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OSBI Mission

The mission of every OSBI member is to insure the safety and security of the citizens of Oklahoma.

OSBI Vision

The OSBI will continue to be the professional law enforcement agency for the State of Oklahoma. We provide specialized apprehension and crime detection services through teamwork, training, research, and implementation of innovative technologies. We recruit and retain the expertise required to meet changing responsibilities. We increase public awareness through proactive publicity and education.

Foreword

The Oklahoma State Bureau of Investigation (OSBI) and the Criminalistics Services Division (CSD) are dedicated to provide quality service and results. The OSBI CSD has adopted the standards set forth by the American Society of Crime Laboratory Directors/Laboratory Accreditation Board (ASCLD/LAB) Legacy and International accreditation programs. In order to facilitate accreditation by the International program, this manual has been organized using the same outline structure as the International Organization for Standardization and the International Electrotechnical Commission (ISO/IEC) 17025 standards. Much of the language in this manual is new. However, some language was extracted from the previous CSD Quality Manual.

Quality Policy

The OSBI CSD management is committed to providing quality and professional service to our customers. It is the objective of the OSBI CSD to provide service that meets or exceeds the customer's needs and to ensure that quality and analytical practices meet or exceed the standards required for accreditation. The management system documents are provided to CSD employees to communicate the procedures which must be followed to provide this level of quality and

service. As indicated in Section 1 below, all CSD personnel are responsible for knowing and implementing these policies. This manual and the laboratory practices will be reviewed regularly in order to attain compliance with ISO/IEC 17025 standards and to continually improve the effectiveness of the management system.

1. Scope

1.1 This manual sets forth the policies and procedures which govern the work performed by members of the OSBI CSD.

1.2 All members of the CSD are responsible for knowing and abiding by all management system policies and procedures.

2. References

The following standards guide the requirements set forth in this policy manual. If the reference listed does not include a date, the most recent revision of the referenced document applies.

ISO/IEC 17025:2005

ASCLD/LAB-*International* Supplemental Requirements – Testing (Effective 04/01/2011)

Quality Assurance Standards for Forensic DNA Testing Laboratories (Effective 07/01/2009)

Quality Assurance Standards for DNA Databasing Laboratories (Effective 07/01/2009)

The FBI Quality Assurance Standards Audit for DNA Databasing Laboratories (Effective 07/01/2009)

The FBI Quality Assurance Standards Audit for Forensic DNA Testing Laboratories (Effective 07/01/2009)

ASCLD/LAB Proficiency Review Program

ASCLD/LAB Policy on Measurement Traceability

ASCLD/LAB Policy on Measurement Uncertainty

ASCLD/LAB Guiding Principles located at

http://www.ascld-lab.org/guiding-principles/

3. Glossary

In addition to the terms and definitions listed below, any definition provided in one of the documents listed in Section 2 also applies.

ADMINISTRATIVE STAFF: The Criminalistics Administrators, CSD Director and Executive Secretary.

ADMINISTRATIVE SUPERVISION: The authority to monitor the day-to-day activities and perform traditional managerial duties of assigned units or laboratories.

CASE FILE: The file folder containing hard copy documentation relevant to a particular case or the electronic file contained within the BEAST that contains documentation relevant to a particular case.

CASE RECORD: The cumulative records which document the quality, technical, and analytical information relevant to a particular case.

COMPLAINT: The expressed dissatisfaction by a customer with the quality or timeliness of work products or services.

CONVENIENCE PACKAGE: Evidence which is properly sealed and marked for identification may be placed in unsealed containers such as boxes or bags for the purpose of grouping items of evidence or for the convenience of carrying the evidence without that container having to meet the "proper seal requirements," as long as evidence security requirements are otherwise met. These containers should be marked as a "convenience package."

CORRECTIVE ACTION: An action or actions implemented to correct circumstances which led to non-conforming work. Successful corrective actions should prevent a reoccurrence of the same type of non-conforming work. This is also referred to as "preventive measures taken" by QAS Standard 14.1.b.5.

CORRECTIVE ACTION PLAN: A plan to resolve a discrepancy identified in casework, database activities, or proficiency testing work which will correct the problem and prevent a future occurrence. (QAS based definition – Std. 14)

CRIMINALISTICS ADMINISTRATOR (CA): Individual who reports directly to the CSD Director and is responsible for supervising Criminalist Supervisors.

CRIMINALIST SUPERVISOR: Individual who reports to a Criminalistics Administrator and supervises criminalists.

CRITICAL CONSUMABLE, SUPPLY, AND SERVICE: A consumable, supply or service which must meet one or more crucial specifications to ensure the quality of the test result. In this context, "crucial" means significant or important.

CUSTOMER (CLIENT): A recipient of the OSBI Criminalistics Services Division reports and/or services. A customer can also be within the Criminalistics or Investigative Services Division.

DERIVATIVE EVIDENCE: Any tangible material removed or derived from an evidence item already having an assigned item number. Examples are cuttings, debris collections, latent lifts, and retained stain samples. Derivative evidence or containers will be marked with appropriate case number, item or sub-item numbers, analyst's initials and date, and listed in the case file.

EVIDENCE: For the purposes of this directive, evidence shall mean all materials submitted for scientific analysis during the course of an official criminal investigation.

EVIDENCE DESTRUCTION FORM: A form used to document permission for the destruction of evidence.

EVIDENCE RELEASE FORM: A form used to document the return or release of evidence to the courts, OSBI employees, or submitting agencies.

EVIDENCE TAPE: Tamper proof tape used in sealing evidence containers.

FUNCTION VERIFICATION: A check to determine if a piece of equipment or instrumentation is working correctly within specified parameters.

MAJOR DEVIATION: A planned and approved modification to current policy or protocol which will apply for a set period of time or to a defined grouping of cases or samples.

MINOR DEVIATION: A planned and approved modification which will be applied to a single case, sample, or single batch of samples/cases.

NO ANALYSIS CASE: Evidence in cases submitted to the laboratory where charges have been dismissed or for some other reason no analysis is required can be returned to the submitting agency.

NON-CONFORMING WORK: Work that does not meet the standards set forth in policy, procedure, protocol, or does not meet the needs of the customer. This may occur due to protocol drift or due to a quality or technical problem with a reagent, supply, or instrument.

ORIGINAL REQUESTING AGENCY: The agency having jurisdiction in the case that made the request for services. Evidence will be returned after analysis to the original requesting agency unless specified otherwise in this policy.

PERFORMANCE CHECK: Actions taken to ensure analysis methods still perform as intended. Performance checks are similar to validations, but more limited in scope.

PHYSICAL EVIDENCE TECHNICIAN: Individual responsible for the reception, storage, documentation, and handling of the physical evidence submitted to an Oklahoma State Bureau of Investigation Laboratory.

PREVENTIVE ACTION: Actions taken to improve circumstances which could lead to non-conforming work. (ISO/IEC 17025:2005 based definition)

PROTOCOL DRIFT: Unintentional and/or unauthorized deviations from current protocol.

PROPER SEAL: An evidence container is "properly sealed" only if its contents cannot readily escape and only if opening the container would result in obvious damage/alteration to the container or its seal. Staples alone cannot provide a sealed condition on evidence packaging. A proper seal would constitute tape sealing, heat-sealing, or lock sealing and initialing the seal. A date on the seal is also recommended.

QUALITY: Adhering to generally recognized standards of good laboratory practice.

QUALITY ASSURANCE (QA): Those processes necessary to provide confidence that the results from OSBI Criminalistics Services Division analysis and testing will satisfy given requirements for quality.

QUALITY ASSURANCE AUDIT: A systematic examination and review to determine whether quality processes and related results comply with the protocols, policies, and procedures, and whether these practices are suitable and effective in achieving the quality objectives.

QUALITY ASSURANCE PROGRAM: OSBI Criminalistics Services Division guidelines describing recognized quality assurance requirements for forensic laboratory analysis and reporting.

QUALITY CONTROL (QC): The day-to-day operational techniques and activities used by the laboratory to consistently provide accurate analytical results that fulfill the requirements for quality.

QUALITY IMPROVEMENT COMMITTEE (QIC): An ongoing committee for the purposes of reviewing and implementing ways to improve the quality of laboratory services.

This committee, which meets at least quarterly, is composed of all Regional and Unit Supervisors, discipline Technical Managers and Administrative Staff.

QUALITY MANAGER (QM): The Criminalistics Administrator assigned the responsibility of overseeing quality operations including proficiency testing, auditing, reviewing non-conforming work, etc.

QUALITY RECORDS: Records generated from quality assurance procedures. This includes, but is not limited to, proficiency tests, corrective and preventive actions, audits, training documentation, continuing education, and testimony review.

REFERENCE MATERIAL: A material for which values are certified by a technically valid procedure and accompanied by, or traceable to a certificate or other documentation, which is issued by a certifying body. Examples include known drug standards and NIST Standard Reference Materials (SRM's) which can include known values for a variety of substances, including DNA profiles.

REFERENCE STANDARD: A traceable standard, generally having the highest metrological quality available, from which measurements are derived. An example would be NIST traceable weights.

REMEDIATION: Steps taken to correct non-conforming work, such as issuing an amended report, re-testing, etc. This is also referred to as "corrective actions taken" by QAS Standard 14.1.b.4.

REQUESTING OFFICER: The individual, authorized by statute, requesting examination of the submitted evidence. Criminalists will not be listed as a requesting officer.

RFLE: Request For Laboratory Examination form.

SAMPLING: The practice of testing a portion of a substance and reporting a conclusion for the whole substance using a statistically based or reasonable assumption of homogeneity of the whole.

SAMPLE SELECTION: The practice of selecting one or more samples from an item for testing based on training and experience. Following analysis, results are reported clearly and unambiguously to indicate that the results reported apply to the sample, not the whole item.

SUBMITTING OFFICER: The person delivering evidence to an OSBI laboratory. Criminalists will be listed as the submitting officer when involved with the collection of evidence.

TECHNICAL MANAGER (TM): The individual assigned the responsibility and authority for the technical operations in a particular discipline.

TECHNICAL PROTOCOLS (PROCEDURES): Technical procedures are a key element in establishing and maintaining quality control within the laboratory. Written procedures will be prepared for those routine tests performed in the OSBI Laboratory. The procedures used may be those developed and adequately validated by an outside agency or laboratory or those developed and validated in-house.

TECHNICAL RECORDS: Documentation generated in the analysis of casework or database samples. This includes reports, examination documentation, quality control results, etc.

TEMPORARY EVIDENCE CLOSURE OR SEAL: Consists of a piece of tape across a box, a paper clip on a folded evidence envelope, or some other closure that would not normally constitute a proper seal on evidence. A temporary closure is acceptable when the analyst will be away from the work area for a short period of time or overnight as long as the evidence is secured in a locking drawer or controlled access evidence area.

TESTING: Analysis conducted at the request of OSBI CSD customers. This may include casework analysis, database sample analysis, or other work mandated for the OSBI CSD. This does not apply to training, research, etc.

TRACEABILITY: The property of a result of a measurement whereby it can be related to appropriate standards, generally international or national standards, through an unbroken chain of comparisons.

VALID COMPLAINT: A complaint that has been verified and that warrants action.

VERIFICATION: Determining whether or not a stated complaint is well founded, and indisputable.

4. Management Requirements

4.1 Organization

4.1.1 Legal Responsibility

The OSBI CSD is a division of the Oklahoma State Bureau of Investigation, which has been granted legal authority by state statute. Refer to O.S. Title 74, Section 150.2. The CSD Director is appointed by the Director of the OSBI and has the responsibility and authority for all laboratory functions and personnel.

4.1.2 Operating Guidelines

The OSBI CSD will provide forensic science service which meets or exceeds the needs of customers. OSBI CSD service will also meet or exceed the applicable standards set forth by ASCLD/LAB.

4.1.3 Management System Scope

The policies and procedures set forth in the management system apply to work performed by CSD personnel in any temporary, mobile, or permanent facility.

4.1.4 Interrelation of the OSBI CSD

In addition to serving customers outside the OSBI, the CSD also provides services to the Investigative Division of the OSBI. An agency organizational chart is located on the OSBI Intranet at http://128.1.2.243:7001/hr_master/faces/orgchart.jspx?_adf.ctrl-state=1475ubhsll_14. (Note: If the organizational chart does not appear, look for an icon in the address bar that looks like a page torn in half. Clicking on this icon should make the browser compatible with the organizational chart.) The responsibilities of the agency director, deputy director, and investigative personnel are located in OSBI Policy 103.

4.1.4.1 The responsibilities and authority of the CSD Director are defined in **Quality Procedure (QP) 1**.

4.1.4.1.1 The OSBI CSD Director shall have sufficient authority to make and enforce decisions.

4.1.5 Management Requirements

The OSBI CSD ensures the effectiveness of the management system through the following steps.

a) Personnel are provided sufficient authority and resources to complete their duties, including implementing the management system and identifying, correcting, and minimizing deviations from policies, procedures, and protocols.

b) Personnel are protected from influences which could adversely affect the quality of work performed. See OSBI Policy 105 and O.S. 257-20-1-9.

c) Confidential case information, including electronically stored and distributed reports and documentation, is protected. Refer to Oklahoma Statute Title 74, Section 150.5.

d) Activities which would bring question to the competence or integrity of the agency and its employees are prohibited. Refer to the OSBI Code of Ethics and OSBI Policy 105.

e) Organizational structure, including relationships between management, technical, and support personnel is defined. An OSBI CSD Organizational Chart is located on the OSBI Intranet on the Criminalistics Page.

f) The authority, responsibilities, and interrelations for any position which impacts the quality of work performed are specified. Refer to the current organizational charts and **QP 1**. Current job descriptions are located at http://www.ok.gov/opm/jfd/jfd_g-page.htm.

1. No employee is accountable to more than one supervisor per function.

g) Testing staff, including trainees, will be supervised by individuals who are familiar with the methods and procedures used. This may be accomplished through the Supervisor's own experience in the methods and procedures used by staff or through the Supervisor's coordination with Technical Managers and/or Criminalistics Administrators familiar with the methods used. Refer to **QP 19** for additional information on training.

h) Each discipline has a technical manager who has the authority, responsibility, and resources required to ensure the appropriate quality of work. Refer to **QP 1** for additional information regarding responsibilities and authority.

i) One CA will be appointed as the QM for the CSD. Refer to the current organizational charts and **QP 1**. Current job descriptions are located at http://www.ok.gov/opm/jfd/jfd_g-page.htm.

j) Key managerial personnel (as defined in section 4.1.8 below) are responsible for naming a designee and notifying employees during planned absences. If a designee is not named, or there is an unplanned absence, the individual's supervisor will be responsible for appointing a designee and notifying employees. Deputies for key managerial personnel are responsible at a minimum, for the critical duties of the position which cannot be delayed until the individual returns.

k) Through routine unit and discipline meetings, all employees are informed of the importance of their activities and how those activities help ensure that the CSD meets the objectives of the management system.

4.1.6 Effectiveness of the Management System

Administrative staff meets regularly and during meetings discusses the effectiveness of the management system and reviews the communication processes used in the laboratory to ensure they are appropriate.

4.1.7 Safety Coordinator

The individual assigned as the OSBI Safety Coordinator (refer to the current organizational chart) has the responsibility and authority for implementing, updating, and ensuring compliance with the health and safety program.

4.1.8 Key and Top Management

Key management personnel includes the following positions:

- CSD Director
- Quality Manager
- Safety Coordinator
- LIMS Administrator
- FSC Building Manager
- Administrative Programs Officer for Evidence
- Technical Managers
- All Supervisors and Administrators

Top management is the CSD Director.

4.2 Management System

4.2.1 Management System Documents

The OSBI CSD management system documents the policies and procedures to be followed in order to ensure the quality of laboratory services provided. The OSBI CSD management system consists of the quality policy manual, the quality procedure manual, and discipline quality and protocol manuals. The documents of the management system are available to all CSD employees on the OSBI Intranet, http://osbinet/main/. Refer to **QP 2** for distribution procedures.

4.2.2 Quality Manual

This document in its entirety is the quality manual and procedures for the OSBI CSD. The **Quality Policy Statement** is located following the Foreword.

4.2.2.1 The ASCLD/LAB Guiding Principles of Professional Responsibility for Crime Laboratories and Forensic Scientists have been included as a reference to this manual (See **Section 2 – References**).

4.2.2.2 The CSD Director ensures that these Guiding Principles are reviewed by all CSD personnel annually and maintains a record of that review, in accordance with **QP 18**.

4.2.3 Management Commitment

Management is committed to developing, implementing, and continually improving the effectiveness of the management system. This is evident through management's involvement in quality procedures including audits, proficiency testing, management system review, etc.

4.2.4 Management Communication

Management communicates the importance of meeting customer, statutory, and regulatory requirements during regular meetings of the Quality Improvement Committee (QIC).

4.2.5 Supporting Procedures

Quality policies are included in the quality manual, which follows the same outline as the ISO/IEC 17025 standards. Procedures governing the implementation of these policies which apply to multiple disciplines are included in the Quality Procedures. Quality policies and technical procedures which apply to a single discipline are

included in the discipline quality and protocol manuals. Discipline specific manuals may amplify but shall not contradict the CSD Quality Manual or Quality Procedures.

4.2.6 Roles and Responsibilities

The roles and responsibilities of technical management and the quality manager are provided in **section 4.1.5** above and the referenced attachments.

4.2.7 Management System Integrity

CSD Management will preserve the integrity of the management system anytime changes to the system are planned and implemented.

4.3 Document Control

4.3.1 General

The OSBI CSD controls all documents included in the management system to ensure the documents are appropriate to the work conducted. The management system consists of internally and externally generated documents. Documents as referenced in this policy include policies, procedures, regulations, standards, software, manuals, etc. Refer to **QP 2** for document control procedures.

4.3.2 Approval and Issue

4.3.2.1 Any technical protocol or discipline quality manual documents will be reviewed by the technical manager or his/her designee. Technical protocols and discipline quality manuals will be approved by the technical manager and the Criminalistics Division Director or designee, in his/her absence.

Management system documents including quality policies and quality procedures will be reviewed by the Quality Manager and will be approved by the Quality Manager and the Criminalistics Division Director or designee, in his/her absence.

4.3.2.2 **QP 2** describes the steps taken to ensure that:

a) The current authorized version of management system documents is available at all OSBI CSD facilities.

b) Management system documents are periodically reviewed and revised as appropriate.

c) Documents which are no longer valid are removed from use promptly.

d) Retired documents that are retained for legal or knowledge preservation purposes are marked appropriately to prevent unintended use.

4.3.2.3 Each internally issued document will be identified with the information specified in **QP 2**.

4.3.3 Document Changes

4.3.3.1 Changes to documents can be made in two ways. Documents are revised following **QP 2**. In addition, changes to documents can be documented using a major deviation, as described in **QP 3**. Both methods follow the same review and approval method.

4.3.3.2 Each internally issued document will include an attached document history page or section. Insertions or alterations made to the document with each revision will be noted in this section, whenever practical.

4.3.3.3 Documents will only be amended as indicated under section 4.3.3.1 above. Amendments may not be made by hand writing on documents.

4.3.3.4 **QP 2** details how changes are made and controlled for documents issued through the OSBI Intranet.

4.4 Review of Requests, Tenders, and Contracts

4.4.1 General

QP 4 establishes the procedures that will be followed for the review of requests, tenders, and contracts. This procedure ensures that:

a) The customer's requirements, which include the type of analysis or methods to be used, are well defined, documented, and understood.

b) The OSBI CSD is capable of meeting the customer's needs.

c) The appropriate test method is selected.

Any differences between the request, tender, or contract will be resolved before work commences. Each contract should be satisfactory to both the OSBI CSD and the customer.

4.4.2 Records

An electronic or hard copy of the RFLE received according to **QP 5** will be maintained with the case file as a record of the request, review, and contract. In addition, any significant changes will be recorded in a conversation log, e-mail, or equivalent document. All records of changes to the contract will also be maintained with the case file (either electronic or hard copy).

