THE STATE of ALASKA
GOVERNOR BILL WALKER

**Department of Public Safety**

SCIENTIFIC CRIME DETECTION LABORATORY

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This is the Alaska Scientific Crime Detection Laboratory's final assessment report for the ASCLD/LAB-*International* on-site assessment that was conducted March 12-16, 2012.

This assessment was conducted on the over 400 requirements of *ISO/IEC 17025:2005*; the *ASCLD/LAB-International Supplemental Requirements for Testing Laboratories* (2011); the *Quality Assurance Standards for Forensic DNA Testing Laboratories* (2011) and the *Quality Assurance Standards for DNA Databasing Laboratories* (2011). As these are copyrighted licensed documents, they are available via the following websites.

- *ISO/IEC 17025:2005* is available for purchase at *http://www.iso.org/iso/home/store.htm*
- *ASCLD/LAB-International Supplemental Requirements for Testing Laboratories is* available for purchase at *http://www.ascld-lab.org/international-accreditation-requirements/*
- *Quality Assurance Standards for Forensic DNA Testing Laboratories* and the *Quality Assurance Standards for DNA Databasing Laboratories* are available at http://www.fbi.gov/about-us/lab/biometric-analysis/codis/stds_testlabs

**ASCLD/LAB-*International***

# Final Assessment Report

## Alaska Department of Public Safety
## Scientific Crime Detection Laboratory
Anchorage, Alaska

## PART 1 – GENERAL INFORMATION

## INTRODUCTION

This is the ASCLD/LAB-*International Final Assessment Report* of the Alaska Department of Public Safety - Scientific Crime Detection Laboratory. The on-site assessment was conducted during the period March 12-16, 2012.

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

**Lead Assessor:**

Edward A. Moilanen - Staff Inspector, ASCLD/LAB / Roscommon, Michigan

**On-Site Technical Assessors:**

Kevin Fortney - Washington State Patrol Crime Laboratory / Cheney, Washington
Lori Bates Wilson - Houston Police Department Crime Laboratory / Houston, Texas
Allison Eastman - Retired from New York State Police / Niskayuna, New York
Eliza Smaltz - Scottsdale Police Department Crime Laboratory / Scottsdale, Arizona
Nat Pearlson - Minnesota BCA Forensic Science Service / Bemidji, Minnesota
Kerri Sage - New York State Police / Albany, New York

## 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); the *Quality Assurance Standards for Forensic DNA Testing Laboratories* (2011); the *Quality Assurance Standards for DNA Databasing 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 |
| Toxicology | Human Performance Forensic Toxicology (Blood Alcohol Only) |
| Biology | DNA-Nuclear<br>Body Fluid Identification<br>Individual Characteristic Database |
| Trace Evidence | Fire Debris |
| Latent Prints | Latent Print Processing<br>Latent Print Comparisons |
| Firearms/Toolmarks | Firearms<br>Toolmarks |
| Crime Scene | Crime Scene Investigation |
| Other | Serial Number Restoration -<br>Considered a part of the Firearms/Toolmarks discipline |

# LABORATORY OVERVIEW

The Alaska Department of Public Safety - Scientific Crime Detection Laboratory is a state government laboratory that provides services and assistance to law enforcement agencies throughout the state of Alaska. The laboratory is located at 5500 E. Tudor Road, Anchorage, Alaska and also has a satellite facility located in Fairbanks, Alaska. Orin Dym is the laboratory director and, at the time of the assessment, the laboratory had a staff of 26 proficiency tested personnel and 15 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 laboratory.

Each requirement for which the assessment team found the laboratory to not be in total conformance was initially marked "No". For each requirement marked "No", the laboratory was provided with a Corrective Action Request (CAR) following the on-site assessment. A copy of each CAR provided to the laboratory is included in Part 2 of this report.

As reflected on the CAR documents in Part 2 of this report, the laboratory has now completed appropriate corrective actions for all CARs issued.

# 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

# OTHER CONSIDERATIONS

*Other Considerations* may include any topic, issue or information of which the ASCLD/LAB Board of Directors needs to be aware in order to make a more fully informed decision regarding the accreditation decision.

In accordance with ASCLD/LAB policy and procedures the following information was provided by the ASCLD/LAB headquarters office immediately prior to the accreditation decision:

**Proficiency Testing**

On-site the assessment team found the laboratory to be in conformance with all applicable proficiency testing requirements. A follow-up check with the ASCLD/LAB Proficiency Program Manager immediately prior to this final report, reveals that the laboratory is currently in conformance with all applicable, ASCLD/LAB external proficiency testing requirements.

**Complaints against the Laboratory**

No pending complaints known to ASCLD/LAB.

## REPORT AUTHORIZATION

This *Final Assessment Report* of the Alaska Department of Public Safety - Scientific Crime Detection Laboratory is issued by Lead Assessor Edward Moilanen. As Lead Assessor, Mr. Moilanen 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 Edward Moilanen**

