrective action stated in the sentence above is accepted. Objective evidence demonstrating compliance will be required. See above laboratory response regarding the memorandum from the Quality Manager. **(The Authorization of Equipment memorandum satisfactorily meets the requirements of the ISO 17025 Clause stated in this finding.)**

CORRECTIVE ACTION REQUEST (CAR) **Number** 13 **of** 18

Clause No.:	5.10.1 Section2.7.D	Source:	ISO 17025:2005 EPPD Crime Lab ISO Controlled Substance Analysis Manual (Effective 2-14-2011)	Level:	1

Requirement: 5.10.1-The results of each test, calibration, or series of tests or calibrations carried out by the laboratory shall be reported accurately, clearly, unambiguously and objectively, and in accordance with any specific instructions in the test or calibration methods.

2.7 D Volumes: liquids greater than one milliliter shall be approximated using a graduated cylinder or appropriated measuring device.

Finding: For Controlled Substance testing, liquids are recorded in approximate volumes using graduated cylinders; however, in one case that was reviewed, the volume reported was not referenced as an approximate volume. Subsequent interview of the analyst revealed that the laboratory practice when reporting the volume of a liquid is not to state the volume as "approximate".

Proposed Corrective Action 1:
On August 19, 2011 training memorandum addresses volumes will not be "approximated" only upon request. A document change form added language to the CAM Draft Chapter 2 section 2.1 letter C and F page 7 **(The statement in paragraph C of Section 2.1 is a little unclear. Do you want to say: "Liquid volumes will be reported as approximate only upon special request? Such measurements will be made using a graduated cylinder.") Yes we will only provide the volume upon special request; otherwise, the weight will be reported in grams. As of 10/25/2011 we modified the formatting and the paragraph c of section 2.1 is now section 2.33 (HYPERLYNK 21). (The revised statement is clear.) In response to measurements and liquid submissions please refer to CAM Measurements found on page 5 of 10 section 2.33 and section M on Liquid Submissions on page 9 of 10 HYPERLYNK 21.** and Liquid Submissions page 11 regarding liquid submissions. **(Although the example for reporting results of Liquid Submissions in the CAM Draft is good, such reporting appears not to be a requirement; i.e. "Suggested Reporting Guidelines".) The word "Suggested" has been removed and now reads "Reporting Guidelines" in the CAM. See HYPERLYNK 2**
This corrective action is approved.
With this approval, it will be necessary to demonstrate 90 days of compliance, effective immediately. To ensure records are in compliance, a sampling of objective evidence in the form of case notes and laboratory reports must be provided to the lead assessor for review and approval at thirty (30) day increments. If the objective evidence provided does not meet compliance requirements, the clock is reset for another 90 days.)

Proposed Corrective Action 2:
On or about September 23, 2011, upon approval from Mr. Fox, an amended laboratory report will be issued reflecting the measurement guidelines COM Draft page 7 **(See statement above re: paragraph C) See proposed corrective action 1** and suggested reporting guidelines (COM Draft Liquid Submissions page 11). **(Although the example for reporting results of Liquid Submissions in the CAM Draft is good, such reporting appears not to be a requirement; i.e. "Suggested Reporting Guidelines".) See proposed corrective action 1, listed above.**
This corrective action is approved.
With this approval, it will be necessary to demonstrate 90 days of compliance, effective immediately. To ensure records are in compliance, a sampling of objective evidence in the form of case notes and laboratory reports must be provided to the lead assessor for review and approval at thirty (30) day increments. If the objective evidence provided does not meet compliance requirements, the clock is reset for another 90 days.)

CORRECTIVE ACTION REQUEST (CAR) **Number** 14 **of** 18

Clause No.:	5.4.1 Section II.1	Source:	ISO 17025:2005 Operations Manual Service overview	Level:	1

Requirement: 5.4.1
The laboratory shall use appropriate methods and procedures for all tests and/or calibrations within its scope. These include sampling, handling, transport, storage and preparation of items to be tested and/or calibrated, and, where appropriate, an estimation of the measurement uncertainty as well as statistical techniques for analysis of test and/or calibration data.

II.1 At this time the El Paso Police Department Crime Laboratory does not provide quantitative analysis of controlled substance or trace samples less than 0.1 milligrams

Finding: In one controlled substance case where a volume measurement was made the analyst used the volume of liquid found in the evidence (a bottle) to calculate the quantity of the controlled substance present. The quantity of controlled substance reported was calculated using the manufacture's dosage milligrams/milliliter listed on the bottle and the volume of liquid measured by the analyst. The analyst did not use accepted quantitative analysis methods nor did the analyst take into account the possibility that the liquid in the bottle was a dilution of the original preparation identified on the label of the bottle. Furthermore, the analyst did not follow the laboratory's quantitative analysis of controlled substances policy.

Proposed Corrective Action 1:
On August 19, 2011 training memorandum addresses volumes will not be "approximated" only upon request. A document change form added language to the CAM Manual Draft Chapter 2 section 2.1 letter C and F page 7 and page 11 regarding liquid submissions . **Please see CAR 13 laboratory responses. (See CAR 13 of 18 responses.)**
Proposed Corrective Action 2:
On or about September 23, 2011, upon approval from Mr. Fox, an amended laboratory report will be issued reflecting the measurement guidelines (COM Draft page 7) and suggested reporting guidelines (COM Draft Liquid Submissions page 11). **(Refer to responses in CAR 13 of 18)** **Please see CAR 13 laboratory responses. (See CAR 13 of 18 responses.)**

EXHIBIT E

Integrated Forensic Laboratories™

CONTROLLED SUSTANCE TESTING CASELOAD REVIEW REPORT

A summary of the findings and recommendations from the technical and administrative review of El Paso Police Department controlled substance case files.

Integrated Forensic Laboratories™
ANSWERS NOW™

Contents

Introduction and Executive Summary 2
Background 2
Personnel 2
Findings 2
Technical 3
Administrative 5
Other 6
Disclaimer 6

Integrated Forensic Laboratories™
ANSWERS NOW™

Introduction and Executive Summary

Integrated Forensic Laboratories, Inc. (IFL) reviewed 122 cases produced by the El Paso Police Department Crime Laboratory (EPPD) for Administrative and Quality errors. While errors where found, no case was found to have either a Type 1 (false identification) or 2 (failure to identify) error on a controlled substance.

IFL reviewed 122 EPPD case files and found no Type I or II errors.

Background

In mid-July, EPPD transferred complete case scans of 122 cases involving instrumentation analysis (GC/MS and/or FTIR). Between mid-July and August 15th, IFL personnel reviewed these cases for possible technical and administrative errors. IFL consulted with EPPD Laboratory staff on several occasions for clarification on selected issues.

Personnel

IFL used two personnel to review the EPPD casework; Ron Fazio and Aliece Watts.

Ronald Fazio, B.S., M.B.A., F-ABC is the Laboratory Directory (LD) for IFL. He has over 20 years' experience in laboratory science; 15 in criminal forensic science alone. He is experienced and court-qualified in controlled substance identification, blood alcohol content (BAC) testing and quantification, firearm/tool mark examination, impression evidence, and crime scene analysis. Mr. Fazio has worked with, or overseen the work on the following instrumentation; SEM, FTIR, GC/MS, GC/FID, GC/FID/FID, GC/ECD, FAA, ICP, Cold Vapor Mercury, LC, HPLC, and others. Besides his experience in forensic testing, Mr. Fazio is an Adjunct Assistant Professor at the University of North Texas – Health Science Center.

Aliece Watts, B.S., M.S., MT(ASCP), PBT(ASCP), F-ABC is Quality Director (QD) for IFL. With over 30 years of laboratory experience and three board certifications (Forensic Biology, Medical Technology and Phlebotomy), Ms. Watts has an extensive background in Forensic DNA and Quality Assurance. She is an experienced ASCLD/LAB International (ISO 17025) assessor and a former member of the Texas Forensic Science Commission, a Governor appointed and Senate approved position. Besides extensive experience of working in crime labs, Ms. Watts is also an experienced college instructor, having taught numerous courses in forensic science.

Findings

IFL examined all 122 cases for technical and administrative type errors. The cases files reviews were based on generally accepted scientific principles and EPPD's SOPs.

Technical

IFL found no Type 1 errors (false identification). No case file was found to have a false identification of a controlled substance. IFL found no Type 2 errors (failure to identify). No case file was found to have a missed identification of a controlled substance.

IFL found several technical errors that are not classified as either Type 1 or 2. A few selected cases are discussed below;

- Case file BY-364 - Morphine was identified, but not reported. Since morphine was correctly identified in the case report, this is not considered to warrant a Type 2 error status. Other controlled substances of the same penalty class were identified; therefore this potential error has not negatlvely affected the use of the report. However, the presence of morphine should have been clearly indicated on the report.
    - Root Failure Finding – Overly complicated case notes and instrumental printouts create information overload, likely causing difficulty in reporting and case review. Recommendation to simplify work notes.
- Case file BY-262 – Case report indicated THC, yet case notes indicated marihuana. Case report indicated possible LSD not tested due to presence of other exhibit (penalty class), but notes indicated insufficient amount to test.
    - Root Failure Finding – Overly complicated case notes and poor Technical Review. Recommendation to simplify work notes and remedial Technical Review training. Lack of clear lab policy on determining what constitutes an 'insufficient sample' for LSD. 'Clear lab policy' is not simply SOPs, but a combination of SOPs and in-house training. Recommendation for further training in penalty group classification.
- Case file BY-560 – Instrument method indicated on case notes different from actual method used.
    - Root Failure Finding – Likely misprint of analyst. Poor Technical Review. Overly complicated case notes. Recommendation to simplify work notes and remedial Technical Review training.
- Case File BY-072 – Case notes indicated three bags of nine were sampled for instrumental confirmation, yet instrumental data indicated only one bag. Case notes indicated 1.32 grams was tested and identified, yet report indicated 3.64 grams identified.
    - Root Failure Finding – Poor Technical Review, improper reporting language. Recommendation to change reporting requirements.
- Case File BY-768 – Case submission indicated 0.2 gram of material submitted, yet exhibit was 2.59 grams. This should have been caught and corrected on submission form.
    - Root Failure Finding – Poor Technical Review.
- Numerous case files – General practice of identifying ("unconfirmed") peaks with ion spectrum(a) in case notes. This problem can be divided into two different, but similar, situations;

- Situation 1 – The Analyst identifies, or attempts to identify, a peak that is indistinguishable from the baseline.
- Situation 2 – The Analyst identifies, or attempts to identify, a non-controlled substance (NCS) peak with a poor ion spectrum.
    - In the first situation, the peak is too small to infer any reliable scientific information. In the second, the spectrum does not present a sufficient quality match to a known spectrum. Regardless, the identification of any NCS ("unconfirmed" or not) be avoided (unless specifically required, i.e. clandestine laboratory case).
        - Root Failure Finding – Lack of clear lab policy. Specifically, EPPD must establish lab policy as to what constitutes a 'significant peak' and what criteria are required for an identification (i.e. SWGDRUG). 'Clear lab policy' is not simply SOPs, but a combination of SOPs and in-house training. Additional training is warranted.

- Numerous case files - Lack of a consistent approach to subsampling. Unless faced with an extreme case that requires hypergeometric (ENFSI) subsampling, EPPD analysts should adhere to penalty group subsampling. The specifics and policy of subsampling should be clearly established among all analysts.
    - Root Failure Finding – Lack of clear lab policy. 'Clear lab policy' is not simply SOPs, but a combination of SOPs and in-house training. Specifically, additional training in subsampling protocol is warranted.
- Numerous case files - Lack of clear reporting language that indicates when subsampling has been conducted. All forensic reports should include clear language when subsampling has been occurred and what portion of the exhibit(s) have been tested.
    - Root Failure Finding – Lack of clear lab policy. 'Clear lab policy' is not simply SOPs, but a combination of SOPs and in-house training. Specifically, including clear language on all reports that involve subsampling.
- Numerous case files - Lack of item description in report. All forensic reports should include descriptions of the evidence. Law enforcement packaging (i.e. "heat-sealed plastic bag") does not need to be included on report, but evidence-related packaging (i.e. "knotted plastic bag") should be included. Actual evidence must also be reported (i.e. "white crystalline material"). This is especially important when not conducting 100% sampling.
    - Root Failure Finding – Lack of clear lab policy. 'Clear lab policy' is not simply SOPs, but a combination of SOPs and in-house training. Specifically, including clear language of exhibit description on all reports.
- Numerous case files – Case Review work sheet initialed that 3 characteristic ion peaks were indicated for the standard and sample, yet this was rarely performed. 'Indicating' three peaks in an ion spectrum is unnecessary as it does not add to the reliability of an identification.

- Root Failure Finding – Poor Technical Review. Although this is not required *per se* in lab SOPs, it is consistently indicated as completed on the case Technical Review forms. Specifically, this requirement should be removed from the Technical Review Form as it does not add to the quality of the analysis or the review.

Review summaries and comments are detailed for all 122 cases on the "EPPD Review Data" Excel file submitted to EPPD on August 16, 2011.

None of the above findings, or those included in the Excel file, constitutes a Type 1 or 2 error in any of the reviewed reports. In general, the two most significant and pervasive errors were; 1) the lack of a consistent policy and reporting of subsampling, and 2) the incorrect "unconfirmed" de facto identification of non-controlled substances in exhibits.

Administrative

In general, the case files were found to be overly complicated and difficult to review.

- Numerous case files – Cursive handwriting is nearly illegible.
  - Recommendation – Cursive handwriting should be avoided. Print is recommended.
- Numerous case files – Item/Exhibit description is confusing.
  - Recommendation – Item/Exhibit descriptions should be simplified and standardized. The use of acronyms (i.e. "pm" for "plant material") is recommended. Acronyms, if used, should be standardized among all lab staff.
- Numerous case files – The handwritten inclusion of instrumentation information (i.e. retention times and methods) is redundant and unnecessary. Adding to worksheet only increases difficultly in reviewing case and can cause errors.
  - Recommendation – Any information included on instrumentation print out(s) is usually sufficient documentation. Lab policy should be reviewed to determine what information should be transferred to worksheet.
- Numerous case files – The case worksheet does not make clear what has been tested; presumptive or confirmative.
  - Recommendation – Change worksheet to <u>clearly</u> indicate what exhibit and/or sub-exhibit has been tested. 'Clearly' means that any competent forensic chemist should be able to interpret the work within a few minutes of review.
- Numerous case files – Exterior packaging described with check boxes on worksheet. The use of check boxes is not recommended as it limits description without simplifying work process.
  - Recommendation – Exterior packaging description should be simplified and standardized. The use of acronyms (i.e. "pb" for "plastic bag") is recommended. Acronyms, if used, should be standardized among lab staff. Exterior packaging description should still be separated from actual evidence description.

