

**ASCLD/LAB-*International***

**Assessment Report**

Michigan State Police - Forensic Science Division

Lansing Forensic Laboratory - 7320 North Canal Road, Lansing, MI 48913

Northville Forensic Laboratory - 42145 W. Seven Mile Road, Northville, MI 48167

Bridgeport Forensic Laboratory - 6296 Dixie Highway, Bridgeport, MI 48722

Sterling Heights Forensic Laboratory - 42800 Merrill Road, Sterling Heights, MI 48314

Grand Rapids Forensic Laboratory - 720 Fuller Avenue NE, Grand Rapids, MI 49503

Grayling Forensic Laboratory - 103 South James Street, Grayling, MI 49738

Marquette Forensic Laboratory - 1924 Industrial Parkway, Marquette, MI 49855

**\***Metropolitan Detroit Forensic Laboratory - 1301 Third Street, Detroit, MI 48226

**\***Initial Assessment/Granting Accreditation

**Assessment Activity:** Reassessment

**Assessment Date:** October 31-November 7, 2016

Lead Assessor:

Richard Frank

**Technical Assessor(s):**

Lansing and Metro Detroit

Nicole Harold

Tate Yeatman

Patricia A. Melton

Lyla Thompson

Theresa Suffecool

Mitchell W. Dinterman

Sara Norris

Thomas L. Price

Jessica A. Toms

Catherine M. Wojcik

Northville

Ryan Coller

Bradley Everett

Jackeline Hamelius Moral

Stephenie Winter Sermeno

Natasha Poe

Karen Sheldon

Doug Eatherton

Sterling Heights and Bridgeport

Nicole Daniels

Vincent Desiderio

Jessica Toms

Kim E. Grey

Alison S. Rees

Robert Zinn

Rebecca Mullen

Grand Rapids

Rebecca Mullen

Adrian D. Hall

Lorraine Heath

Douglas Kelly

Steve Robertson

Marquette and Grayling

Margaret Cuthbert

Aaron Koning

Garry Lawrence

Heidi Robbins

Catherine M. Wojcik

**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, applicable ASCLD/LAB-*International* policies and the documented management system were used for this assessment.

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**Lansing Forensic Laboratory**

**SCOPE OF ASSESSMENT**

The assessment covered the following disciplines and categories:

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| **Field** |
| Forensic Science Testing |
| **Discipline(s)** | **Categories of Testing** |
| Drug Chemistry | Controlled Substance |
| Toxicology | Human Performance Forensic ToxicologyPost-Mortem Forensic Toxicology  |
| Biology | DNA-NuclearBody Fluid IdentificationHair (Screening Only) |
| Trace Evidence | PaintExplosivesGeneral Physical and Chemical AnalysisImpression Evidence (footwear/tires) |
| Firearms/Toolmarks | FirearmsToolmarksSerial Number Restoration |
| Latent Prints | Latent Print ProcessingLatent Print Comparisons |
| Questioned Documents | Document Examination |

**\*During the onsite assessment, the Lansing Forensic Laboratory requested that the Crime Scene discipline be removed from the scope of assessment.**

**Northville Forensic Laboratory**

**SCOPE OF ASSESSMENT**

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| **Field** |
| Forensic Science Testing |
| **Discipline(s)** | **Categories of Testing** |
| Drug Chemistry | Controlled Substance |
| Biology | DNA-NuclearBody Fluid IdentificationHair (Screening Only) |
| Trace Evidence | PaintFiber and Textiles General Physical and Chemical AnalysisImpression Evidence (footwear/tires) |
| Latent Prints | Latent Print ProcessingLatent Print Comparisons |

**\*During the onsite assessment, the Northville Forensic Laboratory requested that the Crime Scene discipline be removed from the scope of assessment.**

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|  **SCOPE OF ASSESSMENT** |

**Bridgeport Forensic Laboratory**

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| **Field** |
| Forensic Science Testing |
| **Discipline(s)** | **Categories of Testing** |
| Drug Chemistry | Controlled Substance |
| Biology | Body Fluid IdentificationHair (Screening Only) |
| Trace Evidence | Fire Debris General Physical and Chemical AnalysisImpression Evidence (footwear/tires) |
| Firearms/Toolmarks | FirearmsToolmarksSerial Number Restoration |
| Latent Prints | Latent Print ProcessingLatent Print Comparisons |
| Questioned Documents | Document Examination |

**\*During the onsite assessment, the Bridgeport Forensic Laboratory requested that the Crime Scene discipline be removed from the scope of assessment.**

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|  **SCOPE OF ASSESSMENT** **Sterling Heights Forensic Laboratory**

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| **Field** |
| Forensic Science Testing |
| **Discipline(s)** | **Categories of Testing** |
| Drug Chemistry | Controlled Substance |
| Biology | Body Fluid IdentificationHair (Screening Only) |
| Trace Evidence | Fire DebrisExplosivesGeneral Physical and Chemical AnalysisImpression Evidence (footwear/tires)  |
| Latent Prints | Latent Print ProcessingLatent Print Comparisons |