Edward A. Moilanen

Signature

September 20, 2012

Date

## DISTRIBUTION LIST

Orin Dym, Laboratory Director

Nita Bolz, Quality Manager

Ralph M. Keaton, ASCLD/LAB Executive Director

John K. Neuner, ASCLD/LAB Accreditation Program Manager

Tracy Cheaney-Plummer, ASCLD/LAB Accreditation Program Manager

# PART 2 – CORRECTIVE ACTION REQUESTS

## CORRECTIVE ACTION REQUEST (CAR) Number 1 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 5.4.1, 5.9.2<br>5.9.2 | Source: | ISO/IEC 17025:2005<br>Lab Qual System Doc | Level: | 1 |
| Requirement: | 5.4.1 - General - The laboratory shall use appropriate methods and procedures for all tests and/or calibrations within its scope…….<br><br>5.9.2 - Quality control data shall be analyzed and, where they are found to be outside pre-defined criteria, planned action shall be taken to correct the problem and to prevent incorrect results from being reported.<br><br>5.9.2 - QA MANUAL - If quality control data is found to be outside of the pre-defined criteria, a planned action will be undertaken to correct the problem and prevent incorrect results from being reported. Discipline procedure manuals will provide additional guidance for that specific discipline. | | | | |
| Finding: | Latent Print procedures require controls for chemical processing. The use of these controls is documented in the latent print case record; however, there are no criteria that define what a positive or negative control result is.<br><br>The Biology positive control testing procedures for analytical batch techniques is not appropriate. The Biology Procedures Manual under section 6.2.1 states: "*If no interpretable profile is obtained with any suitable positive amplification control(s), then a positive amplification control and a designated percentage of the samples in the run (10% of the samples for a casework batch) shall be re-amplified and re-typed. If all interpretable results agree for the samples between the first and second amplification/run, and the positive amplification control yields a correct STR profile for the second amplification/run, then the STR data obtained in the initial amplification/run may be used.*" The procedure allows all the results from the first run with the failed positive control to be reported with only ten percent of the samples being re-amplified and re-typed with a suitable positive control. Ninety percent of the samples are reported even though they were run with a failed (non-interpretable) positive control.<br><br>Blood alcohol procedures (Section 6) require that two analyzed values for each unknown sample must agree within plus or minus .005 or five percent whichever is greater. There is no planned action to be undertaken if this criteria is not met. | | | | |

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|---|---|
| | The Crime Scene discipline has a documented performance check procedure for the alternate light source. The check procedure does not have pre-defined criteria or a planned action to be taken if the test fails.<br><br>The Biology procedure for the 3130 XL genetic analyzer TH 01-9.3-10 resolution test does not define performance criteria for pass or failing the instrument. |
| Corrective Action Due By: | On or before October 8, 2012 |

**CORRECTIVE ACTION**

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|---|---|
| Lab Response: | Criteria defining positive and negative results for controls will be added to the Latent Print Procedure Manual.<br><br>***Finding: Biology Positive Control Procedures*** The DNA laboratory will no longer retain the policy of re-testing only 10% of the casework samples if a positive control fails in that batch of samples. The policy will be amended to: "All casework samples in a batch will be re-analyzed if only one positive control sample was used in that batch and this control fails. The laboratory will routinely include at least 5 positive control samples in every casework batch in order to prevent reanalysis of samples that are limited in DNA content. If at least one of these 5 positive control samples produces acceptable and expected results, the batch will not be reanalyzed. A positive control will be defined as a single source sample whose genetic profile was previously determined and from which a full profile was developed. The positive control may be a previously tested convicted offender sample or a buccal swab freshly obtained from laboratory personnel whose genetic profile(s) was/were previously determined".<br>Note: No casework batches were adversely affected by the 10% reanalysis policy to date.<br><br>***Finding: Blood Alcohol Procedures*** The Quantitative Alcohol Procedure Manual will be revised to include:<br>"If duplicate analyzed values do not agree within plus or minus 0.005 or five percent, whichever is greater, then the sample will be diluted a second time and analyzed. If the second dilution's analyzed values does not fall within plus or minus 0.005 or five percent, whichever is greater, the sample may be diluted a third time. Should the analyzed values of the third dilution not fall within plus or minus 0.005 or five percent, whichever is greater, the sample will be reported as "Sample quality insufficient for quantitation."<br><br>The Forensic Biology procedures will be updated to include the following:<br>"Acceptable results for this test will consist of clear separation (resolution) of these 2 alleles by capillary electrophoresis and both peaks will have to be above the analytical threshold, which is currently set at 100 RFU. If a capillary fails to demonstrate clear resolution of the two peaks and/or the peaks are not greater than 100 RFU, the injection will be repeated for the failing capillaries. If the capillary/capillaries fail(s) a second time, then that capillary will not be used in data collection. The information will also be posted in the maintenance binder and posted on the CE instrument."<br>The Crime Scene Procedure Manual will be updated to reflect the criteria of the performance check and the planned action if the test fails. |

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| | "Check the ALS against a known standard prior to searching a crime scene to ensure the system is functioning properly and the bulb intensity is sufficient to provide adequate fluorescence (ALS+). Record the results of the control test in the notes. If the performance check fails, the test may be repeated one time. If the test still results in no fluorescence, the instrument may require maintenance. If this result interferes with a technician's ability to process a scene or evidence, the Discipline Supervisor will be notified as soon as practicable to determine an appropriate course of action. In the interim, if an agency has an ALS available it may be utilized at the crime scene. Follow the manufacturer's instructions for use and record the instrument make/model in the notes in addition to the combination of goggle color and wavelength of light." |
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the criteria:<br>- Copy of the revised Latent Print Procedure Manual containing definitions for positive and negative control results.<br>- Copy of the revised Biology DNA procedure for the use of positive controls in batch case work. Twelve records of batch DNA runs verifying compliance with the revised procedure (multiple positive controls) and the Standard. Interviews and case record reviews on-site did not reveal an instance when a positive control had failed.<br>- Copy of an audit of past DNA case work confirming no positive control had failed.<br>- Copy of the revised Quantitative Alcohol Procedure Manual, including the planned action to be taken if the acceptance criteria is not met. The documented planned action reflects laboratory practice in past casework.<br>- Copy of the revised Crime Scene Procedure for performance checking the alternate light source. The revision included criteria for pass/fail and planned action to be taken when the performance test fails. A copy of one crime scene report (only one available) including documentation of the performance test of the alternate light source used.<br>- Copy of the revised Forensic Biology Procedure manual describing acceptable performance criteria and planned action if the TH 01-9.3-10 resolution test does not meet the defined criteria for checking the 3120 Genetic Analyzer.<br>- Copies of monthly performance check logs. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes

Revisit Conducted By: _____

Date of Revisit (if applicable): _____

Edward A. Moilanen

Lead Assessor Signature

9-17-12

Date Accepted

## CORRECTIVE ACTION REQUEST (CAR) Number 2 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 4.2.1, 5.4.1 | Source: | ISO/IEC 17025:2005 | 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.<br><br>5.4.1 - General - The laboratory shall use appropriate methods and procedures for all tests and/or calibrations within its scope…<br><br>…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. All instructions, standards, manuals and reference data relevant to the work of the laboratory shall be kept up to date and shall be made readily available to personnel… | | | | |
| Finding: | The Crime Scene discipline does not have procedures or instructions documented or referenced in the Crime Scene procedure manual for the following processes: Sketching; Laser measuring system; Physical developer; Ninhydrin; Bullet trajectory determination. All of these processes are listed by name in the Crime Scene procedure manual for use by Crime Scene personnel. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

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|---|---|
| Lab Response: | A procedure for sketching will be added to the Crime Scene Procedure Manual.<br><br>The Crime Scene Discipline does not perform bullet trajectory determinations, but will develop a procedure to document shooting scenes. As such, the reference to bullet trajectory determinations will be removed from the manual and a procedure for documenting shooting scenes will be added.<br><br>The Crime Scene Procedure Manual will reference the Latent Print Procedure Manual for Ninhydrin. |

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| | Laser measuring systems and Physical developer are not utilized by the Crime Scene Discipline. As such, the reference to them will be removed from the Crime Scene Procedure Manual. |
| Supporting Documentation Provided by Laboratory: | The following revisions to the Crime Scene Procedure Manual were received and reviewed verifying compliance with the Standard:<br>- Copy of the approved crime scene sketching procedures.<br>- Copy of the approved procedure for documenting shooting scenes with reference to bullet trajectory removed.<br>- Copy of the approved Crime Scene Manual with reference to the Latent Print Procedure Manual for Latent Print processing instructions.<br>- Copy of the Crime Scene Procedure Manual revision history page including removal of the use of laser measuring systems and physical developer.<br><br>No crime scenes were processed since the on-site visit requiring procedures applicable to the reported findings and revisions to the Crime Scene Procedure Manual; therefore, a sampling of records will be reviewed during the first surveillance visit, if available. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes
Revisit Conducted By: _____
Date of Revisit (if applicable): _____

Edward A. Moilanen
Lead Assessor Signature

9-17-12
Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 3 of 19

Laboratory Name: ALASKA DPS SCIENTIFIC DETECTION LABORATORY
Laboratory Location: ANCHORAGE, ALASKA
Laboratory Contact Name: NITA BOLZ, QUALITY MANAGER
Contact Number: 907-265-0599
Summation Conference Date: 3-16-12

**FINDING**

| Clause No.: | 4.13.2.1, 4.13.2.2<br>4.13.2.2 | Source: | 2011 Supplemental-Testing<br>Lab Qual System Doc | Level: | 1 |
|---|---|---|---|---|---|
| Requirement: | 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.<br><br>4.13.2.2 - Observations, data and calculations shall be recorded at the time they are made and shall be identifiable to the specific task.<br><br>4.13.2.2 - QA Manual - Examination notes will include observations, data and calculations. These notes will be documented at the time of examination and identifiable to the specific task. If an observation or result is rejected by the analyst or technician the reason must be documented in the case file. | | | | |
| Finding: | All original drug chemistry data generated during the analysis process is not being retained. In the event of carry over, weak sample or over concentration, the data is rejected and deleted. Only the data supporting the reported conclusion is retained and transferred to the LIMS system.<br><br>There is no documentation of rejected drug chemistry data or the reason for the rejection in the case record as required by the laboratory Quality Assurance Manual.<br><br>When laboratory Crime Scene personnel are involved with the collection of evidence at the scene, the Crime Scene examination record is not specific as to who collected the evidence gathered and transported from the scene. An audit of collected Crime Scene evidence did not clarify the issue. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

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|---|---|
| Lab Response: | The Controlled Substances Discipline Manual will be updated to:<br>When instrumental acquisitions are complete, the analyst will review the data and put a copy into the case file. Each electronic copy will include the header information listed above, a total ion chromatogram, and the mass spectrum of each peak labeled by the analyst.<br><br>***Finding: Documentation of Rejected Drug Chemistry***<br>The Controlled Substances Discipline Manual will be updated to:<br>If GC/MS data is rejected, the reason for the rejection will be recorded in the notes and the spectra saved, in addition to the non-rejected data.<br><br>***Finding: Crime Scene***<br>Add definitions to the Crime Scene Procedure Manual for documentation, collection, and packaging.<br>**Collection:** indicates the evidence was moved by the technician and placed in an appropriate container. The container will be marked at a minimum with the following information:<br>Lab or agency number, item or placard number, description, date, and technician's initials.<br>**Packaging:** indicates evidence container was sealed with evidence tape and initialed/dated by the technician.<br>**Documentation:** includes the written description of the item in the technician's notes referenced by the placard number. This may or may not include photographs of each item.<br>Add detail to the Crime Scene Procedure Manual to include:<br>When evidence is collected by the technician it will be placed in an appropriate container and marked. Each container will contain, but is not limited to:<br>Lab or agency number<br>Item or placard number<br>Item description<br>Date<br>Technician's initials<br>Note: the container utilized at the scene may be a temporary container.<br><br>When evidence is packaged by a technician it will be evidence tape-sealed and marked with the technician's initials and the date sealed. Whenever possible these markings should cross the barrier between the evidence tape and the container. The technician's notes will state the item was packaged.<br><br>The evidence list and photo log summarizes all evidence documented at the scene. Each evidence item is identified by a placard number with a brief description. The term "photo" in the associated evidence items column indicates the item was only documented and photographed by the technician, but was not collected and/or packaged. Evidence collected will be assigned an evidence item number which will be recorded under the associated evidence column. |

