

CRIME LAB REPORT

Media and public policy analysis for the forensic science community

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Forensic science commissions: a waste of taxpayer dollars? You be the judge.

“One can reasonably suspect that the individuals involved may have felt pressured to move cases out the door in a timely manner – a cultural problem, if you will, that becomes exacerbated when resources are not sufficient to keep laboratory capacity in line with demand.”

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This wasn't supposed to happen in New York.

After all, the Empire State has a star-studded forensic science commission to provide oversight and protection from the supposed errors, corruption, and misconduct that legal activists would have us believe are running rampant in forensic science laboratories across the United States.

But it *did* happen.

Three instances of forensic science misconduct occurring in three separate laboratories in New York State received a handful of attention over the last eighteen months. Since the Commission on Forensic Science oversees all public forensic laboratories in the state, they designated the State Office of Inspector General (OIG) as the entity to investigate allegations of negligence or misconduct.

New York State Police

According to a 119 page report from the OIG, problems at the New York State Police (NYSP) Forensic Investigation Center first came to light during an April 2008 re-accreditation audit conducted by the American Society of Crime Laboratory Directors - Laboratory Accreditation Board (ASCLD/LAB) when an assessor discovered questionable results and an apparent lack of basic skills and knowledge in the analysis of fibers, as well as incomplete documentation of examinations related to casework in impression evidence.

At the time, the NYSP had only one analyst, Garry Veeder, performing fiber comparisons. Rather than jeopardize its re-accreditation, NYSP decided to cease performing all fiber cases. The NYSP set up a corrective action plan to re-train Veeder and monitor his impression evidence casework.

During an internal investigation, Veeder “admitted to bypassing an analysis required by forensic center protocols and then creating data to give the appearance of having conducted an analysis not actually performed.”

Veeder also told investigators he “lacked the capability of actually performing the test because he was never taught [the] technique and supplied a copy of the reference chart . . . provided to him as part of his training by the prior supervisor in the trace section.”

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“Veeder repeatedly asserted that he was trained to backfill the information using the crib-sheet and that this improper procedure was potentially systemic in the laboratory.”

In early May 2008, Veeder announced that he would retire effective May 30.

But on May 23, two days after he was requested to submit to another interview, Veeder tragically took his own life.

When the results of the NYSP internal investigation were finally submitted to the State Forensic Science Commission, they did not include Veeder’s allegations that the problems in the trace evidence section were potentially systemic to the entire NYSP lab system. So when the OIG conducted its own independent investigation, it determined that the NYSP had “inappropriately and precipitously dismissed Veeder’s implication of other scientists and the deficient training he had received.”

The report further substantiated Veeder’s statement that his former supervisor and trainer, Anthony Piscitelli, had likely been the one who encouraged Veeder to fabricate the data.

At issue was the NYSP requirement to perform a refractive index determination using the *Becke Line method* when examining fiber evidence. According to the OIG report, Piscitelli told investigators “he was not a believer in the determination of refractive index and that he did not require scientists in the trace section to conduct this test.”

Piscitelli volunteered that the refractive index could be obtained from a generally available reference chart and was familiar with the chart Veeder used as a “crib-sheet.”

Fortunately, the OIG determined that there was no evidence that other fiber examiners, who reportedly had extensive training and experience in fiber examinations prior to coming to the NYSP, had used the crib-sheet.

The OIG did discover, however, that several scientists had expressed concerns about the quality of the technical reviews performed in the trace evidence section and that at least one fiber analyst had written a formal complaint as far back as 1994 that was ignored by the laboratory management.

Monroe County

In Rochester, New York’s third-largest city, a seventeen year veteran with the Monroe County Public Safety Laboratory was also investigated by the OIG after an internal lab investigation determined that she falsified quality control data between April and August of 2008.

Linda Teague admitted that she deliberately manipulated instrumental data obtained from a routine test of a solvent blank on a gas chromatograph/mass spectrometer (GC/MS) designed to identify potential contamination and/or problems with the operation of the instrument.