4.4.3 Subcontracted Work

This review process shall apply to work performed by any OSBI laboratory, regardless of which laboratory received the evidence and performed the review. It shall also apply to analysis that is subcontracted to a non-OSBI laboratory.

4.4.4 Deviations

The customer will be informed of deviations from the contract. If an analyst determines that requested analysis is not appropriate or recommends alternate or additional analysis, the customer will be contacted prior to modifying the contract, unless the modification has already been addressed through the general notice to customers, **QMA 1.1**.

4.4.5 Amendments

Any amendment or modification to the contract after analysis begins will be reviewed in the same manner listed under **QP 4**. The person making the amendment will notify the affected personnel.

4.5 Subcontracting of Tests

In order to provide the best service possible, OSBI laboratories may choose to transfer work to another OSBI laboratory or subcontract to an outside vendor. However, when a customer (investigating agency, prosecuting agency or defense attorney) requests evidence be sent out for further testing and specifies where to send the evidence it is not considered subcontracting.

4.5.1 Qualification of Subcontract Laboratory

All OSBI laboratories and any laboratory performing work for the OSBI must be accredited to ISO/IEC 17025 standards.

4.5.2 Customer Notification

The OSBI CSD shall notify customers in writing when subcontracting work to an outside vendor. When appropriate, the OSBI CSD will also obtain approval from the customer, preferably in writing.

4.5.3 Review of Subcontracted Work

The OSBI CSD maintains responsibility for subcontracted work, unless the customer or a regulatory authority specifies which subcontractor will be used.

4.5.4 Records of Subcontractors

The QM will receive and maintain a copy of the accreditation certificate for any laboratory which performs analysis on behalf of the OSBI.

4.6 Purchasing Services and Supplies

4.6.1 General

Selection and purchasing of services and supplies will be made according to OSBI Policy 208. The purchase, receipt, and storage of reagents and consumable materials used for analysis will be conducted according to **QP 8.1**.

4.6.2 Verification of Reagents, Supplies, and Consumable Materials

Any supply, reagent, or consumable item that will affect the quality of analysis will not be used until inspected and/or verified according to **QP 8.1**.

4.6.3 Descriptions of Items Affecting Quality

Items that affect the quality of analysis will be identified on the Internal Purchase Request (IPR) with a description specific enough to ensure the appropriate quality of item is purchased. This description may be a product number, catalog number, a reference to a particular grade or purity, or other technical description. The description provided will be reviewed and approved with the IPR.

4.6.4 Evaluation of Suppliers

The technical manager of each discipline will determine which reagents, consumables, supplies, and services are critical and affect the quality of testing. The

technical managers will also oversee the evaluation of suppliers and maintain a list of approved suppliers, as described in **QP 9**.

4.7 Service to the Customer

4.7.1 Assisting the Customer

The OSBI CSD will cooperate with OSBI customers to ensure that service provided meets customers' needs. This includes clarifying requests for analysis and monitoring the laboratory's work performance. However, the OSBI CSD will ensure that cooperation with one customer does not compromise confidentiality of other customers. Refer to **QP 10** for procedures on customer assistance.

4.7.2 Soliciting Feedback from Customers

The OSBI CSD will seek feedback from customers, primarily through the use of surveys. Feedback will be utilized to improve the management system, analytical procedures, and customer service. **QP 11** details the procedure for soliciting general customer feedback. **QP 32** details the procedure for soliciting feedback specific to testimony provided.

4.8 Complaints

Complaints will be resolved and documented according to **QP 12**.

4.8.1 Quality Complaints

QP 12 will also be used to resolve and document complaints submitted by employees regarding quality aspects of the management system.

4.9 Control of Nonconforming Work

4.9.1 Policy

Any work that does not conform to the requirements set forth in this manual, the Quality Procedures, or in OSBI technical protocols shall be addressed according to **QP 13**. By following the procedure detailed in **QP 13**, OSBI CSD shall ensure that:

a) Responsibilities and authorities for managing nonconforming work are specified and appropriate actions are defined and taken when nonconforming work is identified.

b) The nonconforming work is evaluated to determine the significance.

c) A decision regarding the acceptability of nonconforming work is made and correction is done immediately.

d) The customer is notified and work is recalled when necessary.

e) The responsibility for authorizing work to resume is defined.

4.9.2 Implementation of Corrective Action

If the evaluation of the nonconforming work indicates a significant possibility that the problem could recur, or there is an indication that lab operations do not comply with OSBI policy and procedures, then corrective action procedures outlined in **QP 14.2** will be followed.

4.10 Improvement

The management system will be continually improved using information gained during audits, analysis of statistical data, corrective and preventive actions taken, management review, etc.

4.11 Corrective Action

4.11.1 General

When nonconforming work is identified, it will be addressed according to **QP 13**. This procedure details the appropriate authorities for implementing corrective actions.

4.11.2 Cause Analysis

As indicated in **QP 14.2**, the first step of corrective action will be to investigate the root cause of nonconforming work.

4.11.3 Selection of Corrective Action

After the completion of the root cause analysis, potential corrective actions will be evaluated. The goal of the corrective action is to correct the problem and prevent the problem from recurring. The corrective action plan will also be appropriate to the magnitude and risk of the problem. The corrective action plan most likely to succeed in these areas will be selected and implemented. Any changes necessary as a result of the corrective action investigation will be implemented and documented.

4.11.4 Monitoring Corrective Actions

For each corrective action plan, the results of the corrective action will be monitored to determine effectiveness.

4.11.5 Additional Audits

When the nonconforming work indicates that there is a failure to comply with ISO/IEC 17025 standards or CSD policies and procedures, an audit of the areas of activity in question will be conducted as soon as possible. In addition, an audit may be used following the implementation of a corrective action plan in order to assess the effectiveness of the corrective action.

4.12 Preventive Action

4.12.1 General

Needed improvements or potential sources of nonconformity will be identified and routed as indicated in **QP 15**. Preventive action plans will be developed, implemented, and monitored for effectiveness in order to ensure that opportunities for improvement are exploited and nonconforming work is prevented.

4.12.2 Procedure

QP 15 details how to initiate preventive actions and how to utilize controls or other measures to ensure the preventive action is effective.

4.13 Control of Records

4.13.1 General

4.13.1.1 **QP 16.1** describes the procedure for maintaining quality and technical records. Quality records and technical records are defined in the glossary.

4.13.1.2 Records will be legible and stored in a manner that they are readily retrievable and protected from damage and loss. Retention times for records are also reflected in **QP 16.1**.

4.13.1.3 Records will be kept in secure locations and are confidential.

4.13.1.4 Procedures for records stored electronically are detailed in **QP 16.1**.

4.13.2 Technical Records

4.13.2.1 The OSBI CSD will retain records of examination documentation and supporting documentation, such as quality assurance/quality control documentation, and copies of reports for the period of time defined in **QP 16.1**. Each case record will contain enough information to identify factors affecting uncertainty of measurement, if possible and applicable, and to enable re-analysis to be conducted under conditions as close to the original as possible. The identity of the individuals who sampled evidence, conducted testing, and/or verified results will be reflected in the case record.

4.13.2.2 Observations, data, and calculations must be recorded at the time they are made and must be identifiable to the specific case involved.

4.13.2.2.1 Examination documentation must include at a minimum, the start and end dates of examination.

4.13.2.3 Mistakes in examination documentation will be crossed out with a single line, initialed, and the correct value added alongside. Erasing, obliterating, or otherwise making the original data illegible is not permitted. Similar measures must be taken with records stored electronically to avoid losing or altering original data.

4.13.2.3.1 Any change made to existing hard copy examination documentation will also be initialed by the person making the addition.

4.13.2.3.2 Examination documentation is considered complete when it is submitted for administrative and/or technical review. Any change made to completed examination documentation shall be tracked.

4.13.2.4 Documents maintained as part of the case record are identified in **QP 16.2**.

4.13.2.5 Examination and supporting documentation must be sufficient for another examiner to determine what was done and to independently interpret the data.

4.13.2.5.1 Latent print documentation shall meet all requirements listed in Appendix C of the ASCLD/LAB Supplemental Requirements.

4.13.2.5.2 Operating parameters used during instrumental analysis shall be recorded in the examination documentation, protocol, or another suitable and appropriate location.

4.13.2.6 Each page of examination documentation will bear the case number and examiner's handwritten initials (or secure electronic equivalent of initials or signature).

4.13.2.7 If a technician or other individual prepares examination documentation which another analyst interprets, reports, or testifies to, the person who prepares the examination documentation must initial the page(s) he/she prepares.

4.13.2.8 All administrative documentation, received or generated by the OSBI CSD, must be labeled with the laboratory case number.

4.13.2.9 When multiple cases are analyzed simultaneously, the case number of each case must be appropriately recorded on the printout if the data is recorded on a single printout.

4.13.2.10 Examination documentation should be one-sided. Each side of any two-sided examination documentation will be treated as a separate page (initialed and case numbered).

4.13.2.11 Examination documentation will be permanent in nature.

4.13.2.12 Verifications of analytical findings, such as latent print or firearms identifications, will be conducted by qualified examiners. Verifications will be documented to include what was verified, whether the second examiner agreed, and when the verification was conducted.

4.13.2.13 The meaning of any abbreviations or symbols specific to the OSBI CSD will be documented either in the case record or in discipline quality manuals or protocols.

4.14 Internal Audits

4.14.1

The OSBI CSD shall conduct internal audits as described in **QP 17**.

4.14.1.1 Internal audits will be conducted annually.

4.14.1.2 Documentation of internal audits will be retained as quality records according to **QP 16.1**.

4.14.2

If audit findings identify nonconforming work or indicate that the effectiveness of operations or validity of test results may be questionable, then procedures outlined in **QP 13**, if applicable, and QP 14.2 and/or QP 14.3 will be promptly followed as necessary.

4.14.3

An audit report will be completed according to **QP 17**.

4.14.4

Implementation and effectiveness of any corrective actions generated as a result of an internal audit will be verified and recorded according to **QP 14.2**.

4.14.5

Each OSBI laboratory will submit an Annual Accreditation Audit Report to ASCLD/LAB according to the deadline in **QP 17**.

4.15 Management Reviews

4.15.1

OSBI CSD management will conduct a review of the management system and casework activities, at least annually, to ensure their continued effectiveness and to introduce changes or improvements as needed. The procedure for management system reviews is detailed in **QP 18**. Records of management system reviews will be retained as a quality record according to **QP 16.1**. Management system reviews will include the following topics:

a) suitability of policies and procedures
b) reports from managerial and supervisory personnel
c) outcome of recent internal audits
d) corrective and preventive actions
e) external audits
f) proficiency test results
g) changes in volume and type of analysis
h) customer feedback
i) complaints
j) recommendations for improvement

k) any other relevant factors

4.15.2

Findings from management reviews and the actions taken will be recorded according to **QP 18**. CSD management will ensure that actions are carried out according to an appropriate timetable.

5. Technical Requirements

5.1 General

5.1.1

Several factors impact the reliability of analysis conducted by the OSBI CSD. These may include the following:

- human factors (5.2)
- environmental conditions (5.3)
- protocols and method validation (5.4)
- equipment/instrumentation (5.5)
- measurement traceability (5.6)
- sampling (5.7)
- evidence handling (5.8)

5.1.2

The OSBI CSD shall take account of the factors listed above when developing and validating procedures, training and qualifying personnel, and in the selection and calibration of instrumentation.

5.1.3

The reliability of reagents will be verified according to **QP 8.1**.

5.1.3.1 Reagents prepared in-house will be labeled with the identity of the reagent and the lot number or date of preparation at a minimum. Records identifying who prepared the reagent and documenting the function verification will be maintained.

5.2 Personnel

5.2.1

OSBI CSD Management shall ensure the competence of any individual who performs analysis, operates instrumentation, evaluates results, or signs reports. Work conducted by trainees shall be properly supervised. The education, training, experience, and/or demonstrated skill of an employee shall be used to qualify the individual.

5.2.1.1 Each OSBI CSD discipline shall have a documented training program which will be used to train employees in the knowledge, skills, and abilities necessary to perform analysis. Requirements for discipline training manuals are outlined in **QP 19**.

5.2.1.2 Where applicable, training programs shall also address courtroom testimony.

5.2.2

OSBI CSD Management has established the goals for education, training, and skills of employees. These goals and the procedure for identifying training and conducting training are outlined in each discipline training manual. **QP 19** details how the effectiveness of the training program will be evaluated.

5.2.3

OSBI CSD shall use personnel employed by or under contract to the OSBI. If contract or additional support personnel are used, OSBI CSD will ensure that these personnel are also appropriately supervised and competent for the work they perform. Their work shall also be in accordance with the OSBI CSD Management System.

5.2.4

Current job descriptions for managerial, technical, and key support personnel involved in analysis are located at http://www.ok.gov/opm/jfd/jfd_g-page.htm. More specific job descriptions may also be located in each discipline's quality manual.

5.2.5

OSBI CSD Management shall indicate which procedures and work each employee is authorized to perform by providing a written memo detailing the task(s) and the date that it is confirmed the individual is authorized to perform the work. These authorizations shall be issued and documented as described in **QP 19**.

5.2.6

OSBI CSD personnel shall meet the education and competency requirements detailed in the ASCLD/LAB Supplemental Requirements. Technicians will meet the educational requirements established in the applicable written job description. If there is not an applicable job description available through the Office of Personnel Management, the Supervisor will be responsible for developing a written job description for the technician position(s) in his/her unit.

5.2.7

The OSBI CSD provides access to current literature sources by ordering journals and by providing internet access and on-line subscriptions to employees. OSBI CSD employees also have access to the Oklahoma Department of Libraries catalog of books and periodicals free of charge at http://www.odl.state.ok.us/.

5.3 Facilities

5.3.1

OSBI CSD shall provide laboratory facilities with proper energy sources, lighting, temperature, and other environmental conditions to ensure correct performance of tests and procedures. Employees should exercise caution when conducting sampling or analysis in a location other than a permanent facility, such as a crime scene, to ensure that environmental conditions do not negatively impact the integrity of evidence or results. Accommodations and environmental conditions which would impact results shall be documented in the technical protocols.

5.3.2

When specific environmental conditions are required by the technical procedure or could impact the quality of results, the OSBI CSD shall monitor, control, and record the appropriate environmental conditions. Testing shall be stopped if the environmental conditions would negatively impact test results.

5.3.3

Incompatible testing activities shall be separated by time or space in order to prevent cross-contamination.

5.3.4

Access to laboratories and evidence rooms will be limited to employees assigned to the laboratory unit, evidence technicians assigned to the physical facility, Criminalistics Administrative personnel, and other personnel as authorized by the Criminalistics Services Division Director on a limited or permanent basis.

5.3.4.1 Laboratory security procedures are located in **QP 20**.

5.3.5

Good housekeeping shall be maintained in OSBI CSD facilities. If necessary, technical protocols will be prepared for cleaning/sterilization procedures.

5.3.6

OSBI CSD follows the health and safety program detailed in OSBI Policies 121.0 through 121.5.

5.4 Test Methods and Validation

5.4.1 General

OSBI CSD uses appropriate methods for all testing and evidence handling. Evidence handling procedures are included in **QP 6.1** through **QP 7**. Technical procedures, estimations for uncertainty of measurement, and any statistical techniques for analysis of testing data are included or referenced in discipline specific quality manuals and/or protocols. Instructions on the operation of instrumentation, sample handling and preparation will also be included or referenced in the discipline specific quality manuals and/or protocols, if written instructions are necessary to ensure the quality of test results. Any deviations to these procedures occur only as outlined in **QP 3**.

5.4.1.1 All analytical protocols shall be documented and issued according to **QP 2**.

5.4.1.2 Appropriate controls and standards shall be specified in the analytical records and the results of controls and standards tested shall be documented in the case record.

5.4.2 Selection of Methods

The OSBI CSD shall use analysis methods which meet the needs of the customer and which are appropriate for the testing conducted.

5.4.2.1 The reliability of any new method will be internally validated and the results of the validation study documented prior to implementing the procedure for use in casework. The procedure for suggesting, conducting, documenting, and maintaining records of a validation study are outlined in **QP 21.2**.

5.4.3 Laboratory-developed Methods

Validation of new methods developed by the OSBI CSD shall be planned and conducted by qualified personnel who have the necessary resources. Effective communication shall be maintained and the validation plan shall be updated as the method development proceeds.

5.4.4 Non-standard Methods

Only approved technical procedures will be used in the analysis of casework. If a non-standard method is necessary, the method shall be subject to the agreement of the customer. The agreement with the customer shall include a clear specification of the customer's requirements. The method must be validated prior to use on evidence samples.

5.4.5 Validation of Methods

5.4.5.1 Validation of a method shall provide objective evidence that the method meets the particular requirements for a specific intended use.

5.4.5.2 All methods used by the OSBI CSD shall be validated to ensure that the methods are fit for the intended use. Documentation of validation studies shall record the results obtained, the procedure used, and a conclusion indicating whether the method is fit for the intended use.

5.4.5.3 In order for a method to be determined fit for an intended use, the range and accuracy of the values obtained from the method must be relevant to the customer's needs.

5.4.5.4 Before implementing a validated method new to the OSBI CSD, the reliability of the method will be demonstrated against any documented performance characteristics (such as sensitivity or specificity) of the method. Records of the performance check shall be retained.

5.4.6 Estimation of Uncertainty of Measurement

The procedure for estimating the uncertainty of measurement is located in **QP 22**.

5.4.7 Control of Data

5.4.7.1 Calculations and data transfers shall be subject to appropriate checks in a systematic manner, such as the administrative and technical review process. If an additional check is required, it should be included in the appropriate discipline protocol(s).

5.4.7.2 When computers or automated equipment are used for the acquisition, processing, recording, reporting, storage, or retrieval of test data, OSBI CSD Management shall ensure that:

a) Computer software is documented in sufficient detail and suitably validated.

b) Procedures are used to protect the data; such procedures shall include, but are not limited to, integrity and confidentiality of data entry or collection, data storage, data transmission, and data processing.

c) Computers and equipment are maintained to ensure proper functioning and are provided with environmental and operating conditions necessary to maintain the integrity of the data.

5.5 Equipment

5.5.1

OSBI CSD Management shall furnish each laboratory and/or unit with the equipment necessary to ensure the correct performance of analytical tests conducted. If equipment outside of the immediate control of the OSBI CSD is used for analysis of evidence samples, OSBI CSD Management shall ensure that the equipment meets the standards outlined in ISO/IEC 17025.

5.5.2

Equipment and software used to perform analysis, calibration, or sampling will comply with specifications relevant to the test and shall be adequate to achieve the required accuracy. Calibration programs/procedures will be established as outlined in **QP 24**.

5.5.3

Instruments will be operated by authorized CSD personnel. Authorization for unsupervised use of instruments will be documented in the authorization to work

memo addressed in **section 5.2.5**. OSBI CSD trainees and technicians, practicum students, and interns are authorized to use equipment/instruments in the unit(s) they are assigned to **under the supervision of authorized CSD personnel**. Current instructions for use and maintenance will be included in discipline protocols so that they are readily available for use by the appropriate CSD personnel. Alternately, manufacturers' manuals or use and maintenance instructions may be referenced in the protocol and placed in a designated location for easy access by authorized personnel.

5.5.4

Whenever possible, each instrument used for testing and its software significant to the test result will be uniquely identified. At a minimum, unique asset numbers will be assigned in accordance with OSBI Policy 209.

5.5.5

For each instrument and its software significant to the analysis performed, the following records will be maintained according to **QP 24**:

a) the identity of the instrument and software

b) the manufacturer's name, model number, and serial number and/or asset number

c) documentation of function verification

d) the current location, if appropriate

e) the instruction manual, if available, or a reference to the location of the manual

f) copies of all calibration and adjustment reports/certificates, including the date, result of calibration/adjustment, acceptance criteria, and the due date for the next calibration

g) the maintenance plan, if appropriate, and records of maintenance performed to date

h) description of any damage, malfunction, modification, or repair

5.5.6

Procedures for safe handling, transport, storage, use, and maintenance of measuring equipment are located in **QP 24**.