**\*During the onsite assessment, the Sterling Heights Forensic Laboratory requested that the Crime** **Scene discipline be removed from the scope of assessment.** |

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**SCOPE OF ASSESSMENT**

**Grand Rapids Forensic Laboratory**

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| **Field** |
| Forensic Science Testing |
| **Discipline(s)** | **Categories of Testing** |
| Drug Chemistry | Controlled Substances |
| Biology | DNA-NuclearBody Fluid IdentificationHair (Screening Only) |
| Trace Evidence | PaintFiber and TextilesGlassFire DebrisExplosivesGeneral Physical and Chemical AnalysisImpression Evidence (footwear/tires)  |
| Firearms/Toolmarks | FirearmsToolmarksSerial Number Restoration |
| Latent Prints | Latent Print ProcessingLatent Print Comparisons |

**\*During the onsite assessment, the Grand Rapids Forensic Laboratory requested that the Crime Scene discipline be removed from the scope of assessment.**

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**SCOPE OF ASSESSMENT**

**Grayling Forensic Laboratory**

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| **Field** |
| Forensic Science Testing |
| **Discipline(s)** | **Categories of Testing** |
| Drug Chemistry | Controlled Substances |
| Biology | Body Fluid IdentificationHair (Screening Only) |
| Trace Evidence | Fire DebrisGeneral Physical and Chemical AnalysisImpression Evidence (footwear/tires)  |
| Firearms/Toolmarks | FirearmsToolmarksSerial Number Restoration |
| Latent Prints | Latent Print ProcessingLatent Print Comparisons |

**\*During the onsite assessment, the Grayling Forensic Laboratory requested that the Crime Scene discipline be removed from the scope of assessment.**

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| **SCOPE OF ASSESSMENT****Marquette Forensic Laboratory**

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| **Field** |
| Forensic Science Testing |
| **Discipline(s)** | **Categories of Testing** |
| Drug Chemistry | Controlled Substance |
| Biology | Body Fluid IdentificationHair (Screening Only) |
| Latent Prints | Latent Print ProcessingLatent Print Comparisons |

**\*During the onsite assessment, the Marquette Forensic Laboratory requested that the Crime Scene discipline be removed from the scope of assessment.****SCOPE OF ASSESSMENT****Metro Detroit Forensic Laboratory**

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| **Field** |
| Forensic Science Testing |
| **Discipline(s)** | **Categories of Testing** |
| Drug Chemistry | Controlled Substance |
| Firearms/Toolmarks | FirearmsToolmarksSerial Number Restoration |

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**\*During the onsite assessment, the Metro Detroit Forensic Laboratory requested that the Crime Scene discipline be removed from the scope of assessment.**

**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 laboratory activities. The management team’s commitment to quality was evident in their knowledge and understanding of accreditation requirements and laboratory activities. The assessment team commends the entire staff for their professionalism and the open communication displayed during interviews and witnessing activities. There was some objective evidence of staff not fully understanding management system requirements, which is documented in three nonconformities.

Document Control: Management system documents are uniquely identified and include revision identification and page numbers. An electronic document control system is utilized to ensure that periodic review occurs and is documented and that changes to controlled documents are communicated to the appropriate personnel. The electronic document control system consists of a navigation menu and table of contents. Each of these features can be viewed simultaneously and each accesses controlled documents. The navigation menu was observed to contain hyperlinks to controlled documents which had been archived but not suitably marked or identified as obsolete. The laboratory system corrected this apparent nonconformity while assessors were on-site and the assessment team accepted the action taken as a resolution.

Corrective Action: Appropriate corrective actions are taken when needed. Root cause analyses conducted by the Quality Manager have identified causes for nonconforming work 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. The laboratory system utilizes Forensic Advantage for maintaining most of its technical records in an electronic format and all staff utilize the process effectively. Alterations made to technical records are appropriately tracked.

Internal Audits: Annual internal audits are conducted by trained personnel. Appropriate actions are taken to resolve issues identified during the audits and the effectiveness of those actions is monitored. In response to issues identified during the 2016 internal audit, the laboratory system implemented corrective actions. These corrective actions were observed during the course of this assessment and remain effective.

Management Reviews: Management reviews are conducted annually. The management team establishes reasonable timeframes to complete actions resulting from the review and consistently meets their deadlines. The 2016 Management Review report did not appropriately address two required elements of the management review process: the management system’s overall objectives and reports from managerial and supervisory personnel. During the on-site assessment, the laboratory system prepared an addendum to the original report which corrected this and the assessment team accepted the action taken as resolving the nonconformity.