- Numerous case files – No clear indication that included Affidavits were Administratively Reviewed. Packaging described in at least one Affidavit was different than indicated in case file.
    - Recommendation – Since Affidavits are generated for every case and are a part of the permanent case file, they should be administratively reviewed along with case file. This review should be documented.

Other

Please refer to the Excel file for a full list of all reviewed cases and individual comments.

Disclaimer

The observations and recommendations included in this report do not constitute an audit of EPPD laboratory operations, but rather an independent audit of case files and published laboratory reports. IFL reserves the right to change any of the opinions and recommendations included in this report.

X

Digitally signed by Ronald T. Fazio
Date: 2011.08.16 09:23:39 -05'00'

Ronald T. Fazio, B.S., M.B.A., F-ABC
Laboratory Director

EXHIBIT F

AMERICAN SOCIETY OF CRIME LABORATORY DIRECTORS
LABORATORY ACCREDITATION BOARD

September 2, 2011

Sergeant David Hernandez
El Paso Police Department
Crime Laboratory
911 N. Raynor Street
El Paso, Texas 79903

Dear Sgt. Hernandez:

On August 31, 2011, the ASCLD/LAB Board of Directors reviewed the documentation which you provided in response to the probation imposed upon the El Paso Police Department Crime Laboratory. The Board was pleased that all of the conditions of the probation had been met by your laboratory.

The report which you provided from Integrated Forensics Laboratory (IFL), concerning the review of prior casework, confirmed some of the concerns identified by the ASCLD/LAB assessment team. It is ASCLD/LAB's hope that the training provided through IFL served to address the cause of the concerns.

The Board extended the accreditation of the El Paso PD Crime Laboratory through December 31, 2011 and also extended the probation of the laboratory through the same period of time. However, the conditions of the probation were changed effective immediately.

The El Paso PD Crime Laboratory may resume analysis of all controlled substances cases, however all cases, involving instrumental analysis, which are analyzed through the end of November 2011 must be subjected to 100% external technical review. The technical reviews must be conducted by an analyst(s) currently working in an ASCLD/LAB accredited laboratory who is a currently active controlled substances analyst who is being proficiency tested annually in the controlled substances discipline.

The technical reviewer(s) must agree to provide a summary report of the technical reviews, identifying all issues and concerns identified during the technical review process and summarize all corrective actions required as a result of the technical reviews. The report must cover the reviews of cases analyzed during the three month period from September 1 through November 30. The report must be provided to ASCLD/LAB by December 5, 2011.

If you have any questions or concerns, please feel free to contact us.

Sincerely,

Ralph M. Keaton

Ralph M. Keaton
Executive Director

cc: ASCLD/LAB Board of Directors
ASCLD/LAB Office
Harry Fox, ASCLD/LAB Lead Assessor

Ralph Keaton, Executive Director • 139 J Technology Drive, Garner, NC 27529 • Phone (919) 773-2600 • FAX (919) 773-2602 • E-mail rkeaton@ascld-lab.org

EXHIBIT G

AMERICAN SOCIETY OF CRIME LABORATORY DIRECTORS
LABORATORY ACCREDITATION BOARD

October 19, 2011

Sergeant David Hernandez
El Paso Police Department
Crime Laboratory
911 N. Raynor Street
El Paso, Texas 79903

Dear Sgt. Hernandez:

On August 15, 2011, ASCLD/LAB received appeals from the El Paso Police Department Crime Laboratory, to five (5) Corrective Action Requests (CARs) which were issued during the May 24-26, 2011 assessment of the laboratory. On August 25, ASCLD/LAB Staff Inspector Melissa Smrz was assigned to investigate each of the appeals and to prepare an independent report to give guidance to the Board of Directors in considering the appeals.

On October 4, 2011, the Board reviewed the findings of the assessment team, the appeals and related documentation provided by your laboratory and the report prepared by Ms. Smrz. Based on the available information, the Board addressed each appeal and reached the following conclusions:

Appeal to CAR 4

The appeal to CAR 4 was denied, however the Board concluded that the finding of the assessment team should be expanded and clarified. The Board also concluded that ISO 17025 standards 5.2.1 and 5.2.5 should be separated into separate CARs and that an additional CAR should be added under ISO standard 5.4.1.

The Board concluded that in addition to the assessment team's finding for standard 5.2.1, additional wording should be added, to clarify the basis for the team's finding, as follows: "Analysts were unable to demonstrate in interviews that they had an understanding of the basis for making interpretations of the mass spectral data used to reach the reported conclusions."

It was concluded that ISO 17025 clause 5.2.5 should be separated from CAR 4 and that a new CAR be issued under 5.2.5 with a finding as follows: "The laboratory did not have records authorizing the three analysts' to conduct controlled substance analysis at the time of the onsite visit."

In addition, the Board concluded that an additional CAR should be issued under ISO 17025 clause 5.4.1 "The laboratory shall use appropriate methods and procedures for all tests and/or calibrations within its scope ." and "....The laboratory shall have instructions on the use and operation of all relevant equipment, and on the handling and preparation of items for testing and/or calibration, or both, where the absence of such instructions could jeopardize the results of tests and/or calibrations. ..." and that the finding should be
"The laboratory's controlled substance analysis manual does not include procedures or requirements for data acceptance and criteria for GC/MS analysis, and does not include appropriately referenced procedures from external sources."

Appeal to CAR 15

The Board sustained the laboratory's appeal to CAR 15 and requested that CAR 15 be removed from the full assessment report.

Ralph Keaton, Executive Director • 139 J Technology Drive, Garner, NC 27529 • Phone (919) 773-2600 • FAX (919) 773-2602 • E-mail rkeaton@ascld-lab.org

Appeal to CAR 16

The Board sustained the laboratory's appeal to CAR 16 and requested that CAR 16 be removed from the full assessment report.

The Board recommended that the assessment report include a recommendation that the procedure for the Varian GC/MS ion trap be revised to remove the ambiguity about determining the appropriate slope.

Appeal to CAR 17

The appeal to CAR 17 was denied. The Board recommended that the finding be reworded as follows: "A cause analysis conducted by the laboratory determined one root cause for an incorrect proficiency test result. Review of the same proficiency test file and an interview of the analyst revealed that flawed analytical deduction was another root cause. The analyst was unable to come to a reasonable analytical conclusion based a series of tests that included one presumptive (color) test and one confirmatory (gas chromatograph/mass spectrum) test yielding a positive result for Cocaine and 44 negative confirmatory (gas chromatograph/mass spectrum) tests from a re-sampling of the same item. Furthermore, documentation provided onsite of the corrective actions taken by laboratory management to address the failed proficiency did not include suspension from (and subsequent approval to resume) casework. Case file review by laboratory management did reveal one additional instance of "switched sample".

Appeal to CAR 18

The appeal to CAR 18 was denied. The Board recommended that the finding be reworded as follows: "During a proficiency test, an analyst failed to report the expected and consensus value (No Controlled Substance) after performing multiple and repeated tests (one presumptive and 45 confirmatory). 44 of 45 confirmatory tests yielded the correct result, yet the analyst reported the presence of a drug based on a single positive presumptive and confirmatory tests. During the review and corrective action process, the laboratory management did not consider the ability of the analyst to reach the appropriate conclusion after the numerous and repeated tests conducted. During an interview, the analyst could not demonstrate knowledge regarding how she reached the conclusion after several re-samplings and multiple retests resulted in a different result, other than to say she switched samples. "

A revised full assessment report will be provided to you, in the near future, reflecting the decisions of the Board concerning the appeals.

You should continue to work with Lead Assessor Harry Fox to provide appropriate documentation of conformance as your laboratory completes the assessment process. If you have any questions related to this matter, please feel free to contact me.

Sincerely,

Ralph M. Keaton

Ralph M. Keaton
Executive Director

cc: ASCLD/LAB Board of Directors
ASCLD/LAB Office
Harry Fox, ASCLD/LAB Lead Assessor

EXHIBIT H

Integrated Forensic Laboratories™
ANSWERS NOW ™
901 Clinic Dr. Ste. D110
Euless, Texas 76039
(817) 553-6565
(817) 553-6567 Fax

December 4, 2011

History

As part of its on-going accreditation requirements, the El Paso Police Department (EPPD) Crime Lab (CL) underwent an ASCLD/LAB ISO 17025 audit in May of 2011. The ASCLD/LAB Board subsequently placed the EPPD CL on probation, based primarily on the findings of the May audit.

In July of 2011, Integrated Forensic Laboratories, Inc. (IFL) was contracted by EPPD to perform case reviews, provide training, and provide independent controlled substance competency tests for its CL. On this contract, IFL reviewed 122 cases from three EPPD analysts and found no Type 1 or Type 2 errors. In addition, all three EPPD CL analysts successfully completed the assigned training and competency tests offered by IFL. Please refer to the previous IFL "Caseload Review Report" (issued August 2011) for more information concerning the initial case reviews.

Since August, 2011, IFL has continued to provide case reviews, conducted a ten-day, on-site visit, and continued to provide on-going consultation to EPPD CL.

Site Visit

From November 8th through the 17th, IFL placed its laboratory director, Ron Fazio, at EPPD CL facilities. The purpose of this on-site visit was to:

- Technically review forensic casework,
- Encourage and facilitate case throughput,
- Evaluate the long-term viability of the EPPD lab, and
- Assist with the corrective actions, including SOP revision.

IFL employee Ron Fazio conducted no casework while at EPPD.

While at EPPD, IFL reviewed 79 cases, assisted with the revision of several SOPs, and made several recommendations, including the permanent removal of the Varian ion trap GC/MS from instrumentation.

Case Reviews

On or about November 12th, 2011, EPPD removed one of the original three analysts from the CL. Subsequently, IFL has only reviewed the casework from the remaining two

EPPD analysts. Of the 79 EPPD CL cases reviewed by IFL during the on-site visit, only 4 were completed by the removed analyst.

As of November 30, 2011, IFL has reviewed an additional 11 EPPD CL cases completed outside of the on-site visit.

BZ067	BZ115	BZ049	BZ047	BZ155
BZ013	BZ131	BZ167	BZ040	BZ117
BZ330	BZ086	BZ168	BZ100	BZ053
BY070	BZ180	BZ076	BZ044	BZ083
BZ029	BZ086	BZ106	BZ096	BZ055
BZ035	BZ069	BZ091	BY998	BZ059
BY638	BZ101	BZ090	BZ021	BZ054
BY628	BZ063	BZ111	BZ132	BZ060
BZ024	BZ125	BZ081	BZ058	BZ138
BZ128	BZ092	BZ074	BZ037	BZ182
BZ142	BZ103	BZ160	BZ041	BZ036
BZ089	BZ107	BZ031	BZ045	BZ077
BZ048	BZ165	BZ170	BZ052	BZ161
BZ027	BZ121	BY152	BZ051	BZ079
BZ129	BZ080	BZ150	BZ124	BZ154
BZ122	BZ119	BZ025	BZ127	

With the exception of minor administrative errors (not uncommon or cause for concern) that were immediately corrected, all but one case were approved for issuance.

The single case (BZ-021) not approved was due to poor case documentation and the misidentification of a non-controlled substance. Since the original case analyst is no longer conducting forensic casework for the EPPD CL, IFL recommended this case be re-analyzed by a current analyst.

In general, IFL found the work conducted by the remaining two EPPD CL analysts to be sound and free from technical errors.

IFL is continuing to review casework for the EPPD CL and can submit additional future reports, upon request.

Recommendations

Below are a summary of the recommendations of IFL. All of the recommendations were made verbally during the on-site visit.

- IFL recommends that EPPD source and hire a technically competent laboratory manager. The position must have the authority to enact supervisory actions required for corrective actions. IFL believes that this is absolutely necessary to ensure the future viability of the EPPD CL. The laboratory manager must be experienced and capable in criminal forensic science and in particular, controlled substance testing.

- IFL recommends that the Varian Ion Trap GC/MS be permanently removed from service. The differences between the ion trap (Varian) and quadrupole (Thermo DSQII) technologies create significant operational difficulties. Furthermore, while ion trap mass spectrometry offers technological advantages over quadrupole; the advantages are nearly pointless in normal controlled substance testing. IT should be noted that the Varian has been removed from service since June of this year. Permanent removal will require its removal from the EPPD CL. The Varian's potential trade-in value for other goods and services should be considered.

- IFL recommends that EPPD consider adding redundancy in its existing GC/MS system. 'Redundancy' refers to adding a completely identical GC/MS system. Unfortunately, EPPD's existing system is a Thermo DSQII, a very expensive GC/MS. Nonetheless, EPPD should consider redundancy, whether through an additional DSQII or a different system. Redundancy will assist with maintaining caseload throughput. IFL found the included Thermo DSQII software to be less than optimal.

- IFL recommends that EPPD analysts expand their exposure to the criminal forensic testing community. This can be achieved through:
    - Private consulting,
    - Participation in forensic organizations,
    - Touring and internships in other labs,
    - Continuing education in other, but related disciplines in criminal forensics,
    - Publication and presentations, and
    - Certification.

- IFL does not recommend outsourcing the lab functions to another agency. Furthermore, at this point, IFL does not recommend a cost-benefit study to evaluate the possibility. Unless an outsourcing lab can offer full controlled substance testing (including marihuana testing) for less than the current operational costs, there is no reason to consider the possibility. If, however, EPPD is to consider an outsourcing lab, it must also consider the outsourcing lab's turn-around time, customer service, and testimony offerings. In addition, EPPD must also consider the logistics of evidence transport.

- IFL recommends that the EPPD crime lab take measures to monitor and increase the perceived customer satisfaction of the lab's services. It should be noted that the primary customer of the EPPD crime lab are the EPPD investigators.