5.5.7

Instruments and equipment which have been mishandled or have been shown to be outside acceptable limits will be taken out of service. Out of service instruments and equipment will be clearly labeled as out of service until repairs are made and the instrument/equipment is placed back in service following a successful function verification/calibration. The impact of the defect or departure from acceptable limits will be evaluated and procedures outlined in **QP 13** will be initiated.

5.5.8

Whenever possible, equipment which requires calibration will be labeled to show the status of the calibration, including the date of the last calibration and when recalibration is due.

5.5.9

When equipment goes outside the direct control of the CSD, whether for repair or another purpose, the function and calibration status will be checked and shown to be satisfactory before the equipment is returned to service. This may also apply if instruments are taken out of casework service in order to conduct research. Refer to **QP 21.1**.

5.5.10

If intermediate calibration checks are needed to maintain confidence in the calibration status of equipment, the checks will be done according to a written protocol approved by the appropriate Technical Manager.

5.5.11

Where calibrations result in correction factors that must be used, the discipline shall implement a procedure to ensure that any copies (e.g. in computer software) are correctly updated.

5.5.12

Applicable controls, defined in protocol, will be used to safeguard test and calibration equipment including hardware and software from adjustments which would invalidate the test and/or calibration results.

5.6 Measurement Traceability

5.6.1 General

Any equipment used for testing or calibration which has a significant impact on the accuracy or validity of the test, calibration, or sampling shall be calibrated before being placed in service. This includes any equipment used for subsidiary measurements such as environmental conditions, if it would have a significant impact on the validity or accuracy of results.

The requirements for equipment calibration procedures are outlined in **QP 24**.

5.6.1.1 As specified in **QP 24**, the procedures for checking the calibration of equipment are established based on the specific requirements of the tests being conducted. Under normal circumstances, a check of calibration will be conducted after any shut down and following service or other substantial maintenance. Calibration check intervals will not be less stringent than the manufacturer's recommendations.

5.6.2 Specific Requirements

5.6.2.1 Calibration The OSBI does not provide calibration services as defined by ISO/IEC 17025.

5.6.2.2 Testing

5.6.2.2.1 As indicated in **QP 23** and **QP 24**, the calibration program for equipment is designed to ensure that calibrations and measurements are traceable to the International System of Units (SI), if possible. This is not required if the associated contribution of the calibration to the total uncertainty of the test results is negligible. In this situation, the OSBI CSD shall ensure that the equipment used provides the uncertainty of measurement needed.

5.6.2.2.2 Where traceability of measurements to SI is not possible and/or relevant, the OSBI CSD shall provide confidence in measurements by establishing traceability to appropriate standards such as certified reference materials, specified methods, and/or consensus standards.

5.6.3 Reference Standards and Materials

5.6.3.1 Reference Standards **QP 25** outlines the procedures for the calibration of reference standards. Reference standards will be calibrated by an organization

capable of providing traceability to SI units as described in ISO/IEC 17025 standard 5.6.2.1. Reference standards will only be used for calibration unless it can be demonstrated that other use will not invalidate their performance as a reference standard. Reference standards will be calibrated before and after adjustments.

5.6.3.2 Reference Materials As specified in **QP 26**, reference materials will be traceable to SI units of measurement, or to certified reference materials, whenever possible. Accuracy of internal reference materials will be checked as far as is technically and economically practical.

5.6.3.2.1 Reference collections of data or items encountered in casework that are maintained for identification, comparison, or interpretation purposes shall be fully documented, uniquely identified, and properly controlled.

5.6.3.3 Intermediate Checks When checks are needed to ensure confidence in the calibration status of reference, primary, transfer or working standards and reference materials, these checks will be carried out according to defined procedures and schedules.

5.6.3.4 Transport and Storage **QP 25** establishes the procedures for safe handling, transport, storage, and use of reference standards. These procedures prevent contamination and deterioration of the standards and protect their integrity.

5.7 Sampling

The OSBI CSD will not report results based on a statistical sampling method (see **glossary**). The OSBI CSD may report results for a whole based on testing a portion in limited circumstances which include toxicology analysis and the identification of controlled substances. Discipline quality manuals and protocols will specify the necessary steps to ensure homogeneity of toxicology samples and the amount of sample to be used for analysis. State statute establishes a legal basis for homogeneity for the identification of controlled substances and the amount of sample to be tested will be based on the analyst's training and experience.

5.8 Evidence Handling

5.8.1

The procedures for transportation, receipt, handling, protection, storage, retention and/or disposal of evidence items are included in **QP 5** through **QP 7**. These

procedures include all provisions necessary to protect the integrity of evidence and the interests of the OSBI CSD and our customers.

5.8.1.1 Through compliance with the evidence handling procedures outlined in **QP 5** through **QP 7**, the OSBI CSD documents the chain of custody for evidence received and analyzed by the laboratory. The minimum components of a chain of custody record include the person (by signature or electronic equivalent) or location receiving evidence, the date of receipt or transfer, and a description or unique identifier of the evidence.

In order to ensure a complete and accurate chain of custody, all employees will document evidence transactions in the LIMS at the time evidence is physically moved from one location to another, unless exceptions are provided for in evidence handling procedures. In addition, employees shall not share LIMS passwords with anyone. Failure to comply with this policy will result in progressive discipline.

Failure to comply with evidence handling procedures may also result in progressive discipline.

5.8.1.1.1 As detailed in **QP 6.1**, when evidence is subdivided in the laboratory, the OSBI CSD requires the same chain of custody documentation for any sub- items created.

5.8.1.1.2 As described in **QP 5**, evidence accepted and stored by the OSBI CSD will be properly sealed.

5.8.2

The OSBI CSD utilizes the "BEAST" Laboratory Information Management System (LIMS) to identify evidence items while they are in OSBI CSD custody. This system, in conjunction with the evidence handling procedures, ensures that evidence cannot be confused physically or when referred to in the case record or other documentation. The system allows for sub-dividing groups of evidence items, transfer of evidence within the laboratory, and receipt and return of evidence.

5.8.3

When evidence is received, any abnormalities regarding the packaging or condition of evidence will be recorded. If there is doubt whether the item is suitable for testing or if the item does not match the description provided, the customer will be consulted for clarification and the conversation recorded using the "Narrative" button on the "Case Info" tab in the LIMS before proceeding.

5.8.4

QP 6.1 details the procedures for preventing loss, deterioration, or damage to evidence items during storage and handling. This includes ensuring the security and proper environmental conditions of evidence storage locations. Requirements for monitoring refrigerators and freezers used to store evidence are located in QP 6.4.

5.8.4.1 All evidence will be stored in a secured, limited access storage area when not in the process of examination.

5.8.4.2 QP 6.1 details how to secure unattended evidence in the process of examination.

5.8.4.2.1 QP 6.1 also clearly defines when evidence is considered to be in the process of examination.

5.8.4.3 Each item of evidence shall be marked with the case number and item number. If it is not possible to mark the evidence or if marking the evidence with the item number could affect the integrity of the evidence, then the proximal container or tag shall be labeled.

5.8.4.4 When evidence, such as latent prints or impressions, can only be recorded or collected by photography and the image itself is not recoverable, the photograph or negative of the image shall be treated as evidence.

5.8.4.5 OSBI CSD personnel collecting evidence at a crime scene will ensure that the evidence is protected from loss, cross-transfer, contamination, and deleterious change, whether in a sealed or unsealed container, during transport to the laboratory. Crime scene evidence shall be appropriately identified, packaged, and entered into the LIMS as soon as practical.

5.8.4.6 The OSBI CSD maintains individual characteristic databases (ICD's) in the Latent Evidence Unit, CODIS Unit, and Firearms Unit. Procedures for the operation of ICD's are located or referenced in the appropriate discipline/unit quality manuals and/or protocols. These procedures must address the elements described in 5.8.4.6.1 through 5.8.4.6.3.

5.8.4.6.1 The policy must specify whether ICD samples will be treated as evidence, reference materials, or examination records.

5.8.4.6.2 ICD samples under the control of the OSBI CSD will be uniquely identified.

5.8.4.6.3 ICD samples under the control of the OSBI CSD will be

protected from loss, cross transfer, contamination and deleterious change.

5.8.4.6.4 Access to ICD's shall be limited to persons authorized by the CSD Director. The CSD Director has delegated the authority to approve access to the Latent Evidence TM (AFIS), Firearms TM (IBIS), and the CODIS Administrator. These designees shall authorize individuals to access and operate ICD's in the analyst's Authorization to Work memo (see **QP 19**).

5.9 Assuring Quality of Test Results

5.9.1

The OSBI CSD procedures for monitoring the validity of tests are located in technical protocols as appropriate. In addition, procedures for proficiency tests, re-examination, and reviews are referenced below. Quality control data will be recorded in a way to allow trends to be detected and whenever practical, statistical techniques will be used to review the data. OSBI CSD quality control monitoring is planned and reviewed according to the procedures referenced. Monitoring includes the following:

a) use of appropriate controls and standards, which are specified in protocols and recorded in case records

b) regular use of certified or secondary reference materials, as appropriate

c) internal and external proficiency testing

d) re-analysis of casework

5.9.2

Quality control data will be analyzed and planned action will be taken to correct the problem if the quality control data is outside the predefined window for acceptability.

5.9.3

The OSBI CSD proficiency testing program is located in **QP 30**.

5.9.4

Technical review of casework will be conducted according to **QP 31** in order to routinely verify that conclusions reported are accurate and supported by the

examination documentation. **QP 31** further defines the scope of a technical review, how technical reviews will be documented, and what actions will take place if a discrepancy is noted.

5.9.5

Administrative review of casework will be conducted according to **QP 31** to ensure that reports and case records are accurate and complete. All OSBI CSD reports, with the exception of no analysis reports, will be administratively reviewed prior to release.

5.9.6

Testimony provided by OSBI CSD analysts will be monitored according to **QP 32**.

5.10 Reporting Results

5.10.1 General

The results of all testing, examinations, and any evidence collection not inherent to a reported result that is conducted by OSBI CSD personnel will be reported accurately, clearly, unambiguously, and objectively in a Criminalistics Examination Report. Additional instructions on ensuring the clarity of reported results are located in **QP 28**.

5.10.1.1 In the event that a request for analysis is canceled, no-analysis or partial analytical reports will be issued according to **QP 28**.

5.10.2 Test Reports

Analytical reports will be prepared and issued according to **QP 28**.

5.10.3 Test Reports – Additional Requirements

5.10.3.1 OSBI CSD reports and/or case records will include the following information:

a) Deviations from, additions to, or exclusions from the protocol and specific test conditions as necessary for interpretation of the test results shall be recorded in the case record.

b) When relevant, a statement of compliance with requirements or specifications should be included in the case record.

c) Where applicable, a statement on the estimated uncertainty of measurement should be included in the test report. Under most circumstances, records for uncertainty of measurement will be maintained by the laboratory and available on request. A statement should be included in the report when it is relevant to the validity of the test result, the customer requests the statement, or if the uncertainty affects compliance to a specification limit.

d) Opinions and interpretations shall be included in the report when necessary. For example, expert opinions regarding comparison of latent prints or interpretations of DNA profiles.

e) Additional information shall be included in the report and/or case record as required by the method or by the customer.

5.10.3.2 If a sampling plan is used to analyze evidence, the following information shall be included in the case record:

a) the date of sampling

b) identification of the item sampled

c) location of sampling

d) reference to the plan and procedures used

e) details of any environmental conditions during sampling that may affect the test results

f) any standard or other specification for the sampling method and any deviations, additions to, or exclusions from the specification

5.10.3.3 **QP 33** describes the procedure used for releasing case information.

5.10.3.4 Any OSBI CSD analyst who issues a report or testifies based on the examination documentation generated by another individual shall complete and document a review of all relevant pages of documentation in the case record.

5.10.3.5 When associations are made, the significance of the association shall be communicated clearly and qualified in the report.

5.10.3.6 If comparisons are performed and result in an elimination, the elimination shall be clearly communicated in the report.

5.10.3.7 If results are inconclusive, the reason why no definitive conclusion could be reached shall be documented in the report.

5.10.4 Calibration Certificates

The OSBI CSD does not issue calibration certificates.

5.10.5 Opinions and Interpretations

The OSBI CSD issues reports including opinions and interpretations only for forensic disciplines which have been appropriately validated and documents the training of each analyst issuing reports with opinions and interpretations. Opinions and interpretations shall be clearly identified in OSBI CSD reports.

5.10.6 Testing Results from Subcontractors

When analysis is subcontracted, the subcontractor shall provide a case record and report which meet the same requirements as OSBI reports and case records. The OSBI shall maintain a copy of the case record, and after reviewing the case record and report, the subcontractor's report will be sent to the customer.

5.10.7 Electronic Transmission of Results

Reports issued electronically must meet the same requirements stated above.

5.10.8 Format of Reports

OSBI CSD reports shall be formatted in a manner to accommodate the types of tests conducted and to minimize the possibility for misunderstanding or misuse.

5.10.9 Amendments to Reports

Modifications to OSBI CSD reports shall be handled according to **QP 28**. Analysis conducted subsequent to the issuance of a report will be included in a separate, uniquely identified report. Corrections to an issued report will be made by issuing a corrected report and indicating which report it replaces.

I. Scope

This procedure explains the responsibilities and authority of key CSD personnel.

II. Procedure

A. Responsibilities of CSD Personnel

1. CSD Director

The CSD Director will promote and direct the quality system and ensure that the policies and objectives are documented, as well as communicated to, understood by, and implemented by CSD personnel. The CSD Director serves as the laboratory director for the Forensic Science Center (FSC) and is an ex officio member of all CSD committees.

2. Criminalistics Administrators

Each Criminalistics Administrator (CA) will be assigned the administrative supervision of specific laboratories and/or laboratory units. Each CA will also be assigned additional responsibilities as indicated below.

a) The CA responsible for the administrative supervision of the Forensic Science Center (FSC) Toxicology Unit, Forensic Chemistry Unit, FSC Physical Evidence Unit, Northwest Regional Laboratory, Southwest Regional Laboratory, and the Eastern Regional Laboratory is responsible for the statewide coordination of these forensic disciplines and units/laboratories. This position will also be responsible for overseeing or coordinating CSD drug destruction activities and responding to Open Record Requests. All activities will comply with quality standards set forth by the OSBI CSD.

b) The CA assigned the administrative supervision of the FSC Forensic Biology Unit, FSC Specialized Forensic Biology Unit, FSC CODIS Unit, Latent Evidence Unit, Firearms/Toolmarks Unit, and the Northeast Regional Laboratory at Tahlequah is responsible for the statewide coordination of these disciplines/units/laboratories. All activities will comply with quality standards set forth by the OSBI CSD.

c) The third CA position is responsible for the administrative supervision of the Forensic Biology Technical Manager. This position will also serve as the Division Quality Manager and will be responsible for coordinating CSD activities in the area of quality control/quality assurance. This includes, but is not limited to, proficiency testing, laboratory accreditation, testimony monitoring, and audits. The CA assigned to this position will also be responsible for lab surveys, complaints, and coordinating or overseeing CSD grant management.

3. Administrative Programs Officer – LIMS Administrator

The LIMS Administrator is responsible for the statewide administration and coordination of the CSD's Laboratory Information Management System (LIMS) known as the BEAST. This includes:

a) Implementing programs or procedures.
b) Troubleshooting and upgrading the system as needed.
c) Approving users/access.
d) Training users.
e) Developing and/or modifying management and Crystal reports as needed.
f) Ensuring security of the data maintained in the BEAST.
g) Monitoring, managing, and procuring the resources necessary for employees to access and utilize the BEAST.
h) Preparing monthly, quarterly, and yearly statistical reports and other management reports as needed for the CSD Director.
i) Overseeing the OkLEX-LIMS external user access to OSBI lab reports.

4. Administrative Programs Officer – Evidence Discipline

The administrative programs officer over the evidence unit at FSC is the Technical Manager for the physical evidence discipline of the CSD. Responsibilities of this position include:

a) Oversee the storage, maintenance, archival, and destruction of technical records.
b) Oversee and coordinate statewide activities of the physical evidence technicians/units.
c) Assist with Laboratory Information Management System (LIMS) administration by correcting custody record and deleting incorrect items/sub-items when needed.
d) In coordination with the Quality Manager, develop, draft, and revise policies and procedures related to the acceptance, handling, tracking, storage, return, and destruction of evidence.
e) Perform supervisory duties for the Physical Evidence Unit at FSC.

5. Administrative Programs Officer – FSC Facilities Manager

The administrative programs officer responsible for managing the FSC Facilities shall:

a) Maintain and oversee Forensic Science Center facility.
b) Coordinate FSC facility related purchasing activities with the Purchasing Section.
c) Monitor FSC facility management/control systems.
d) Coordinate with contractors as repair or maintenance is needed.
e) Act as primary responder to after hours building alarms/issues.
f) Oversee janitorial contract staff.
g) Oversee maintenance of CSD pool vehicles and submission of fleet reports.

6. Safety Program Coordinator

The OSBI Safety Program Coordinator will be identified on the Organizational Chart (located on the OSBI Intranet). The responsibilities of the Safety Program Coordinator are listed in OSBI Policy 121.0.

7. Technical Managers

Each discipline in the OSBI CSD shall have a Technical Manager. The Technical Managers will be identified on the most current organizational chart. Each OSBI CSD Technical Manager shall:

a) Oversee implementation of the OSBI CSD Quality System within the discipline.

b) Assist with management reviews as described in **QP 18**.

c) Review and approve all technical procedures within the discipline.

d) Implement and review quality documentation within the discipline.

e) Stay abreast of recommendations made by Scientific Working Groups for the discipline and incorporate appropriate recommendations.

f) Educate all discipline members in the implementation of the quality assurance program and confirm that all members of the discipline understand the importance of the program.

g) Participate in audits and inspections when requested.

h) Oversee training, competency testing and evaluation of analysts.

i) Issue and update Authorizations to Work as needed.

8. Criminalist Supervisors

Each OSBI CSD Criminalist Supervisor shall:

a) Assist with management reviews as described in **QP 18** and disseminate information regularly to members of their unit.

b) Ensure that members of the unit understand and follow all quality assurance procedures.

c) Know and follow the CSD Quality Assurance Program.

d) Make recommendations to improve quality within the discipline and division.

e) Educate all unit members in the implementation of the quality assurance and safety programs and confirm that all members of the discipline understand the importance of the program.

f) Serve as laboratory director, if assigned to a regional laboratory.

g) Supervisors are to be knowledgeable regarding the quality of casework produced by their staff.

9. Criminalists

Each Criminalist shall:

a) Know, understand and apply quality procedures that pertain to their specific discipline.

b) Ensure completeness of laboratory reports, notes and essential documentation and make recommendations and suggestions for improvements of procedures used for the examination of forensic evidence.

c) Advise Technical Manager and/or Supervisor of any technical problems or questionable results and make recommendations for improvements.

10. Physical Evidence Technicians

Each physical evidence technician shall:

a) Know, understand and apply all quality procedures that apply to proper evidence handling including evidence submission, transfer, return, or destruction.

b) Notify the Technical Manager and/or Supervisor of any concerns relating to the quality assurance program of the Division.

11. Laboratory Analysts and Technicians

Each laboratory analyst, laboratory technician, or part time employee shall:

a) Know, understand, and apply quality procedures that apply to their specific discipline or job task.

b) Notify the Technical Manager and/or Supervisor of any concerns relating to the quality assurance program of the Division.

B. Authority of CSD Personnel

1. CSD Director

The CSD Director has the authority to make and enforce decisions impacting any and all work produced by the division.