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In August 2008, one of Teague's co-workers received a batch of cases for technical review. The reviewer noted the presence of + signs on the instrumental data for the solvent blanks and brought this to the attention of the section supervisor.

When confronted, Teague initially stated that she had only been doing this data manipulation for about a month and even claimed that most labs do not run a solvent blank.

Teague was immediately removed from casework and an extensive review was conducted of her previous casework. After Teague retired in lieu of termination, the laboratory also agreed to re-test any of Teague's cases upon request.

There were no differences found related to the positive or negative results of her examinations, but there were discrepancies related to the total weights of the substances tested.

Most revealing perhaps were the statements made by other chemists with whom Teague worked on a daily basis. They told investigators that she was the section's "top producer" and "completed more analyses than any other chemist at the lab." One of her colleagues was quoted as saying that "Teague was a work horse who moved more cases than any other [forensic chemist of equal seniority]."

Investigators found no evidence that Teague had removed any of the substances for personal use. When she was asked to explain her sampling methodology, Teague told investigators "I never really worried about the amount I took because sometimes if I took too little I would have to go back then start all over again. I didn't want to be slowed down."

Erie County

Finally, on February 27, 2009 chemist Kelly McHugh with the Erie County Department of Central Police Services Forensic Laboratory in Buffalo consulted with her supervisor that she had received conflicting results from a positive cobalt thiocyanate color test for cocaine and a negative GC/MS. The supervisor reminded her that she was required by laboratory policy to also conduct the Marquis color test before reporting the sample negative.

When the case report was submitted to the supervisor for technical review, the case file indicated that the Marquis test had been performed. The chain of custody record, however, clearly showed that the evidence had been in the evidence room at the time the test had reportedly been conducted.

The lab's policy was that a minimum of 20% of chemistry cases be submitted for technical review. Due to past problems with what had been characterized as "sloppy" work, however, McHugh's work was being subjected to 100% technical review.

McHugh was suspended from casework and was subsequently terminated for falsification of a report and refusal to answer questions at an administrative hearing. An internal investigation conducted by the laboratory, however, discovered other problems with McHugh's case work,

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including discrepancies that the laboratory determined should have been exposed during technical review.

As a result, the laboratory instituted a new policy of 100% technical review, hired a full-time quality manager, and required its chemists to note specifically in the chain of custody when evidence is actually being examined on the bench.

In December, McHugh plead guilty in Buffalo City Court to Attempted Tampering with Public Records in the Second Degree, with her sentencing scheduled for May 14, 2010.

The Bottom Line

So what does this all mean? What were the root causes of these systemic failures? What was supposed to be the role of the New York Forensic Science Commission in preventing these failures and responding to them once they finally came to light?

In the case of the NYSP, it appears that a “shortcut” conveniently employed by an analyst prior to the rigors of accreditation-mandated quality standards was passed down to a subordinate analyst, Garry Veeder, during his training. Since the service was infrequently conducted and was technically reviewed either by the analyst who invented the shortcut or an individual that was not properly qualified to conduct reviews, the deviation went undetected for some time.

In Monroe and Erie Counties, however, the problems occurred in relatively high-volume sections of the laboratory and were identified very quickly. One can reasonably suspect that the individuals involved may have felt pressured to move cases out the door in a timely manner – a cultural problem, if you will, that becomes exacerbated when resources are not sufficient to keep laboratory capacity in line with demand.

In all three of these unfortunate instances of malpractice, the subsequent investigations were conducted by internal laboratory personnel and representatives of the New York State Office of Inspector General.

According to its website, the Inspector General's Office is entrusted with the responsibility of ensuring that State government, its employees, and those who work with the state meet the highest standards of honesty, accountability, and efficiency.

Based on a full review of the investigative reports, it appears that the investigations were all very thorough.