- IFL recommends that EPPD continue to monitor, evaluate, and improve case throughput. Improving case throughput is not simply establishing arbitrary caseload goals, but rather a systematic approach of identifying and alleviating throughput bottlenecks. This is a long-term project and should not be undertaken lightly. Outside consultants are highly recommended.

- IFL recommends that EPPD CL re-test any forensic case (that will require testimony) that was worked by anyone no longer employed by the EPPD CL as a forensic analyst. IFL feels this is absolutely necessary to ensure the quality of the testimony provided.

Conclusions

It is this examiner's opinion that the casework conducted by the two EPPD CL analysts, Arturo Herrera and Nahum Najera, is sound. However, their casework should continue to be administratively and technically reviewed by an outside analyst until a competent lab manager is employed.

It is this examiner's opinion that ASCLD/LAB should fully evaluate the qualifications of the future lab manager, including their assigned authority, when the position is filled. The continued success of the EPPD CL will depend on the abilities and authority of this new hire.

It is this examiner's opinion that the EPPD CL should continue to provide controlled substance testing.

_____

Ronald T. Fazio, B.S., M.B.A., F-ABC
President and Laboratory Director
Integrated Forensic Laboratories, Inc.

EXHIBIT I

AMERICAN SOCIETY OF CRIME LABORATORY DIRECTORS
LABORATORY ACCREDITATION BOARD

December 23, 2011

Sergeant David Hernandez
El Paso Police Department
Crime Laboratory
911 N. Raynor St.
El Paso, Texas 79903

Dear Sgt. Hernandez:

On December 16, the ASCLD/LAB Board of Directors reviewed the report prepared by Integrated Forensics concerning the three month technical review of case records generated by personnel of your laboratory. The Board concluded that your laboratory has satisfactorily complied with all conditions of the probation imposed on the El Paso Police Department Crime Laboratory. Effective December 16, 2011, the sanction of probation was lifted from the El Paso Police Department Crime Laboratory. The laboratory remains in good standing with ASCLD/LAB.

In addition to removal of probation, the Board extended the Legacy accreditation of the El Paso Police Department Crime Laboratory until April 6, 2012. This extension was granted with the expectation that your laboratory will continue to work toward full conformance with the requirements of the ASCLD/LAB-*International* Accreditation Program within the period of the extension.

Your full cooperation during this period of probation has been recognized and greatly appreciated. Should you have any questions concerning the extension, please feel free to contact us.

Sincerely,

Ralph M. Keaton

Ralph M. Keaton
Executive Director

cc: ASCLD/LAB Board and Office
Harry Fox, ASCLD/LAB Lead Assessor

Ralph Keaton, Executive Director • 139 J Technology Drive, Garner, NC 27529 • Phone (919) 773-2600 • FAX (919) 773-2602 • E-mail rkeaton@ascld-lab.org

EXHIBIT J

AMERICAN SOCIETY OF CRIME LABORATORY DIRECTORS

LABORATORY ACCREDITATION BOARD

March 26, 2011

Ronald Fazio
El Paso Police Department
Crime Laboratory
911 N. Raynor Street
El Paso, Texas 79903

Dear Mr. Fazio:

On March 20, 2012, the ASCLD/LAB Board of Directors considered the application for ASCLD/LAB-*International* accreditation from the El Paso Police Department Crime Laboratory. Based upon the documentation provided in the final assessment report and in accordance with the recommendation of Lead Assessor Harry Fox, the Board is satisfied that the laboratory meets or exceeds the requirements for accreditation as set forth in ISO/IEC 17025:2005 and the applicable ASCLD/LAB-*International* Supplemental Requirements. As you know, the assessment and accreditation process also considered conformance with your program's own documented management system.

It is my pleasure to advise you that the El Paso Police Department Crime Laboratory was accredited on March 20, 2012, in the Field of Forensic Science Testing. The specific scope of accreditation is declared on a *Scope of Accreditation* document provided as an attachment. The accreditation is for a period of five (5) years, ending on March 19, 2017. An original (full-size) accreditation certificate and original *Scope of Accreditation* document will be shipped to your attention via commercial delivery service.

Accreditation is granted only after a thorough evaluation of the laboratory's management system and technical procedures and practices. Accreditation is the result of an extensive commitment of resources and much preparation by the management and personnel of the entire program. I commend the efforts of all employees involved in this achievement.

Accredited laboratories are expected to maintain the high standards which were required to achieve accreditation. In addition to maintaining conformance with accreditation standards, please read and ensure the laboratory's ongoing compliance with the enclosed obligations of ASCLD/LAB accredited laboratories.

The El Paso Police Department Crime Laboratory will also be expected to participate in external proficiency testing and, where an approved test provider is available, agree for test results to be reviewed by the appropriate Proficiency Review Committee (PRC), as outlined in the *ASCLD/LAB Proficiency Review Program* document available on our website. The laboratory will be expected to conduct an annual internal audit and submit an Annual Report to ASCLD/LAB in accordance with program requirements.

Further, ASCLD/LAB will conduct annual, on-site surveillance visits about every twelve months or so during the first five year accreditation cycle. The cycle for surveillance visits begins on the date of accreditation, so the first annual surveillance visit will be scheduled following the submission of the first

Ralph Keaton, Executive Director • 139 J Technology Drive, Garner, NC 27529 • Phone (919) 773-2600 • FAX (919) 773-2602 • E-mail rkeaton@ascld-lab.org

annual report due on or about March 20, 2013. Surveillance visits and activities for the El Paso Police Department Crime Laboratory will be coordinated with you at the appropriate time.

The El Paso Police Department Crime Laboratory will be invoiced for an annual accreditation fee near the end of each calendar year. The fee is based on the number of proficiency tested personnel in the program. The invoice will be calculated in accordance with the budget approved at the annual ASCLD/LAB Delegate Assembly meeting, and it will include an additional amount to cover the cost of the annual surveillance visit.

As the director of an accredited laboratory you are a voting member of the ASCLD/LAB Delegate Assembly. You are invited and encouraged to participate in the accreditation process and to exercise your vote on issues which are presented to the Delegate Assembly, either by mail ballot or at the annual meeting. Should you desire to appoint an alternate delegate, please notify ASCLD/LAB in writing.

On behalf of the Board, I extend my sincere congratulations to you and to all personnel of your laboratory. If you have any questions or if we might assist you in any way please feel free to get in touch with us.

My best wishes to you and your staff.

Sincerely,

Pamela L. Bordner

Pamela L. Bordner
Chair, ASCLD/LAB Board

cc: Ralph Keaton, ASCLD/LAB Executive Director
John Neuner, ASCLD/LAB Accreditation Program Manager
Tracy Cheaney-Plummer, ASCLD/LAB Accreditation Program Manager
Harry Fox, ASCLD/LAB Lead Assessor

EXHIBIT K

TABLE OF CONTENTS
EPPDCL INVESTIGATION

VOLUME I

1. TFSC complaint form and supporting material filed by Innocence Project (National) on September 2, 2011

2. Lab Organizational Charts

3. EPPDCL Employee Chart – Dates of Employment

ASCLD-LAB Correspondence with EPPDCL:

4. December 9, 2011 email from Ralph Keaton to Sergeant Hernandez regarding accreditation extension request

5. December 5, 2011 letter from Lt. Valenzuela to Ralph Keaton regarding extension of Legacy accreditation.

6. November 9, 2011 letter from John K. Neuner to Sergeant Hernandez clarifying certain CARs

7. Clean version of revised ASCLD-LAB assessment report issued November 9, 2011

8. Redline version of revised ASCLD-LAB assessment report issued November 9, 2011

9. October 19, 2011 correspondence from Ralph Keaton to Sergeant Hernandez regarding lab's appeal

10. September 2, 2011 letter from Ralph Keaton to Sergeant Hernandez allowing extension of accreditation and probation with conditions

11. June 27, 2011 letter from Ralph Keaton to Sergeant Hernandez placing lab on probation

12. March 3, 2006 letter from Ralph Keaton to Sergeant Valenzuela regarding accreditation

VOLUME II

Controlled Substance Analysis Manual (Various Versions):

1. Version 5: Current Controlled Substance Analysis Manual dated 10-25-11

2. Version 4: Controlled Substance Analysis Manual dated 5-19-11

3. Version 3: Controlled Substance Analysis Manual dated 2-14-11

4. Version 2: Controlled Substance Analysis Manual marked "Archived 021611"

5. Version 1: Original Controlled Substance Manual (created in 2006 for Legacy accreditation)

6. E-mail explaining various amendments to Controlled Substance Analysis Manual

Other Lab Manuals and Training Programs:

7. Laboratory Operations Manual

8. Crime Laboratory Health and Safety Manual

9. Training Program for Controlled Substance Analysis

Management System Audits

10. Management System Audit 11-3-10

Proficiency Testing and CV's of Lab Director and analysts:

11. Reports of various proficiency tests from 2007 to present

12. Hernandez curriculum vitae

13. Herrera curriculum vitae

14. Najera curriculum vitae

15. Sifuentes curriculum vitae

Corrective Action Reports with Lead Assessor Comments:

13. Corrective Action Report containing comments from lead assessor after November 6, 2011

14. Corrective Action Report containing comments from lead assessor after September 1, 2011

15. Corrective Action Report containing comments from lead assessor between July 27, 2011 and September 1, 2011

Reports from Integrated Forensics (independent lab conducting technical review):

16. Site visit report December 4, 2011

17. Controlled substance testing caseload review report issued August 16, 2011

VOLUME III

<u>EPPDCL's Notice of Appeal to ASCLD-LAB with Exhibits:</u>

1. Notice of Appeal
2. Exhibit A
3. Exhibit B
4. Exhibit C
5. Exhibit D
6. Exhibit E: BY-159
7. Exhibit E: BY-177
8. Exhibit E: BY-261
9. Exhibit E: BY-317
10. Exhibit E: BY-479
11. Exhibit E: BY-518
12. Exhibit E: BY-538
13. Exhibit E: BY-661
14. Exhibit E: BY-852
15. Exhibit E: BY-367
16. Exhibit E: BY-077
17. Exhibit E: BY-066
18. Exhibit F
19. Exhibit G
20. Exhibit H
21. Exhibit I
22. Exhibit J
23. Exhibit K
24. Exhibit L
25. Exhibit M
26. Exhibit N
27. Exhibit O
28. Exhibit P
29. Exhibit Q
30. Exhibit R
31. Exhibit S
32. Exhibit T

VOLUME IV

Documents from EPPDCL site visit

1. 11.8.11 Lab Report
2. 11.11.11 Lab Report
3. 11.16.11 Lab Report
4. 12.5.11 Lab Report
5. EPPDCL Budget Information
6. IFL Invoices
7. EPPDCL Lab Director Job Posting
8. Monthly Activity Reports
9. Lab Case Log Books

EXHIBIT L

Texas Forensic Science Commission

Justice Through Science

January 18, 2012

Via E-mail

Assistant Chief Michelle Gardner
El Paso Police Department
2 Civic Center Plaza
El Paso, Texas 79901

RE: Texas Forensic Science Commission, Complaint #11-11

Dear Assistant Chief Gardner:

Thank you for attending the Texas Forensic Science Commission's ("FSC" or "Commission") meeting on Friday, January 13, 2012. This letter summarizes the FSC's recommendations to the El Paso Police Department's Crime Laboratory ("EPPDCL") as discussed during the meeting.

1) By February 7, 2012, the Texas Department of Public Safety ("DPS") will conduct an audit of the EPPDCL, including but not limited to: (a) technical and administrative review of every controlled substance case processed by EPPDCL since November 1, 2011; (b) interviews with each laboratory employee, ensuring that new policies and procedures have been implemented and are understood by the examiners; and (c) any other applicable audit standards that DPS would typically utilize when conducting an internal audit of a DPS system laboratory.

2) By April 6, 2012, DPS will re-test every controlled substance examination performed by analyst Sifuentes, giving priority to the 60 cases on the DPS list with the greatest possible impact.

Commission Office

Lynn M. Robitaille
Commission General Counsel

Leigh M. Tomlin
Commission Coordinator

Texas Forensic Science Commission
1700 North Congress Avenue, Suite 445
Austin, Texas 78701

Phone: 1 (888) 296-4232
Direct: (512) 936-0770
Fax: 1 (888) 305-2432

3) Within seven days, the City of El Paso will retain a qualified full-time interim laboratory director for EPPDCL until a permanent qualified laboratory director is hired. The hiring of a permanent qualified laboratory director shall be accomplished by April 6, 2012 (the expiration date for EPPDCL's ASCLD-LAB Legacy accreditation).

4) The interim laboratory director will conduct technical and administrative review of all casework performed during his or her tenure.

5) The EPPDCL shall provide periodic progress reports to the Commission regarding the hiring of the permanent qualified laboratory director.

It is the Commission's understanding that these recommendations are acceptable to the EPPDCL and the City of El Paso. If this understanding is incorrect or if circumstances change for any reason, please contact me as soon as possible.

At its next meeting in April, the Commission will engage in further deliberations regarding the complaint in this matter pursuant to its enabling statute (TEX. CODE CRIM. PROC. §38.01). Commissioners may make additional recommendations at that time. If you have any questions, please feel free to contact our office.

Sincerely,

Lynn M. Robitaille

cc: John Batoon, City of El Paso
Jaime Esparza, El Paso District Attorney
Ron Fazio, Integrated Forensics
Pat Johnson, Department of Public Safety
Ralph Keaton, ASCLD-LAB
Stephen Saloom, Innocence Project (Complainant)
Sushma Smith, Office of Senator Jose Rodríguez
FSC Members

EXHIBIT M

Texas Department of Public Safety – Crime Lab Service
Quality Assurance Section

2012 External Audit Report

EL PASO POLICE DEPARTMENT CRIME LABORATORY

General Information

This is the External Audit Report of the El Paso Police Department, Crime Laboratory (EPPDCL). The on-site audit was conducted on 1/30/2012 to 2/2/2012.

The audit team consisted of the following members:

Lead Auditor: Forrest W. Davis, Quality Assurance Coordinator

Auditors: Diana Salas, System Quality Assurance Specialist
Melissa Brooke Harrison, Forensic Scientist
Richard Drew Fout, Forensic Scientist

Report prepared by Quality Assurance Coordinator Forrest W. Davis with concurrence of audit team. Where appropriate, laboratory responses are indicated within the body of the report.