Personnel: Detailed training programs exist for each discipline to ensure the competence of personnel. The training budget is sufficient to allow each staff member to participate in annual external training related to an assigned discipline. Authorizations to perform testing activities are available for all applicable staff and are readily available for review on the MSP Laboratory System Dashboard secure web-based database.

Technical Methods: The technical methods used are appropriate for the scope of work conducted. The methods are readily accessible to all analysts on the MSP Laboratory System Dashboard secure web-based database.

Measurement Uncertainty: Measurement uncertainty has been estimated for the disciplines of Drug Chemistry and Toxicology. Reporting of the uncertainty is in conformance with the ASCLD/LAB Policy on Measurement Uncertainty in Drug Chemistry, but not in Toxicology. This nonconformity is documented. No special customer need for reporting measurement uncertainty information beyond that required in the Policy was noted.

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

Evidence Handling: With the exception of the nonconformity found in the protection of large items of evidence and the chain of custody of Firearms evidence which is documented as a nonconformity, evidence is appropriately identified, sealed, handled and secured.

Proficiency Testing: The proficiency testing program meets accreditation requirements. A documented schedule of proficiency testing is established that demonstrates required testing in categories on the Scope of Accreditation and is scheduled to be accomplished for the entire period of accreditation.

Reporting: Results are accurately reported. Opinions are clearly identified and the significance of an association made through comparative analysis is properly qualified.

**CONCLUSIONS**

Based upon a sampling of objective evidence during the assessment activity, one or more nonconformities must be addressed to be operating in conformance with applicable accreditation requirements (refer to the attached Nonconformities and Comments form). 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: Richard Frank

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|  |  | November 21, 2016 |
| Signature |  | Date |

**DISTRIBUTION LIST**

Scott Marier, Acting Division Commander/Laboratory System Director

John Bowen, Laboratory Assistant Division Commander

Gary S. Daniels, Lansing Forensic Laboratory Director

Beth Clark, Northville Forensic Laboratory Director

Ryan Larrison, Bridgeport Forensic Laboratory Director

Robert May, Sterling Heights Forensic Laboratory Director

Lt. James Pierson, Grand Rapids Forensic Laboratory Director

Connie J. Swander, Grayling Forensic Laboratory Director

Jason Welch, Marquette Forensic Laboratory Director

Charles B. Morden, Metropolitan Detroit Forensic Laboratory

Jeffrey Nye, Laboratory System Quality Assurance Manager

ASCLD/LAB Office



**ASCLD/LAB-*International***

**Nonconformities and Comments - To Be Resolved**

**Michigan State Police, Forensic Science Division**

Lansing, MI

Detroit, MI

Northville, MI

Bridgeport, MI

Sterling Heights, MI

Grand Rapids, MI

Grayling, MI

Marquette, MI

**Assessment**

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| --- | --- |
| **Dates:** | October 31-November 7, 2016 |
| **Assessor:** | Richard Frank  |

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**

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| **Premises Name (if more than one):** | Bridgeport and Lansing |

**REQUIREMENT:** ASCLD/LAB-International 2011 Testing Supplemental

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

**DESCRIPTION OF THE NONCONFORMITY:**

The laboratory designated Technical Leader for Questioned Documents does not have technical training or technical experience in Questioned Documents. A review of the Technical Leader’s training and Authorization to Perform records revealed their technical training and experience to be in the Trace Evidence discipline.

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| **DUE DATE for Resolution Plan:**  | 12/21/16 |
| **DUE DATE for Resolution Completion:** | 2/19/17 |

**PLAN AND TIME SCHEDULE FOR RESOLUTION**

**Plan and time schedule submitted by Forensic Service Provider:**

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| **Date Submitted:** | 11/30/2016 |

**Information:**

Currently, the Michigan State Police employs a Technical Leader collectively over the Trace Chemistry and Questioned Documents disciplines. MSP has previously contracted with qualified Questioned Document examiners from ASCLD-LAB accredited laboratories to assist with internal audits. Additionally, the current Technical Leader relied upon Questioned Document unit members for technical guidance. Upon acceptance of the remediation plan, the MSP will immediately designate an individual responsible for the technical functions of the Questioned Document discipline that has the required training and casework experience in the discipline. This individual will support the collective Trace Chemistry/Questioned Documents Technical Leader in technical matters.

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| **Date Submitted:** | Click here to enter date. |

**Information:**

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**Revision requested or Acceptance by the Assessor:**

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| **Date Responding:** | 12/5/16 |

**Information:**

The proposed action is accepted. The laboratory is requested to provide as objective evidence of implementation the action taken, the name of the individual appointed and the technical training and experience in Questioned Documents of that individual.

