ASCLD/LAB-*International* Assessment Report

Alaska Department of Public Safety
Scientific Crime Detection Laboratory

4805 Dr. Martin Luther King Jr Avenue, Anchorage, AK 99507

Assessment Activity: Reassessment
Assessment Date: January 30-February 3, 2017

Lead Assessor:
Amanda Julian
Technical Assessor(s):
Dan Anderson
William R. Dietz
Danielle N. Hankinson
Steven R. Renteria
Jeffrey Riolo
Steve Scott
Dawn A. Walters

ASSESSMENT OBJECTIVES

To evaluate the management and technical operations and to report the findings in a fair and impartial manner to the customer and to ASCLD/LAB for the purpose of renewing ASCLD/LAB-*International* accreditation in accordance with the scope of this assessment. Applicable requirements from ISO/IEC 17025:2005, the ASCLD/LAB-*International* Supplemental Requirements for the Accreditation of Forensic Science Testing Laboratories (2011), FBI Quality Assurance Standards for Forensic DNA Testing Laboratories and DNA Databasing Laboratories, applicable ASCLD/LAB-*International* policies and the documented management system were used for this assessment.

Continued on the next page

SCOPE OF ASSESSMENT

The assessment covered the following disciplines and categories:

Field	
Forensic Science Testing	
Discipline(s)	**Categories of Testing**
Drug Chemistry	Controlled Substances
Toxicology	Human Performance Forensic Toxicology (blood alcohol only) Post-Mortem Forensic Toxicology
Biology	DNA-Nuclear Body Fluid Identification Individual Characteristic Database
Firearms/Toolmarks	Firearms Toolmarks Serial Number Restoration
Latent Prints	Latent Print Processing Latent Print Comparisons Impression Evidence (footwear only)
Crime Scene	Crime Scene Investigation

SUMMARY OF ASSESSMENT TEAM FINDINGS

In general, the assessment team observed the overall operation to be as follows:]

Management System: Policies and procedures have been established that are appropriate for the scope of its activities. The management team's commitment to quality was evident in their knowledge and understanding of accreditation requirements. The management system is well-understood with the one exception noted later in this report. The assessment team commends the entire staff for their professionalism and the open communication style displayed during interviews and witnessing activities.

Document Control: Management system documents are uniquely identified and include revision identification and page numbers. A document control system is utilized to ensure that periodic review occurs and is documented, that changes to controlled documents are communicated to the appropriate personnel and that personnel have reviewed those changes.

Corrective Action: Appropriate corrective actions are taken when needed. Root cause analyses conducted by the Quality Manager have identified causes for nonconforming work that were not obvious and have effectively eliminated recurrence.

Technical Records: Technical records contain sufficient information to establish an audit trail and to support the conclusions of the analyst with one exception noted later in this report. Procedures for quality and technical records are established and maintained with one exception. Alterations made to technical records are appropriately tracked.

Internal Audits: Annual internal audits are conducted and records kept, with one exception noted later in this report. Appropriate actions are taken to resolve issues identified during the audits and the effectiveness of those actions is monitored.

Management Reviews: Management reviews are conducted annually and include all required elements.

Personnel: Training programs exist for each discipline to ensure the competence of personnel.

Technical Methods: The technical methods used are appropriate for the scope of work conducted except as noted later in this report. Validation and/or verification records were sufficient to demonstrate that the methods were fit for the intended use.

Measurement Uncertainty: Measurement uncertainty has been estimated for the disciplines of Drug Chemistry, Toxicology and Firearms. Reporting of the uncertainty is in conformance with the ASCLD/LAB Policy on Measurement Uncertainty. No special customer need for reporting measurement uncertainty information beyond that required in the Policy was noted.

Measurement Traceability: Measurement traceability has been established through the calibration of equipment using an appropriate supplier of external calibration services and the use of certified reference materials, as appropriate.

Evidence Handling: Evidence is appropriately identified, sealed and secured. A complete chain of custody is maintained.

Proficiency Testing: The proficiency testing program is being administered in accordance with requirements.

Reporting: Results are accurately reported and opinions are clearly identified except as noted later in this report.