Objectives of the Audit

To conduct a professional assessment of the management and technical operations of the laboratory in accordance with the accreditation requirements specified below, and to report the findings of the assessment in a fair and impartial manner to the laboratory, DPS Director, and Forensic Science Commission.

- Technical and Administrative review of every controlled substance case processed by EPPDCL since November 1, 2011;
- Interviews with each laboratory employee, ensuring that new policies and procedures have been implemented and are understood by the examiners;

While observations and/or potential findings about any of the general accreditation requirements listed above and/or El Paso PD Crime Lab management system requirement not listed may be made during the audit,

The audit was conducted to assess the management and technical operations of the laboratory in accordance with laboratory policy and accreditation requirements in the standards ISO/IEC 17025:2005 and 2006 ASCLD/LAB-International Supplemental Requirements. The audit report is representative of the findings and laboratory responses, which serve as a basis for quality improvements and/or corrective actions.

Emphasis for the audit was concentrated in the following areas: Case Documentation (including peer case review), Quality Assurance/Quality Control, Evidence Handling, and with emphasis on the following clauses/policies:

El Paso Laboratory Management System Documentation	2008 ASCLD/LAB Legacy (continued)
2008 ASCLD/LAB Legacy	2.2.2
1.3.3.1	2.2.3
1.3.3.4	2.2.4
1.4.2.1	
1.4.2.2	ISO 17025:2005
1.4.2.3	4.2.1
1.4.2.5	4.13.2.1
1.4.2.7	2011 ASCLD/LAB-International Supplement
1.4.2.8	4.1.5.h.1
1.4.2.16	4.13.2.5
1.4.2.22	4.13.2.5.2
1.4.2.23	5.9.4
1.4.2.25	5.9.4.2
1.4.3.5	5.9.5

Laboratory Overview

The El Paso Police Department Crime Laboratory conducts analyses in Controlled Substances for the El Paso metropolitan area. The laboratory is located at El Paso Police Department Headquarters, 911 Raynor, El Paso, Texas.

The laboratory is currently staffed with 5 employees.

Administration	3 employees (including 1 director, 1 evidence technician, and 1 administrative assistant)
Controlled Substances	2 examiners (including 1 who also performs the duty of Quality Manager and Technical Leader)

It was determined by the Forensic Science Commission, Texas DPS Deputy Assistant Director of Crime Laboratories, and El Paso Police Department that an external audit of the laboratory was necessary to review casework and assess the status of the laboratory since November 2011.

The laboratory had been in the process of remediating several findings from an ISO 17025 assessment conducted by ASCLD/LAB-*International*, May 24-26, 2011. The state of the laboratory was that some policies and procedures had been under revision for remediation and the Integrated Forensic Laboratory (IFL) from Euless, Texas had been conducting case reviews for the laboratory July 2011 to January 2012. On or about November 12, 2011 EPPDCL removed one analyst from casework with the remaining two analysts continuing to conduct casework. Mr. Ron Fazio (IFL) was appointed Interim Laboratory Director on or about January 21, 2012. He was also present for this audit.

Evidence Handling

As part of case review, interviews, and case documentation audit trail, it was determined that the practices and documentation of chain of custody was in an acceptable condition, except as follows:

Finding:

Management System: Controlled Substance Analysis Manual (Section 9.6)
9.6 Exceptions

A. If an exhibit appears to have been altered, or could be easily altered (i.e. capsules and liquid medications), it will be extracted and analyzed in accordance with Chapter 12, Unknown Substances. If, however, the exhibit is in unbroken tamper-resistant packaging, it may be extracted and analyzed as described above.

- For one Case (BZ-076), a pharmaceutical liquid in an unsealed bottle was analyzed as if it were in a sealed bottle. The exhibit was not analyzed as if it were an unknown substance as required by Controlled Substance Analysis Manual (Section 9.6).

Laboratory Response/Action Plan

- It was identified by the laboratory that the investigator had opened the bottle. If the laboratory is not able to confirm this issue with administrative documentation, then they will issue an amended report.

Finding:

Management System: Controlled Substance Analysis Manual (Section 7.23) Residues and Trace Samples

C. The solvent is evaporated from the GC/MS vial containing the sample and the dry vial with residue is put in a zip-lock bag and returned with the rest of the case exhibit.

- For one Case (BZ-190), the extract from the trace sample which was consumed in analysis was not evaporated from the GC/MS vial and kept with the rest of the case exhibit as required by Controlled Substance Analysis Manual (Section 7.23 C).

Laboratory Response/Action Plan

- The analyst has inferred this from the available computer investigative database, but had not annotated the casefile.
- On February 2, 2012, the analyst was counseled concerning the requirements of EPPD CL SOPs and SWGDRUG guidelines.
- On February 6, 2012, EPPD CL received email confirmation that Detective Jose Lucero had opened the bottle for field presumptive testing. This email confirmation has been added to the casefile.

Casework Documentation

The casework documentation for all cases completed since November 1, 2011 was reviewed (total 134 cases). The following observations were identified.

Finding:

Management System: Laboratory Operations Manual XX Section 6 Case Documentation Practices Abbreviations

S. Where abbreviations or symbols specific to the laboratory are used in the examination, the meaning of the abbreviations or symbols shall be documented in the analyst case worksheet.

- Five abbreviations (MS, DL, XS, CXS, and GWT) were used in casework documentation. According to the Laboratory Operations Manual (Section XX 6 S) the meaning of the abbreviations shall be documented in the case notes.

Laboratory Response/Action Plan

- The EPPD CL is revising the controlled substance worksheet. One of the revisions will include a list of accepted abbreviations in the footer of the worksheet.
- EPPD CL SOPs will be revised to include definitions of accepted abbreviations. Expected completion is February 15, 2012.

Finding:

Management System: Controlled Substance Analysis Manual (Section 11) Cautionary Guidelines (Revised 10/11/2011)

11.11 The analyst will compare the exhibit analyte ion spectrum to the corresponding reference standard and/or library. The analyst does not need to document this step, but must document any issue that negatively affects the comparison of spectra. The analyst will consider the totality of the spectra, including but not limited to;
A. Overall characteristic pattern of the ion spectra and the correspondence of the major ions.
3rd party literature may be referenced (i.e. Clarks)
B. Missing ions and the possible causes of such
C. Additional ions and the possible causes of such
D. Molecular weight ion search

11.12 Poor ion spectra will be addressed and documented. These can include;
A. Overabundance of analyte
B. Excessive split
C. Excessive column/septum bleed
D. Low signal-to-noise ratio
E. Contamination
F. Sampling/extraction technique
G. Other

- It was observed in case review that the preliminary testing and GCMS spectrum (molecular weight ion, major ions, and the overall fragmentation pattern) indicated the reported test result. However, explanation of extraneous and/or missing ions quality of the exhibit GCMS spectrum in 31 cases was not documented as required in Controlled Substance Analysis Manual 11.12.

Laboratory Response/Action Plan

- During the audit, the laboratory began evaluating methods to improve the quality of the chromatography and mass spectral analysis. A 30:1 split method was validated to replace the 100:1 split method that had been routinely used by the laboratory. It was the opinion of the audit team that at least one exhibit from case (BY-733) should be reanalyzed by GCMS to improve the quality of the mass spectra and eliminate the "artifacts" that were observed.
- The laboratory is in the process of annotating the examination documentation of the relevant spectrum in the identified cases.
- As of February 8, 2012, all cases identified have been amended. Specifically, extraneous and/or missing ions have been addressed. All amended spectra will be reviewed and either approved or denied by lab manger by February 15, 2012.

Finding:

Management System: Controlled Substance Analysis Manual (Section 6) Fourier Transform Infrared Spectrometry (Ftir) Thermo Electron Nicolet 380 with ATR Adapter (Revised 10/11/2011)

6.39 The software will present a list of possible compounds with their spectra from the library. The spectrum of the library must match the exhibit. The quality of the match must be greater than 90 for confirmation. The number associated with the quality of the match is not a 'quantification' of the purity of the compound in the exhibit. If the quality of the spectral match is less than 90, the analyst must attempt a Neat analysis or proceed to GC/MS testing. The analyst will write "Poor Spectral Match" on the exhibit spectrum. (Revised 11/11/11)

- In 13 cases where the FTIR was used for confirmation, there was insufficient information in the case record to indicate the quality of the spectral library match. The Controlled Substance Analysis Manual Section 6.39 requires spectral match to be greater than 90. If the spectral match is less than 90, the analyst will write "poor spectral match" and must attempt a neat analysis or proceed to GC/MS testing.

Laboratory Response/Action Plan

- The laboratory re-analyzed FTIR spectra used for confirmation. The laboratory will be revising the procedures to remove the 90% criteria.
- On February 2, 2012, EPPD CL analysts received 4 hours of remedial training on FTIR spectral interpretation.
- As of February 8, 2012, all samples identified as having poor FTIR spectra have been re-analyzed via GC/MS. None produced different identifications.

Finding:

Management System Laboratory Operations Manual (Section XX 7) Evidence Handling and Documentation, Reporting Guidelines

C. The name and address of the customer; identification of the method used (sampling plan); a description of, the condition of, and unambiguous identification of the item(s) tested (comments in footnote or in controlled substance worksheet); the date of receipt of the test where this is critical to the validity and application of the results, and the date(s) of performance of the test or; reference to the sampling plan or procedures used by the laboratory or other bodies where these are relevant to the validity or application of the results (standards and samples are run within a 24-hour clock and recorded in the instrument retention time log (Binders C and F found in the laboratory) and the 2011 Analysis Primary Standard Binder (G); the type of test, where appropriate, the units of measurement; the name(s), function(s) and signature(s) or equivalent identification of person(s) authorizing the test report (technical review signatures); and where relevant, a statement to the effect that the results relate only to the items tested or calibrated. (Revised 04/25/2011).

Management System Controlled Substance Analysis Manual (Section 2.39) Reporting Guidelines

2.39 The laboratory report shall include the name and address of the customer; identification of the method used (sampling plan); a description of, the condition of, and unambiguous identification of the item(s) tested (comments in footnote or in controlled substance worksheet); the date of receipt of the test where this is critical to the validity and application of the results, and the date(s) of performance of the test or; reference to the sampling plan or procedures used by the laboratory or other bodies where these are relevant to the validity or application of the results (standards and samples are run within a 24-hour clock and recorded in the instrument retention time log (Binders C and F found in the laboratory) and the 2011 Analysis Primary Standard Binder (G); the type of test, where appropriate, the units of measurement; the name(s), function(s) and signature(s) or equivalent identification of person(s) authorizing the test report (technical review signatures); and where relevant, a statement to the effect that the results relate only to the items tested or calibrated.

- In 22 of 134 cases, the laboratory report did not include references to the sampling plan/method used as required in the Laboratory Operations Manual (Section XX 7 C) and Controlled Substance Analysis Manual (Section 2.39).

Laboratory Response/Action Plan

- The reporting procedures regarding sampling plan/method are being revised, such that 100% sampling is inferred based on net weight and tested weight.
- Expected completion by February 15, 2012.

Quality Assurance / Quality Control

The quality records were reviewed as it pertains to audit trail, review of case documentation, and interviews with analysts.

Instrument quality assurance and quality control was identified as being in an acceptable condition with regard to both laboratory policy and accreditation standards. It was recognized that the laboratory was in a transitional stage of development for many of their procedures as they were in the process of remediation.

The competence of the analysts was evaluated through review of training records, interviews, and review of proficiency testing records. It appears that analysts have good technical skills; however additional training and experience in the areas of instrument troubleshooting, critical evaluation of results, and awareness and exchange of practices/processes with other forensic laboratories as well as the forensic community would be beneficial to the laboratory and the quality of the work.

Comments/Recommendations

It is recommended that the practice of truncation of Net Weight be used instead of rounding-up the Net Weight.

The auditors did note that the make/model of the GCMS currently being used by the laboratory was not commonly used in the field of forensic drug analysis and that it does not facilitate inter-laboratory comparisons, collections/libraries, and results from other forensic laboratories.

It was the opinion of the audit team that when the FTIR was used for identification/confirmation of the substance the quality of the spectral match in the signature region of the specta should have a nearly 100% correspondence with a known standard. For some cases that were reviewed, the audit team recognized that an FTIR of a mixture indicated by masked or additional peaks in the signature region can also support conclusions, but should not be used for identification.

- On February 2, 2012, EPPD CL analysts received 4 hours of remedial training on FTIR spectral interpretation.
- As of February 8, 2012, all samples identified as having poor FTIR spectra have been re-analyzed via GC/MS. None produced different identifications.

Generally, the scientific procedures were acceptable, however there were some procedures that lead to inconsistency within the laboratory based on observations in case review, such as inconsistencies in sub division of evidence, abbreviations, reporting, determinations for THC/Marihuana, FTIR evaluation criteria, inconsistencies in documentation of ions in mass spectra, and recorded conclusions. It is recommended that the procedures be reviewed to simplify and streamline to improve their effectiveness.

For two cases BZ-036 and BZ-249, the laboratory reported a pharmaceutical substance as hydrocodone, also additional notes were included. It is the opinion of the audit team that since Hydrocodone is listed in two penalty groups (PG1 and PG3) it could be misinterpreted by the customer if it is not properly qualified. In the Texas Health and Safety Code, dihydrocodeinone and hydrocodone are listed as synonyms in PG3 with one or more active, nonnarcotic ingredients in recognized therapeutic amounts. It is recommended that dihydrocodeinone be reported because it is found only in one penalty group.

- As of February 8, 2012, district attorneys have been contacted in a personal meeting and via email explaining PG classification. Furthermore, crime lab personnel have been counseled on language concerning hydrocodone / dihydrocodeinone .

Summary

The standards evaluated for the period of time of this audit were determined to be in compliance, with the exception of the findings noted in this report.

The El Paso Police Department Crime Laboratory is producing a work product, where no significant issues were observed which produced incorrect test results.

It is evident that all personnel are able to work together to achieve the goals of the EPPDCL.

The laboratory responses and/or corrective actions indicated will be reviewed by the audit team and a follow-up report issued upon completion.