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| **Date Responding:** |  |

**Information:**

**OBJECTIVE EVIDENCE OF PLAN IMPLEMENTATION**

**Objective Evidence submitted by the Forensic Service Provider:**

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| **Date:** | 01/24/2017 |

**Information:**

The MSP Forensic Science Division has appointed Lt. Mark Goff as having technical responsibility over the Questioned Documents discipline. Lt. Goff currently serves as Lab Manager over the Questioned Documents discipline located at the Lansing Laboratory. He is a qualified Questioned Documents examiner (July 2012) and serves as a member of the Questioned Documents subcommittee of the Organization of Scientific Area Committees. Lt. Goff’s complete training and qualifications are included within his Statement of Qualifications, attached (NC1\_Communication, NC1\_SOQ Goff).

**Revision requested or Acceptance by the Assessor:**

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| **Date:** | Click here to enter date. |

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**SUMMARY OF PLAN AND OBJECTIVE EVIDENCE**

**TO BE COMPLETED BY THE ASSESSOR at the completion of resolution**

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| **Date:** | Click here to enter date. |

**Summary of Plan:**

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**Summary of Objective Evidence:**

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**NC 2**

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| **Premises Name (if more than one):** | Lansing |

**REQUIREMENT:** ASCLD/LAB-International 2011 Testing Supplemental

**5.4.6** - Estimation of uncertainty of measurement

See the most current, published version of *ASCLD/LAB Policy on Measurement Uncertainty* (available at www.ascld-lab.org). Conformance with the most current, published policy is required to achieve and maintain accreditation.

**REQUIREMENT:** ISO/IEC 17025:2005

**5.4.6.3** - When estimating the uncertainty of measurement, all uncertainty components which are of importance in the given situation shall be taken into account using appropriate methods of analysis.

**REQUIREMENT:** ASCLD/LAB Policy on Measurement Uncertainty

**4.1** - ASCLD/LAB-*International* applicant and accredited testing and calibration laboratories shall record the following elements for each estimation of measurement uncertainty:

…

(d) All uncertainty components considered,

(e) All uncertainty components of significance and how they were evaluated,….

**DESCRIPTION OF THE NONCONFORMITY:**

During review of Toxicology procedure 1.11-Measurement of Uncertainty, the uncertainty associated with the calibration of the pipettes used in preparation of calibrators was not being included in the estimation of uncertainty; the uncertainty associated with the certified reference material was being incorrectly quantified in the uncertainty budget; the uncertainties from the calibration certificates are being divided by 2, incorrectly identified as a rectangular distribution, and then divided by the square root of 3.

There are no records documenting 2 of the 9 elements required in the ASCLD/LAB Policy on Measurement Uncertainty, 4.1(d)-All uncertainty components considered and (e)-All uncertainty components of significance and how they were evaluated. MU for pipettes was not included.

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| **DUE DATE for Resolution Plan:**  | 12/21/16 |
| **DUE DATE for Resolution Completion:** | 2/19/17 |

**PLAN AND TIME SCHEDULE FOR RESOLUTION**

**Plan and time schedule submitted by Forensic Service Provider:**

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| **Date Submitted:** | 11/30/2016 |

**Information:**

The Hamilton pipettor-dilutors will be calibrated by an ISO 17025 certified calibration provider approved by the Toxicology Technical Leader within two weeks of the accepted remediation plan. Upon completion of the calibration, the Measurement Uncertainty will be recalculated using the correct divisor (2 instead of the square root of 3) and the pipettor-dilutor calibration results. Once the calculation is complete, a review will be conducted and corrective action initiated if the revised Measurement Uncertainty value provided significantly more uncertainty than previously reported. Procedures and reporting will be updated if the Measurement Uncertainty value differs from the current value.

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**Revision requested or Acceptance by the Assessor:**

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| **Date Responding:** | 12/5/16 |

**Information:**

The proposed action is accepted. The laboratory is requested to provide the results of the pipettor-dilutor calibration, the recalculation of the Measurement Uncertainty and the results of the review. If applicable, the updating and reporting updates are requested to be provided if the Measurement Uncertainty value differs from the current value.

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**Information:**

**OBJECTIVE EVIDENCE OF PLAN IMPLEMENTATION**

**Objective Evidence submitted by the Forensic Service Provider:**

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| **Date:** | 01/24/2017 |

**Information:**

The Hamilton pipettor-dilutors were calibrated using an ISO 17025:2005 accredited provider, Calibrate Inc. The calibration report and accompanying accreditation certificate are attached (NC3\_Calibration, NC3\_Accreditation Cert). The Measurement Uncertainty was recalculated using the correct divisor and updated pipettor-dilutor calibration data, attached (NC2\_Uncertainty Calc). Upon review, the Measurement Uncertainty was unchanged (NC2\_Uncertainty Review). Further corrective actions were not necessary.