CONCLUSIONS

Based upon a sampling of objective evidence during the assessment activity, one or more nonconformities were required to be addressed (refer to the attached Nonconformities and Comments form). All nonconformities have been appropriately resolved and operations are in conformance with applicable accreditation requirements. Comments are provided. Comments are an opportunity for potential improvement of a conforming practice.

REPORT AUTHORIZATION

As the lead assessor, I affirm that this report represents a true and accurate accounting of the findings of the ASCLD/LAB-*International* assessment activity.

Lead Assessor: Amanda Julian

Amanda D. Julian
Signature

May 19, 2017
Date

DISTRIBUTION LIST

Orin W. Dym, Forensic Laboratory Manager
Ashley Lankford, Laboratory Quality Assurance Manager
ASCLD/LAB Office

ASCLD/LAB-*International*
Nonconformities and Comments - Resolved

Alaska Department of Public Safety – Scientific Crime Detection Laboratory
Assessment
Dates: January 30 – February 3, 2017
Assessor: Amanda Julian

INSTRUCTIONS

FOR EACH NONCONFORMITY LISTED:
As applicable, a forensic service provider must follow requirements in ISO/IEC 17025:2005, 4.9 Control of nonconforming testing and/or calibration work and/or 4.11 Corrective action as well as the provider's own management system requirements for the resolution of all nonconformities identified during an assessment activity. Actions taken to resolve a nonconformity may include correction, corrective action based on root cause analysis or a combination of both. The type of action taken will be based on an evaluation of the significance of the nonconforming work (4.9) or the necessity to perform corrective action based on management system policy and procedure (4.11).

- Within 30 days of the assessment activity report date, a plan for resolution and a time schedule for implementation must be provided and accepted.
    - Describe the plan for achieving and documenting conformity which may include: correction, evaluation of significance, halting and resuming work, customer notification, corrective action, monitoring of effectiveness or additional audits.
- Within 90 days of the assessment activity report date, objective evidence of plan implementation to a level to ensure no negative impact to the work product or integrity of the evidence/item must be provided and accepted.
    - If corrective action is required by the plan, it is acknowledged that there will be instances where all aspects of the corrective action process may take more than 90 days to complete. However, within the 90 days, sufficient objective evidence must be provided to ensure that there is no longer a negative impact to the work product or integrity of the evidence/item.

FOR EACH COMMENT PROVIDED: There is no requirement to respond to a comment.

NC 1

Premises Name (if more than one): Click here to enter text.

REQUIREMENT: ISO/IEC 17025:2005
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.

DESCRIPTION OF THE NONCONFORMITY:
It was determined that the laboratory's requirements as listed in LP 2016 R0 for verifications of exclusions in the latent print section are not clearly understood by laboratory staff.

DUE DATE for Resolution Plan: 3/29/17
DUE DATE for Resolution Completion: 5/28/17

SUMMARY OF PLAN AND OBJECTIVE EVIDENCE
Date: 5/15/17
Summary of Plan:
The expectation for verifications in the latent print discipline will be updated to address the concept of source and the verification requirement between "no match" versus "exclusion" decisions.

Summary of Objective Evidence:
The latent print procedure for verifications was addressed; training was given on the update to the members and an example of a report utilizing the new procedure was provided. The nonconformity is resolved.

NC 2

Premises Name (if more than one): Click here to enter text.

REQUIREMENT: ISO/IEC 17025:2005
4.13.1.1 - The laboratory shall establish and maintain procedures for identification, collection, indexing, access, filing, storage, maintenance and disposal of quality and technical records. Quality records shall include reports from internal audits and management reviews as well as records of corrective and preventive actions.

DESCRIPTION OF THE NONCONFORMITY:
The laboratory procedures do not cover the topic of the disposal of quality and technical records.

DUE DATE for Resolution Plan: 3/29/17
DUE DATE for Resolution Completion: 5/28/17

SUMMARY OF PLAN AND OBJECTIVE EVIDENCE
Date: 5/15/17
Summary of Plan:
The quality manual will be updated to reflect the policy followed for records disposal.