This leads *Crime Lab Report* to question the real purpose of the New York State Commission on Forensic Science, which was established by Article 49-B of the State Executive Law to develop minimum standards and a program of accreditation for all forensic laboratories in New York State.

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Twelve of the fourteen members of the Commission are appointed by the governor. There is no requirement to include a forensic scientist - only a laboratory director and the chair of the New York State Crime Laboratory Advisory Committee, which may or may not actually be a forensic scientist.

It appears that the Commission simply defers the responsibility for investigating labs to the OIG, which relies to a large extent on the laboratory's own guidelines, as mandated by accreditation, to conduct an investigation when issues relating to quality are discovered.

It also appears that in at least two of the cases mentioned here, the OIG was actually in agreement with the corrective actions taken by the laboratory.

The Office of Forensic Services is the entity that actually monitors laboratory compliance with accreditation standards established by the Commission on Forensic Science. Last September, John Hicks gave a presentation to crime lab directors at their annual meeting in California in which he outlined some of the observations he made while serving as the Office's director.

On a positive note, the Commission, along with the New York State Department of Public Health, officially recognized and adopted the accreditation standards from the American Society of Crime Laboratory Directors/Laboratory Accreditation Board, the American Board of Forensic Toxicology, and the FBI Quality Assurance Standards for Forensic DNA Testing Laboratories. The law and the process have helped to guide New York's twenty-two state and local labs towards adopting more uniform standards. They have also facilitated the exchange of information among laboratories and technical working groups.

Additionally, there is now access to a variety of specialized technical training courses for laboratory personnel, increased awareness of the needs of forensic labs by legislators and other government officials, and a level of transparency that comes from the public meeting process.

Sadly, but predictably, the Commission is also fraught with problems such as too many members with limited or no experience in forensic science or crime lab management, inflated representation by members of the legal community, no term limits for the Commission members, and procedural delays that slow the implementation of policy changes or new technology.

Even more troubling, some commission members simply have no understanding or appreciation for accreditation or the robustness of the required quality management systems. Worse, some commission members present themselves as being more interested in publicly rebuking labs or using their position as a platform from which to advocate their own personal or political causes.

New York is not alone. Similar problems are now, in fact, brewing in Texas where political wrangling has essentially forced a complete overhaul of the state's Forensic Science Commission.

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So we ask again, what was the real motive in the formation of the New York State Commission on Forensic Science? The Commission obviously had no role in preventing or detecting the lapses that occurred at these three laboratories.

Crime Lab Report has been, and continues to be, a strong advocate for accreditation as the best and most tested solution for identifying and preventing problems in our nation's crime laboratories. Although accreditation standards, or any standards for that matter, cannot fully guarantee that instances of malpractice will never occur, New York should at least be commended for leadership in making accreditation mandatory across the state.

But the forensic laboratory community at large was far ahead of New York. The American Society of Crime Laboratory Directors (ASCLD) recognized the importance of accreditation nearly thirty-five years ago when it laid the groundwork for the widely acclaimed program of accreditation currently administered by its strategic partner, ASCLD/LAB.

The three cases presented here are real life illustrations of the effectiveness of this program, which now provides accreditation to well over 80% of the publicly funded laboratories in the United States.

It's time for our elected officials and journalists to recognize what forensic science professionals have known for years. Professional peer oversight, strong leadership, and the responsible allocation of resources are the keys to quality in science.

Crime Lab Report remains stunned and disappointed that so many commentators, both inside and outside of the profession, will not fully acknowledge that forensic science laboratories have basic organizational needs just like every other industry and every other profession. When those needs are met, great things happen in forensic science.

When those needs are not met, however, bad things happen. It's not a difficult concept to understand.

Then again, it's also not difficult to understand that there are those who, for their own unique reasons, desperately want the challenges of the forensic science community to be perceived as remarkably complex. For if it was so, an entirely new industry and governmental platform of forensic science oversight might seem justified.

And who do you suppose would benefit from that? *****

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