**Revision requested or Acceptance by the Assessor:**

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| **Date:** | Click here to enter date. |

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**SUMMARY OF PLAN AND OBJECTIVE EVIDENCE**

**TO BE COMPLETED BY THE ASSESSOR at the completion of resolution**

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| **Date:** | Click here to enter date. |

**Summary of Plan:**

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**Summary of Objective Evidence:**

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**NC 3**

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| **Premises Name (if more than one):** | Lansing |

**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, 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.

**REQUIREMENT:** Toxicology Procedures Manual

**5.2.1** - Pipettors

All pipettors and pipettor dilutors shall be calibrated each calendar year by an approved external calibration company and the accompanying records shall be maintained.

**DESCRIPTION OF THE NONCONFORMITY:**

The pipettor-diluter used for alcohol analysis was not calibrated annually by a calibration service provider that is accredited to ISO/IEC 17025.  The laboratory management system does not clearly define what "approved" means and laboratory staff does not clearly understand what is meant by approved.

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| **DUE DATE for Resolution Plan:**  | 12/21/16 |
| **DUE DATE for Resolution Completion:** | 2/19/17 |

**PLAN AND TIME SCHEDULE FOR RESOLUTION**

**Plan and time schedule submitted by Forensic Service Provider:**

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| **Date Submitted:** | 11/30/2016 |

**Information:**

The Michigan State Police utilized the manufacturer of the pipettor-dilutors for calibration services. The manufacturer is ISO 17025 qualified as a repair facility, not as a calibration provider. LOM 2.8.1 indicates calibration procedures shall be established for critical measurements and these procedures will be outlined in the discipline-specific procedure manuals. Section 5.2 Pipettors, Balances and pH Meter of the Toxicology Procedure Manual will be amended to include specific guidance on approved calibration providers. The Hamilton pipettor-dilutors will be calibrated following the amended procedure within two weeks of the accepted remediation plan.

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| **Date Submitted:** | Click here to enter date. |

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**Revision requested or Acceptance by the Assessor:**

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| **Date Responding:** | 12/5/16 |

**Information:**

The proposed action is accepted. A copy of the revised Section 5.2 and records of the calibrations accomplished as a result of the amended procedure are requested to be provided as objective evidence of implementation.

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| **Date Responding:** | Click here to enter date. |

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**OBJECTIVE EVIDENCE OF PLAN IMPLEMENTATION**

**Objective Evidence submitted by the Forensic Service Provider:**

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| **Date:** | 01/24/2017 |

**Information:**

Section 5.2 of the Toxicology Procedure Manual was amended to clarify the requirement of calibration utilizing an ISO 17025:2005 provider (NC3\_Calibration Procedure). The Hamilton pipettor-dilutors were recalibrated using Calibrate Inc. on November 29, 2016. The calibration and accreditation certificates are attached (NC3\_Calibration, NC3\_Accreditation Cert).

**Revision requested or Acceptance by the Assessor:**

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| **Date:** | Click here to enter date. |

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**SUMMARY OF PLAN AND OBJECTIVE EVIDENCE**

**TO BE COMPLETED BY THE ASSESSOR at the completion of resolution**

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| **Date:** | Click here to enter date. |

**Summary of Plan:**

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**Summary of Objective Evidence:**

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**NC 4**

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| **Premises Name (if more than one):** | Lansing, Metro Detroit, Bridgeport, Grand Rapids, Grayling |

**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, 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.

**REQUIREMENT:** Firearms and Toolmarks Procedure Manual, 2.4, 3.4, 4.4, 5.4, 7.4, 8.4, 9.4

The unique identifier assigned or serial number of the instrumentation used shall be listed in the notes section of the worksheet.

**DESCRIPTION OF THE NONCONFORMITY:**

The unique identifier or serial number of the instrumentation used in Firearms and Toolmarks examinations is not being recorded in the notes section of the worksheet as required by Firearms and Toolmarks procedures.

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| **DUE DATE for Resolution Plan:**  | 12/21/16 |
| **DUE DATE for Resolution Completion:** | 2/19/17 |

**PLAN AND TIME SCHEDULE FOR RESOLUTION**

**Plan and time schedule submitted by Forensic Service Provider:**

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| **Date Submitted:** | 11/30/2016 |

**Information:**

Section 5.4 of the Firearms Procedure Manual will be amended to allow for a list of individually-assigned equipment to be maintained on the Michigan State Police document management site as opposed to the current policy of including the instrumentation used in each case file.

The Management System requirements for approvals of updated policies will be communicated to all staff members during a previously scheduled Forensic Science Division Symposium (December 8, 2016) and followed up by written communication to all staff members to ensure complete coverage of the communication.

Both of these steps will be completed within two weeks of the remediation plan acceptance.

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**Revision requested or Acceptance by the Assessor:**

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| **Date Responding:** | 12/5/16 |

**Information:**

The proposed action is accepted. The revised Section 5.4 of the Firearms Procedures Manual and a copy of the communication to all staff members are requested to be provided as objective evidence of implementation.