Summary of Objective Evidence:
The updated quality manual was provided as objective evidence. The nonconformity is resolved.

NC 3

Premises Name (if more than one): Click here to enter text.

REQUIREMENT: ISO/IEC 17025:2005

4.13.2.1 - The laboratory shall retain records of original observations, derived data and sufficient information to establish an audit trail, calibration records, staff records and a copy of each test report or calibration certificate issued, for a defined period. The records for each test or calibration shall contain sufficient information to facilitate, if possible, identification of factors affecting the uncertainty and to enable the test or calibration to be repeated under conditions as close as possible to the original. The records shall include the identity of personnel responsible for the sampling, performance of each test and/or calibration and checking of results.

REQUIREMENT: 2011 QAS Forensic DNA Testing Laboratories

11.1 b and c –

- b. Does the laboratory maintain all analytical documentation generated by analysts related to case analyses?
- c. Does the laboratory retain, in hard copy or electronic format, sufficient documentation for each technical analysis to support the report conclusions such that another qualified individual could interpret and evaluate the data?

DESCRIPTION OF THE NONCONFORMITY:

Two case records were identified in which the original observations and data from the DNA analysis cannot be located.

DUE DATE for Resolution Plan: 3/29/17

DUE DATE for Resolution Completion: 5/28/17

SUMMARY OF PLAN AND OBJECTIVE EVIDENCE

Date: 5/15/17

Summary of Plan:

Files were reviewed, the missing documentation was located and added to the case records as appropriate. The procedure was revised to require a different work flow when administratively reviewing the scanned data that becomes part of the final case record. The new procedure was followed up on to ensure compliance.

Summary of Objective Evidence:

A revised manual, case record and review process documentation were provided as objective evidence. The nonconformity is resolved.

NC 4

Premises Name (if more than one): Click here to enter text.

REQUIREMENT: ISO/IEC 17025:2005

4.14.1 - The laboratory shall periodically, and in accordance with a predetermined schedule and procedure, conduct internal audits of its activities to verify that its operations continue to comply with the requirements of the management system and this International Standard. The internal audit program shall address all elements of the management system, including the testing and/or calibration activities. It is the responsibility of the quality manager to plan and organize audits as required by the schedule and requested by management. Such audits shall be carried out by trained and qualified personnel who are, wherever resources permit, independent of the activity to be audited.

DESCRIPTION OF THE NONCONFORMITY:

For the 2016 internal audit, the laboratory does not have objective evidence to demonstrate that each element of the management system was audited or that the personnel conducting the audits were trained.

DUE DATE for Resolution Plan: 3/29/17

DUE DATE for Resolution Completion: 5/28/17

SUMMARY OF PLAN AND OBJECTIVE EVIDENCE

Date: 5/15/17

Summary of Plan:

The 2017 internal audit plan will include identifying individuals requiring training to assist with the audit, providing and documenting the training, conducting the audit, and retaining the documentation via a modified conformance file indicating that all elements of the management system were covered. Trained auditors will be identified and checklists will be maintained to document the audits.

Summary of Objective Evidence:

Trained internal auditors have been identified and a checklist will be used as a method of maintaining records of the audits. The internal audit plan for 2017 was submitted as objective evidence. The nonconformity is resolved.

NC 5

Premises Name (if more than one): Click here to enter text.

REQUIREMENT: ISO/IEC 17025:2005

5.4.1 - The laboratory shall use appropriate methods and procedures for all tests and/or calibrations within its scope. ...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. ...

DESCRIPTION OF THE NONCONFORMITY:

The crime scene procedure for presumptive blood testing includes several options such as BlueStar and Hemastix, but no instructions on how to conduct the tests are present in CSPM 2016 R0.

DUE DATE for Resolution Plan: 3/29/17

DUE DATE for Resolution Completion: 5/28/17

SUMMARY OF PLAN AND OBJECTIVE EVIDENCE

Date: 5/15/17

Summary of Plan:

The crime scene procedures will be updated to include instructions on presumptive testing for blood.

Summary of Objective Evidence:

The updated crime scene procedure manual was provided as objective evidence. The nonconformity is resolved.