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| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the applicable Manual revisions and the Standards:<br>- Copy of the revised Controlled Substances Discipline Manual effective 7-1-12<br>- Copies of seven (7) case records containing documentation of all generated data.<br>- Copies of seven (7) case records containing documentation of all data - rejected and non-rejected. The reason for the data rejection was documented.<br>- Copy of the revised Crime Scene Procedure Manual. Effective 7-2-12<br>- Copies of four (4) crime scene case records. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes

Revisit Conducted By: _____

Date of Revisit (if applicable): _____

Edward A. Morlanes
Lead Assessor Signature

9-17-12
Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 4 of 19

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|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 4.2.1 | Source: | ISO/IEC 17025:2005 | Level: | 1 |
| Requirement: | 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. | | | | |
| Finding: | There is no procedure for following up if a DNA offender profile is non-interpretable and cannot be uploaded. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | This finding will be remedied by an update to the CODIS Administrative Manual (section 3.1).<br>Additional paragraphs will be added at the end of this section as follows:<br>"While there is no absolute minimum number of core loci required for an offender sample to be entered into the state database, data must be present at all 13 core loci for an offender sample to be uploaded to NDIS. When an offender profile fails to generate a profile for all 13 core loci and the lab does not possess a duplicate offender sample for the individual, the analyst or CODIS Administrator will first remove the state ID number from the case record in LIMS. This ensures that any new sample for the offender will result in a new request for analysis. The analyst will also enter "profile failed" in the "NO" field in the "Individuals" tab in LIMS. A verification of the individual's qualifying offense, and current locate information, is then requested of the legal assistant. If the offender has a qualifying offense, the analyst will attempt to request a new sample. This can be done by contacting correctional facilities for incarcerated persons, probation/parole officers, and/or Department of Law personnel when an offender is not in custody, but has an upcoming court date. The request will be documented in the case record in the LIMS. It is recognized that there is not always a mechanism by which to obtain the new sample." |

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| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the Standard:<br><br>- Copy of the updated CODIS Procedure<br><br>The updated procedure documents the laboratory practice as reviewed on site including follow-up actions if the profile in non-interpretable. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes
Revisit Conducted By:
Date of Revisit (if applicable):

Edward A. Marlowe
Lead Assessor Signature

9-17-12
Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 5 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 5.8.4.2.1, 5.8.4.2.1 | Source: | 2011 Supplemental-Testing Lab Qual System Doc | Level: | 1 |
| Requirement: | 5.8.4.2.1 - Laboratory policy concerning evidence in the process of examination / analysis cannot be open-ended and shall be based upon a justifiable expectation of frequent examination/analysis.<br><br>5.8.4.2.1 - QA MANUAL - The laboratory defines evidence in the process of examination as during the work day. All evidence will be secured overnight in locked areas. | | | | |
| Finding: | The laboratory policy concerning evidence in the process of examination is open ended and does not limit the amount of time evidence can be left secured and in the process of examination. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | The Laboratory's Quality Assurance Manual 2012 R1 (effective 7-1-12) states: 5.8.4.2.1 - "The Laboratory defines evidence in the process of examination for no longer than 45 days. Evidence in the process of examination can be stored unsealed in a secure limited access area."<br>A crystal report titled "Evidence in Possession" was placed in LIMS to allow management to review evidence in possession. This report contains the date of transfer to the individual which allows management to monitor time of possession. |
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the Standard and the revised policy:<br><br>- 34 page report on evidence in the process of examination within the laboratory<br>- Copy of the revised Quality Assurance Manual effective 7-1-12 |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes
Revisit Conducted By:
Date of Revisit (if applicable):

Edward A. Moilanen
Lead Assessor Signature

9-17-12
Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 6 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 4.2.1<br>4.13.2.5.1 | Source: | ISO/IEC 17025:2005<br>Lab Qual System Doc | 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.<br><br>4.13.2.5.1 - Latent Print Procedures - All exclusions of individuals must be verified by a second analyst. | | | | |
| Finding: | A Latent Print case record review revealed reported exclusions of individuals were not verified as required by laboratory procedure. An electronic search of latent print reports since September of 2010 revealed three reports in which exclusions were made. The three reports included nine exclusions. None of the exclusions were verified. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | ***Finding: Latent Print Exclusions not Verified***<br>The Latent Print Discipline will create a list of cases needing attention and will document verification of exclusions in cases.<br>The Latent Print Supervisor will check and keep a list of all exclusions made for one year.<br>From the Quality Manager on 8/10/2012 – No exclusions made it casework in July 2012.<br>From the Quality Manager on 8/30/2012 –No exclusions made it casework in August 2012 |

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|---|---|
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the procedure and the Standard:<br>- Copies of verification reports for the exclusions that had been reported and not verified since 2010. All exclusions reported since 2010 are now verified. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes

Revisit Conducted By: _____

Date of Revisit (if applicable): _____

Edward A. Moilanen

Lead Assessor Signature

9-18-12

Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 7 of 19

Laboratory Name: ALASKA DPS SCIENTIFIC DETECTION LABORATORY
Laboratory Location: ANCHORAGE, ALASKA
Laboratory Contact Name: NITA BOLZ, QUALITY MANAGER
Contact Number: 907-265-0599
Summation Conference Date: 3-16-12

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 5.1.3.1 | Source: | 2011 Supplemental-Testing | Level: | 1 |
| Requirement: | Reagents prepared in the laboratory shall be labeled with, at a minimum, the identity of the reagent and the date of preparation or lot number. Records shall be maintained identifying who made the reagent and that its reliability was tested and the reagent worked as expected. The reliability testing shall occur before use or, if appropriate, concurrent with the test. | | | | |
| Finding: | Two small reagent bottles were observed in the latent print processing hood. One had the name of the reagent on it while the second had no identification on it. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | Day use reagent bottles in the latent print hoods have been labeled with the name of the reagent. The Latent Print Procedure manual has been revised to read "for latent print evidence processing, chemicals are decanted into "day use" containers. These "day use" containers are emptied at the end of each day." |
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the Standard and the revised procedure:<br>- Photographs of twelve (12) labeled Latent Print processing day use reagent bottles.<br>- Laboratory practice observed on site included properly labeled and logged stock reagent containers. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes
Revisit Conducted By:
Date of Revisit (if applicable):