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| **Date Responding:** | Click here to enter date. |

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**OBJECTIVE EVIDENCE OF PLAN IMPLEMENTATION**

**Objective Evidence submitted by the Forensic Service Provider:**

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| **Date:** | 1/24/2017 |

**Information:**

The revised Firearms Procedure Manual Section 5.4 is attached detailing the policy regarding documentation of unique identifier of instrumentation used (NC4\_Firearms 5.0, NC4\_Firearms Discipline Page). Communication of the policy occurred at a previously scheduled Forensic Science Division Symposium on December 8, 2016 where Mr. Nye provided an overview of the Assessment (NC4\_Symposium Agenda and Slide).

**Revision requested or Acceptance by the Assessor:**

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| **Date:** | Click here to enter date. |

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**SUMMARY OF PLAN AND OBJECTIVE EVIDENCE**

**TO BE COMPLETED BY THE ASSESSOR at the completion of resolution**

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| **Date:** | Click here to enter date. |

**Summary of Plan:**

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**Summary of Objective Evidence:**

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**NC 5**

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| **Premises Name (if more than one):** | Bridgeport, Metro Detroit |

**REQUIREMENT:** ASCLD/LAB-International 2011 Testing Supplemental

**5.8.1.1** -Forensic science laboratories shall be able to demonstrate that the evidence examined and reported on was that submitted to the laboratory. A “chain of custody” record, which reflects the receipt of evidence and all internal transfers, shall be maintained. Each person shall acknowledge by a signature, initials, equivalent identification, or secure electronic equivalent, at the time of transfer, when they take possession of evidence or transfer evidence to a storage location. The chain of custody shall include the date of receipt or transfer and a description or unique identifier of the evidence.

**DESCRIPTION OF THE NONCONFORMITY:**

The transfer of items of evidence from one analyst to another in the Firearms Unit for independent checks on critical findings (verification) and the transfer of evidence cartridge cases from the analyst to the IBIS Technician for entry are not being documented in the Chain of Custody for the case. In both circumstances, the analyst does not always remain in visual contact or within close proximity of the items after they are transferred.

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| **DUE DATE for Resolution Plan:**  | 12/21/16 |
| **DUE DATE for Resolution Completion:** | 2/19/17 |

**PLAN AND TIME SCHEDULE FOR RESOLUTION**

**Plan and time schedule submitted by Forensic Service Provider:**

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| **Date Submitted:** | 11/30/2016 |

**Information:**

LOM 4.4.1 Chain of Custody will be amended to include a requirement for all internal transfers of evidence to be documented within Forensic Advantage, the MSP Laboratory Information Management System. In addition, the Firearms Procedure Manual section 5.0 Microscope Comparison will be amended to also require internal transfers to be documented within the Forensic Advantage Laboratory Information Management System. These policy amendments will be completed and communicated to staff within two weeks of the remediation plan acceptance.

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| **Date Submitted:** | Click here to enter date. |

**Information:**

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**Revision requested or Acceptance by the Assessor:**

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| **Date Responding:** | 12/5/16 |

**Information:**

The proposed action is accepted. The laboratory is requested to provide copies of the amended LOM 4.4.1, Section 5.0 of the Firearms Procedure Manual and a copy of the communication to staff, along with results of an internal audit of the Bridgeport and Metro Detroit Firearms chain-of-custody records thirty (30) days after implementation of the revised management system documents.

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| **Date Responding:** | Click here to enter date. |

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**OBJECTIVE EVIDENCE OF PLAN IMPLEMENTATION**

**Objective Evidence submitted by the Forensic Service Provider:**

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| **Date:** | 1/24/2017 |

**Information:**

Copies of the amended LOM 4.4.1 (NC5\_LOM4.4), Section 5.0 of the Firearms Procedure Manual (NC5\_Verification Chain of Custody) and communication to staff (NC5\_Communication) are attached. An internal memorandum detailing the internal audit of the Bridgeport and Metro Detroit Firearms chain-of-custody records was completed approximately thirty (30) days after implementation of the revised management system documents and is attached (NC5\_Audit).

**Revision requested or Acceptance by the Assessor:**

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| **Date:** | Click here to enter date. |

**Information:**

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**SUMMARY OF PLAN AND OBJECTIVE EVIDENCE**

**TO BE COMPLETED BY THE ASSESSOR at the completion of resolution**

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| **Date:** | Click here to enter date. |

**Summary of Plan:**

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**Summary of Objective Evidence:**

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**NC 6**

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| **Premises Name (if more than one):** | Grayling, Sterling Heights |

**REQUIREMENT:** ISO/IEC 17025:2005

**5.8.4** -The laboratory shall have procedures and appropriate facilities for avoiding deterioration, loss or damage to the test or calibration item during storage, handling and preparation. Handling instructions provided with the item shall be followed. When items have to be stored or conditioned under specified environmental conditions, these conditions shall be maintained, monitored and recorded. Where a test or calibration item or a portion of an item is to be held secure, the laboratory shall have arrangements for storage and security that protect the condition and integrity of the secured items or portions concerned.