2. Criminalistics Administrators

Under the administrative direction of the CSD Director, the Criminalistics Administrators have the following authority:

a) The Quality Manager will have the express authority to immediately halt any laboratory activity that fails to exhibit the required levels of accuracy, specificity, reliability or validity with respect to the CSD Quality Assurance program.

b) Technical decisions made by each Criminalistics Administrator responsible for the coordination of a forensic discipline will apply to all personnel engaged in any capacity within the affected forensic discipline. These decisions will be made after consultation with the Technical Manager for the discipline.

c) Authority of each Criminalistics Administrator shall include but not be limited to the assignment of specific duties or responsibilities to specific personnel and the review of the activity of those personnel engaged in these duties including all quality practices adopted by the OSBI CSD.

3. Safety Program Coordinator

The Safety Program Coordinator has the express authority to immediately halt any laboratory activity which is determined to fall outside established safety policies and procedures and applicable laws.

4. Technical Managers

The technical manager of each discipline has the following authority:

a) Technical managers will assign and approve forensic procedures. All procedures will address and include practices consistent with the quality standards.

b) Technical managers have the authority to suspend any work which does not comply with the OSBI CSD Quality System or any applicable quality standards.

5. Criminalist Supervisors

Criminalist supervisors have the authority to suspend any work which does not comply with the OSBI CSD Quality System or any other applicable quality standards. Criminalist supervisors should only suspend work activities after consultation with the appropriate technical manager and CSD Administration. However, if the appropriate individuals are not available and the situation warrants work suspension, the supervisor should suspend the appropriate work activities and consult with the technical manager and administration as soon as they are available.

III. Attachments

None

I. Scope

All management system documents will be approved, issued, modified, and controlled according to this procedure. Management system documents include policies/procedures developed internally, externally prepared documents or standards which are referenced or used (user's manuals, applicable standards, etc.), and software (internally or externally developed) used for testing purposes.

II. Procedure

A. Control

1. All approved, internally generated CSD management system documents (policies, procedures, protocols, training manuals, quality manuals, major deviations, forms, etc.) will be placed on the OSBI Intranet. Any hard copy or other electronic copy is considered an uncontrolled document.

2. Uncontrolled copies may be made, if necessary, to reference at a work area that doesn't have easy access to the OSBI Intranet. However, CSD employees creating or using uncontrolled copies must verify the uncontrolled copy is still current <u>before each use</u> and immediately dispose of any uncontrolled copy that is not current.

3. Uncontrolled copies may also be made for the purpose of responding to discovery requests/orders.

4. External documents, software, and any other management system documents which are not distributed through the OSBI Intranet will be referenced in the CSD or appropriate discipline quality manual, protocol, or an attachment to the appropriate document. The reference must identify the current revision/version approved for use and the distribution or location of the document.

5. The individual responsible for the initial approval of internally generated documents (Quality Manager (QM) or appropriate Technical Manager) shall maintain a copy of the current version that can be edited when the document requires revision (see section II.E.4 below).

B. Approval

1. Technical protocols/procedures, discipline quality manuals, and related attachments and references will be approved by the appropriate Technical Manager and the CSD Director or designee.

2. The CSD Quality Manual, Quality Procedures, and related attachments and references will be approved by the QM and the CSD Director or designee.

3. CSD documents distributed through the OSBI Intranet will include the signature of the individuals who have approved the document.

C. Issue

Once approved, the document(s) shall be distributed to the designated point(s) of issue. When a document is replaced or rescinded, it shall be removed from the point(s) of issue at the time it is replaced or no longer effective.

1. Approved CSD documents distributed through the OSBI Intranet, with the exception of forms, will be scanned or otherwise converted to pdf format prior to placing the documents on the Intranet.

2. Documents may be added to and removed from the OSBI Intranet by the Quality Manager, appropriate Technical Manager, FSC Executive Secretary or designee.

3. Documents referenced by the CSD or discipline quality manuals will be added to or removed from the designated point(s) of issue by the QM, appropriate Technical Manager, or designee.

4. Externally generated management documents will be available at each location where related work is conducted. For example, any externally generated management documents referenced by analysts conducting drug analysis will be located at each regional laboratory providing drug analysis.

D. Notification

For internally generated management documents, an e-mail will be sent to the appropriate individuals indicating that the document has been issued, revised, or rescinded. The e-mail will be sent by the Quality Manager, appropriate Technical Manager, FSC Executive Secretary, or designee.

A copy of the notification will be archived to the appropriate folder in the following directory:
\\pm-fsc13000s\qa\Lab-System_Records\Management_System_Documents\Notifications.

E. Storing and Archiving Controlled Documents

Discipline TM's and the QM shall save current and archived controlled documents which they draft, revise, and approve, as described below. Controlled documents shall be saved in the appropriate folder in the following directory:

\\pm-fsc13000s\qa\Lab-System_Records\Management_System_Documents\.

1. All controlled documents will be saved as PDF files and will be named in the following format: DC#_REV#_MM-DD-YY. DC# refers to the document number (e.g. LP-1, QP 28, etc) and REV# is the document revision number. MM-DD-YY is the effective date of the protocol. Once a controlled document has been replaced by a new revision or rescinded, the date it is replaced by a new revision or rescinded shall be added to the file name. For example, LP-1_Rev8_12-3-09_5-7-10 would be the archive file name for the 8th revision of LP-1 and would reflect that the document went into effect on 12-3-09 and was replaced on 5-7-10. If LP-1, Rev 8 was rescinded (see section II.I), the original file (LP_1_Rev8_12-3-09) would be replaced by the rescinded file (LP-1_Rev8-R_12-3-09_5-7-10).

2. All controlled documents will be retained indefinitely.

3. Major deviations shall be stored and archived in the same manner as controlled documents. When naming major deviations, the file name should include an identification that the file is a deviation, the policy number and revision it modifies, and the date(s) the deviation is/was effective. For example, "Deviation_QM_QP_Rev_1_(4-15-13)" would represent an active deviation that went into effect on 4-15-13. Once deviations have been replaced by a revised version of the appropriate policy, they will be archived by added the last effective date to the file name.

4. In addition to retaining the PDF file for all versions of controlled documents, the current version of every document needs to be retained in Word format. Each individual responsible for maintaining controlled documents (e.g. TM's and QM) may store the most current revision in Word format on his/her hard drive. However, a copy of the most current version should also be stored in the appropriate folder on the Quality Server (\\pm-fsc13000s\qa). When revising documents, care should be taken to name working documents in a manner that identifies the most current draft to avoid confusion. For example, QM_QP_Rev2_DRAFT_11-19-13 could be used to name the draft revision 2 that was created or updated on 11-19-13. **Once a document has been issued, any prior revisions and drafts should be moved or deleted to avoid creating a future document from an obsolete version.** Word documents must be locked, stored in a limited access folder, password protected, or otherwise protected from unintentional modifications.

F. Identification

Internally generated CSD management system documents will be uniquely identified and include the following:

1. document number
2. title
3. date of issue and/or revision number

4. page numbering
5. total number of pages or mark indicating the end of the document
6. issuing authority

Forms or other attachments to management system documents will be identified in the following manner:

1. unique form number
2. date of issue and/or revision number
3. page number and total number of pages (e.g. page X of Y) or the designator "AΩ" may be used to indicate a one page form

Revision numbers for forms and attachments may be tracked independent of the document revision number. The current attachment revision number (if applicable), changes made to attachments, and approval of attachments will be included in the attachment, history, and approval section of the document it is attached to.

G. Format

All OSBI CSD Controlled Documents shall be formatted as described below.

1. Each document shall have a history page or history section which will be located following the approval page or section. The history may be saved electronically as a separate file.

2. Each policy and protocol must include an effective date which indicates when the policy will go into effect. Issue dates (when the document was provided to employees) and revision dates (when the work of modifying the document was conducted) will not be required and do not need to be referenced.

3. Document revision numbers and the effective date for the document will be located in the header and/or footer of the document.

4. A list of required forms and any other externally issued controlled documents which are required to be used for a protocol or policy (e.g. user's manual, etc) will be located in either the header of the parent document or in a section that follows the main text of the policy. Other references (e.g. journal articles or textbooks used as a basis for the protocol) may be listed in a "references" section, but are not required.

5. Protocols should include the following information, as applicable:

    a. Appropriate identification;
    b. Scope;
    c. Description of the type of item to be tested;
    d. Parameters or quantities and ranges to be determined;
    e. Apparatus and equipment, including technical performance requirements;
    f. Reference standards and reference materials required;
    g. Environmental conditions required and any stabilization period needed;

h. Description of the procedure, including
   i. Affixing of identification marks, handling, transporting, storing and preparation of items,
   ii. Checks to be made before the work is started,
   iii. Checks that the equipment is working properly and, where required, calibration and adjustment of the equipment before each use,
   iv. The method of recording the observations and results,
   v. Any safety measures to be observed;
i. Criteria and/or requirements for approval/rejection;
j. Data to be recorded and method of analysis and presentation;
k. The uncertainty of the procedure for estimating uncertainty.

H. Review and Revision

1. Management system documents will be reviewed annually.

2. Internally generated CSD documents will include a history section or attachment which will be used to document the completion of revisions and, when possible, identify modifications made during revision. Management system documents which are reviewed and found not to need revision should be documented in the history section/attachment.

3. Temporary deviations or modifications implemented between annual review/revision will be documented and issued according to **QP 3**.

I. Rescinding Controlled Documents

When a controlled document needs to be rescinded and will not be replaced by a new revision, the following actions shall occur:

1. The history page or section will be updated to show the date that the policy will no longer be in effect.

2. The approval page will be modified to show "date rescinded" instead of "date approved" and signed by the appropriate authorizing individuals.

3. The revision number of the document will be modified to add an "R" at the end to show the document is rescinded. For example, if the 9th revision of a document is rescinded, the revision number would be "Rev. 9-R."

4. Notification of personnel will be conducted in the same manner used for document revisions.

III. Attachments

None

I. Scope

This procedure explains the process to follow when a CSD employee believes that a deviation from a current CSD-authored, controlled document is necessary. This procedure does not apply to any policies or procedures issued from outside the CSD. Any deviations from CSD policy, procedure, or protocol which do not comply with this procedure are considered protocol drift and must be evaluated as potential non-conforming work according to **QP 13**.

II. Procedure

A. Requirements and recommendations

In order to ensure the quality of analysis conducted and services provided, written policies, procedures, and protocols have been established and issued to all appropriate CSD personnel. However, due to the variability of evidence and circumstances encountered, many protocols, procedures, and policies are worded to include **recommendations** (indicated by "should") instead of **requirements** (indicated by "shall", "will", or "must"). All CSD personnel are expected to follow both requirements and recommendations set forth in CSD policies, procedures, and protocols, with the following exceptions:

1. Planned deviations from **requirements** can be requested and conducted following approval of a minor or major deviation as indicated below.

2. CSD employees may deviate from **recommendations** stated in protocol, procedure, or policy, provided the employee can articulate a legitimate reason which warrants the deviation.

3. CSD employees should make a notation explaining the deviation from **recommended** procedure.

4. If an employee is not certain whether circumstances warrant a deviation from **recommended** procedure, he/she should consult the Supervisor for assistance.

B. Minor deviations

CSD employees will complete the following steps to request, approve, and document authorization to deviate from current policy, procedure, or protocol for an individual sample, case, or batch of samples/cases.

1. The employee will describe the proposed deviation to his or her Technical Manager (TM) or designee and obtain approval before implementing the deviation.

2. The TM or designee will evaluate the benefits and risks of the proposed deviation to determine if the circumstances warrant the deviation. The TM or designee will

consult with any appropriate individual (e.g. CSD Quality Manager or TM (if a designee is the approving individual)), if necessary, to thoroughly evaluate the benefits and risks of the deviation.

3. If approved, the deviation will be documented in the case notes when applicable to case work and documented in a relevant location for non-case work activities.

4. The approval will be documented by initialing a short description of the deviation in the case notes or applicable materials in non-case work activities.

5. Alternately, a description of the requested minor deviation may be documented electronically by the analyst in the narrative section of the electronic case file. The TM or designee may document his/her approval electronically by logging into the case and entering a narrative indicating his/her approval.

C. Major deviations

CSD employees will complete the following steps to request, approve, and document authorization to deviate from current policy, procedure, or protocol for a defined period of time or grouping of cases or samples. These steps will also be used to initiate, approve, and document permanent changes to policies, procedures, and protocols in between annual review and revision of controlled documents.

1. The requesting individual will complete Section I of the Deviation Request Form (**CSD QPA 3.1**) and specify on the form:

   a) the applicable protocol, procedure, or policy
   b) a description of the requested deviation
   c) the specific instance(s) for which the deviation is requested
   d) the reason for the deviation

2. The requesting individual will then forward the form for approval as indicated below.

3. Prior to implementation, all major deviations must be approved by the same authorities responsible for approving the document being modified.

   a) Section II must be completed by the appropriate Technical Manager for any deviation impacting a discipline quality manual or protocol approved by the TM.
   b) Section III must be completed by the Quality Manager for any deviation impacting the CSD Quality Manual, any Quality Procedure, attachment, or any other management system document initially approved by the QM.
   c) Section IV must be completed by the CSD Director or designee for all major

deviation requests.

d) Any deviation request for a document which was also originally approved by another individual must be routed to that individual for evaluation and approval. This additional evaluation and approval should be documented on an attached memo or e-mail.

4. Individuals responsible for reviewing a deviation request will evaluate the request in the same fashion as the document being modified. This review includes an evaluation of the merit and risk of the deviation and whether the proposed modification complies with any and all applicable standards.

5. Major deviations which are approved will be issued in the same fashion as the controlled documents affected by the deviation. The FSC administrative office will retain a copy of approved deviation requests.

6. Deviation requests which are not approved will not be disseminated or retained. The individual denying the deviation request should notify the requestor of the decision.

7. Approved deviations may be effective once signed by the CSD Director or designee. When necessary to delay the implementation of a deviation until employees have had an opportunity to be notified of the deviation, the CSD Director, QM, or TM may indicate an effective date on the bottom of the form. If the effective date is left blank, the deviation is effective on the date it was signed by the CSD Director.

8. Major deviations should be routed and approved/disapproved by the appropriate persons within two weeks of the date of request.

III. Attachments

OSBI CSD QPA 3.1, Rev 1 Deviation Request Form

I. Scope

This procedure will be used to evaluate all requests for laboratory examination and provide response to the customer requesting analysis. Whenever OSBI CSD personnel accept evidence for analysis, the entry of the evidence into the OSBI CSD system constitutes a contract with the customer.

II. Procedure

A. Review of Requests

The following steps shall be taken to review all requests for analysis. This includes requests made at the time of evidence submittal (see **QP 5**) and subsequent requests or amendments made after evidence has already been received by the OSBI CSD.

1. Verify that the individual requesting the analysis is authorized by statute to request services from the OSBI CSD. The agencies and individuals authorized to request services are listed in Title 74, Sections 150.2 and 150.5.

2. Verify that the type of evidence being submitted falls within the acceptance requirements described in **QMA 2**.

3. Verify that the OSBI CSD is capable of providing the type and degree of service requested. A list of available services/methods is listed in **QMA 4.1**.

4. Check to see if the request is for a service that has any specific limitations as listed in **QMA 4.2**. If so, ensure that the submission meets the appropriate limitations or that approval for an exception is documented by the appropriate individual.

5. If necessary, consult the appropriate Supervisor or Criminalistics Administrator to determine that the request meets the criteria listed above.

B. Tenders

Based on the results of the review conducted, one of three responses will be given to the customer.

1. If the request meets the criteria listed in II.A.1 through II.A.3, the analysis will be conducted.

2. If the request does not meet the criteria but can be modified to meet the criteria, the modification will be proposed to the customer. If the customer agrees, then the analysis agreed to in the modification will be conducted. For example, if a customer requested blood typing, DNA analysis could be proposed as an

alternative.

3. If the request does not meet the criteria and cannot be modified to meet the criteria, the requested analysis will not be conducted and the evidence will not be accepted. In this situation, the customer will be notified of the reason that the analysis cannot be conducted.

4. Under most circumstances, the customer will be notified of the inability to conduct analysis in the same fashion that the request was received. For example, if the request is made in person, the customer will be informed in person at the time the request is made.

5. The customer may be notified in a different fashion when the alternate method provides for better or more direct communication or when the customer cannot be reached by the same method that the request was received.

C. Contracts

When the OSBI CSD agrees to conduct analysis for a customer, a contract is established between the OSBI CSD and the customer. This contract is established in the following ways.

1. For requests received for evidence that has not yet been submitted, the contract is established by following the evidence intake procedure in **QP 5**. The electronic submission record or a printed copy of the submission represents the contract established.

2. Requests received for evidence that has been submitted constitute an amendment to the original contract. Once an amendment has been agreed upon by the OSBI CSD and the customer, it will be documented in the narrative section located on the "Case Info" tab or by placing a copy of the communication (e-mail, letter, etc.) in the case file.

3. The OSBI has published a notice to customers (**OSBI CSD QMA 1.1**) regarding some deviations which may be made in the normal course of analysis. When necessary additional notifications may and/or should be made. A record of any notification made will be maintained in the case file.

III. Attachments

None

I. Scope

These procedures shall be used by any OSBI CSD employee when receiving evidence.

II. Procedure

A. Review of the Request

Conduct a review of the request as described in **QP 4**. With the exception of blood alcohol kits, each request for examination shall be submitted on the Request for Laboratory Examination (RFLE) form (**OSBI CSD QPA 5.1**).

1. If the OSBI CSD does not have the capability to provide the service requested, return the evidence to the submitter. If possible, provide assistance to the customer in locating a laboratory that can provide the services needed. A list of potential service providers is located in **QMA 5**.

2. If the OSBI CSD can provide the needed service, accept and log-in the evidence as described below.

3. For in person submissions, check that the RFLE has been signed by the submitting officer. If it has been signed, verify that the identity of the officer submitting the evidence matches that of the signature. If it has not been signed, ask the officer to sign the officer RFLE before proceeding.

B. Evaluation of Evidence Integrity Concerns

Inspect the evidence to ensure that it is packaged in a manner that will preserve the integrity of the evidence.

1. Evaluate each package to ensure that it is appropriate for the type of evidence it contains. For example, arson samples should be in arson cans while evidence with dried biological stains should be in packaging that will prevent mold or bacterial growth.

2. Evaluate the seals on each package to ensure that they protect the evidence from loss, cross-transfer, contamination, and deleterious change. Ensure that the officer's initials or other identifying mark are on each seal. Ask the officer to add his/her initials or identifying mark if initials are not present. Refer to **QMA 3** for more information regarding proper seals.

3. Determine whether there are any special storage conditions (e.g. store refrigerated) which need to be observed to protect the evidence.

4. Evaluate the items grouped together in each package and the types of analysis requested. If necessary, have the officer re-package items to ensure more efficient flow of evidence. For example, if a projectile which needs Firearms analysis is packaged with clothing which needs Biology analysis, have the officer repackage the projectile into a new container.

C. Evaluation and Identification of Safety Concerns

Inspect the evidence submitted to ensure that the evidence is packaged and labeled in a manner which ensures the safety of CSD personnel.

1. When firearms are submitted, have the officer indicate on his/her RFLE and the evidence package whether the weapon is unloaded. (Officers should be instructed to indicate unloaded only if they have direct knowledge that the weapon is unloaded.) If there is no indication that the weapon has been rendered safe and the submitting officer does not have direct knowledge of the weapon's status have a qualified individual verify that the firearm(s) has/have been unloaded or otherwise rendered safe. Have the qualified individual document that the firearm is unloaded/rendered safe on the evidence package.

2. Ensure that chemicals, including any known carcinogens, mutagens, toxic substances, and volatile or foul smelling compounds are properly labeled and packaged according to safety policy and MSDS recommendations.

3. Ensure any sharp item (syringe, knife, glass, etc.) is packaged in a fashion that prevents the item from puncturing the package and potentially injuring CSD personnel.

4. Ensure that proper warning labels are on each package. This includes biohazard, sharps, and any other necessary hazard label.

5. Liquid evidence, with the exception of toxicology blood kits, must be double packaged in such a manner that the outer package would contain liquid in the event that the inner package was broken or leaked. For example, a properly sealed evidence package that contains liquid evidence could be placed into a bucket for storage and transport to prevent breaks and contain any liquid in the event of a break or leak. The bucket can be a convenience container and does not need to be properly sealed.