As a result of action by ANAB on April 3, 2017, NC #6 of 9 has been removed from this report. The remaining NCs have not been renumbered.

NC 7

Premises Name (if more than one): Click here to enter text.

REQUIREMENT: ASCLD/LAB-International 2011 Testing Supplemental
5.9.1.1 - Appropriate controls and standards shall be specified in the methods and their use recorded in the case record.

REQUIREMENT: ISO/IEC 17025:2005
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.

REQUIREMENT: CSPM 2016 R0, Section 9.3 - Presumptive Testing for Blood
Presumptive test results and positive and negative controls are recorded in the notes.

REQUIREMENT: FWM 2016 R2, Section 5.1.3 - Technical Requirements – General
Any Positive or Negative control results for casework are recorded in the Analyst's case notes.

DESCRIPTION OF THE NONCONFORMITY:
All required quality control procedures for the presumptive testing of blood in crime scene and the use of potassium thiocyanate in impression evidence are being performed, but the quality control results are not being recorded in the case record.

DUE DATE for Resolution Plan: 3/29/17
DUE DATE for Resolution Completion: 5/28/17

SUMMARY OF PLAN AND OBJECTIVE EVIDENCE
Date: 5/15/17
Summary of Plan:
The crime scene and footwear manuals will be updated to indicate quality control record requirements.

Summary of Objective Evidence:
The updated procedure manuals and case record examples were provided as objective evidence. The nonconformity is resolved.

NC 8

Premises Name (if more than one): Click here to enter text.

REQUIREMENT: ASCLD/LAB-International 2011 Testing Supplemental
5.9.4.1 - At a minimum, the technical review shall include a review of all examination records and the test report to ensure:

- Conformance with proper technical procedures (test methods) and applicable laboratory policies and procedures;
- Accuracy of test reports and that the data supports the results and/or conclusions in the test report;
- Associations are properly qualified in the test report; and
- The test report contains all required information.

DESCRIPTION OF THE NONCONFORMITY:
The technical review process did not accomplish the objective as four out of twenty-two records in latent prints that were reviewed during the assessment identified corrections needed to the information within the case record.

DUE DATE for Resolution Plan: 3/29/17
DUE DATE for Resolution Completion: 5/28/17

UMMARY OF PLAN AND OBJECTIVE EVIDENCE
Date: 5/15/17
Summary of Plan:
Case file review will be conducted to determine the extent of the administrative review issue. The procedure manual and administrative review form will be revised to require use of the checklist. Amended reports will be issued as necessary.

Summary of Objective Evidence:
An updated manual and checklist were provided as objective evidence, along with examples of the review process documentation and amended reports that were issued. The nonconformity is resolved.

NC 9

Premises Name (if more than one): Click here to enter text.

REQUIREMENT: ISO/IEC 17025:2005
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.

The results shall be reported, usually in a test report or a calibration certificate (see Note 1), and shall include all the information requested by the customer and necessary for the interpretation of the test or calibration results and all information required by the method used. This information is normally that required by 5.10.2, and 5.10.3 or 5.10.4.

DESCRIPTION OF THE NONCONFORMITY:
Results of requests for "footwear intelligence" are not being communicated in a test report.

DUE DATE for Resolution Plan: 3/29/17
DUE DATE for Resolution Completion: 5/28/17

SUMMARY OF PLAN AND OBJECTIVE EVIDENCE
Date: 5/15/17
Summary of Plan:
Footwear intelligence requests will be communicated through test reports requiring technical and administrative review. The footwear procedures manual will be revised to require issuance of a report when "footwear intelligence" requests are made.

Summary of Objective Evidence:
The updated manual and a case record example were provided as objective evidence. The nonconformity is resolved.

CM 1

COMMENT:
The laboratory has report templates with hard-coded statements that are not removed when they do not apply, such as uncertainty of measurement parameters. Modifying the templates could improve report clarity for the customers.

CM 2

COMMENT:
The laboratory currently requires periodic completion of an Advanced Technical Review form. The laboratory could benefit from clarifying the process and frequency of the review.