**DESCRIPTION OF THE NONCONFORMITY:**

Large items submitted to the Sterling Heights laboratory for examination are stored in an unsecured area.

Areas of interest on large items that are submitted to the Sterling Heights and Grayling laboratories are not covered or sealed to protect those areas from deterioration, loss or damage.

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| **DUE DATE for Resolution Plan:**  | 12/21/16 |
| **DUE DATE for Resolution Completion:** | 2/19/17 |

**PLAN AND TIME SCHEDULE FOR RESOLUTION**

**Plan and time schedule submitted by Forensic Service Provider:**

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| **Date Submitted:** | 11/30/2016 |

**Information:**

Vacant space at the Sterling Heights laboratory (approximately 56’9” by 9’) will be secured with a keyed locked door and designated as an evidence storage vault for large items within our Forensic Advantage Laboratory Information Management System within 30 days of the acceptance of the remediation plan. Access limitations will be in accordance with other evidence vaults at that location. LOM 4.8 Evidence Collected at Crime Scenes and LOM 4.1 Evidence Submission (4.1.1) will be amended to require protection of areas of interest for large evidence items that are unable to be packaged and sealed. Monitoring of large evidence item handling at the Sterling Heights and Grayling laboratories will be conducted throughout the remediation process to ensure the amended procedures are followed.

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| **Date Submitted:** | Click here to enter date. |

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**Revision requested or Acceptance by the Assessor:**

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| **Date Responding:** | 12/5/16 |

**Information:**

The proposed actions are accepted. The laboratory is requested to provide records of implementation of the secured space in Sterling Heights, copies of the revisions to LOM 4.8 Evidence Collected at Crime Scenes and LOM 4.1 Evidence Submission (4.1.1) and the results of an internal audit of large evidence items in Sterling Heights and Grayling laboratories as objective evidence of successful implementation.

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| **Date Responding:** | Click here to enter date. |

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**OBJECTIVE EVIDENCE OF PLAN IMPLEMENTATION**

**Objective Evidence submitted by the Forensic Service Provider:**

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| **Date:** | 1/24/2017 |

**Information:**

Unused space at the Sterling Heights Laboratory was identified for large evidentiary item storage. The attached floor diagram (NC6\_Floor Plan) depicts the Firearms Range as the designated storage location. The location was secured with a keyed lock to the same extent existing property storage locations are secured, (NC6\_Photo Door). A screen shot of our Laboratory Information Management System documenting the establishment of a Large Evidence storage location at the Sterling Heights laboratory is attached (NC6\_Forensic Advantage). LOM 4.8 Evidence Collected at Crime Scenes was amended to include a reference to LOM 4.1 Evidence Submission (NC6\_LOM4.8). LOM 4.1 Evidence Submission was amended to require protection of areas of interest for large items of evidence that are unable to be secured within an out container that is able to be sealed (NC6\_LOM4.1.1). The Sterling Heights and Grayling Laboratory Director reviewed submissions to their respective laboratories and they did not receive any items of evidence that were unable to be secured in a sealed outer container. However, our Marquette laboratory is under the same quality system and was able to provide photos of a large item of evidence that was handled according to the revised LOM 4.1 Evidence Submission (NC6\_Photos).

**Revision requested or Acceptance by the Assessor:**

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| **Date:** | Click here to enter date. |

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**SUMMARY OF PLAN AND OBJECTIVE EVIDENCE**

**TO BE COMPLETED BY THE ASSESSOR at the completion of resolution**

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| **Date:** | Click here to enter date. |

**Summary of Plan:**

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**Summary of Objective Evidence:**

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**NC 7**

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| **Premises Name (if more than one):** | Northville, Grand Rapids |

**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:** Laboratory Biology Procedures Manual

**2.17.1.3** -Match Estimation Utility

Forensic Mixture and Forensic Partial profiles entered into the CODIS database shall utilize the Match Estimation utility in Popstats to determine the appropriate Specimen Category to be selected. Select the respective Forensic Mixture or Forensic Partial Specimen Category for those profiles that satisfy the statistical threshold for match rarity of approximately one in the size of the NDIS database. Select the respective Forensic Mixture SDIS or Forensic Partial SDIS Specimen Category for those profiles that have a match rarity greater than one in the size of the NDIS database.

**REQUIREMENT:** 2011 QAS Forensic DNA Testing Laboratories

**12.2.7.2** - Prior to entry of a DNA profile into a searchable category of SDIS, were the following criteria verified by two concordant assessments by a qualified analyst or technical reviewer:

a. Eligibility for CODIS?...

c. Appropriate specimen category?