D. Data Entry

Transfer information provided on the RFLE (or other submission paperwork for cases such as DUI) into the BEAST by creating a new case using manual creation or by creating a new submission on an existing case. If it is not certain whether the submission is the first submission in a case, a search should be done with the information provided to ensure there will not be duplicate case numbers assigned to the same case. Fields in the BEAST which have a question mark in the box have a drop down menu available which can be used as needed.

1. Use the "Type of Offense" from the RFLE to select the most appropriate case type in the "Case Type" field.

2. Enter the County of Offense in the "County" field.

3. For a rush request, select "1" for the case priority. For a routine/normal request, select "2" as the case priority.

4. If a report should not be sent to the DA, check the box for "DA Case Restriction."

5. Select the appropriate agency in the "Department" field. Verify that the appropriate county of offense has been entered (#2 above), keeping in mind that some agencies have jurisdiction which covers more than one county.

6. The name of the officer requesting analysis shall be entered in the "Case Officer" field **using the drop down menu**. The case officer is listed on the RFLE as the "Requesting Officer." If the officer's name is not present in the drop down menu, contact the LIMS Administrator, the APO for Evidence, or another individual with authorization to add officers to this menu.

7. Select the appropriate submission method in the "Submission Type" field.

8. For items received by mail, enter the shipping or mailing tracking number in the "Tracking Number" field by scanning the barcode or typing the number. For blood alcohol kits, if the tracking number is entered manually or if there is an agency barcode number/label on the mailing container, make a copy of the mailing container to capture the tracking labels. Scan the copy of the mailing container into the BEAST (see II.F).

9. In the "Department Case" field on the top half of the screen, enter the appropriate department case number or "NONE*" if an agency case number is not provided. Agency case numbers will be recorded as shown on the RFLE. If the case number appears to include additional information (e.g. property receipt number), it will be entered as shown, unless the officer instructs otherwise.

10. **Using the drop down menu**, enter the name of the officer bringing evidence to the lab in the "Submitted By" field. If the officer's name is not present in the drop down menu, contact the LIMS Administrator, the APO for Evidence, or another individual with authorization to add officers to this menu.
    If the submitting officer works at a different agency than the case officer, select the submitting officer's agency first from the second field on the "Submitted By" line and then select the submitting officer from the drop down list in the first field. If the evidence is not submitted in person (e.g. mail, UPS, etc) the name of the individual listed on the RFLE as "Submitting Officer" shall be listed in the "Submitted By" field. If the "Submitting Officer" line on the RFLE is blank, then the name of the requesting officer should be entered into the "Submitted By" field.

11. On the "Offense / Date" line, leave the first three fields blank and record the date of offense in the fourth field.

12. In the "Name ID" column on the "Names" tab, hit F4 to list any identifying numbers provided such as social security numbers (SSN), OSBI numbers, and Department of Corrections (DOC) numbers. Driver's license numbers or any other numbers not in the F4 field may be listed by typing them directly into the Name ID field and adding an abbreviation to identify the type of number listed. For example, DL 1233425 would indicate driver's license number 1233425.

13. If a case does not have a suspect or victim (e.g. controlled buy), select "O" in the "Type" field on the "Names" tab. Then, enter the agency case number in the "Last" field.

14. Enter each outer package of evidence on the "Containers" tab.

    a) Enter a letter designation for each outer package in the "Cont. #" column.

    b) Select a description of the evidence package that most closely describes the package from the drop down list in the "Package" column. If an appropriate description is not in the list, select "miscellaneous."

    c) Assign one item number to each container of evidence.

    d) Select the analysis needed from the "Service Req(s) F4" column.

15. Enter item specific information on the "Items" tab.

    a) In the "Pkg." column, enter ITEM or the type of evidence collection kit (DUI, SAKIT, etc).

b) In the "Type" column, select "EVIDENCE" or the appropriate evidence code from the drop down list. For evidence collection kits, such as blood alcohol, sexual assault, or gun-shot residue kits, select the appropriate kit type. The sexual assault kit type should reflect the agency that provided the kit (OCPD, OSBI, or TPD).

c) For blood alcohol kits, highlight the "Attribute F4" column, press the F4 key, and enter the blood kit and citation number in the window that opens.

d) In the "Description F7" column, enter the description of what is in each package based on the information provided by the officer and/or the labeling on the package.

16. If another agency or individual needs to receive a copy of the report, enter the appropriate information on the "Distribution" tab.

E. Finalize Case Creation

Finish creating the case by completing the following steps.

1. For all cases, once the information has been entered into the BEAST, click the "Quick Create" button.

2. For in person submissions, type the name of the individual submitting the evidence and capture his/her signature using the signature pad. Click on "Save Signature" when he/she has finished signing.

3. For in person submissions, offer the submitting officer a copy of the BEAST generated submittal receipt.

F. Scan Any Necessary Documents

Scan a copy of blood alcohol kits, officer RFLE's, officer affidavits and any other necessary documentation by completing the following steps.

1. Insert the document into the scanner in the proper orientation, according to the scanner instructions.

2. Open the case within the BEAST.

3. With the "Case Info" tab selected, hit the F11 key or click on the "Documents F11" button.

4. Click on the "Scan_Doc" button in the lower right corner of the window that opens.

5. Select “black and white picture or text” and set the page size to “Letter” in the window that opens and click “Scan.”

6. When prompted for a document description, include the case number and “BA kit”, “affidavit”, or an appropriate description of the document scanned and then click “ok.”

G. Label Evidence and Folder

Ensure the evidence and case file(s) are properly identified by completing the following steps.

1. Apply the appropriate barcodes to the package(s) and file folder(s) or RFLE.

2. If the county and agency are not displayed on the barcode, label the evidence package(s) with this information.

3. If the evidence packaging does not have the department/agency case number or suspect and victim information, ask the officer to add the appropriate information if his/her agency will need it to identify the evidence when it is returned.

H. Transfer Evidence and Folder to Proper Storage Location

Transfer evidence to the appropriate vault by performing the following steps. Then, use the same process to transfer the folder to an appropriate location (file system or electronic file, etc).

1. Scan the barcode representing the location to which the evidence will be transferred.

2. Scan the barcode for each evidence package being transferred.

3. Either scan the barcode representing “Process Transaction” or select enter.

III. Attachments

OSBI CSD QPA 5.1, Rev. 2

I. Scope

This procedure outlines the process for handling evidence within the OSBI CSD. Evidence handling procedures include uniquely identifying evidence, labeling evidence items and/or packaging, and preventing contamination.

II. Procedure

A. EVIDENCE INVENTORY

1. An initial inventory of evidence containers (packages) is created during the evidence intake process. Refer to **QP 5**.

2. During the examination of evidence, analysts will create an inventory of evidence items contained within any package or container of evidence that is opened for analysis. Any significant discrepancies between evidence received and the labeling on the officer's RFLE or evidence packaging should be noted and verified using a method appropriate to the significance and potential impact of the discrepancy. For example, a package listed or labeled as containing 28 tablets which contains only 24 could be verified by repeating the count multiple times or having a second examiner repeat the count. A more significant discrepancy (e.g. a mislabeled reference sample) may require contacting the submitting agency for verification and/or submission of a new reference sample. The action taken to verify the correct information shall be noted in the case record.

3. The inventory of evidence should include a unique item number or sub-item number for each evidence item or package (if package not opened) observed by the analyst and a description of the item or package.

4. Analysts creating an inventory of evidence which may be forwarded for latent evidence analysis should be cautious when assigning sub-item numbers, since latent evidence analysis may often be conducted on the packaging of an item tested by another discipline (e.g. the packaging is an item for analysis). Whenever possible, the analyst creating the inventory should communicate with a latent evidence analyst to ensure that the inventory is created in a manner which facilitates analysis and reporting by both disciplines.

B. ITEMIZING EVIDENCE

The following procedure will be used to assign a unique item number or sub-item number to each piece of evidence analyzed.

1. Item numbers will be assigned using the default item numbering system currently in effect in the "BEAST" Laboratory Information Management System (LIMS). Each

"parent" container or package is assigned an item number at the time of intake.

2. Parent item numbers will not be added, edited, deleted, or otherwise modified without prior approval of the Administrative Programs Officer responsible for the FSC Evidence Unit, or designee.

3. Sub-item numbers will also be assigned using the default numbering system in effect in the BEAST. Sub-item numbers may be edited, but only under the following circumstances.

   a. Sub-item numbers may be edited in order to match a sub-item number previously assigned for evidence that has been re-submitted.

   b. In addition, sub-item numbers may be edited if necessary to maintain consistency with a legacy numbering system. For example, if a case was analyzed prior to the BEAST and additional evidence is submitted, the sub-item numbers can be changed to the item numbers that would have been assigned under the original numbering system.

4. Analysts will use the following method to create, on the "Items" tab, an inventory of evidence items and/or packages contained within each container of evidence that is opened for analysis. Exceptions to this method are covered in section II.B.5.

   a. Upon opening each container of evidence, the analyst will determine how many items or packages are present in the container. Analysts may exercise some discretion to determine what is an item. Under some circumstances multiple pieces of evidence may be considered one item, provided that the remaining applicable requirements of this procedure are followed.

   b. If only one item is present in the package, analysis should be completed and documented using the parent item number assigned to the package. However, if the item has been previously itemized or was submitted in relation to a case that was previously analyzed using a different numbering method, a sub-item should be created in order to maintain consistent numbering. See II.B.3.

   c. If more than one item is present in the package, the analyst will use the sample button to create the correct number of sub-items. Alternately, the parent package can be sampled once, and the sub-item can be "duped" to create the correct number of sub-items.

5. Sub-item numbers will also be assigned to derivative evidence as necessary to accurately document the chain of custody and report results.

   a. Sub-items of evidence which are generated as a work product are not required to

be created on the "Items" tab, if they will not be retained or transferred for further analysis. Examples may include sperm cell search slides and DNA cuttings, extracts, and dilutions.

b. An alternate numbering system may be used to distinguish between multiple stains, swabs, etc., during the testing process. Sub-item numbers will be assigned to all derivative evidence that will be retained/transferred for further analysis.
c. Evidence has been sub-divided anytime a portion of an evidence sample is removed and is not consumed in testing or returned to the original package. When evidence is sub-divided, a sub-item number must be assigned and created on the items tab so that chain of custody can be accurately tracked in the same fashion as the parent item.

d. All assigned sub-item numbers will be recorded/created on the items tab.

C. LABELING EVIDENCE

1. The first Criminalist examining a piece of evidence will mark the item with the laboratory case number, item number, date, and his/her handwritten initials. Any Criminalist who subsequently examines the evidence will mark the item with the date and his/her handwritten initials.

2. If the evidence itself cannot be labeled or labeling the item itself could compromise the integrity of the evidence, the proximal container will be labeled.

3. All evidence items and/or their proximal containers will be legibly marked in such a way that the examiner's identifying marks or entry into the container does not cover, obliterate, or substantially alter another examiner's or officer's seal or markings whenever possible. In this way a traceable chain of seals is maintained.

4. When evidence is re-sealed after analysis, the examining Criminalist will mark the outer container with the item/sub-item number(s) contained within the evidence package. The Criminalist should also confirm that all outer evidence containers bear the case number, examiner's initials, container designator, and bar codes. Additionally, outer evidence containers should bear the county of offense and the submitting agency.

D. DIGITAL EVIDENCE

1. When evidence, such as latent prints and impressions, can only be recorded or collected by photography (including digital images) and the evidence in the image is not recoverable, the photograph or negative of the image must be treated as evidence.

2. Photos such as these, that are treated as evidence, must be handled in the following manner:

   a) The photographs must be labeled with, or contain in the image, the case number, date taken, analyst initials, and a unique photo number (i.e. Photo 1) or an item/sub-item evidence number. Whenever possible, this information should be included in the image.

   b) The photographs must be listed in the case file, in either hard copy or electronic format.

   c) In latent evidence cases, photographs and negatives can be retained in the case file.

E. EVIDENCE HANDLING

Each analyst is responsible for ensuring that all evidence examined is protected from loss, contamination, cross transfer, and deleterious change.

1. Evidence will be handled taking precautions to prevent any unauthorized alteration, any cross-contamination, or any deleterious changes by the following method or combination of methods:

   a) Analysts shall obtain approval from the TM and/or QM prior to combining samples of evidence which may originate from a different source, even if located on or submitted as a single item (e.g. multiple biological stains on a single item, multiple tablets or syringes submitted as a single item).

   b) Generally, open and examine only one container of evidence at a time.

   c) Suspect and victim evidence will be searched in separate areas or at different times after decontamination measures are employed to prevent cross-contamination.

   d) Every reasonable attempt will be made to maintain and preserve informative samples of biological evidence in serology related cases. Analysis of consumption samples will be documented according to **QP 16.2**. Requests for additional documentation or observation will be handled according to **QP 10**.

   e) Representative samples of all informative biological material will be preserved in a manner to minimize degradation of the material and allow for future testing as required. These items may be retained, if necessary, or returned to the submitting agency.

2. All evidence received of insufficient quantity to allow a representative sample after testing should be photographed and documented according to CSD **QP 16.2** prior to examination. In addition, any work product of the analysis, such as DNA extracts, that may permit retesting, will be preserved and retained in such a way as to prevent degradation.

F. EVIDENCE STORAGE

1. Temporary closure of evidence is encouraged for evidence in overnight lockup to prevent the possibility of loss, cross transfer, contamination, or deleterious change. Locking cabinets, drawers, etc. will be provided and used by Criminalists for securing evidence overnight or when the Criminalist will be away from the laboratory. During the process of examining evidence, if an examiner needs to leave for a short period of time, such as for lunch, it is not necessary to pack up the evidence being examined if it is in a secure area (e.g., a limited-access laboratory room).

2. Large items or boxes of evidence in the process of being examined will not be required for lock-up as long as they are closed and/or sealed in a secured restricted access lab area when the Criminalist will be away for short periods of time.

3. Evidence such as fingerprints and/or projectiles in unsolved cases that are subject to frequent requests for comparison may be treated as "evidence in the process of examination." "Evidence in the process of examination" may be stored unsealed in a secure, limited access area, as long as the evidence is protected from loss, cross-transfer, contamination, and/or deleterious change. After 30 consecutive days of no analysis or new requests for comparisons, a case is no longer considered "in the process of examination." Cases no longer in the process of examination should be closed and the evidence sealed properly until analysis resumes or a new service request is received.

4. Evidence will be stored in conditions which prevent degradation or other deleterious change. Blood and urine samples submitted for Toxicology analysis will be stored refrigerated upon receipt and until they are disposed of according to statute or returned to the appropriate agency.

5. DNA extracts, including those in the process of examination, must be stored refrigerated or frozen.

G. TRANSPORTING EVIDENCE

1. Evidence collected from a crime scene must be protected from loss, cross transfer, contamination, and/or deleterious change, whether in a sealed or unsealed

container, during transportation to an evidence facility. Where appropriate, further processing to preserve, evaluate, document, or render evidence safe shall be accomplished prior to final packaging. Evidence collected from a crime scene must be appropriately identified, packaged, and entered into the secured electronic evidence tracking system as soon as practical.

2. Evidence that has been received into the custody of the OSBI CSD that must be transported to another facility should be sealed prior to transport.

3. Evidence being transported to another facility should not be left in an unoccupied vehicle overnight.

4. Transportation of evidence will be documented using the evidence transaction procedures outlined in **QP 7**.

III. Attachments

None

I. Scope

When evidence is needed for purposes other than casework analysis, this procedure shall be followed to ensure that the non-casework use of evidence is documented and communicated to OSBI customers.

II. Procedure

A. Approved Non-Casework Use of Evidence

There are several different circumstances other than casework analysis when the use of evidentiary samples is essential to further the mission and goals of the OSBI CSD. These include:

1. Research or validations which improve the quality or types of services the OSBI CSD can provide.

2. Training of CSD employees.

3. Quality control purposes, such as re-analysis casework.

B. Preferred Sources of Evidence for Non-Casework Use

In order to ensure that non-casework use of evidence does not conflict with the OSBI CSD's responsibility to preserve and protect the integrity of evidence, the following sources of evidence will be used in the order listed as appropriate. With the exception of evidence returned for destruction, **at least half of all samples must be retained or returned to the submitting agency**.

1. Evidence which has been resubmitted to the OSBI CSD for destruction or which is eligible for destruction based on state statute (e.g. toxicology samples).

2. Evidence from a no-analysis case, where there is no possibility for a later request for analysis. For example, evidence from a no-analysis case where the suspect has pled guilty.

3. Evidence from adjudicated cases or no-analysis cases with a potential that a request for analysis will be received later.

4. Evidence from active, non-adjudicated cases.

C. Notifying Customers of Non-Casework Use of Evidence

Notification will be provided to customers regarding non-casework use of evidence and whenever practical, an attempt will be made to obtain written authorization for non-casework use of evidence.

1. Notifications may be handled in the following manner:

   a) All customers will be notified of the OSBI's policy regarding non-casework use of evidence by the posting of this policy and the attachment (**OSBI CSD QPA 6.2.1**) on the OSBI website.

   b) For evidence samples retrieved from destruction evidence, no further notification is required.

   c) For evidence from adjudicated cases, or no-analysis cases with no possibility of future requests, a second notification will be sent to the investigating agency or the prosecuting agency, at a minimum. This notification may be through a letter, memo, or e-mail. Alternately, this notification may be done by adding a statement to the Criminalistics Examination Report which states that a portion of the evidence is being retained in accordance with OSBI CSD QP 6.2 and the notification posted on the OSBI website.

   d) For evidence from non-adjudicated cases, the second notification must be sent to the prosecuting agency and defense counsel. Including a statement in the report like that described in II.C.1.c above will be considered notification of both prosecution and defense.

2. As indicated in **OSBI CSD QP 6.2.1**, authorization will be documented through the submittal of evidence for analysis or destruction.

D. Documenting Non-Casework Use of Evidence

When evidence is used for non-casework purposes it will be documented as indicated below.

1. Re-analysis of casework samples will be documented according to **QP 30** and all applicable discipline protocols.

2. Use of destruction evidence will be documented on the destruction form.

3. Use of no-analysis, adjudicated, or non-adjudicated casework will be documented in the case record.

a) The information may be recorded in a case narrative or as part of the examination documentation, whichever is most appropriate.

b) The amount and item/sub-item numbers of samples taken and the purpose of sampling will be documented. The amount of sample taken may be recorded by a specific size, weight or other measurement. Alternately, if additional samples or aliquots are taken which are the same size as that used in casework analysis, the documentation could simply reflect "1 additional test sample taken for training purposes" or a similar notation.

III. Attachments

OSBI CSD QPA 6.2.1, Rev. 0

I. Scope

This procedure outlines the process for maintaining property rooms and evidence vaults within the OSBI CSD. Supervisors are responsible for ensuring that property rooms designated for their unit/lab are properly maintained, according to the requirements listed below.

II. Procedure

A. GENERAL MAINTENANCE

1. All CSD employees who have access to evidence rooms or handle evidence are responsible for ensuring that evidence is properly sealed, labeled, and stored. Any employee who observes a problem with an evidence seal, packaging, labeling, or storage shall notify the appropriate supervisor(s) and correct the problem.

2. Problems noted with evidence handling, sealing, packaging, labeling, or storage will be evaluated according to **QP 13**. The Administrative Programs Officer (APO) for Evidence will have the final authority to determine which level of response is warranted (simple correction, corrective action, or non-conforming results). The Evidence APO will be responsible for tracking evidence related simple corrections and notifying other supervisors as needed so that issues are addressed quickly and do not grow in scope. If necessary or desirable, discipline Supervisors and/or Technical Managers may record evidence related simple corrections on the discipline (e.g. biology, chemistry) specific simple correction log.

3. Property rooms will be neat and organized. Locations for varying types of evidence (pending analysis, ready for return, retain, etc.) will be clearly identified.