Report Authorization

This Audit Report of the El Paso Police Department is issued by the Quality Assurance Coordinator Forrest Davis. Mr. Davis has reviewed the contents of this report and affirms that the report represents a true and accurate accounting of the findings of the Texas DPS assessment team.

Forrest W. Davis	Quality Assurance Coordinator	2/9/2012
Name	Title	Date

Texas Department of Public Safety – Crime Lab Service
Quality Assurance Section

2012 Supplemental – External Audit Report

EL PASO POLICE DEPARTMENT CRIME LABORATORY

General Information

This is a Supplemental report of the External Audit Report of the El Paso Police Department Crime Laboratory (EPPDCL) issued February 9, 2012, which provides clarification to a statement made by the auditors.

In the "Comments/Recommendations" Section:

Revised statement

The auditors did note that the make/model***/method*** of the GCMS currently being used by the laboratory was ***different*** from those used ***by most other*** forensic ***laboratories in Texas. The auditors believed that this difference may have contributed to the laboratory's inability to share or use GCMS data in*** inter-laboratory comparisons, collections/libraries, and results from other forensic laboratories.

Original statement

The auditors did note that the make/model of the GCMS currently being used by the laboratory was not commonly used in the field of forensic drug analysis and that it does not facilitate inter-laboratory comparisons, collections/libraries, and results from other forensic laboratories.

Report Authorization

This Report of the El Paso Police Department is issued by the Quality Assurance Coordinator Forrest Davis. Mr. Davis has reviewed the contents of this report and affirms that the report represents a true and accurate accounting of the findings of the Texas DPS assessment team.

Forrest W. Davis	Quality Assurance Coordinator	3/11/2014
Name	Title	Date

TEXAS DEPARTMENT OF PUBLIC SAFETY

5805 N LAMAR BLVD • BOX 4087 • AUSTIN, TEXAS 78773-0001
512/424-2000
www.dps.texas.gov

STEVEN C. McCRAW
DIRECTOR
DAVID G. BAKER
CHERYL MacBRIDE
DEPUTY DIRECTORS

COMMISSION
A. CYNTHIA LEON, CHAIR
CARIN MARCY BARTH
ADA BROWN
ALLAN B. POLUNSKY
JOHN STEEN

April 9, 2012

Lynn Robitaille
Texas Forensic Science Commission
1700 N. Congress Ave, Ste 445
Austin, TX 78701

Dear Lynn:

At the request of the Texas Forensic Science Commission during their January 13, 2012 meeting, the DPS Crime Laboratory Service agreed both to conduct an audit of the El Paso Police Department Crime Laboratory, and to analyze evidence in cases previously analyzed in their lab by analyst Sifuentes. Those two projects were completed and the results reported to your office.

Because the Department of Public Safety accredits this laboratory, I have reviewed these audits and evidence retesting findings and wish to provide my assessment.

At the Commission's request, the laboratory audit was of work conducted in the lab after procedure changes were implemented on/around September 2011. Note that analyst Sifuentes was no longer working in the lab at this time. Based upon the audit by DPS Lab Quality Assurance Coordinator Forrest Davis, along with three Chemists from DPS, it is our opinion that the analyses of drug evidence performed in the lab is appropriate and meets accreditation standards. Follow-up testing records provided to Forrest last week further indicate that the testing performed is within accreditation standards.

Regarding the analysis of evidence previously tested by the El Paso PD Lab analyst Sifuentes, the DPS El Paso Regional Lab staff analyzed evidence in sixty drug cases and the DPS Midland Regional Laboratory staff analyzed evidence in forty drug cases. Spread sheets from each of these DPS laboratories reflecting the side by side results of the DPS testing and the El Paso PD Lab testing on all 100 cases is attached. Note first that the DPS now assumes responsibility for the test results it has reported on these 100 cases and DPS Forensic Scientists will be available to provide court testimony to their findings as needed. The evidence will be returned to the El Paso PD as is our standard practice.

I have spoken to Manager Bob Wheeler of the DPS Midland Lab and Manager Ann Falknor of the DPS El Paso Lab and it is their opinions that the results of the analysis of evidence by Ms. Sifuentes appear to be consistent with the results obtained by the DPS Forensic Scientists. The problem was

the manner in which evidence was removed from the original containers and reorganized, making it difficult to re-analyze the evidence and link the results of the DPS tests for each item to the results obtained by Ms. Sifuentes. Based upon the findings of Forrest Davis in the lab audit, this problem of "reorganizing" the items of evidence within a case no longer exists in the El Paso PD Crime Lab.

Based upon this evaluation, the DPS will concur with the accreditation of the El Paso Police Department Crime Lab authorized by ASCLD/LAB, and will extend DPS accreditation for the duration which ASCLD/LAB offers. The duration of DPS accreditation will be subject to any later decision made by DPS to conduct further audits.

Sincerely,

D. Pat Johnson
Deputy Assistant Director
Crime Lab

2012 Supplemental Review - External Audit Report-

EL PASO POLICE DEPARTMENT CRIME LABORATORY

General Information

This is the Supplemental Review of the External Audit Report of the El Paso Police Department, Crime Laboratory (EPPDCL), which includes follow-up review of corrective actions and casework since the audit that was conducted on 1/30/2012 to 2/2/2012. The original audit report issued February 9, 2012.

Follow-up Review

Audit Finding:

Management System: Laboratory Operations Manual XX Section 6 Case Documentation Practices Abbreviations

S. Where abbreviations or symbols specific to the laboratory are used in the examination, the meaning of the abbreviations or symbols shall be documented in the analyst case worksheet.

- Five abbreviations (MS, DL, XS, CXS, and GWT) were used in casework documentation. According to the Laboratory Operations Manual (Section XX 6 S) the meaning of the abbreviations shall be documented in the case notes.

Laboratory Response/Action Plan

- The EPPD CL is revising the controlled substance worksheet. One of the revisions will include a list of accepted abbreviations in the footer of the worksheet.
- EPPD CL SOPs will be revised to include definitions of accepted abbreviations.

Supplemental Review

- As of February 15, 2012, EPPD CL SOPs had been revised to include definitions of accepted abbreviations. No further action necessary.

Finding:

Management System: Controlled Substance Analysis Manual (Section 11) Cautionary Guidelines (Revised 10/11/2011)

11.11 The analyst will compare the exhibit analyte ion spectrum to the corresponding reference standard and/or library. The analyst does not need to document this step, but must document any issue that negatively affects the comparison of spectra. The analyst will consider the totality of the spectra, including but not limited to;
A. Overall characteristic pattern of the ion spectra and the correspondence of the major ions.
3rd party literature may be referenced (i.e. Clarks)
B. Missing ions and the possible causes of such
C. Additional ions and the possible causes of such
D. Molecular weight ion search

11.12 Poor ion spectra will be addressed and documented. These can include;
A. Overabundance of analyte
B. Excessive split
C. Excessive column/septum bleed
D. Low signal-to-noise ratio
E. Contamination
F. Sampling/extraction technique
G. Other

- It was observed in case review that the preliminary testing and GCMS spectrum (molecular weight ion, major ions, and the overall fragmentation pattern) indicated the reported test result. However, explanation of extraneous and/or missing ions quality of the exhibit GCMS spectrum in 31 cases was not documented as required in Controlled Substance Analysis Manual 11.12.

Laboratory Response/Action Plan

- During the audit, the laboratory began evaluating methods to improve the quality of the chromatography and mass spectral analysis. A 30:1 split method was validated to replace the 100:1 split method that had been routinely used by the laboratory. It was the opinion of the audit team that at least one exhibit from case (BY-733) should be reanalyzed by GCMS to improve the quality of the mass spectra and eliminate the "artifacts" that were observed.
- The laboratory is in the process of annotating the examination documentation of the relevant spectrum in the identified cases.
- As of February 8, 2012, all cases identified have been amended. Specifically, extraneous and/or missing ions have been addressed. All amended spectra will be reviewed and either approved or denied by lab manger by February 15, 2012.

Supplemental Review

- As of February 15, 2012, reviewed all amended spectra provided.
- As of April 4, 2012, five additional cases completed after the audit that involved GCMS spectra were reviewed. These spectra did not have extraneous and/or missing ions previously identified by the audit team. Identification and evaluation of the spectra was as required in Controlled Substance Analysis Manual. No further action necessary.
- As of April 6, 2012, the spectra for one exhibit in case BY-733 had been reanalyzed and improved the quality of the spectra produced. No further action necessary.

Finding:

Management System: Controlled Substance Analysis Manual (Section 6) Fourier Transform Infrared Spectrometry (Ftir) Thermo Electron Nicolet 380 with ATR Adapter (Revised 10/11/2011)

6.39 The software will present a list of possible compounds with their spectra from the library. The spectrum of the library must match the exhibit. The quality of the match must be greater than 90 for confirmation. The number associated with the quality of the match is not a 'quantification' of the purity of the compound in the exhibit. If the quality of the spectral match is less than 90, the analyst must attempt a Neat analysis or proceed to GC/MS testing. The analyst will write "Poor Spectral Match" on the exhibit spectrum. (Revised 11/11/11)

- In 13 cases where the FTIR was used for confirmation, there was insufficient information in the case record to indicate the quality of the spectral library match. The Controlled Substance Analysis Manual Section 6.39 requires spectral match to be greater than 90. If the spectral match is less than 90, the analyst will write "poor spectral match" and must attempt a neat analysis or proceed to GC/MS testing.

Laboratory Response/Action Plan

- The laboratory re-analyzed FTIR spectra used for confirmation. The laboratory will be revising the procedures to remove the 90% criteria.
- On February 2, 2012, EPPD CL analysts received 4 hours of remedial training on FTIR spectral interpretation.
- As of February 8, 2012, all samples identified as having poor FTIR spectra have been re-analyzed via GC/MS. None produced different identifications.

Supplemental Review

- As of April 4, 2012, six additional cases completed after the audit that involved FTIR spectra were reviewed. Identification and evaluation of the spectra was as required in Controlled Substance Analysis Manual. No further action necessary.

Finding:

Management System Laboratory Operations Manual (Section XX 7) Evidence Handling and Documentation, Reporting Guidelines

C. The name and address of the customer; identification of the method used (sampling plan); a description of, the condition of, and unambiguous identification of the item(s) tested (comments in footnote or in controlled substance worksheet); the date of receipt of the test where this is critical to the validity and application of the results, and the date(s) of performance of the test or; reference to the sampling plan or procedures used by the

laboratory or other bodies where these are relevant to the validity or application of the results (standards and samples are run within a 24-hour clock and recorded in the instrument retention time log (Binders C and F found in the laboratory) and the 2011 Analysis Primary Standard Binder (G); the type of test, where appropriate, the units of measurement; the name(s), function(s) and signature(s) or equivalent identification of person(s) authorizing the test report (technical review signatures); and where relevant, a statement to the effect that the results relate only to the items tested or calibrated. (Revised 04/25/2011).

Management System Controlled Substance Analysis Manual (Section 2.39) Reporting Guidelines

2.39 The laboratory report shall include the name and address of the customer; identification of the method used (sampling plan); a description of, the condition of, and unambiguous identification of the item(s) tested (comments in footnote or in controlled substance worksheet); the date of receipt of the test where this is critical to the validity and application of the results, and the date(s) of performance of the test or; reference to the sampling plan or procedures used by the laboratory or other bodies where these are relevant to the validity or application of the results (standards and samples are run within a 24-hour clock and recorded in the instrument retention time log (Binders C and F found in the laboratory) and the 2011 Analysis Primary Standard Binder (G); the type of test, where appropriate, the units of measurement; the name(s), function(s) and signature(s) or equivalent identification of person(s) authorizing the test report (technical review signatures); and where relevant, a statement to the effect that the results relate only to the items tested or calibrated.

- In 22 of 134 cases, the laboratory report did not include references to the sampling plan/method used as required in the Laboratory Operations Manual (Section XX 7 C) and Controlled Substance Analysis Manual (Section 2.39).

Laboratory Response/Action Plan

- The reporting procedures regarding sampling plan/method are being revised, such that 100% sampling is inferred based on net weight and tested weight.

Supplemental Review

- As of February 15, 2012, EPPD CL SOPs were revised. No further action necessary.

Summary

It is the opinion of this reviewer and one of the technical auditors that the quality of the spectra vastly improved since the audit. The substances were identified correctly in the eight cases reviewed.

All corrective actions were compliant with standards, policies, and procedures.

Report Authorization

This Report of the El Paso Police Department is issued by the Quality Assurance Coordinator Forrest Davis. Mr. Davis has reviewed the contents of this report and affirms that the report represents a true and accurate accounting of the findings of the Texas DPS assessment team.

Forrest W. Davis	Quality Assurance Coordinator	4/9/2012
Name	Title	Date

EXHIBIT N

JAIME ESPARZA
DISTRICT ATTORNEY
THIRTY-FOURTH JUDICIAL DISTRICT
(El Paso, Culberson and Hudspeth Counties)

Date

Attorney name
Address

RE: SoT v. ___
cause number 1

NOTICE REGARDING RECENT ASSESSMENT OF
THE EL PASO POLICE DEPARTMENT CRIME LABORATORY

On June 27, 2011, the American Society of Crime Laboratory Directors Laboratory Accreditation Board (hereinafter "the Board") issued a Full Assessment Report of its on-site assessment of the El Paso Police Department Crime Laboratory (hereinafter "the EPPD lab") conducted during the period of May 24-26, 2011. As a result of the Board's findings, the EPPD lab has been placed on probation until September 2, 2011.

Attached hereto is the cover letter, dated June 27, 2011, the Board sent to the EPPD lab explaining the conditions of the EPPD lab's probation. The Board's complete (23-page) Full Assessment Report, dated June 27, 2011, has been posted and is available for review on the 34th Judicial District Attorney's website (www.epcounty.com/da), the El Paso County Attorney's website (www.epcounty.com/ca), and the El Paso Police Department's website (www.ep.....).