**DESCRIPTION OF THE NONCONFORMITY:**

In the Grand Rapids and Northville Biology Units, not all analysts understand the policies regarding selection of appropriate specimen category, SDIS versus NDIS eligibility, and the use of the moderate match estimation (MME). In Grand Rapids, the MME is not always verified by two concordant assessments by a qualified analyst or technical reviewer prior to upload into CODIS as required by the FBI QAS.

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| **DUE DATE for Resolution Plan:**  | 12/21/16 |
| **DUE DATE for Resolution Completion:** | 2/19/17 |

**PLAN AND TIME SCHEDULE FOR RESOLUTION**

**Plan and time schedule submitted by Forensic Service Provider:**

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| **Date Submitted:** | 11/30/2016 |

**Information:**

Section 2.6 DNA Case File of the Biology/DNA Procedure Manual will be amended requiring addition of the MME. Inclusion in the case file will ensure at least two independent reviews of the MME. The DNA Technical Leader, with assistance from the State CODIS Administrator, will provide training materials to each LDIS Administrator regarding the various specimen categories in CODIS, when each is utilized and the role of the MME. A written quiz will be utilized to evaluate the effectiveness of the training. Each of these will be completed within 30 days of the remediation plan acceptance.

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| **Date Submitted:** | Click here to enter date. |

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**Revision requested or Acceptance by the Assessor:**

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| **Date Responding:** | 12/5/16 |

**Information:**

The proposed actions are accepted. The laboratory is requested to provide a copy of the revised Section 2.6 of the DNA Case File of the Biology/DNA Procedure Manual, a copy of the training materials, and the results of the written quiz. An internal audit of the implementation in the Grand Rapids laboratory needs to be conducted after thirty days and records of that audit provided to demonstrate effective implementation.

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| **Date Responding:** | Click here to enter date. |

**Information:**

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**OBJECTIVE EVIDENCE OF PLAN IMPLEMENTATION**

**Objective Evidence submitted by the Forensic Service Provider:**

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| **Date:** | 1/24/2017 |

**Information:**

A copy of the revised Section 2.6 of the DNA Case File of the Biology/DNA Procedure Manual (NC7\_2.6) and the training materials (NC7\_Training Materials) are attached. Every member of the DNA discipline successfully passed a written quiz assessing the training provided. An internal audit of the implementation at all three of the DNA labs was completed with no issues noted (NC7\_Audit).

**Revision requested or Acceptance by the Assessor:**

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| **Date:** | Click here to enter date. |

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**SUMMARY OF PLAN AND OBJECTIVE EVIDENCE**

**TO BE COMPLETED BY THE ASSESSOR at the completion of resolution**

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| **Date:** | Click here to enter date. |

**Summary of Plan:**

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**Summary of Objective Evidence:**

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**CM 1**

**COMMENT:**

The Biology Training Manual, section 20.1.2 only requires DNA analysts to observe 10 technical reviews being performed by a qualified analyst before being authorized to perform independent technical reviews. ASCLD/LAB Testing Supplemental 5.9.4.2 requires that technical reviews be conducted by individuals authorized by laboratory management based on expertise gained through training and casework experience. Section 20.1.2 of the Biology Training Manual would not meet this standard. In practice, review of training records revealed that analysts are performing supervised technical reviews prior to being authorized to perform independent technical reviews. Laboratory procedure should reflect actual practice and compliance with accreditation requirements.

**Response from the Forensic Service Provider (Responses to Comments are optional):**

The Biology/DNA training manual will be amended to provide further clarification to prevent newly trained analysts from completing technical reviews without the required casework experience.

**CM 2**

**COMMENT:**

The MSP has declared that it elected to adopt the following means of meeting the requirements in sub-clauses of 5.10.2 and 5.10.3: Ensuring that the case record relating to a specific investigation containing all of the relevant information required by ISO/IEC 17025. In Latent Prints, the laboratory is meeting the requirements of accreditation by a providing information through a combination of the test report and the examination record; however, in receiving only the test report, the customer may not have all information necessary for the interpretation of the test results with only the report that is issued. Customers may have to request information from the examination record to supplement the test report to have full results that allow for the interpretation of all the test results. The MSP should consider the needs of the customer in its initial test report to avoid customers having to request additional information contained in the examination record.

**Response from the Forensic Service Provider (Responses to Comments are optional):**

Policies and procedures are currently being evaluated, balanced with the expectations and needs of our customers.

**CM 3**

**COMMENT:**

The MSP should consider bringing uniformity to whether activated carbon test strips obtained during Fire Debris testing are considered to be work product or evidence. Some laboratories consider them to be work product and dispose of the strips after analysis. Other laboratories consider them as evidence and retain them with the original evidence or retain them as a sub-item of evidence.

**Response from the Forensic Service Provider (Responses to Comments are optional):**

Activated carbon test strips obtained during Fire Debris testing are considered to be work product. Policies and procedures will be updated to clarify this.