4. The primary method for organizing evidence will be to sort evidence in numerical order based on laboratory case number. When necessary, alternate organization methods may be used in addition to or in place of the primary method. For example, evidence pending return to agency may be more appropriately sorted based on agency or county. Similarly, units with evidence that cannot be feasibly grouped due to discrepancies in packaging size or storage requirements will need to modify their organization method accordingly.

5. The organization method will be communicated to all who access and use the property room or vault. All individuals accessing the vault will be responsible for maintaining the organization. For example, analysts pulling evidence for analysis will adjust the packaging so that there are not random “gaps” between cases. Likewise, evidence technicians bringing new evidence will place evidence neatly in the appropriate area.

B. EVIDENCE ROOM INVENTORY SCHEDULE

Periodic evidence room inventories will be conducted to monitor for and correct any discrepancies. Evidence inventories will be scheduled based upon the frequency of turn-over or movement of evidence for that particular location.

1. Locations with **evidence pending analysis** will be inventoried at least **once per quarter** (January – March, April – June, July – September, October – December).

2. Locations with **evidence pending return to agency** will be inventoried at least **once per quarter**.

3. Locations with **retained or long-term storage,** with the exception of the FSC Long Term Storage Property Room, will be inventoried at least **annually**.

4. All locations within the FSC Working Property room will be inventoried at least annually.

C. CONDUCTING EVIDENCE ROOM INVENTORIES

The following procedure may be used as a guide to conducting an evidence room inventory, using a Janam device.

1. Select "HOME."
2. Select the PLC INVENTORY program.
3. Tap the blue header for a drop down menu.
4. Delete items and information from previous scans.
5. Scan the barcode for the location of interest, such as "Working Property Room."
6. Scan all items in the location selected.
7. After all items are scanned, return the scanner to its cradle.
8. Start "HOTSYNC.EXE."
9. Press the orange button on the cradle. A two tone beep indicates that the sync was successful.
10. Log in to the BEAST PLC INVENTORY program using your regular BEAST User ID and password.
11. Click on "Select an Inventory" on the screen that appears.
12. Next, select "New Inventory."
13. Enter a name for the inventory. Include in the file name the location, date, and identity of the individual conducting the inventory.
14. Select "Process Data."
15. Then, select "Inventory Reports."
16. Select the items for report, then click "PRINT." Only items with a quantity of zero may be omitted from the report.
17. Click on "OK" and then print or export the crystal report that is generated.

18. The following categories are tracked by the inventory report:

    a) Misplaced Items – Items which are scanned but the computer records indicate should not be in the location inventoried.
    b) Missing Items – Items which were not scanned, but the computer records indicate they should be in the location inventoried.
    c) Deleted/Invalid Items – Items which were scanned but there is no computer record found in the database. Items may have been deleted and re-entered. This invalidates the barcode. A new label should be printed.
    d) Not in Container Items – These items were scanned. The computer records indicate that these items should be in a container.
    e) Found Items – These items were scanned and are in the correct location.

D. REPORTING EVIDENCE ROOM INVENTORIES

Unit/Laboratory Supervisors will be responsible for maintaining a copy of evidence room inventory reports and any appropriate, related documentation. In addition, Supervisors will be responsible for reporting inventory results as follows:

1. Any problems identified as a result of the inventory will be reported to the Evidence APO and addressed appropriately according to **QP 13**.

2. Information detailing the status of evidence room inventories will be reported as part of the management system review quarterly and reports as outlined in **QP 18**.

E. CUSTODY INQUIRY PERSONAL INVENTORIES - SCHEDULE

In order to ensure that any incorrect evidence transactions are identified promptly, each employee who routinely has evidence in his/her possession will conduct a check of his/her personal inventory by running a custody inquiry as described below. This helps ensure that any mistakes identified can be corrected prior to evidence leaving CSD custody.

1. Evidence Technicians shall conduct a custody inquiry at the close of business each day provided that evidence transactions were conducted on that day.

2. Analysts shall conduct a custody inquiry at least once per week provided that evidence transactions were conducted during the week.

F. CONDUCTING A CUSTODY INQUIRY

The following procedure should be used to conduct a personal evidence inventory, or custody inquiry.

1. Click the “Custody Inquiry” button at top of the BEAST home screen.
2. Type “AN” in the “Custody Of” box on the screen that appears.
3. Type your user name in the “Location” box on the same screen.
4. Click the “Search” button or hit Enter.
5. Review the list and compare to all evidence in your physical custody.
6. Notify the Evidence APO if any custody corrections need to be made. The Evidence APO may make corrections or may instruct the employee how to make the appropriate correction.

III. Attachments

None

I. Scope

Refrigerators and freezers used to store evidence shall be monitored to ensure each unit is maintained in a fashion that protects the evidence from degradation, cross contamination, or other deleterious change. This procedure shall be used to properly maintain all refrigerators and freezers used to store evidence. This includes refrigerators and freezers which are used intermittently for evidence storage. Refrigerators/freezers purchased for evidence storage which have not yet been placed into service may be exempted from this procedure, provided they are clearly and appropriately labeled.

II. Procedure

A. Temperature Ranges

The following temperature ranges are guidelines to be used when determining the high and low point for temperature monitoring systems.

1. Standard refrigerators: 0˚C to 10˚C
2. Small refrigerator/freezer units: -20˚C to 10˚C
3. Refrigerator/freezer combination (with probe located in freezer): -30˚C to 5˚C
4. Standard freezers: -30˚C to 0˚C

B. Guidelines for Proper Operation

1. Contents of each refrigerator/freezer should be arranged and reasonably limited to allow proper air circulation to allow for effective cooling.

2. Thermometers should be placed in an easily visible location.

3. Thermometer bulbs, sensors, and probes should be free from contact with evidence, shelving, and other materials.

4. “Frost-free” refrigerator/freezer units have short duration defrost cycles which will create some temperature variation. This should be taken into account when recording temperatures, placing temperature probes, and setting the high and low points on the alarm monitoring pad. For proper monitoring, the alarm probe must be placed in a position where the temperature does not fluctuate enough during defrost cycles to set off the alarm.

5. Care should be taken when placing evidence into freezers which require manual defrosting. Additional steps should be taken to protect evidence from water damage that could occur due to an unintended defrost during a freezer failure or power outage. For example, avoid placing evidence on the very bottom of the freezer and consider draping plastic over evidence to divert any drips.

C. Alarm Monitoring

1. All refrigerators and stand alone freezers used to store evidence will have a remote alarm monitoring device installed.

2. The OSBI maintains a contract with an alarm monitoring company. If a refrigerator or freezer temperature falls outside the acceptable range outside of business hours, the alarm company will notify the OSBI according to contract specifications. The appropriate supervisor or designee will then be notified to investigate the source of the alarm.

3. The supervisor or designee will be responsible for taking appropriate actions as indicated in section II.E below.

D. Manual Monitoring

1. Thermometers will also be used to regularly check the temperature of refrigerators and freezers. Thermometers used will measure in ˚C and must have a range that spans the temperature range designated for the unit being monitored.

2. At least once per week, the temperature will be recorded on the Temperature Monitoring Form (**OSBI CSD QPA 6.4.1**) or an alternate temperature log which records the same information included on OSBI CSD QPA 6.4.1. The person recording the temperature shall check previous readings to monitor for any trends which would indicate the performance of the refrigerator or freezer may be declining. If a single reading appears to indicate a negative trend (concern that unit is not operating properly), a second reading will be taken later in the day and the supervisor will be notified.

3. When the temperature is checked and logged, the refrigerator or freezer will also be inspected for mold, mildew, excess frost/ice buildup or any other possible deleterious condition that may require maintenance. Appropriate and immediate action will be taken to remedy any deleterious condition, if possible. For maintenance that cannot

be performed immediately (e.g. manual defrosting or maintenance that requires a service technician) the supervisor will be notified so the maintenance can be scheduled as soon as practical.

E. OUT OF RANGE TEMPERATURE

When a refrigerator or freezer temperature falls outside the acceptable range, the following actions shall be taken to investigate and correct the issue.

1. The unit shall be inspected to attempt to determine the cause of the variance. If the cause is readily identified (e.g. a door not properly closed, evidence stacked in a fashion that prevents air circulation, etc.) then appropriate steps will be taken to correct the issue and the temperature will be closely monitored to ensure that the steps taken corrected the problem.

2. If the cause cannot be easily determined or corrected by in-house personnel, the unit shall be emptied. The contents shall be transferred to a working unit (if possible) or to a temporary storage until expedient arrangement can be made for proper storage. The unit shall be marked with an "Out of Service" sign. The date shall be recorded both on the sign and in the maintenance record. The unit supervisor or designee shall arrange to have the unit repaired or replaced.

F. POWER OUTAGES

Power outages may periodically occur due to inclement weather or utility maintenance work. The following steps should be taken to ensure a power outage does not damage evidence stored in refrigerators and freezers.

1. Whenever practical, refrigerators and freezers used to store evidence should be placed on a properly maintained backup generator.

2. Staff should be trained on the proper operation of any backup system or generator in use.

3. Staff should also be trained on appropriate steps to take in the event that a power failure occurs and a backup generator is not available. This includes methods to identify and triage the most critical evidence (e.g. whole blood, tissue, bone samples should be prioritized above more stable evidence such as DNA extracts; freezers with frost buildup should be handled before frost free units, etc.), alternate storage locations and methods, etc.

4. Training provided shall be documented in the employee's training folder (see **QP 19**).

III. Attachments

OSBI CSD QPA 6.4.1, Rev. 0

I. Scope

The security and integrity of all evidence in the possession of the OSBI CSD will be preserved. Transfer, return, and/or destruction of evidence will be conducted according to the specifications of this procedure.

II. Procedure

NOTE: Scanning evidence for any custody transaction must be performed accurately to ensure proper chain of custody. It is vital when transferring, returning, or destroying evidence to ensure all packages have been scanned properly. Packages should be counted manually and compared to the count on the screen to ensure no package is overlooked.

A. Documenting Chain of Custody for Evidence Transfers

The following process will be used to document evidence transfers at the time of the transfer.

Scan the appropriate barcodes as indicated below.

a) Location (the person receiving the evidence or the vault/storage area where the evidence will be placed)
b) Item (the barcodes associated with all items being moved)
c) Process chain of custody (or hit enter/click save)

B. Evidence Transfers

The following method will be used to transfer evidence between individuals or locations. For the purposes of this section, an evidence transfer refers to evidence that has been analyzed in one unit or laboratory and is being routed to another unit or laboratory for additional analysis. Evidence which has been received (but not analyzed) by one laboratory which must be transported to another laboratory for analysis does not constitute an evidence transfer as described in this section. Evidence transports must be documented according to section II.A above.

1. Routing Evidence

a) The individual initiating an evidence transfer will verify that an assignment for the target unit exists in the BEAST. If there is no assignment for the target unit, the individual initiating the transfer will create the assignment.
b) Evidence transfers can be done directly from analyst to analyst. This should be done whenever necessary to ensure the efficient and timely analysis of evidence.

2. Prepare Evidence Packaging

   a) Create a new container, if necessary, for the item(s) to be transferred.

      i. From the items tab, click on the barcode button located next to the "Cont#" field.
      ii. In the window that opens, click on "New."
      iii. Select the appropriate package type.
      iv. Select the item(s) that are being placed in the new container.
      v. Click on "OK" and enter password when prompted.
      vi. Click the barcode button again, ensure that the newly created container is selected, and then click on print label.
      vii. Attach the barcode label to the container.

   b) Verify that the package(s) is/are properly sealed and labeled. At a minimum, packages should be labeled with the following information:

      i. case number
      ii. item number(s) included
      iii. analyst initials
      iv. barcode label
      v. county and agency (this information should be on the barcode label)
      vi. any applicable hazard labels

   c) For evidence that will be physically transferred by another individual (such as an evidence technician) the following steps will be taken to identify evidence pending transfer:

      i. Complete the evidence transfer form (**OSBI CSD QPA 7.3**). Attach the form to the evidence with a staple or paper clip. Do not use tape, unless the evidence container is a bucket or other container which requires tape in order to securely attach the form.
      ii. Move the evidence to a location specified for evidence transfers.

   d) Following transport of the evidence (if applicable) to the target lab, the following actions will take place:

      i. The individual receiving the evidence at the target lab will remove the transfer form from the evidence and check to see if a case file exists for the target unit. If a case file exists, the transfer form will be routed to the target unit. If no case file has been created yet for the target unit, one will be created and the transfer form will be attached to the outside of the file and then routed to the target unit.
      ii. The evidence being transferred will be placed in the target unit's property

room or vault in the location designated for pending evidence.

iii. The supervisor or designee of the target unit will review the information on the transfer form and ensure that the case is assigned to an analyst or prioritized as necessary.

iv. The transfer form may be retained in the case file while the assignment is in progress, but will be shredded prior to the assignment being closed.

C. Evidence Returns

With the exception of evidence samples which require or warrant retention or which are authorized for destruction, evidence will be returned to the appropriate submitting or requesting agency.

1. Evidence will generally be returned in person but may be returned by certified mail (with return receipt requested) or private courier (UPS, FedEx).

2. For evidence returned at an OSBI CSD facility, perform the following steps:

   a) Scan the barcode for "return to agency."
   b) Scan the barcode(s) for the item(s)/container(s) being returned.
   c) Type the agency receiving the evidence and any comments necessary in the "Comments" field. For example, if evidence is returned to an agency other than the requesting agency, an explanation or comment should be entered.
   d) Scan the barcode for "process chain of custody" or click on "Save."
   e) Enter your password and click "OK."
   f) Type in the name of the individual receiving the evidence, have them sign on the signature pad, and click "Save Signature."
   g) Give a printed copy of the evidence receipt to the individual.

3. For evidence returned at remote locations, perform the following steps:

   a) Transfer the evidence to the custody of the individual that will be returning the evidence.
   b) Prepare (a) hard copy evidence release form(s) (**OSBI CSD QPA 7.2**).
   c) Deliver the evidence to the appropriate agency and have the individual receiving the items print and sign his/her name on each form and date the form(s).
   d) Document the date and time of the transfer.
   e) After returning to a CSD facility, attach an imaged copy of the signed release form to the appropriate BEAST case file.
   f) Update the chain of custody record to reflect the return to agency. This can be done by coordinating with the Administrative Programs Officer over the Evidence discipline.

D. Evidence Destruction

The following procedure for evidence destruction applies to items that are currently in the custody of the OSBI CSD or that are brought to the OSBI CSD specifically for destruction. This can include dog drugs, provided that the agency has already had a property officer weigh the dog drugs and record the weights on the DEA form 41. If an agency needs to submit dog drugs for destruction but has not weighed the dog drugs and recorded the weights on DEA form 41, then they must submit these drugs for destruction only at FSC and only during a scheduled appointment with the OSBI CSD Dog Drug Coordinator, or designee.

1. Toxicology evidence submitted in relation to an impaired driving case shall not be destroyed until after 60 days from the date of collection, in accordance with O.S. Title 47, Section 752.

2. Drug and other evidence will be destroyed after receiving written authorization from the OSBI Case Agent, the submitting agency, the district attorney having jurisdiction in the case, or by applicable statutes. **OSBI CSD QPA 7.1** must be completely filled out by a law enforcement representative for the proper destruction.

3. Completed destruction forms should be attached to the electronic case file in the BEAST using the same procedure described in **QP 5**, section II.F. The file name for the electronic copy of the destruction form should include the case number and an indication that the file is a destruction form.

4. Destruction forms do not need to be imaged for any evidence that has been returned to the agency and is then brought back to the OSBI solely for destruction.

5. The Criminalistics Administrator over the FSC physical evidence unit will coordinate the destruction of evidence.

6. Any laboratory facility may accept drug items for destruction. Items received for destruction should be maintained under seal, if possible. Destruction items are not considered evidence. Guidelines for accepting items for destruction can be found in the appropriate section of the OSBI Physical Evidence Technician Training Manual, located on the intranet.

7. To update the chain of custody for destruction of evidence still in the custody of the OSBI CSD, perform the following steps.

   a) Scan the barcode for the evidence disposition "destroyed." If the destruction form is received by mail, scan the barcode for "destroyed, no signature."
   b) Scan the barcodes for the item(s)/container(s) being destroyed.

c) Enter the destruction number in the comments field, if applicable.
d) Scan the barcode for "process chain of custody."
e) Enter your password and then click on "OK."

III. Attachments

OSBI CSD QPA 7.1, Rev. 1 Evidence Destruction Form
OSBI CSD QPA 7.2, Rev. 1 Evidence Release Form
OSBI CSD QPA 7.3, Rev. 1 Evidence Transfer Form

I. Scope

The OSBI CSD recognizes that the quality of reagents, supplies, consumables, and services used are an integral part of providing quality and reliable test results. This procedure will be used to guide the purchase, receipt, and verification of reagents, supplies, consumables, and services required for testing procedures.

II. Procedure

A. Identification of Necessary Quality of Products/Services

1. All reagents, supplies, or consumable materials used in analysis will be identified in analytical protocols proportional to the degree to which they impact the quality of the test. For example, a reagent or supply which does not impact quality may not be specifically listed or may be listed with no clarifying information (e.g. "methanol"). A reagent which does impact the quality of the testing will be described in fashion that ensures the proper quality of reagent or supply is ordered and used for the test (e.g. "methanol – 95% purity" or "methanol – reagent grade").

2. Technical Managers (TM's) <u>may</u> choose to consolidate this information into a single list to make it easier to identify reagents and supplies affecting quality of analysis as they are received.

3. Critical reagents or supplies, which must be tested to confirm the purity or quality prior to use, must be identified by the discipline TM in analytical protocols or another suitable location.

B. Purchasing Quality Reagents, Supplies, and Consumables

1. An Internal Purchase Request (IPR) will be filled out with sufficient detail to identify the quality of reagent or supply needed.

2. If a substitution is necessary, the discipline TM should be consulted to determine if the substitution is acceptable.

3. IPR's for items that affect the quality of the tests shall be reviewed and approved for technical content. This review may be done by the individual(s) with approval responsibility according to OSBI Policy 208, provided he/she has sufficient technical knowledge to ensure the appropriate quality product has been requested. If the approving individual does not have sufficient technical knowledge to conduct an appropriate review, he or she should consult with the TM.

4. When consultation with the TM is necessary for a review of technical content or for a substitution, it may be documented in one of the following ways, or an equivalent

method:

i. by summarizing the consultation with TM in the comments field in the IPR system during the approval process;
ii. by adding a memo or e-mail as an attachment to the electronic IPR.

C. Receiving Reagents, Supplies, and Consumables

1. Upon receipt, all reagents will be marked with the date the item is received. In addition, upon opening a container of a chemical or reagent for the first time, the analyst opening the container will initial and date the container. Date of receipt and date opened should also be marked on supplies or consumables if the age of the supply will impact the quality of the product.

2. In some circumstances (such as reagent kits with multiple components within each kit) it may not be feasible to mark each reagent container with the date received and/or the date opened. In these circumstances, an alternate labeling or tracking method may be established, provided that the method implemented facilitates effective trouble shooting, corrective action and identification of potentially impacted cases in the event reagent failure or contamination is suspected. If an alternate labeling or tracking method is necessary, it shall be included in an appropriate discipline specific quality manual or protocol.

3. All containers will indicate a lot number and expiration date, if applicable.

D. Storage of Reagents, Supplies, and Consumables

1. Once reagents and supplies are received, they should be stored according to the manufacturer's recommendations.

2. Reagents and supplies affecting the quality of analysis that have not been inspected or verified must be stored either in a separate location from those that have been inspected and approved, or in another manner which prevents uninspected materials from being used in casework.

E. Inspection of Quality Reagents and Supplies

1. At a minimum, the reagent or supply will be inspected to ensure that it meets the quality criteria established in the protocol. This may be as simple as comparing the part number, described quality (e.g. % purity, or grade), or other relevant information on the reagent or supply received to that included in the IPR and/or the appropriate technical protocol.