Sincerely,

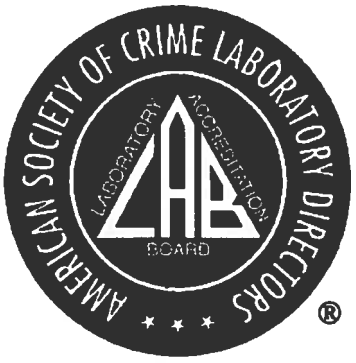
Lori C. Hughes

Lori C. Hughes
Assistant District Attorney

El Paso County Courthouse • 500 East San Antonio Street, 2nd Floor
El Paso, Texas 79901-2420 • (915) 546-2059 • Fax (915) 533-5520 • Victims Assistance (915) 546-2091
www.da-elpaso.com

EXHIBIT O

ASCLD/LAB
INSPECTION REPORT



EL PASO POLICE DEPARTMENT
CRIME LABORATORY

MARCH 3, 2006

INTRODUCTION

This is a report of the ASCLD/LAB accreditation inspection of the El Paso Police Department Crime Laboratory. The initial inspection was conducted during July 18-20, 2005. Staff Inspector Michael Hurley conducted a follow-up site visit during February 28-March 1, 2006.

The ASCLD/LAB inspection team consisted of the following members:

Michael Hurley, Staff Inspector, ASCLD/LAB, Eugene, Oregon
Susan Gross, Minnesota Bureau of Apprehension, St. Paul, Minnesota

The inspection was performed using the principles, standards and criteria established in the 2003 version of the ASCLD/LAB Accreditation Manual.

LABORATORY OVERVIEW

The El Paso Police Department Crime Laboratory is a component of the Criminalistics Section of the El Paso Police Department. The laboratory provides services to criminal justice agencies primarily in the city and county of El Paso Texas. The laboratory which is located at Police Headquarters, Criminalistics, 911 N. Raynor Street, El Paso, Texas is seeking accreditation for the first time. The Crime Laboratory Director is Sergeant Jorge Valenzuela. He reports to Lieutenant Anthony Kozak director of the Criminalistics Section. The Laboratory provides services in Controlled Substances. The Laboratory has a staff of 4 testifying analysts and 2 support staff.

INSPECTION TEAM FINDINGS

The inspection team's scoring of each of the ASCLD/LAB Accreditation Standards and Evaluation Criteria from the 2003 Accreditation Manual follows. Each criterion for which the inspection team determined the laboratory to be in compliance is scored "Yes." Each criterion for which the inspection team found the laboratory to not be in total compliance is scored "No." Each criterion which is not applicable to the inspection of this laboratory is scored "N/A." The "Summary" portion of the report documents the basis for all non-compliance and all non-applicable findings of the Inspection Team.

STANDARDS AND CRITERIA

The laboratory should establish objectives which are relevant to the community that it serves and communicate them to all employees orally and in written form.

		Yes	No	N/A
1.1.1.1 (I)	Does the laboratory have a written statement of its objectives?	✓	___	___
1.1.1.2 (I)	Do the objectives appear to be relevant to the needs of the community serviced by the laboratory?	✓	___	___
1.1.1.3 (D)	Does the laboratory staff understand and support the objectives?	✓	___	___

A laboratory or its parent agency should have a formal written budget which is consistent with the forensic services provided by it.

1.1.2.1 (I)	Does the laboratory or its parent agency have a formal written budget?	✓	___	___
1.1.2.2 (I)	Is the budget adequate to meet the written objectives?	✓	___	___

Clearly written and well understood procedures must exist for handling and preserving the integrity of evidence; laboratory security; preparation, storage, security and disposition of case records and reports; and for maintenance and calibration of equipment and instruments. Clearly written and well understood procedures should also exist for control of materials and supplies; inventory of equipment and instruments; duty hours; leave time; job requirements and descriptions; personnel evaluations and objectives; and for employee grievances.

Do clearly written and well understood procedures exist for the following:

1.1.2.3 (E)	Handling and preserving the integrity of evidence.	✓	___	___
1.1.2.4 (E)	Laboratory security.	✓	___	___
1.1.2.5 (E)	Preparation, storage, security and disposition of case records or reports.	✓	___	___
1.1.2.6 (D)	Control of materials and supplies.	✓	___	___
1.1.2.7 (E)	Calibration of equipment and instruments.	✓	___	___
1.1.2.8 (D)	Inventory of equipment and instruments.	✓	___	___
1.1.2.9 (I)	Duty hours.	✓	___	___
1.1.2.10 (I)	Leave time.	✓	___	___
1.1.2.11 (D)	Job requirements and descriptions.	✓	___	___

		Yes	No	N/A
1.1.2.12 (D)	Personnel evaluations and objectives.	✓		
1.1.2.13 (D)	Employee grievances.	✓		

A laboratory should have a management information system which provides information which assists the laboratory in accomplishing its objectives.

1.1.2.14 (I)	Does the laboratory have and use a management information system?	✓		

The laboratory manager should be able to relate the organizational structure to interacting variables such as those stated in the principle.

1.2.1.1 (D)	Does the organizational structure group the work and personnel in a manner that allows for efficiency of operation, taking into account the interrelation of various forensic disciplines?	✓		
1.2.1.2 (D)	Has the laboratory director considered and taken appropriate action to correct any discrepancies with regard to numbers of personnel when grouping work and resources?	✓		

The laboratory director should have authority commensurate with the assigned responsibilities.

1.2.2.1 (I)	Is the laboratory director's authority well defined?	✓		
1.2.2.2 (I)	Does the laboratory director have authority commensurate with responsibilities?	✓		

Delegation of authority within the laboratory should follow the organizational process outlined in the principle.

1.2.2.3 (I)	Is there sufficient delegation of authority?	✓		
1.2.2.4 (I)	Is authority of supervisors commensurate with their responsibilities?	✓		
1.2.2.5 (I)	Is each subordinate accountable to one and only one immediate supervisor per function?	✓		
1.2.2.6 (I)	Are performance expectations established and are they understood by laboratory personnel?	✓		

Constructive discussion should occur between supervisors and subordinates.

1.3.1.1 (D)	Is there constructive discussion between supervisors and subordinates?	✓		

Supervisors should carefully and objectively review laboratory activities and personnel.

		Yes	No	N/A
1.3.1.2 (I)	Do supervisors carefully and objectively review laboratory activities and personnel?	✓	___	___

Supervisory techniques should encourage creative thinking and objectivity and should recognize meritorious performance of subordinates.

1.3.1.3 (D)	Do the supervisory techniques encourage creative, objective thinking and recognize meritorious performance?	✓	___	___

Channels of communication within the laboratory should exist for coordination of case work and to ensure wide dissemination of technical information. Vertical, horizontal and diagonal channels of communication should exist within and external to the laboratory.

1.3.2.1 (D)	Do clear vertical, horizontal and diagonal channels of communication exist within and external to the laboratory?	✓	___	___

Vertical channels of communication should normally be used for administrative functions.

1.3.2.2 (D)	Are vertical channels of communication used for administrative functions?	✓	___	___

Staff meetings should be conducted on a regular basis.

1.3.2.3 (D)	Are staff meetings held on a regular basis?	✓	___	___

A training program to develop the technical skills of employees is essential in each applicable functional area.

1.3.3.1 (E)	Does the laboratory have and use a documented training program in each functional area for employees who are new, untrained or in need of remedial training?	✓	___	___

A formalized personnel development program is important to prepare employees to assume more responsible jobs.

1.3.3.2 (I)	Does the laboratory have an employee development program?	✓	___	___

The laboratory should maintain an adequate forensic library to include literature published in the applicable functional areas.

1.3.3.3 (I)	Does the forensic library contain current books, journals, and other literature dealing with each functional area?	✓	___	___

A system or procedure should exist to encourage a review of appropriate new literature by personnel.

		Yes	No	N/A
1.3.3.4 (I)	Does a system exist to encourage each examiner to review appropriate new literature?	✓		

A chain of custody record (e.g., signature, date, description of evidence) must be maintained which provides a comprehensive, documented history of each evidence transfer over which the laboratory has control.

1.4.1.1 (E)	Does the laboratory have a written or secure electronic chain of custody record with all necessary data which provides for complete tracking of all evidence?	✓		

Each individual item of evidence must be marked for identification, when practical. If the item does not lend itself to marking, its proximal container or identifying tag must be marked.

1.4.1.2 (E)	Is all evidence marked for identification?	✓		

Evidence seals must be designed and used to protect the integrity of the evidence.

1.4.1.3 (E)	Is evidence stored under proper seal?	✓		

Procedural precautions must exist which reduce the risk of evidence loss, cross transfer, contamination and /or other deleterious change.

1.4.1.4 (E)	Is evidence protected from loss, cross transfer, contamination and/or deleterious change?	✓		

A secure area for overnight and/or long-term storage of evidence must be available.

1.4.1.5 (E)	Is there a secure area for overnight and/or long-term storage of evidence?	✓		

All elements of a laboratory's quality system must be clearly documented in a quality manual which is kept current under the responsibility of a quality manager.

1.4.2.1 (E)	Does the laboratory have a comprehensive quality manual?	✓		

A laboratory must have an individual designated as the Quality Manager.

1.4.2.2 (E)	Is an individual designated as the quality manager?	✓		

To verify that its operations continue to comply with the requirements of its quality system and the standards under which ASCLD/LAB accreditation was granted, each laboratory must conduct an annual audit of its operations and submit an Annual Accreditation Audit Report (Appendix 6) to ASCLD/LAB, by April 1, each year.

		Yes	No	N/A
1.4.2.3 (E)	Did the laboratory conduct and document an annual audit of its operations and submit an annual accreditation audit report to ASCLD/LAB by the required deadline?	___	___	✓

The quality system requires that laboratory management conduct a review at least once yearly to ensure the continued suitability and effectiveness of such a system.

1.4.2.4 (E)	Does the laboratory conduct and document an annual review of its quality system?	✓	___	___

Procedures used must be generally accepted in the field or supported by data gathered and recorded in a scientific manner.

1.4.2.5 (E)	Are the procedures used generally accepted in the field or supported by data gathered and recorded in a scientific manner?	✓	___	___

New technical procedures must be validated to prove their efficacy in examining evidence material before being implemented on casework.

1.4.2.6 (E)	Are new technical procedures scientifically validated before being used in casework and is the validation documentation available for review?	✓	___	___

The laboratory must maintain written copies of appropriate technical procedures.

1.4.2.7 (E)	Are the technical procedures used by the laboratory documented and are the documents available to laboratory personnel for review?	✓	___	___

Controls and standard samples must be used and documented in the case record to ensure the validity of the testing parameters and, thereby, the conclusion.

1.4.2.8 (E)	Are appropriate controls and standards specified in the procedures and are they used and documented in the case record to ensure the validity of examination results?	✓	___	___

The quality of the standard samples and reagents must be adequate for the procedure used.

1.4.2.9 (E)	Is the quality of the standard samples and reagents adequate for the procedure used?	✓	___	___

All reagents must be routinely tested for their reliability.

1.4.2.10 (E)	Does the laboratory routinely check the reliability of its reagents?	✓	___	___

Instruments/equipment should be adequate for the procedures used.

1.4.2.11 (I)	Are the instruments/equipment adequate for the procedures used?	✓	___	___

Instruments/equipment should be maintained in proper working order.

		Yes	No	N/A
1.4.2.12 (I)	Are the instruments/equipment in proper working order?	✓	___	___

Instruments/equipment must be properly calibrated and calibration records maintained for all calibrated instruments.

1.4.2.13 (E)	Are the instruments/equipment properly calibrated?	✓	___	___

The laboratory must create and maintain a case record for administrative and examination documentation generated or received by the laboratory on each case which it receives. Examination documentation such as notes, worksheets, photographs, spectra, printouts, charts, and other data or records which support conclusions must be generated and kept in the case record.

1.4.2.14 (E)	Do the examiners generate and does the laboratory maintain, in a case record, all the notes, worksheets, photographs, spectra, printouts, charts and other data or records used by examiners to support their conclusions?	✓	___	___
1.4.2.15 (E)	Does the laboratory maintain case related administrative documentation generated and received, in a retrievable form?	✓	___	___

It is essential that a representative number of reports be subjected to a technical review.

1.4.2.16 (E)	Does the laboratory have, use and document a system of technical review of the reports to ensure that the conclusions of its examiners are reasonable and within the constraints of scientific knowledge?	✓	___	___

Administrative reviews must be conducted to ensure the completeness and correctness of the reports issued.

1.4.2.17 (E)	Does the laboratory conduct and document administrative reviews of all reports issued?	✓	___	___

The laboratory must have and follow a written procedure whereby the testimony of each examiner is monitored at least once every year.

1.4.2.18 (E)	Does the laboratory monitor the testimony of each examiner at least annually and is the examiner given feedback from the evaluation?	✓	___	___

The laboratory must have a written procedure which it uses to initiate a review and to take corrective action when the laboratory has an indication of a significant problem with a technical procedure or the work of an analyst.

		Yes	No	N/A
1.4.2.19 (E)	If the laboratory has an indication of a significant technical problem, is there a procedure in writing and in use whereby the laboratory initiates a review and takes any corrective action required?	✓	___	___

Each laboratory must have a documented program of proficiency testing which measures the capability of its examiners and the reliability of its analytical results.

1.4.3.1 (E)	Does the laboratory have a documented program of proficiency testing?	✓	___	___

The laboratory must participate in proficiency testing programs in which samples are provided by an external test provider. ASCLD/LAB approved providers must be used where available.

1.4.3.2 (E)	Does the laboratory participate in proficiency testing programs conducted by approved test providers or by other external provider(s) when no approved provider is available?	✓	___	___

Each Examiner should be proficiency tested annually in each subdiscipline in which casework is performed.

1.4.3.3 (I)	Was each examiner proficiency tested annually in each subdiscipline in which casework was performed?	✓	___	___

The laboratory should conduct annual proficiency testing in each discipline using re-examination or blind techniques.

1.4.3.4 (I)	Does the laboratory conduct proficiency testing using re-examination or blind techniques?	✓	___	___

MANAGEMENT

The laboratory director should have a minimum of a baccalaureate degree in a natural science, criminalistics or a closely related field. If the director lacks a scientific background, then there should be support within management by personnel with appropriate scientific background.

2.1.1 (I)	Does the laboratory director possess a degree in a natural science, criminalistics or in a closely related field, or is the laboratory director supported by scientific personnel of sufficient managerial rank and authority?	✓	___	___

A laboratory director should have at least five years of forensic science experience performing casework in one of the ASCLD/LAB accredited disciplines.