Edward A. Marlanee
Lead Assessor Signature

9-26-12
Date Accepted

## CORRECTIVE ACTION REQUEST (CAR) Number 8 of 19

Laboratory Name: ALASKA DPS SCIENTIFIC DETECTION LABORATORY
Laboratory Location: ANCHORAGE, ALASKA
Laboratory Contact Name: NITA BOLZ, QUALITY MANAGER
Contact Number: 907-265-0599
Summation Conference Date: 3-16-12

**FINDING**

| Clause No.: | 5.5.2, 5.5.5 (c, f)<br>1.2 | Source: | ISO/IEC 17025:2005<br>Lab Qual System Doc | Level: | 1 |
|---|---|---|---|---|---|
| Requirement: | 5.5.2 - Equipment and its software used for testing, calibration and sampling shall be capable of achieving the accuracy required and shall comply with specifications relevant to the tests and/or calibrations concerned. Calibration programmes shall be established for key quantities or values of the instruments where these properties have a significant effect on the results. Before being placed into service, equipment (including that used for sampling) shall be calibrated or checked to establish that it meets the laboratory's specification requirements and complies with the relevant standard specifications. It shall be checked and/or calibrated before use (see 5.6).<br><br>5.5.5 - Records shall be maintained of each item of equipment and its software significant to the tests and/or calibrations performed. The records shall include at least the following:<br><br>c) checks that equipment complies with the specification (see 5.5.2);<br>f) dates, results and copies of reports and certificates of all calibrations, adjustments, acceptance criteria, and the due date of next calibration;<br><br>Firearms Procedure Manual<br>1.2 USAGE<br>1.2.1 - The comparison microscope will be checked prior to use to insure that it is functioning properly<br>1.2.2 - The check will be performed by placing two similar items on each stage (test to test) and observing the agreement…<br>1.2.3 - This check does not need to be documented. | | | | |
| Finding: | Procedures are established to performance check the firearms comparison microscopes, trigger pull weights and crime scene and biology alternate light sources. The procedures state these checks do not have to be documented. There is no documentation that the required checks are being done. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | Updated Firearms Toolmark Manual FATM 2012 RO Appendix 3, page 206 on Trigger Pull Devices contains the requirement to document the yearly trigger pull weights performance checks.<br><br>Firearms/Toolmark procedures have been updated to include documentation of the required comparison microscope performance test.<br><br>Crime Scene Procedure Manual Section 9.5 has been updated to include documentation of the required performance check of the alternate light source.<br><br>Forensic Biology procedures have been updated to include documentation of the alternate light source performance checks. |
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying conformance with the Standard and the revised procedures:<br><br>- Revised Firearms Procedure Manual requiring documentation of the trigger pull weight performance checks and comparison microscope performance checks – 7-7-12<br>- Documentation for the firearms trigger pull weights performance check dated 8-27-12<br>- Copies of five (5) case records, from July and August, documenting the performance check of the comparison microscope<br>- Revised Forensic Biology procedures for checking and documenting the performance of the alternate light source – 7-5-12<br>- Copies of eight (8) Biology Screening case records, from July, documenting the performance check of the alternate light source used<br>- Revised Crime Scene Procedures for checking and documenting the performance of the alternate light source – 7-2-12<br>- One (1) copy of a crime scene case record (only one in which the ALS was used) including documentation of the alternate light source performance test |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes

Revisit Conducted By: _____

Date of Revisit (if applicable): _____

Edward A. Moilanen

Lead Assessor Signature

9-18-12

Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 9 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 5.6.3.2.1 | Source: | 2011 Supplemental-Testing | Level: | 1 |
| Requirement: | Reference collections of data or items/materials encountered in casework which are maintained for identification, comparison or interpretation purposes (for example, mass spectra, motor vehicle paints or headlamp lenses, drug samples, typewriter print styles, wood fragments, bullets, cartridges, DNA profiles, frequency databases) shall be fully documented, uniquely identified and properly controlled. | | | | |
| Finding: | Firearms bullet collections used to identify the caliber of evidence bullets are not uniquely identified or documented. Collections contain more than one reference standard per caliber. When a comparison is made and reported, the specific bullet used to make the comparison cannot be identified. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | ***Finding: Firearms Bullet Collection***<br>The Firearms Procedure Manual FA-II-6 will be updated to:<br>6.1.4 Each item in the reference collection is to be uniquely identified and documented. When a comparison is made and reported, the specific ammunition reference standard utilized must be identified in the case file. |
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed confirming compliance with the Standard and the revised procedure:<br>- Copy of the revised Firearms Procedure Manual 6.1.4 – effective 7-7-12<br>- Copy of the jacketed handgun bullet standard log uniquely identifying and documenting reference handgun ammunition<br>- Copy of one case record (only case completed) in which the reference ammunition used is specifically identified<br>Since there were limited records to review at this time, a sampling of records will be reviewed during the first surveillance visit, if available. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes

Revisit Conducted By: _____

Date of Revisit (if applicable): _____

Edward A. Marlanee
Lead Assessor Signature

9-18-12
Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 10 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 5.1.3 | Source: | 2011 Supplemental-Testing | Level: | 1 |
| Requirement: | The laboratory shall have a procedure for routinely checking the reliability of its reagents. | | | | |
| Finding: | Expired DNA M48 kits are being used for extraction of DNA from database samples. The kits are performance checked once beyond the manufacturer's stated expiration date and at that time given a one year expiration extension. There is no documentation to support the one year extension. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | Forensic Biology Procedure, Sections 1.2 on re-verifying reagent expiration dates, has been deleted. Reagents will not be used in casework that have expired manufacturer's dates. The DNA M48 kits are no longer in use as the QiagenBioRobot M48 has been phased out as an automated DNA extraction device. |
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed confirming compliance with the Standard and the revised procedure:<br>- Copy of the Forensic Biology Procedures revision history, dated 7-5-12, verifying deletion of section 1.2. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes

Revisit Conducted By: _____

Date of Revisit (if applicable): _____

Edward A. Marlanee

Lead Assessor Signature

9-18-12

Date Accepted

## CORRECTIVE ACTION REQUEST (CAR) Number 11 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 4.2.1<br>3-H | Source: | ISO/IEC 17025:2005<br>Lab Qual System Doc | 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.<br><br>Section 3: Controlled Substances Procedure Manual – page 32<br>....To assure that contamination or mishandling of evidence does not occur, the laboratory adheres to the following practices:<br>H – placement of auto sampler vials is checked before starting sequence. | | | | |
| Finding: | There is no documentation in Controlled Substances case records that the placement of auto sampler vials is being checked before starting the sequence. Interview results were not consistent on whether the checks were being made. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | The following portion of the Controlled Substances Discipline Manual will be removed and no longer required as noted in the attached revision history of the manual.<br><br>"3.1 All autosampler runs will be checked for proper sequencing prior to starting and once the run is complete. This does not need to be documented."<br><br>- **Section 3.1, GC/MS, U of M and Good Laboratory Practice**, p. 29, **deleted**<br>Placement of autosampler vials is checked before starting sequence.<br>6-27-2012, Supervisor |

| | |
|---|---|
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed confirming compliance with the Standard:<br>- Copy of the Controlled Substances Manual revision history, dated 7-1-12, noting Section 3.1 on page 29 was deleted on 6-27-12. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes
Revisit Conducted By:
Date of Revisit (if applicable):

Edward A. Norlander
Lead Assessor Signature

9-18-12
Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 12 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 5.6.3.1<br>5.6.3.1 | Source: | ISO/IEC 17025:2005<br>Lab Qual System Doc | Level: | 1 |
| Requirement: | 5.6.3.1- Reference standards - The laboratory shall have a programme and procedure for the calibration of its reference standards. Reference standards shall be calibrated by a body that can provide traceability as described in 5.6.2.1. Such reference standards of measurement held by the laboratory shall be used for calibration only and for no other purpose, unless it can be shown that their performance as reference standards would not be invalidated. Reference standards shall be calibrated before and after any adjustment.<br><br>QAM 5.6.3.1 - Each discipline will have a procedure for the calibration of their reference standards. | | | | |
| Finding: | The Firearms discipline does not have a procedure for calibrating the following reference standards: gauge block; traceable ruler; 10 gram weight standard used for checking the performance of the firearms balance. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | The Firearms Procedure Manual will be updated to:<br>A NIST-certified gauge block and NIST-traceable rulers will be utilized. The NIST-certified gauge block Certificate of Accuracy will be maintained in the LIMS. The Certificates of Calibration for the NIST-traceable rulers will be maintained in the LIMS. The gauge block and rulers will be replaced every two years.<br><br>The 10 gram weight will no longer be used as a reference standard. The firearms balance is annually calibrated by an outside vendor. Certified weights from the chemistry section will be used for performance checking the balance.<br><br>FATM 2012 R0 Appendix 3 page 207 addresses rulers and gauge blocks<br>FATM 2012 R0 Appendix 3 page 205addresses the annual calibration of the firearms balance. Reference to the 10 gram weight has been deleted. |

| | |
|---|---|
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the Standard:<br>- Copy of the revised Firearms/Toolmark Procedure Manual requiring use of NIST certified gauge block and rulers. The revision requires replacement of the NIST certified gauge block and ruler every two years.<br>- Copy of a manufacturer's certificate of NIST calibration dated 3-12-12 for the 48 inch and 12 inch NIST traceable rulers currently in use.<br>- Copy of a manufacturer's certificate of NIST calibration dated 4-23-12 for the gauge block currently in use.<br>- Copy of the revised Firearms/Toolmark Procedure Manual requiring annual external calibration of the firearms balance. Reference to the 10 gram weight has been deleted. Calibration records for the balance were reviewed on site. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes

Revisit Conducted By: _____

Date of Revisit (if applicable): _____

Edward A. Norlander

Lead Assessor Signature

9-26-12

Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 13 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| Clause No.: | 4.15.1 | Source: | ISO/IEC 17025:2005 | Level: | 1 |
|---|---|---|---|---|---|
| Requirement: | In accordance with a predetermined schedule and procedure, the laboratory's top management shall periodically conduct a review of the laboratory's management system and testing and/or calibration activities to ensure their continuing suitability and effectiveness, and to introduce necessary changes or improvements.<br><br>The review shall take account of:<br>• the suitability of policies and procedures;<br>• reports from managerial and supervisory personnel;<br>• the outcome of recent internal audits; … | | | | |
| Finding: | The 2011 Management Review of the Quality System was not effective. Several corrective actions generated as the result of this ASCLD-LAB International assessment resulted from unsuitable procedures or the lack of procedures. Laboratory policies were documented; however, the procedures and instructions for implementing the policies were not all documented. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | Laboratory top and key management held the first management review in July 2011. This review was held prior to the annual internal audit. In retrospect the 2011 management review was performed prematurely. The Laboratory Quality Assurance Manual was changed in December 2011 to require the management review to be held after the annual internal audit.<br><br>The 2012 Management review will take account of and document all requirements under 4.15.1 to include specifically:<br><br>• the suitability of policies and procedures<br>• reports from managerial and supervisory personnel<br>• the outcome of recent internal audits. |

| | |
|---|---|
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed:<br><br>- Copy of the Quality Manual requiring the management review to take place after the internal audits. The 2012 Management Review will take place in December 2012. Actions taken as the result of this assessment remediated the concerns the assessment team had regarding the effectiveness of the 2011 Management Review.<br><br>The 2012 Management Review will be reviewed during the first surveillance visit. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes

Revisit Conducted By: _____

Date of Revisit (if applicable): _____

Edward A. Norlander

Lead Assessor Signature

9-18-12

Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 14 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 5.10.3.7 | Source: | 2011 Supplemental-Testing | Level: | 1 |
| Requirement: | When no definitive conclusions can be reached, the test report shall clearly communicate the reason(s). | | | | |
| Finding: | The following laboratory disciplines do not communicate the reasons for no definitive conclusions in the test report: Firearms; Latent Prints. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | The Latent Print and Firearms/Toolmark manuals will be updated to require documentation of the reasons for opinions with no definitive conclusions.<br><br>The Laboratory Quality Assurance Manual will be updated to:<br>5.10.3.7 When a definitive conclusion cannot be reached, the test report will clearly communicate the reason(s). |
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the Standard and the revised procedures:<br><br>- Copy of the revised Firearms/Toolmark Procedure Manual requiring the reason for opinions with no definitive conclusion to be documented. 7-7-12<br>- Copies of two firearms reports (only two available) with no definitive conclusions documented as required.<br>- Copy of the revised Latent Print Manual requiring documentation of the reasons for no definitive conclusions. 7-1-12<br>- Six (6) copies of latent print reports with no definitive conclusions documented as required.<br>- Copy of the Quality Manual revision requiring the test report to clearly communicate the reason(s) when no definite conclusion can be reached. 7-1-12 |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes
Revisit Conducted By:
Date of Revisit (if applicable):

Edward A. Moilanen
Lead Assessor Signature

9-18-12
Date Accepted

## CORRECTIVE ACTION REQUEST (CAR) Number 15 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 4.2.1 | Source: | ISO/IEC 17025:2011 | Level: | 2 |
| Requirement: | 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. | | | | |
| Finding: | DNA personnel select testing cases to be worked based on a four tier hierarchy which includes: 1- Committee Cases (Alaska Dept. of Law); 2- Non Dept. of Law cases which contain all necessary evidence for complete testing; 3- Backlog Sexual Assault cases; 4- Property Crimes. The selection process is understood; however, there is no documented procedure for this selection process. | | | | |
| Corrective Action Due By: | On or before first surveillance visit | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | The Laboratory Quality Assurance Manual will be updated to include the following in a new Appendix titled "Case Assignment":<br>"The routine system of case assignment is based on submission date to the laboratory. Cases are generally worked in the order received. Exceptions are made based on rush requests made by the customer. These requests are normally based on court dates or the need for investigative information. Discipline supervisors or their designee evaluate and approve rush requests when appropriate. Reasons for approved rush requests are documented in the LIMS." |
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the Standard:<br>- Copy of the updated Quality Assurance Manual reflecting documentation of the laboratory practice observed during the on-site assessment. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes

Revisit Conducted By: _____

Date of Revisit (if applicable): _____

Edward A. Wollaeger
Lead Assessor Signature

9-18-12
Date Accepted

## CORRECTIVE ACTION REQUEST (CAR) Number 16 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 5.9.2<br>5.1.3 | Source: | ISO/IEC 17025:2005<br>2011 Supplemental-Testing | Level: | 1 |
| Requirement: | 5.9.2 - Quality control data shall be analyzed and, where they are found to be outside pre-defined criteria, planned action shall be taken to correct the problem and to prevent incorrect results from being reported.<br><br>5.1.3 - The laboratory shall establish a documented procedure for routinely checking the reliability of its reagents. | | | | |
| Finding: | Although the laboratory evaluates Biology DNA critical reagents prior to use in casework, instructions for conducting these evaluations are missing several steps and do not define performance criteria for acceptance or rejection of the reagent lots. The documentation does not address parameters for establishing acceptable criteria for new critical reagents/kits. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | The following critical reagent verification evaluation details will be added in the Forensic Biology Procedures:<br><br>"Critical reagents, as specified by the FBI DNA QA Standard 9, require testing on established samples before use on evidentiary or casework samples.<br>Using a positive control(s) - i.e. an established sample(s) to assess the performance of a critical reagent, provides a basis for the minimum acceptable performance that can be reasonably expected from that critical reagent based on results of previous testing on the established sample(s). A critical reagent that performs below the minimum acceptable level will be rejected and not used on evidentiary or casework samples.<br><br>Critical reagents will also be tested using a negative control sample(s) or reagent blank(s) which determine if there is any contamination in the reagent being tested. If the negative control fails – i.e. contamination is detected in the test results, the reagent will be rejected and not used on evidentiary or casework samples." |

| | |
|---|---|
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the Standard:<br>- Copy of the revision to the Forensic Biology Procedures. The documented procedure includes acceptance criteria observed in use by the laboratory during the on site assessment. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes
Revisit Conducted By:
Date of Revisit (if applicable):

Edward A. Moilanen
Lead Assessor Signature

9-18-12
Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 17 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| Clause No.: | 4.14.1, 4.14.4 | Source: | ISO/IEC 17025:2005 | Level: | 1 |
|---|---|---|---|---|---|
| Requirement: | 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 programme 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.<br><br>4.14.4 - Follow-up audit activities shall verify and record the implementation and effectiveness of the corrective action taken. | | | | |
| Finding: | The most recent (2011) internal audit reports do not all identify the auditor nor the dates of the audit. Not all of the issues and findings identified in the 2011 internal audits for Toxicology, Crime Scene and Latent Prints have documented follow-up.<br><br>The 2011 Firearms internal audit does not identify all the areas covered; however issues, findings and actions taken as the result of findings are documented. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | The Quality Manager will provide a summary of the internal audits performed documenting auditor names and dates for each discipline. All issues and findings will be updated with follow-up information. |
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed confirming compliance with the Standard:<br><br>- Copies of all 2011 internal audit summary reports with the identity of the auditors and the dates of the audit documented.<br>- Documented follow-up for all issues and findings in the 2011 internal audits.<br>- Copy of the 2011 firearms audit document identifying all areas covered. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes
Revisit Conducted By: _____
Date of Revisit (if applicable): _____