2. In addition to inspecting reagents or supplies upon receipt to ensure the proper

quality of product was received, the quality of reagents and supplies will also be continually monitored through the evaluation of standards and controls established in discipline protocols. Any quality concern identified through the use of standards and controls will be handled according to **QP 13** thru **QP 15** as appropriate.

3. All reagents prepared in-house must demonstrate proper function. Function verification should include testing the reagent or item in the same manner it will be used in testing. Function verification should be completed prior to using the item for testing samples which could not be retested.

4. Reagents used for DNA analysis will be evaluated in a method which complies with the current Quality Assurance Standards for DNA Testing Laboratories.

F. Documenting Preparation and Inspection of Reagents/Supplies

1. If the reagent or product is inspected to verify that the proper purity or quality of reagent was received (in lieu of conducting a function verification test), a copy of the packing slip, invoice or other document should be marked to indicate the quality was verified, the date, and the initials of the person verifying the item. This documentation must be maintained if it is the only record that the quality of the reagent or product was verified.

2. Any product inserts (or Certificates of Analysis) received, which indicate the quality or purity of a reagent, should be retained. Unit Supervisors are responsible for ensuring these are properly retained and communicating to staff where the inserts and/or certificates will be retained. The lot number(s) and date received should be noted on the document.

3. The following information will be recorded, as applicable, when reagents are prepared and/or their function is verified by OSBI staff:

   a) Name of reagent
   b) Lot number
   c) Expiration date
   d) Name, amount, supplier, lot number, and expiration date of each component
   e) Brief narrative detailing method for preparation
   f) Identity (e.g. initials, signature, or electronic equivalent) of analyst preparing the reagent
   g) Date of preparation
   h) Procedure used to verify the function of the reagent
   i) Indication whether the reagent was acceptable or not
   j) Identity (e.g. initials, signature, or electronic equivalent) of analyst verifying the reagent

k) Date verification conducted and/or reagent approved for use

4. When a reagent is prepared only for use as a component of another reagent, the verification information should be recorded for the combined reagent and is not needed for the individual component reagents.

5. Reagents such as Takayama which are made and used in small quantities and expended or discarded within a short time frame (~ one week) should have the preparation and verification information listed in II.F.3 recorded for the initial preparation. Subsequent preparations using the same component lot numbers and amounts do not need to be recorded. However, function verification and/or control results must be recorded in the case record for each preparation.

6. Records of reagent preparation and verification must be retained and available for inspection. These records should be maintained in a reagent logbook for each discipline or in the Chemical Inventory system in the BEAST (see **QP 8.2**). The Supervisor of each unit is responsible for maintaining any archived hard copy reagent records.

7. The reagent container must, at a minimum, bear the name of the reagent, the identity of the individual preparing the reagent (for reagents prepared in-house), and the lot number. The preparation date will be used for the lot number for in-house reagents. For example, a reagent prepared on July 20, 2003 would have the lot number 72003. Expiration dates should be placed on the front of the container if applicable.

8. Documentation of reagent preparation and evaluation of reagents used for DNA analysis will be maintained according to the Forensic Biology Quality Manual.

III. Attachments

None

I. Scope

The BEAST LIMS provides a laboratory asset manager system that can be used to organize chemical inventory, reference collections, and general laboratory assets such as computers or instruments. This policy outlines the procedure for utilizing the Chemical Inventory/Laboratory Asset Manger Program on the LIMS System. The chemical inventory program can be started by running the cheminv.exe program in the labora folder of your laboratory. Your user ID and password are the same ones you currently use to login to the BEAST.

II. Procedure

A. Definition of Asset Classes

The following categories of assests are available in the Chemical Inventory program. The OSBI CSD is not currently using the "Other Asset" or "Firearm" classes.

1. *Chemical/Purchased Reagent:* Chemical or a reagent that is purchased from an outside source
2. *Prepared Reagent:* Reagent that is prepared in house
3. *Instrument:* Laboratory instruments
4. *Other Asset:* Assets that do not fit into any of the other categories
5. *Firearm:* Catalog of the a firearm reference collection

B. User Permissions

There are three levels of permissions set up for Chemical Inventory User's which are described below. The Technical Leader for each discipline will be responsible for determining which level of permission will be given to individuals within the discipline.

1. **Chemical Inventory Manager (CHMGR)** – This group code provides the highest level of permissions, including the authority to delete records when needed. Each Technical Leader shall designate one individual to be the Chemical Manager for their discipline. If necessary, the Technical Leader may select a second Chemical Manager designee as a backup.
2. **Forensic Scientist (FS)** – This group code provides the user permission to add and edit entries.
3. **Chemical Inventory Inquiry (CHMIQ)** – This group code provides users permission to view records only.

C. Viewing an Asset Record

1. Select your laboratory location and section in the top left hand corner of the screen.

2. In the "Work With" box, choose which class of assets you would like to view
3. All currently available chemicals/assets of that class will appear as a list under "Name"
4. Click on the item you would like to view, the window will automatically populate with that chemicals/assets information
5. There are several tabs which can be viewed. These include "Chemical Info", "Manufacturer/Vendor", "Safety Info", "Lab Status Info", and "History of Custody"
6. If the "Images" button is red, there are images that have been uploaded which can be viewed by clicking this button

D. Adding an Asset Record

1. Select your laboratory location and section in the top left hand corner of the screen.
2. In the "Work With" box, choose which class of assets you would like to add
3. Click the "Add" button on the bottom, left side of the main screen
4. Enter or select the Asset Type Code. Any default information for this type code will automatically be filled in. If you do not find the Asset Type Code you are looking for, please contact your designated Chemical Inventory Manager.
5. It is important to choose the correct Asset Type Code as the BEAST uses this code to pull the lot numbers into the matrix or reagent panel.
6. Click on the "Lab Status Info" tab and verify the "Date Received" is correct. This automatically fills in with today's date. Fill in the expiration date if required. Once the date listed in expiration date has passed, this lot number should not be able to be selected as a chemical used in casework in the BEAST. If an asset is showing up in the BEAST past this date, please notify your designated Chemical Inventory Manager.
7. Enter any additional information about the asset on any of the tabs (Chemical Info, Manufacturer/Vendor, Safety Info, Lab Status Info, or History of Custody) and hit save.
8. A barcode label for the new chemical/asset that was added will print automatically.
9. Transfer the new asset to its proper location (see section II.J)
10. Upload any documents/images that will be attached to this asset (see section II.F)

E. Editing an Asset Record

1. Select your laboratory location and section in the top left hand corner of the screen.
2. In the "Works With" box, choose which class of assets you would like to edit
3. Select the asset record that needs to be modified
4. Click the "Edit" button, which can be found on the bottom of the main screen

beside the "Add" button.
5. Make any necessary changes and hit "Save"

F. Uploading Document/Images

MSDS, QA/QC documents, packing receipts, certificates of analysis, or other documents can be uploaded and attached to individual chemical/asset records. This can be done when a new asset record is added or by editing an asset record at a later time.

1. Locate and select the asset record to which you want to attach an image/document.
2. Hit the "Images" button to bring up the "MSDS Viewer" box
3. Click on the "Attach Doc" button and choose the document/image that you want to attach
4. To change the title of the image/document that is displayed in the list under description, click on the "Edit Desc" box and enter the new description in the "Enter Description" box
5. The document/image that is attached to the asset record can be viewed by clicking on the "Images" button or by going to the "Safety Info" tab for that record.

G. Deleting an Asset Record

In the event an asset record is deleted, it will **no longer be able to be viewed**. This is different than disposing of an asset if it is expired or expended (see Section II.I below). If a record needs to be deleted, contact your designated Chemical Inventory Manager.

H. Searching for an Asset Record

After logging into Chemical Inventory, you can scan the barcode of the asset to view the asset record. To find it without scanning the barcode, follow this procedure:

1. Select your laboratory location and section in the top left hand corner of the screen.
2. In the "Work With" Box, choose which class of assets you would like to search
3. Click on the "Search" button, which can be found on the left hand side, under the "Work With" box. The Search Record window will display.
4. Fill in the search criteria in the appropriate box. For example, to find Methanol, you would type "Methanol" into the Name box. Alternately, existing reagents or assets can be searched by clicking on the question mark in the "Type" Field.
5. On the bottom left hand corner of this screen is a box titled "Disposed". Choose "No" to search currently available chemicals/assets only, choose "Yes" to search only chemicals/assets that have been transferred to expended, or choose "Both" to search currently available as well as expended chemicals/assets.

6. The results of your search will be displayed in a list in the box on the bottom left hand side of the screen, under "Name".
7. Clicking on the "View All" button, located beside the "Search" button will clear the search results.

I. Expended/Expired Chemicals

1. Expended/Expired Chemicals should not show up as available for use in the BEAST after the date that is listed on the "Lab Status Info" tab in the "Expiration Date" box. (If an expired/expended lot is showing up, please contact your designated Chemical Inventory Manager). If no date was originally entered, the asset record should be edited and the date entered that reflects the expended/expiration date.
2. The Expended/Expired Chemical Asset Record must **NOT** be deleted.
3. The Expended/Expired Chemical will be transferred (see section II.J) to Expended Chemicals of the appropriate laboratory.

J. Transferring Custody

1. In the "Work With" Box, choose which class of assets you would like to transfer
2. Click on the Transfer button, found at the center bottom of the main page. The items currently displayed in the list under "Names" will appear in the "Process Chain of Custody" window.
3. Select the item(s) that are being transferred, by checking the box to the left of the asset. If you want all items selected, you can hit the "Select All" button.
4. Select the location where the items are being transferred to.
   a. Hit the "?" box to the right of "Transfer To". This brings up a "Select Custody Location" box.
   b. Hit the "?" to the right of "Custody Of" to open the "Custody Of" box
   c. Choose your storage location depending on if the chemical is currently in use or is expended/expired.
   d. If the asset is currently in use, choose the appropriate laboratory Chemical Storage, then click OK. Alternatively, you can double click on the appropriate laboratory Chemical Storage and not have to click OK. Now choose the unit where the chemical is utilized, and click OK (or double click)
   e. If the asset has been expended or is expired, choose "Chemical Disposition" and then "Expended Chemicals" for the appropriate laboratory.
5. Click on the "Transfer Items" button. If the transfer is successful, "Update O.K." will flash across the screen.
6. When items are transferred to expended, the asset will no longer be shown on the list of assets under the "Name" on the main page of chemical inventory. However, the information is available to view by using the search button.

III. Attachments

None

I. Scope

Critical reagents, supplies, and services which affect the quality of testing will be obtained from reliable suppliers. The following process will be used to evaluate suppliers to determine the reliability of services and/or supplies they provide.

II. Procedure

A. Evaluation

One of the following methods will be used to evaluate suppliers of critical reagents, supplies, and services.

1. The first time a new supplier is used, an in-house verification process will be performed to verify the quality of reagent supplied. If the reagent/supply ordered does not already have a verification process established, the Technical Manager (TM) will be responsible for determining the method appropriate for verification and determining what documentation must be maintained as a record of the verification. This verification should be performed using non-probative or non-casework samples before the reagent/supply is used for testing purposes and should verify that the reagent/supply is free from contamination and yields the expected results.

2. For suppliers used prior to the original issue of this document, historical data can be reviewed to confirm the supplier's reliability.

B. Documentation

The evaluation process and approved suppliers will be documented in the following manner.

1. The TM for each discipline will maintain a list of all approved suppliers for critical reagents, supplies, and services. The list should include the name of the supplier and the reagents, supplies, or services obtained from the supplier.

2. The evaluation process will be documented in the following manner.

   a) Examination documentation and results of an in-house verification process will be maintained in a location designated by the TM.

   b) Evaluation of suppliers which is based on historical data will be summarized in a memo by the TM and retained.

C. Handling Quality Problems with Reagents, Supplies, and Services

When quality concerns are identified with reagents, supplies, or services, the following response will be taken.

1. If the quality concern potentially impacts or did impact testing, the non-conforming work will be reported and documented according to **QP 13** and **QP 14.1** through **QP 14.3**, as applicable.

2. The supplier will be removed from the list of approved suppliers if, based on the severity of the quality concern, the supplier's response to the concern, and the record of past transactions with the supplier, such action is appropriate.

3. Any significant quality concern will be documented and a copy of the documentation will be forwarded to the OSBI purchasing office.

4. If a supplier is removed from the list of approved suppliers, the purchasing office will be notified and steps taken to file a vendor complaint with the Department of Central Services according to OSBI Policy 208.

III. Attachments

None

I. Scope

The OSBI CSD will cooperate with customers to clarify service requests and allow monitoring of CSD progress and/or testing as necessary. This procedure outlines methods to ensure this service while protecting the confidentiality of other customers.

II. Procedure

A. Consultations with Customers

1. In order to ensure that both OSBI CSD employees and the customer understand the services that will be provided and the customer is informed of the progress, CSD employees shall be available for consultation.

    a) Analysts and/or Supervisors will be available to consult with customers at the time evidence is submitted. Individuals receiving evidence will contact an analyst/Supervisor when necessary.

    b) Analysts and/or Supervisors will contact customers when significant changes (e.g. projected completion dates, additional analysis possible/recommended, etc.) occur.

    c) Analysts will be available to meet in person with officers or attorneys to review evidence or explain testing results.

    d) CSD employees will provide updates on the progress or status of work as requested. For open assignments which have been given to an analyst, status inquiries will be forwarded to the appropriate analyst.

2. Locations for Consultations

    a) Consultation rooms are available at the FSC to allow for private discussion and examination of evidence.

    b) Consultation may also be conducted in an alternate lab space or location, but CSD employees will ensure that customers are not given access to confidential information from other cases. This includes case files and evidence packaging with suspect/victim information on it.

B. Requests to Monitor/Observe Analysis

In order to ensure confidentiality of case information, limit potential for contamination, ensure security of evidence and case records, and to provide the best service possible to all customers, outside observers will not be allowed in laboratory spaces under normal

circumstances, unless expressly ordered by the court. However, under certain circumstances, such as the analysis of consumption samples, monitoring of analysis may be necessary. Requests will be evaluated in the following manner.

1. The analyst receiving a request to observe testing will forward the request through his/her Supervisor to the Criminalistics Administrator (CA).

2. The CA will evaluate the request to determine how critical the requested analysis is, whether the observation would be better accommodated through an alternate method, and what the impact of allowing the observation will be on other pending cases (e.g. loss in productivity, etc.). The CA will consult with the customer, analyst, CSD Director, and OSBI Legal Counsel as needed to determine the appropriate course of action.

3. Once the course of action is decided, the CA will inform the analyst, the customer, and any other personnel as appropriate.

C. Performing Analysis with an Observer

When observation of analysis is ordered by the court or agreed upon by the OSBI CSD, the following steps will be taken.

1. If practical, the analysis will be conducted in the training laboratory at FSC. Prior to analysis, the analyst will ensure that all instruments are up to date on maintenance and quality control checks. The analyst will also obtain a key to secure the appropriate room(s) as necessary during the analysis process.

2. If the analysis cannot be conducted in the FSC training lab, the analysis may be conducted in other OSBI CSD facilities. Under these circumstances, if necessary to ensure confidentiality of other cases, the analysis will be scheduled outside normal working hours and at the convenience of the OSBI analyst.

3. The observer(s) will wear the appropriate personal protective equipment (PPE) as instructed by the analyst.

4. The observer(s) will be asked to refrain from speaking during certain portions of analysis, such as sample transfers, to reduce the potential for distractions.

5. If the observer(s) will be in areas where DNA evidence is handled, the observer(s) will be expected to provide a DNA sample.

6. The observer(s) may be asked to provide identifying information so that a background check can be completed.

D. Alternate Methods for Monitoring/Observation of Testing

The following alternate methods of observation may also be proposed.

1. The OSBI CSD may elect to send the samples to an independent laboratory for analysis.

2. The analysis may be videotaped and a DVD documenting the analysis provided to the customer. Under these circumstances, the customer will be expected to reimburse the OSBI CSD for the cost of videotaping and providing the DVD's.

3. If possible, a closed circuit feed may be set up to enable the observer(s) to monitor analysis from a separate room or location.

E. Requests for Assistance with Verifications or Technical Reviews

In some circumstances, some customers (such as local police laboratories) may request assistance conducting verifications or technical reviews of work they've performed. These requests may be met by performing work in-house or by conducting work as if a contract employee of the customer's lab. All requests for assistance with verifications or technical reviews must be forwarded through the chain to the CSD Director, who will coordinate necessary discussion with the customer and determine whether assistance will be provided.

1. <u>In-House Analysis</u>

   A request for verification may be handled by analyzing the case in the same fashion as any other case, following all applicable discipline and CSD policies and procedures.

2. <u>Conducting "Contract" Work</u>

   Prior to approving OSBI employees to conduct verifications or technical reviews as unpaid "contract" employees of another laboratory, the CSD Director may direct a review of the applicable policies and procedures of the requesting laboratory. This review may be conducted to ensure that any OSBI CSD employee is protected from reviewing or verifying work which may not be in compliance with accreditation standards and/or good laboratory practice.

   Alternately, verifications can be conducted by OSBI employees working as "contract" employees of the customer's laboratory. In order to do this, the OSBI employee must receive training from the customer regarding the applicable policies and procedures. The OSBI employee will then perform and document the requested verification(s) according to the customer's policies. Any request for assistance

performing technical reviews for another laboratory must be handled in this same fashion.

Prior to conducting this type of work, OSBI employees must prepare a Memorandum of Understanding (MOU) detailing the work to be done. The MOU should be signed by the CSD Director and an authorized employee at the customer laboratory before any work is conducted.

III. Attachments

None

I. Scope

The OSBI CSD will routinely solicit customers for positive and negative feedback to identify any potential areas for improvement of the CSD management system and testing services.

II. Procedure

A. Feedback Regarding Testimony

In order to solicit feedback regarding courtroom testimony provided by CSD personnel, the witness critique form will be distributed as indicated in **QP 32**.

B. General Feedback

The following methods will be used to solicit feedback regarding services provided by the OSBI CSD.

1. The OSBI Forensic Laboratory Survey (**OSBI CSD QPA 11.1**) is available on the OSBI website.

2. In addition, hard copies of the survey should be available at each CSD facility.

3. CSD employees may also complete applicable portions of the survey (such as additional comments – ideas for improvement or complaints) based on feedback received during a consultation or conversation with a customer. The employee receiving the feedback should ask the customer for his/her permission to document the comments and for permission to include the customer's contact information.

4. The CSD Administrative Staff or a designee may contact customers for additional input as needed.

C. Analysis of Feedback

Feedback received from customers will be used and analyzed in the following manner.

1. Suggestions for improvement will be forwarded for consideration as preventive measures according to **QP 15**.

2. Critique forms and survey results will further be analyzed during the management system review to identify trends which indicate further opportunity for improvement. See **QP 18**.

III. Attachments

OSBI CSD QPA 11.1, Rev. 5

I. Scope

This policy is applicable to internal and customer complaints of a technical or administrative nature. It does not apply to personnel or human resources issues which should be forwarded to the appropriate Supervisor. Complaints may identify opportunities for improvement within the quality system. Valid complaints will be dealt with in a responsible and appropriate manner.

II. Procedure

A. Filing a Complaint

1. CSD employees wishing to file a complaint will route a memo that thoroughly describes the issue to the Quality Manager (QM).

2. In the event that a customer indicates dissatisfaction with the OSBI CSD, the employee speaking with the customer should take any appropriate action to remedy the situation or to connect the customer with an individual with the authority and/or capability to resolve the situation. After taking appropriate steps to resolve the situation, the employee should offer the name and phone number of the QM to the customer. The employee receiving the complaint should also offer to document and route the complaint according to this policy.

3. If appropriate, individuals filing complaints against the quality system may submit their complaint to the CSD Director, who may personally handle the complaint or assign the complaint to a Criminalistics Administrator (CA) for verification, investigation, and resolution.