2.1.2 (D)	Does the laboratory director have at least five years of forensic science experience?	✓	___	___

Additional education in management or business administration by college course work or short training courses (or both) is recommended.

		Yes	No	N/A
2.1.3 (D)	Does the laboratory director have some formal training in management?	✓	___	___

The laboratory director should have at least two years of experience in management.

2.1.4 (D)	Does the laboratory director have at least two years of managerial experience?	✓	___	___

CONTROLLED SUBSTANCES

Examiners must have education and experience/training commensurate with the examinations and testimony provided. A baccalaureate degree in a natural science, criminalistics or in a closely related field is required.

2.2.1 (E)	Does each examiner possess a baccalaureate degree in a natural science, criminalistics or in a closely related field and does each have experience/training commensurate with the examinations and testimony provided?	✓	___	___

Examiners must have a good understanding of the principles, uses and limitations of the instruments, and the methods and procedures as applied to the tasks performed.

2.2.2 (E)	Does each examiner understand the instruments, and the methods and procedures used?	✓	___	___

Examiners must have successfully completed a competency test.

2.2.3 (E)	Did each examiner successfully complete a competency test prior to assuming casework responsibility?	___	___	✓

A proficiency test must be successfully completed by each examiner at least annually.

2.2.4 (E)	Did each examiner successfully complete an annual proficiency test?	✓	___	___

TOXICOLOGY

Examiners must have education and experience/training commensurate with the examinations and testimony provided. A baccalaureate degree in a natural science, toxicology, criminalistics or in a closely related field is required.

2.3.1 (E)	Does each examiner have a baccalaureate degree in a natural science, toxicology, criminalistics or in a closely related field and does each have experience/training commensurate with the examinations and testimony provided?	___	___	✓

Examiners must have a good understanding of the principles, uses and limitations of the instruments, and the methods and procedures applied to the tasks performed.

		Yes	No	N/A
2.3.2 (E)	Does each examiner understand the instruments, and the methods and procedures used?	___	___	✓

Examiners must have successfully completed a competency test.

2.3.3 (E)	Did each examiner successfully complete a competency test prior to assuming casework responsibility?	___	___	✓

A proficiency test must be successfully completed by each examiner at least annually.

2.3.4 (E)	Did each examiner successfully complete an annual proficiency test?	___	___	✓

TRACE EVIDENCE

Examiners must have education and experience/training commensurate with the examinations and testimony provided. A baccalaureate degree in a natural science, criminalistics or in a closely related field is required.

2.4.1 (E)	Does each examiner possess a baccalaureate degree in a natural science, criminalistics or in a closely related field and does each have experience/training commensurate with the examinations and testimony provided?	___	___	✓

Examiners must have a good understanding of the principles, uses and limitations of the instruments, and the methods and procedures applied to the tasks performed.

2.4.2 (E)	Does each examiner understand the instruments, and the methods and procedures used?	___	___	✓

A competency test must be successfully completed prior to working cases of each evidence type.

2.4.3 (E)	Did each examiner successfully complete a competency test in each of the subdisciplines processed prior to assuming casework responsibility?	___	___	✓

A proficiency test must be successfully completed by each examiner at least annually.

2.4.4 (E)	Did each examiner successfully complete an annual proficiency test?	___	___	✓

BIOLOGY

Examiners must have education and experience/training commensurate with the examinations and testimony provided. A baccalaureate degree in a natural science, criminalistics or in a closely related field is required.

		Yes	No	N/A
2.5.1 (E)	Does each examiner possess a baccalaureate degree in a natural science, criminalistics or in a closely related field and does each have experience/training commensurate with the examinations and testimony provided?	___	___	✓
2.5.2 (E)	Does each examiner performing DNA analysis have education, training and experience consistent with those required by the quality assurance audit document?	___	___	✓

Examiners must have a good understanding of the principles, uses and limitations of the instruments, and the methods and procedures applied to the tasks performed.

2.5.3 (E)	Does each examiner understand the instruments, and the methods and procedures used?	___	___	✓

Examiners must have successfully completed a competency test.

2.5.4 (E)	Did each examiner successfully complete a competency test prior to assuming casework responsibility?	___	___	✓

A proficiency test must be successfully completed by each examiner at least annually?

2.5.5 (E)	Did each examiner successfully complete an annual proficiency test?	___	___	✓

Two proficiency tests must be successfully completed by each DNA examiner annually.

2.5.6 (E)	Did each examiner performing DNA analysis successfully complete two annual proficiency tests from an approved test provider?	___	___	✓

FIREARMS/TOOLMARKS

Firearms/toolmarks examiners should have a baccalaureate degree with science courses.

2.6.1 (I)	Does each examiner possess a baccalaureate degree with science courses?	___	___	✓

Examiners must have a good understanding of the principles, uses and limitations of the instruments, and the methods and procedures used as applied to the tasks performed.

2.6.2 (E)	Does each examiner understand the instruments, and the methods and procedures used?	___	___	✓

Examiners must have education and experience/training commensurate with the examinations and testimony provided. Independent case examinations must not be undertaken until extensive instruction from a qualified examiner has been completed.

		Yes	No	N/A
2.6.3 (E)	Did each examiner have extensive training from a qualified examiner and does each have experience commensurate with the examinations and testimony provided?	___	___	✓

Examiners must successfully complete a competency test.

2.6.4 (E)	Did each examiner successfully complete a competency test prior to assuming case work responsibility?	___	___	✓

A proficiency test must be successfully completed by each examiner at least annually.

2.6.5 (E)	Did each examiner successfully complete an annual proficiency test?	___	___	✓

QUESTIONED DOCUMENTS

Questioned document examiners should have a baccalaureate degree with science courses.

2.7.1 (I)	Does each examiner possess a baccalaureate degree with science courses?	___	___	✓

Examiners must have a good understanding of the principles, uses and limitations of the instruments, and the methods and procedures used as applied to the tasks performed.

2.7.2 (E)	Does each examiner understand the instruments, and the methods and procedures used?	___	___	✓

Examiners must have education and training/experience commensurate with the examinations and testimony provided. Independent case examinations must not be undertaken until extensive instruction from a qualified document examiner has been completed.

2.7.3 (E)	Did each examiner have extensive training from a qualified examiner and does each have experience commensurate with the examinations and testimony provided?	___	___	✓

Examiners must have successfully completed a competency test.

2.7.4 (E)	Did each examiner successfully complete a competency test prior to assuming case work responsibility?	___	___	✓

A proficiency test must be successfully completed by each examiner at least annually.

2.7.5 (E)	Did each examiner successfully complete an annual proficiency test?	___	___	✓

LATENT PRINTS

Latent print examiners should have a baccalaureate degree with science courses.

		Yes	No	N/A
2.8.1 (I)	Does each examiner possess a baccalaureate degree with science courses?	___	___	✓

Examiners must have a good understanding of the concept of individualization and the principles, uses and limitations of the instruments, and the methods and procedures used as applied to the tasks performed.

2.8.2 (E)	Does each examiner understand the instruments, and the methods and procedures used?	___	___	✓

Examiners must have education and training/experience commensurate with the examinations and testimony provided. Independent case examinations must not be undertaken until extensive instruction from a qualified latent print examiner has been completed.

2.8.3 (E)	Did each examiner have extensive training from a qualified examiner and does each have experience commensurate with the examinations and testimony provided?	___	___	✓

Examiners must have successfully completed a competency test.

2.8.4 (E)	Did each examiner successfully complete a competency test prior to assuming casework responsibility?	___	___	✓

A proficiency test must be successfully completed by each examiner at least annually.

2.8.5 (E)	Did each examiner successfully complete an annual proficiency test?	___	___	✓

TECHNICAL SUPPORT

The individual must meet the specification of the job description.

2.9.1 (E)	Do technical support personnel meet the requirements of their job descriptions?	___	___	✓

The job description and the duties performed must be in agreement.

2.9.2 (E)	Are the job descriptions and the duties performed in agreement?	___	___	✓

Technical support staff must have successfully completed an appropriate competency test.

2.9.3 (E)	Did each member of the technical support staff successfully complete an appropriate competency test prior to assuming casework responsibility?	___	___	✓

Technical support personnel must successfully complete an appropriate proficiency test annually.

		Yes	No	N/A
2.9.4 (E)	Did all technical support personnel successfully complete an appropriate proficiency test, annually?	___	___	✓

Two proficiency tests must be successfully completed annually by all technical support personnel performing DNA analysis.

2.9.5 (E)	Did all technical support personnel performing DNA analysis successfully complete two annual proficiency tests from an approved test provider?	___	___	✓

CRIME SCENE

The examiner must meet the requirements of the job description.

2.10.1 (E)	Do examiners meet the requirements of their job descriptions?	___	___	✓

Examiners must have a good understanding of the concept and theory of scene security and integrity, and the uses and limitations of the equipment, methods and procedures used to document and process crime scenes, as applied to the tasks performed.

2.10.2 (E)	Does each examiner understand the equipment, methods and procedures used?	___	___	✓

Examiners must have training and experience commensurate with the examinations, documentation and testimony provided, as applied to the tasks performed. Independent examinations and documentation at crime scenes must not be undertaken until extensive instruction from a qualified examiner has been completed.

2.10.3 (E)	Did each examiner have extensive training from a qualified examiner and does each have experience commensurate with the examinations/documentation and testimony provided?	___	___	✓

Examiners must have successfully completed a competency test(s) as applied to the task(s) performed.

2.10.4 (E)	Did each examiner successfully complete a competency test(s) prior to primary responsibility for the examination, documentation and processing of a crime scene?	___	___	✓

A proficiency test must be completed by each person conducting crime scene examinations at least annually. The proficiency test should reflect the types of procedures, methods and equipment as applied to the typical task(s) performed.

2.10.5 (E)	Did each examiner successfully complete an annual proficiency test?	___	___	✓

DIGITAL EVIDENCE

Digital evidence examiners should have a baccalaureate degree with science courses.

		Yes	No	N/A
2.11.1 (I)	Does each examiner possess a baccalaureate degree with science courses?	___	___	✓

Examiners must have a good understanding of the principles, uses and limitations of the hardware, software, and the methods and procedures as applied to the tasks performed.

2.11.2 (E)	Does each examiner understand the equipment, programs, methods and procedures used?	___	___	✓

Examiners must have education and training/experience commensurate with the examinations and testimony provided. Independent case examinations must not be undertaken until extensive instruction from a qualified examiner has been completed.

2.11.3 (E)	Does each examiner have experience commensurate with the examinations/documentation and testimony provided?	___	___	✓

Examiners must have successfully completed a competency test.

2.11.4 (E)	Did each examiner successfully complete a competency test in each subdiscipline prior to assuming casework responsibility?	___	___	✓

A proficiency test must be successfully completed by each examiner at least annually.

2.11.5 (E)	Did each examiner successfully complete an annual proficiency test?	___	___	✓

Each employee should have adequate work space to accomplish assigned tasks.

3.1.1 (I)	Does each employee have adequate work space to accomplish assigned tasks?	✓	___	___

Sufficient space should be provided for storage of supplies, equipment and tools.

3.1.2 (D)	Is there sufficient space provided for storage of supplies, equipment and tools?	✓	___	___

Examiners should have space available for writing reports and other official communications.

3.1.3 (I)	Is there adequate space available for examiners for writing reports and other official communications?	✓	___	___

Adequate and appropriate space should exist for records and reference materials.

		Yes	No	N/A
3.1.4 (I)	Is there adequate and appropriate space available for records, reference works and other necessary documents?	✓	___	___

Sufficient space should be available for instrumentation/equipment to facilitate its operation.

3.1.5 (I)	Is adequate space available for instrumentation/equipment to facilitate its operation?	✓	___	___

Accessories should be stored near instrumentation/equipment to facilitate its use and operation.

3.1.6 (D)	Are accessories stored near instrumentation/equipment to facilitate its use and operation?	✓	___	___

The physical design should permit the efficient flow of evidence from the time of its acceptance until its proper disposal.

3.2.1 (I)	Does the physical design permit the efficient flow of evidence from the time of its acceptance until its proper disposal?	✓	___	___

The relative locations of functional areas should facilitate the use of equipment and instruments.

3.2.2 (D)	Do the relative locations of functional areas facilitate the use of equipment and instruments?	✓	___	___

Adequate and proper lighting should be available for personnel to carry out assigned tasks.

3.2.3 (I)	Is there adequate and proper lighting available for personnel to carry out assigned tasks?	✓	___	___

Adequate and proper plumbing and wiring should be available and accessible to carry out assigned tasks.

3.2.4 (I)	Is there adequate and proper plumbing and wiring available and accessible to carry out assigned tasks?	✓	___	___

The laboratory should have proper general ventilation.

3.2.5 (I)	Does the laboratory have proper general ventilation?	✓	___	___

There should be adequate heating, cooling and humidity control in the laboratory.

3.2.6 (I)	Is the heating, cooling and humidity control in the laboratory adequate?	✓	___	___

Access to the operational area of the laboratory must be controllable and limited to those individuals who are assigned to routinely work in the area or to those individuals designated by the laboratory director to have access.

		Yes	No	N/A
3.3.1 (E)	Is access to the operational area of the laboratory controllable and limited?	✓	___	___

All exterior entrance/exit points require adequate security control.

3.3.2 (E)	Do all exterior entrance/exit points have adequate security control?	✓	___	___

Internal areas requiring limited/controlled access must have a lock system.

3.3.3 (E)	Do all internal areas requiring limited/controlled access have a lock system?	✓	___	___

Accountability of all keys, magnetic cards, etc., must be documented and their distribution limited to those individuals designated by the laboratory director to have access.

3.3.4 (E)	Is distribution of all keys, magnetic cards, etc., documented and is distribution limited to those individuals designated by the laboratory director to have access?	✓	___	___

The laboratory must be monitored during vacant hours by an intrusion alarm or by security personnel.

3.3.5 (E)	Is the laboratory secured during vacant hours by means of an intrusion alarm or by security personnel?	✓	___	___

The laboratory should have a fire detection system.