Edward A. Vorlander
Lead Assessor Signature

9-26-12
Date Accepted

## CORRECTIVE ACTION REQUEST (CAR) Number 18 of 19

| | |
|---|---|
| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

| | | | | | |
|---|---|---|---|---|---|
| Clause No.: | 5.9.4.1<br>CH 12 | Source: | 2011 Supplemental-Testing<br>Lab Qual System Doc | Level: | 1 |
| Requirement: | 5.9.4.1 - At a minimum, the technical review shall include a review of all examination records and the test report to ensure:<br>• Conformance with proper technical procedures (test methods) and applicable laboratory policies and procedures;<br>• Accuracy of test reports and that the data supports the results and/or conclusions in the test report;<br>• Associations are properly qualified in the test report; and<br>• The test report contains all required information.<br><br>DNA QA Manual Chapter 12 page 25:<br>"The laboratory documents the completion of technical review of forensic case work. This includes review of all DNA typing data to verify that they are supported by raw or analyzed data – electronic and/or printed." | | | | |
| Finding: | Technical review in Biology does not include all of the electronic data generated by the primary analyst as required by the DNA QA Manual and the standard. Staff interviews revealed the laboratory's technical review of the primary analyst's work includes only DNA profile data appearing in electropherograms printed to hard copy by the primary analyst and therefore not all data generated by the primary analyst is reviewed. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

| | |
|---|---|
| Lab Response: | The DNA analysts are only reviewing the printed data that supported the conclusion. So if a sample was re-amped then only the final amp data would be printed and reviewed as the first amp would be stored electronically, but not part of the printed data. The new wording in the DNAQAM clarifies that only the final amp data and not necessarily all amp data is technically reviewed.<br><br>DNAQA Manual – Chapter 12 page 25 of 41 (active version) pertains to the FBI QAS for data review. This section will be updated to: |

| | |
|---|---|
| | "(a) Case notes, worksheets and electronic and/or printed electropherograms that were used to draw the reported conclusions. Data that is not used for drawing the reported conclusions will not be routinely reviewed unless the technical reviewer and/or the technical manager require a review of this material." |
| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the Standard:<br>- Copy of the updated DNA Quality Manual 7-1-12 documenting the laboratory policy of technically reviewing all examination records (printed or electronic) used to draw the reported conclusions.<br>- The update clarifies the laboratory policy and reflects the laboratory practice as observed while on site. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes
Revisit Conducted By:
Date of Revisit (if applicable):

Edward A. Morlan
Lead Assessor Signature

9-24-12
Date Accepted

# CORRECTIVE ACTION REQUEST (CAR) Number 19 of 19

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| Laboratory Name: | ALASKA DPS SCIENTIFIC DETECTION LABORATORY |
| Laboratory Location: | ANCHORAGE, ALASKA |
| Laboratory Contact Name: | NITA BOLZ, QUALITY MANAGER |
| Contact Number: | 907-265-0599 |
| Summation Conference Date: | 3-16-12 |

**FINDING**

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| Clause No.: | 5.6.1<br>5.6.1.1 | Source: | ISO/IEC 17025:2005<br>2011 Supplemental-Testing | Level: | 1 |
| Requirement: | 5.6.1 - General - All equipment used for tests and/or calibrations, including equipment for subsidiary measurements (e.g. for environmental conditions) having a significant effect on the accuracy or validity of the result of the test, calibration or sampling shall be calibrated before being put into service. The laboratory shall have an established programme and procedure for the calibration of its equipment.<br><br>5.6.1.1 - Procedures to check calibration of equipment shall be established depending on the specific requirements of the testing being carried out. It will normally be necessary to check calibration after any shut down, whether deliberate or otherwise and following service or other substantial maintenance. In general, calibration check intervals shall not be less stringent than manufacturers' recommendations. | | | | |
| Finding: | The external calibration service used to calibrate laboratory balances is not an ISO accredited calibration service. The calibration laboratory is in the process of achieving ISO accreditation and their calibration report is ISO compliant. Currently there is no ISO accredited calibration laboratory in Alaska. | | | | |
| Corrective Action Due By: | On or before October 8, 2012 | | | | |

**CORRECTIVE ACTION**

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| Lab Response: | From the Quality Manager on 6/21/2012 - I met with the President of Alaska Metrology on June 19, 2012. The company has completed their onsite assessment. All findings of nonconformance except for one have been completed. Alaska Metrology expects their ISO 17025 accreditation by the end of July 2012.<br><br>From the Quality Manager on 8/10/2012 – Accreditation has not been received as of today. Waiting on update.<br><br>From the Quality Manager on 8/31/2012- Alaska Metrology received their calibration accreditation under 17025:2005 on August 30, 2012. Attached is their certificate and scope of accreditation. |

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| Supporting Documentation Provided by Laboratory: | The following objective evidence was received and reviewed verifying compliance with the Standards:<br><br>- Copy of the accreditation certificate, including the scope of accreditation for the company that externally calibrated the applicable laboratory balances. The calibration work completed for the laboratory was ISO 17025 compliant; however, official accreditation status was not achieved until August 30, 2012 as verified by the submitted documentation. |

**ACCEPTANCE**

Was a revisit required? ☒ No ☐ Yes
Revisit Conducted By:
Date of Revisit (if applicable):

Edward A. Marlanee
Lead Assessor Signature

9-18-12
Date Accepted