3.3.6 (I)	Does the laboratory have a fire detection system?	✓	___	___

All elements of a laboratory's health and safety program must be clearly documented in a manual. The program should be monitored and the manual kept current by a health and safety manager.

3.4.1 (I)	Does the laboratory have an effective health and safety program documented in a manual?	✓	___	___
3.4.2 (I)	Is an individual designated as the health and safety manager?	✓	___	___
3.4.3 (I)	Is the health and safety program monitored regularly and reviewed annually to ensure that its requirements are being met?	✓	___	___

The laboratory should have available and encourage the use of safety devices (particularly those required in its health and safety manual). Examples of such devices are goggles, face protectors, ear protectors, gloves and fire extinguishers.

		Yes	No	N/A
3.4.4 (I)	Does the laboratory have available and encourage the use of safety devices, particularly those required by its health and safety manual?	✓	___	___

Proper equipment and material should be available for the handling of carcinogenic, toxic and/or other dangerous material spills.

3.4.5 (I)	Does the laboratory have proper equipment and material available for the handling of carcinogenic, toxic and/or other dangerous material spills?	✓	___	___

The laboratory should have safety shower and eye wash equipment in appropriate locations and in good working condition.

3.4.6 (I)	Does the laboratory have safety shower and eye wash equipment in appropriate locations and in good working condition?	✓	___	___

Exhaust hoods must be available to maintain a safe work environment.

3.4.7 (I)	Are sufficient exhaust hoods available to maintain a safe work environment?	✓	___	___

Sufficient first-aid kits should be available and strategically located.

3.4.8 (I)	Are sufficient first-aid kits available and strategically located?	✓	___	___

An adequate number of personnel should hold current certification in first-aid.

3.4.9 (I)	Does the laboratory have an adequate number of personnel holding current certification in first-aid?	✓	___	___

Space should be provided for safe storage of volatile, flammable, explosive and other hazardous materials.

3.4.10 (I)	Is appropriate space provided for safe storage of volatile, flammable, explosive and other hazardous materials?	✓	___	___

Emergency exits from the laboratory should be in compliance with safe working requirements.

3.4.11 (I)	Are the emergency exits from the laboratory adequate for safe exit in an emergency?	✓	___	___

General cleanliness and good-housekeeping should be apparent.

3.4.12 (D)	Is there general cleanliness and apparent good-housekeeping in the laboratory?	✓	___	___

SUMMARY

The following summarizes the criteria for which the Inspection Team determined the laboratory to not be in compliance at the time of the initial inspection and documents the basis for the findings under the heading of Original inspection finding. The report also documents, as Supplemental findings, the laboratory's compliance with those criteria since the initial inspection.

1.1.2.3 (E) Do clearly written and well understood procedures exist for handling and preserving the integrity of evidence?

Original inspection finding:
Clearly written and well understood procedures do not exist for recording the chain of custody, the use of sub-item or exhibit numbers when samples are taken from the original exhibits, or for properly marking and sealing the evidence.

Supplemental finding
Evidence handling and documentation procedures were revised. The new procedures are clearly written and on-site review during the revisit revealed that the procedures are understood and being followed.

1.1.2.5 (E) Do clearly written and well understood procedures exist for preparation, storage, security and disposition of case records or reports?

Policy QM 7.2 states "in part" that "The case file will contain the information received or generated regarding the case." Documentation generated by the Narcotics Custodians related to collection of evidence at scenes, photographs, reports, and delivery and processing of evidence at the laboratory is not documented in the case record.

The laboratory procedure does not address security or disposition of case records or reports.

Supplemental finding
Narcotics custodians are no longer members of the laboratory.

A detailed procedure addressing the preparation, storage, security and disposition of case records or reports has been added to the laboratory Operations/Quality Manual. On-site review during the revisit revealed that the procedures are understood and being followed.

1.3.3.1 (E) Does the laboratory have and use a documented training program in each functional area for employees who are new, untrained or in need of remedial training?

Original inspection finding:
The laboratory has two conflicting training documents (The Crime Lab Training and Reference Manual and The Crime Laboratory Controlled Substance Analysis Manual – Section 11. Drug Analyst Training) which address training for Controlled Substances identification. Neither document clearly indicates the requirements for satisfactory completion of training, or the type of documentation that is recorded and maintained.

Supplemental finding
The Controlled Substance Analysis Manual was extensively revised and the section on training was removed. A new Controlled Substances Training Program was written which clearly defines the requirements for satisfactory completion of training.

The training program includes a checklist to document the training process. The checklist has been utilized in the remedial training provided to the drug analysts.

1.4.1.1 (E) Does the laboratory have a written or secure electronic chain of custody record with all necessary data which provides for complete tracking of all evidence?

Original inspection finding:
The laboratory custody record does not include the Narcotics Custodian who retrieves evidence from the drop boxes and logs the cases into the laboratory.

Person-to-person transfers are not documented by both parties and person-to-place transfers are not documented. Samples taken from larger "parent" exhibits are not given a unique identifier or tracked in the chain of custody record.

Supplemental finding
Narcotics custodians are no longer members of the laboratory.

On-site review of chain of custody records revealed that the records now contain all necessary information including person-to-person and person-to-place transfers for the complete tracking of all evidence.

1.4.1.2 (E) Is all evidence marked for identification?

Original inspection finding:
Numerous boxes of evidence in the intake area of the main narcotics vault were not marked with the laboratory case number as required by laboratory policy QM 6.1.2.

Items removed from a parent exhibit are not marked with a unique identifier.

Supplemental finding
The main narcotics vault is no longer under the control of laboratory staff. On-site review of the laboratory evidence vault revealed all evidence to be properly marked for identification.

1.4.1.3 (E) Is evidence stored under proper seal?

Original inspection finding:
Numerous boxes of evidence present in the main narcotics vault are not properly sealed. The bottoms of the boxes are closed with a clear tape which is not initialed or otherwise marked to document the person sealing the evidence. The type of tape utilized does not show obvious damage/alteration to the container if removed and replaced.

Supplemental finding
The main narcotics vault is no longer under the control of laboratory staff. On-site review of the laboratory evidence vault revealed all evidence to be properly sealed.

1.4.2.1 (E) Does the laboratory have a comprehensive quality manual?

Original inspection finding:
The laboratory quality manual does not contain or reference all of the required elements of a laboratory quality system. Elements not addressed include:

- Relevant organizational charts
- Type and extent of laboratory services
- Laboratory protocol permitting departures from documented polices and procedures
- Disclosure of information

Elements which were not adequately addressed include:

- Control and maintenance of documentation of case records and procedures manuals.
- Handling of evidence
- Practices for ensuring continued competence of examiners

Supplemental finding
The laboratory Operations Manual and Quality Manual have been combined into a single document which now contains all the elements necessary for a comprehensive quality manual.

1.4.2.2 (E) Is an individual designated as the quality manager?

Original inspection finding:
An analyst is designated as the quality manager; however the scope of responsibilities and the authority for this individual was not clearly defined or understood. This individual was not performing most of the specified responsibilities of a quality manager.

Supplemental finding
The laboratory director is now designated as the quality manager and is performing the specified responsibilities of the quality manager.

1.4.2.5 (E) Are the procedures used generally accepted in the field or supported by data gathered and recorded in a scientific manner?

Original inspection finding:
The procedure used for cocaine quantitation (Controlled Substance Method 7.2) utilizes a cocaine base standard. The procedure does not determine if the sample being quantitated is in the base or salt form.

Supplemental finding
The procedure for cocaine quantitation has been removed from the Controlled Substance Analysis Procedures. The laboratory does not do quantitative analysis.

1.4.2.7 (E) Are the technical procedures used by the laboratory documented and are the documents available to laboratory personnel for review?

Original inspection finding:
The laboratory uses procedures for crystal tests and for quantitation of methamphetamine and heroin which are not documented.

Supplemental finding
The Controlled Substance Analysis Procedures were extensively revised. The laboratory does not do quantitative analysis and does not utilize crystal tests.

1.4.2.8 (E) Are appropriate controls and standards specified in the procedures and are they used and documented in the case record to ensure the validity of examination results?

Original inspection finding:
The laboratory's Controlled Substance Manual 7.1 requires a blank sample to be analyzed in addition to the suspect substance. These blank samples are not being run or documented.

Supplemental finding
On-site review of case records revealed that the blank samples are being run and are documented in the case record. Positive and negative controls are specified in the revised procedures.

1.4.2.9 (E) Is the quality of the standard samples and reagents adequate for the procedure used?

Original inspection finding:
Standards which have no documented certificate of analysis or which have no documented verification to a traceable standard are being utilized.

Supplemental finding
On-site review of the laboratory standards, standards log and case records revealed the standards utilized are now documented with a certificate of analysis or have been verified to a traceable standard.

1.4.2.10 (E) Does the laboratory routinely check the reliability of its reagents?

Original inspection finding:
Not all reagents are checked on a monthly basis as required by laboratory policy, Controlled Substance Manual 4.1.2.

Supplemental finding
On-site review of the reagent logs revealed that the reagents are being checked prior to each use or at least on a monthly basis.

1.4.2.13 (E) Are the instruments/equipment properly calibrated?

Original inspection finding:
One balance in the Controlled Substance laboratory was not calibrated/verified as required by laboratory policy QM 5.1.1.B which requires monthly verifications.

The procedure for checking balances does not specify tolerances or acceptable range.

Supplemental finding
The balances are now checked at least monthly and the balance check log sheet for each balance now specifies the tolerances or acceptable range.

1.4.2.14 (E) Do the examiners generate and does the laboratory maintain, in a case record, all the notes, worksheets, photographs, spectra, printouts, charts and other data or records used by examiners to support their conclusions?

Original inspection finding:
Examination documentation contained numerous obliterations, and cross-outs without initials and the use of white-out. Both sides of pages were being utilized and not treated as separate pages. Numerous pages did not contain the case number and/or examiner initials. Page numbers and dates required by laboratory policy, where not documented on numerous pages of examination documents.

Examination documentation for one case involving the "identification" of methamphetamine contained spectra which did not support this identification. The standard spectrum was not present in the case record.

Most of the documentation of examinations of work performed by Narcotics Custodians is not maintained in the case record. Case notes are destroyed and documentation of weights of evidence recorded by the Narcotics Custodian's and reported by the Controlled Substance analysts are not initialed and dated in the case record by the Narcotics Custodian's.

Examiners are not recording observations of significant features used in the microscopic examination of marijuana.

Supplemental finding
Review of casework conducted since the initial visit revealed that examinations are properly documented and the documentation supports the conclusions of the examiners.

Microscopic observations of marijuana are now fully documented in the case record.

1.4.2.15 (E) Does the laboratory maintain case related administrative documentation generated and received, in a retrievable form?

Original inspection finding:
Policy QM 7.2 states "in part" that "The case file will contain the information received or generated regarding the case." Crime scene response reports and chain of custody records for evidence examined by Narcotics Custodian's are not maintained in the case record.

Supplemental finding
The Narcotics custodians are no longer members of the laboratory staff.

1.4.2.16 (E) Does the laboratory have, use and document a system of technical review of the reports to ensure that the conclusions of its examiners are reasonable and within the constraints of scientific knowledge?

Original inspection finding:
The laboratory does not have a system of technical review for non-marijuana casework to ensure that conclusions of its examiners are reasonable and within constraints of scientific knowledge.

Supplemental finding
During the on-site revisit, casework which had been completed but not released since the initial inspection was reviewed. All cases have been technically reviewed. The laboratory is

in the process of implementing a Technical Review Checklist for use in all technical reviews to ensure a proper and consistent review. The laboratory policy is to technically review all casework.

1.4.3.4 (I) Does the laboratory conduct proficiency testing using re-examination or blind techniques?

Original inspection finding:
The laboratory does not conduct proficiency testing using re-examination or blind techniques.

Supplemental finding
Review of proficiency test records for the latter part of 2005 revealed the laboratory has now implemented blind proficiency testing and plan to continue blind as well as re-examination techniques in their proficiency testing program.

2.2.2 (E) Does each examiner understand the instruments, and the methods and procedures used?

Original inspection finding:
The controlled substance examiners do not have a firm understanding of the instruments, methods, procedures used and interpretation of data/results for samples other than marijuana.

Methamphetamine was identified in one case in which the spectral data did not support the identification. The presumptive testing and spectral interpretation do not support the conclusion reached in this case. The analyst and technical reviewer for this case do not have an understanding of the ion chromatogram for methamphetamine (mass and ratio of ions). Both examiners failed to take into account a two minute difference between the retention time of the standard and question sample as well as differences in the mass and ratios of the ions.

Supplemental finding
The controlled substance examiners have completed an extensive remedial training program and have been competency tested. Interviews with laboratory staff revealed that they now have a good understanding of the methods and instrumentation used.

The case which was identified in the initial inspection as not having documentation to support the conclusion has been the subject of reanalysis and an extensive corrective action. Examination documentation for this case now supports the conclusion of the examiner. The examiner and technical reviewer in this case have both been counseled regarding the case and have received remedial training.

3.2.1 (I) Does the physical design permit the efficient flow of evidence from the time of its acceptance until its proper disposal?

Original inspection finding:
The main evidence vault is located off-site several minutes from the laboratory. This creates problems for the efficient flow of evidence.

Supplemental finding
The laboratory is no longer responsible for the main evidence vault located off-site. Responsibility has been transferred to the Property Section of the department. Evidence is

delivered by members of the property section directly to an analyst at the laboratory who places it in the vault within the lab.

All criteria for 2.3 Toxicology, 2.4 Trace Evidence, 2.5 Biology, 2.6 Firearms/Toolmarks, 2.7 Questioned Documents, 2.8 Latent Prints, 2.9 Technical Support, 2.10 Crime Scene and 2.11 Digital Evidence were scored N/A because the laboratory does not perform work in the disciplines.

SUMMATION OF CRITERIA RATINGS

	Total Possible	Total Yes	Total No	Total N/A	Total Number Yes/No
Essential	78	36	0	42	36
Important	47	43	0	4	43
Desirable	20	20	0	0	20

Percent Essential: 100%

Percent Important: 100%

Percent Desirable: 100%

Areas sought for accreditation are as follows:

Controlled Substances

Prepared by: Michael Hurley, Staff Inspector

Ralph M. Keaton

Ralph M. Keaton, Executive Director