4. In the event of a conflict of interest, the QM may also forward a complaint to the CSD Director for handling.

B. Verifying and Acknowledging Complaints

1. Upon receiving a written complaint, the QM or designee, will begin a Complaint Tracking Form (**OSBI CSD QPA 12.1**) and assign a tracking number.

2. The QM or designee is responsible for investigating the condition(s) stated in the complaint. If the condition(s) can be verified, the complaint will be reviewed to determine its validity. Validity will be determined based on the significance and impact of the condition. The purpose of validity screening is to eliminate complaints that do not deal with substantive or appropriate issues. The verification and validity status will be identified on the Complaint Tracking Form.

3. Following the verification and validity screening, the QM or designee will notify the complainant of the status of the complaint. This notification may be oral,

written, or by e-mail. The notification will be documented on the Complaint Tracking Form.

C. Investigating and Resolving Complaints

1. The QM or designee may forward the complaint package to the appropriate CA, Technical Manager (TM), or Supervisor for investigation and determination of appropriate action(s). When forwarding complaint packages, the QM or designee should include an appropriate timeline. The selected manager's name and date will be entered on the Complaint Tracking Form.

2. The CA, TM, or Supervisor selected in II.C.1 is responsible for investigating the situation, condition, or action that caused the complaint and after consultation with the CSD Director, recommending a course of action, if necessary, to remedy, as appropriate.

3. The selected CA, TM, or Supervisor will report the cause and recommended actions to the QM and CSD Director. The QM or designee will enter the date the report was received on the Complaint Tracking Form and forward the report to the appropriate manager for approval of proposed actions. When approval is obtained, the selected manager will implement the approved actions.

4. The QM or designee will track the progress of the complaint process to ensure timeliness and will periodically analyze the complaint instances to determine if there are systemic or underlying problems that require attention.

D. Final Notification

Upon completion of actions dealing with a complaint, the QM or designee will notify the complainant that the complaint has been resolved. The completion date and notification date will be documented on the Complaint Tracking Form.

III. Attachments

OSBI CSD QPA 12.1 Rev. 1

I. Scope

This procedure will be used as an evaluation tool to determine the proper method for documenting and addressing work that does not comply with OSBI CSD policies and procedures or meet the agreed needs of the customer. This procedure should be applied to work that impacts the accuracy of results, the accuracy of the audit trail, and the integrity of evidence.

II. Procedure

A. Responsibilities and Authority

1. It is the responsibility of every CSD employee to report all observations of non-conforming work.

2. Every Supervisor and Technical Manager (TM), in addition to all CSD administrative staff, is responsible for and has the authority to immediately suspend any observed non-conforming work activity that could result in erroneous reports or unreliable testing data.

3. Authority to resume work that has been suspended lies with the appropriate TM or Criminalistics Administrator (CA). The authority to resume suspended DNA work belongs to the Forensic Biology TM.

B. Levels of Non-Conformance

There are three key levels of non-conforming work. In order to determine the appropriate mechanism for addressing the non-conforming work, an evaluation of the scope and significance must be performed. A description of each level is provided below, along with a graphical representation of the three levels. However, it is important to note that it may be challenging to decide which is the most appropriate mechanism to address and document the nonconforming work. Regardless of which level is selected, care should be taken to ensure that the steps adequately address correcting the problem, minimizing potential for recurrence, and recalling reports and notifying customers if necessary.

1. Simple Correction – The nature of the non-conforming work is limited in scope and significance. The problem identified is easily corrected and does not cast doubt on the overall reliability of results.

2. Corrective Action Necessary– The nature of the non-conforming work is such that it will continue to occur without a proper root cause analysis and appropriate corrective action. While corrective action is necessary, there is still no doubt regarding the overall reliability of test results.

3. Non-conforming Results – The nature of non-conforming work is such that the reliability of test results is questioned. There is potential that erroneous or invalid results have been reported. Corrective action may be required, but it is imperative to first address suspension of work and recall of reports.

Potential Impact (Significance)				
	HIGH	NCR	NCR	NCR
	MEDIUM	CAR	CAR	NCR
	LOW	SIMPLE CORRECTION	CAR	NCR
		LOW	MEDIUM	HIGH
	Frequency of Occurrence (Scope)			

C. Response to Non-Conforming Work

Once the level of non-conforming work has been identified, it will be handled as indicated below.

1. Simple corrections will be addressed by following **QP 14.1**.
2. Corrective actions will be handled following **QP 14.2**.
3. Non-conforming Results will be handled according to **QP 14.3**.

III. Attachments

None

I. Scope

The following procedure will be used to correct any simple corrections. This procedure will also be used to monitor simple corrections for any developing patterns which would require an elevated response.

II. Procedure

Simple corrections will be addressed in the following manner.

A. Instances of protocol drift or other errors which are limited in scope and significance will be corrected and the correction documented in an appropriate location in the case record. The TM, or designee, will approve the correction before the report is issued. He or she will document his or her approval in an appropriate manner, such as initialing the correction or placing a narrative in the BEAST file.

B. Technical managers of disciplines with more than one unit will be responsible for establishing the method for logging simple corrections that impact their discipline. TM's may delegate the authority for logging simple corrections to supervisors. However, TM's must ensure that a periodic evaluation of simple correction logs is conducted to monitor for patterns or repetition that is spread among different units.

C. When simple corrections are routinely required under the same circumstances or for the same individual, the TM will be responsible for notifying the QM according to **QP 14.2**.

III. Attachments

None

I. Scope

This procedure will be followed when non-conforming work or a departure from management system or technical procedures or policies has occurred and there is potential for recurrence if no corrective action is taken.

II. Procedure

A. Tracking Corrective Actions

The following procedure will be used to initiate and track corrective actions.

1. The individual who identified the circumstances requiring corrective action will contact the discipline TM and verify that the circumstance should be addressed through the corrective action process.

2. The TM, or designee, will review the circumstances to ensure that the issue does require corrective action according to this procedure. The TM may determine upon review that the issue should be addressed as a simple correction or as non-conforming results. If the issue needs to be addressed as a simple correction, the TM will ensure that the issue is handled in accordance with **QP 14.1**. If the issue needs to be addressed as non-conforming results, the TM will notify the QM in accordance with **QP 14.3**.

3. After completing the review, the TM, or designee, will notify the QM who will assign each CAR a tracking number and log the CAR onto the CAR tracking spreadsheet located at \\pm-fsc13000s\qa\Spreadsheets.

4. The QM, or designee, will then designate individuals to:

   a. complete sections I and II of the Corrective Action Request (CAR) form (**CSD QPA 14.2.1**),
   b. conduct a root cause analysis and develop a corrective action plan, and
   c. conduct a review of the cause analysis and proposed corrective action plan.

   Upon completion of each assigned portion, the designee(s) shall forward the CAR to the individual(s) assigned to conduct the next portion.

5. In the event that a CSD employee disagrees with the determination made by the TM regarding the level of corrective action required he/she shall notify the QM regarding his/her concerns. The QM will mediate discussion and have the final authority for deciding what level of correction/corrective action is required.

B. Cause Analysis

The process for developing a corrective action will start with a root cause analysis. In addition, consideration should be taken to the amount of time that will be needed to conduct a root cause analysis and complete the necessary corrective action plan. An evaluation should be made to determine whether work should be suspended, based on the time needed to resolve the issue and the risk for additional non-conforming work. If suspension of work is necessary, the TM or Criminalistics Administrator (CA) of the impacted area must communicate the suspension to the appropriate individual(s) including administration.

1. The appropriate designee(s), will conduct an investigation to determine the root cause(s) of the problem.

2. If the root cause is not obvious, a systematic analysis of all potential causes will be conducted. The designee will list all potential causes that are evaluated.

3. If necessary, the designee, may create a committee or conduct a unit/discipline meeting to gather additional input regarding potential causes.

C. Developing Corrective Actions

Once a root cause is identified or all potential causes are listed, potential corrective actions will be listed and evaluated to determine the corrective action(s) most likely to prevent a future occurrence of the same type of problem.

1. The designee will list possible corrective actions and how each action would correct the root cause(s) or potential cause listed.

2. After compiling a list of possible corrective actions, the designee will review the list and select the corrective action(s) most likely to eliminate the problem and prevent a recurrence. The corrective action(s) must also be appropriate to the magnitude of the problem.

3. The designee will also list or describe the mechanism(s) that will be used to monitor the implementation of the corrective action(s) and determine whether the corrective action(s) has/have been effective.

D. Selecting and Implementing Corrective Actions

1. Once the designee has determined the most appropriate corrective action(s) and a method for monitoring, he/she will include his/her recommendation on or with the Corrective Action Request (**OSBI CSD QPA 14.2.1**).

2. The proposed corrective action plan and monitoring mechanism will be reviewed and approved by the appropriate designee.

3. The designee shall document and implement the changes required as part of the corrective action.

E. Monitoring Corrective Actions

The TM, or designee, will monitor activities according to the method approved as part of the corrective action plan.

1. If the monitoring of the corrective action indicates that it is not/was not effective, the matter will be re-evaluated for a subsequent cause-analysis and/or selection of an alternate corrective action. The TM, or designee, will document the additional cause analysis and/or selection of an alternate corrective action on an attachment to the original corrective action request form.

2. If the nature of the non-conforming work indicates a failure to comply with laboratory policies/procedures or applicable accreditation standards, the appropriate areas of activity will be audited as soon as possible. The audit may be conducted following the implementation of corrective action to further assess the effectiveness of the corrective action. The TM, or designee, of the impacted area will be responsible for coordinating and documenting this audit. He or she may request assistance from other audit trained supervisors and analysts, TM's, CA's, or the Quality Manager.

F. Authorization to Resume Work

If work was suspended in conjunction with the corrective action request, the Supervisor will be responsible for requesting authorization for work to resume. The TM or CA will verify the corrective action plan has been completed and will indicate in Section VII of the form whether or not the resumption of work is approved.

G. Notification of Administration

Unit supervisors and discipline TM's will be notified when it is determined that a situation requires a CAR. The individual responsible for completing sections I and II of the form shall notify the Supervisor and TM if they have not already been informed. In addition, CSD Administration shall be notified as indicated below.

1. The designees assigned to complete the various sections of the CAR form, will provide a copy of the corrective action request form to the appropriate CA, the Quality Manager (QM), and CSD Director at the following steps in the process:

a) Once sections I through V have been completed.
b) Once sections VI and VII, if applicable, have been completed.

2. The Quality Manager, CA's, and CSD Director retain the authority to direct CSD employees to conduct and document additional cause analysis, monitoring, and corrective action, if necessary.

III. Attachments

OSBI CSD QPA 14.2.1, Rev. 0

I. Scope

The following procedure will be used to investigate and respond to non-conforming work that indicates that erroneous results may have been reported.

II. Procedure

When non-conforming results are identified, the following actions will be taken. It is imperative that the actions described happen as quickly as possible and that the documentation be forwarded as soon as is practical.

A. Completing and Routing NCR Report

1. Any CSD employee who believes he/she has identified potentially non-conforming results shall notify the QM. The QM will discuss the issue with the necessary personnel and instruct the appropriate individuals to complete the necessary sections of the Non-Conforming Results (NCR) Report (**OSBI CSD QPA 14.3.1**).

2. The following shall be considered when evaluating non-conforming results.

   a) Evaluate the **scope** of the non-conforming work.

      i. Determine and document whether the non-conforming work is limited to the case/event reported or if the non-conforming work may extend to other cases/work.

      ii. If the full scope of the non-conforming work is not immediately apparent, document what steps must be taken to identify all work potentially impacted, including who will be responsible for all steps and when the review will be completed.

   b) Evaluate the **significance** of the non-conforming work.

      i. Document whether the non-conforming work impacted results. For example, were incorrect results reported or were results invalid due to the non-conforming work?

      ii. If the significance of the non-conforming work is not readily apparent, determine what steps must be taken to further investigate the matter and document the plan. Include in the plan who will be responsible and when the investigation should be completed.

   c) Based on the scope and significance of the non-conforming work, take appropriate action and **document the actions taken** on the non-conforming results report.

i. Have erroneous or invalid results been reported? If so, recall work or issue amended reports and contact the customer to explain the non-conforming work, as appropriate.

ii. Is there a need to suspend work activities? Suspension of work may pertain to an individual analyst, a particular method, etc. Any suspension of work must be clearly communicated to the employees affected and should be limited to the work activities impacted.

iii. Is corrective action required? Generally, corrective action will be required for non-conforming work which meets one or more of the following criteria:

a. The scope of the non-conforming work is broad and impacts work conducted by multiple analysts and/or over a range of time.
b. The significance of the non-conforming work is serious. Incorrect or invalid results were reported.
c. The problem could recur without corrective action.
d. There is doubt regarding whether OSBI CSD operations comply with agency and/or CSD policies and procedures.
e. The non-conforming work has been previously reported, regardless of scope or significance.

d) Determine the most appropriate method for remediation of the non-conforming work.

i. If corrective action is not required, document the method for remediation in the appropriate location on the non-conforming work report.
ii. If corrective action is required, but it is most appropriate to remediate the reported non-conforming work prior to the completion of the corrective action plan, document the proposed method of remediation on the non-conforming work report.
iii. If corrective action is required and the remediation of the reported non-conforming work would best be addressed in conjunction with the corrective action plan, indicate this on the non-conforming work report.

e) If corrective action is required, conduct a root cause analysis and develop a corrective action plan according to **QP 14.2**.

B. Review of NCR Reports

Once the NCR report has been completed through section IV, the report will be forwarded to the individual assigned to review the NCR report. The reviewer will take the steps indicated to review and approve the report.

1. The individual responsible for the review detailed in Section V will evaluate and document for each section, whether the steps taken were:

   a) Adequate and approved, as is,
   b) Require modification and approved with the modification specified, or
   c) Are not adequate and require additional action.

2. If further action is needed, the reviewer will provide instruction for what additional steps must be taken and return the report back to the appropriate individual.

3. Once the NCR report has been approved, it will be routed to the appropriate TM, or designee, for implementation of the remediation, if applicable. The TM, or designee, will be responsible for documenting the completion of the remediation, and maintaining a record of the NCR report.

C. Resuming Work

If work was suspended during the evaluation of the non-conforming results, the decision to resume work will be made by the TM or the appropriate CA. Authorization to resume work will be documented at the bottom of the NCR report.

D. Notification of Administration

Unit supervisors and discipline TM's will be notified when it is determined that a situation constitutes non-conforming results. The individual responsible for completing sections I and II of the form shall notify the Supervisor and TM if they have not already been informed. In addition, CSD Administration shall be notified as indicated below.

1. A copy of the NCR report will be provided to the appropriate CA, the Quality Manager (QM), and CSD Director at the following steps in the process:

   a) Once sections I through V have been completed.
   b) Once sections VI and VIIhave been completed, if applicable.

2. The Quality Manager, CA's, and CSD Director retain the authority to direct CSD employees to take additional action and/or document additional information, if necessary.

III. Attachments

OSBI CSD QPA 14.3.1, Rev. 0

I. Scope

All CSD employees are responsible for monitoring work flow, technical procedures, and management system practices for potential improvements and/or potential sources of nonconformities. CSD employees will follow this procedure for documenting, routing, implementing, and monitoring preventive actions **which are not already covered under another procedure**. Preventive actions which can be adequately addressed by a change to policy or procedure will be requested and documented in accordance with **QP 3**.

II. Procedure

A. Recommending Preventive Actions

1. Any CSD employee who identifies a potential source for non-conforming work or improvement to the CSD technical operations or management system must submit a suggestion in writing through his/her supervisory chain. The written suggestion (which may be in memo or e-mail format) must include the following elements:

    a. A description of the problem or opportunity for improvement,
    b. An explanation of any potential for nonconforming work,
    c. A proposed action plan or description of the steps necessary to implement the suggestion, and
    d. A proposed control mechanism for monitoring the effectiveness of the suggested change.

2. Any CSD employee who receives a suggestion for improvement or preventive action from a customer shall forward the information according to section II.A.1 above.

B. Review and Approval of Preventive Actions

1. Preventive actions will be reviewed and approved at the lowest management level appropriate to the suggested change. For example:

    a. Proposed changes to work flow processes impacting a single unit should be reviewed and approved or disapproved by the unit supervisor.
    b. Proposed changes to technical procedures should be reviewed by any impacted supervisors and the appropriate technical manager, but approved or disapproved by the technical manager.
    c. Proposed changes to case acceptance policies or other changes which may impact customer service or satisfaction should be routed to and approved or disapproved by the CSD Director.

2. Individuals reviewing and/or approving suggested preventive actions should research further or make modifications to the suggestion as necessary to ensure that it complies with section II.A.1 above.

C. Implementation and Documentation of Preventive Actions

1. The individual approving a preventive action will be responsible for directing the implementation of the plan and monitoring the implementation and effectiveness of the plan. Alternately, the approving individual can designate one or more individuals to implement and monitor the plan.

2. Supervisors will be responsible for maintaining documentation of preventive actions that are proposed. Supervisors will also be responsible for reporting on the status of preventive actions in accordance with **QP 18**.

3. Individuals who review and/or approve preventive actions should ensure that the status of the review, approval, and implementation is communicated to affected employees in a timely fashion.

III. Attachments

None

I. Scope

This procedure will be used for quality and technical records to ensure that they are readily identifiable and retrievable, protected from damage, and kept confidential.

II. Procedure

A. Identification of Records

Quality and technical records, whether hard copy or electronic, will be identified in the following manner.

1. Case files are identified by the laboratory case number. The case file may be further identified by the unit or discipline, when necessary.

2. Technical records which are not stored in the case file, such as quality control records associated with batched cases, will be identified in a manner that facilitates associating the data with the proper case(s). For example, quality control results could be identified by an instrument name or number and date/time of the run.

3. Quality records should be identified with sufficient detail to facilitate proper filing and storage.

B. Indexing/Filing Records

Technical and quality records will be indexed and filed according to the record identification.

1. Case files will be stored numerically according to the case number.

2. Quality records will be indexed according to subject, location, and/or date.

C. Collection and Storage of Records

Hard copy technical and quality records will be stored in designated areas with appropriately controlled access.

1. Unassigned case files pending analysis will be stored in a secure location designated by the supervisor.

2. Case files and technical records for cases in the process of examination will be stored in the analyst's work area or other appropriate and designated location.

3. Completed case files will be stored in a file room or other designated secure area of the appropriate CSD facility until they are archived.

4. Technical records such as quality control results, reagent logs, etc., will be stored in an orderly fashion in (a) location(s) designated by the supervisor.

5. Quality records will be stored as specified by the Quality Manager (QM).

D. Access of Records

1. Access to quality and technical records will be limited to those CSD employees that require access to conduct analysis and assist customers. This includes management, analysts, and physical evidence and analytical technicians.

2. Other CSD employees, practicum students, contractors, and visitors will be restricted from accessing technical and quality records according to **QP 20**.

3. Access will be limited by restricting access to the physical storage location (e.g. file room).

4. Access to electronic records will be further restricted by issuing user names and passwords and setting appropriate permissions.

E. Maintenance of Records

1. Technical and quality records may be maintained in hard copy or electronic format.

2. When case files are maintained in an electronic format and no hard copy file is created, the BEAST barcode which is automatically generated to track the hard copy file will be scanned to the location code "electronic case file."

3. Technical records will be maintained in accordance with current administrative rules which can be found at www.oar.state.ok.us. Administrative rules governing the OSBI are located in Title 375 and section 8 of that title covers record retention.

4. Quality records will be maintained for a minimum of one accreditation cycle or five years, whichever is longer.

5. Management system documents will be maintained indefinitely.

6. Original records will not be removed from OSBI CSD facilities, with the following exceptions.

   a) Case files may be removed for the purpose of referencing during courtroom testimony or meetings with attorneys or officers.

   b) Case files or other technical records will only be removed from OSBI laboratory facilities for regular business purposes such as transfer of cases, court,

conferences with court officials or investigators, or with permission of the unit supervisor or Criminalistics Administrator over the unit.

c) Quality records may be removed from OSBI CSD facilities only at the permission of the QM.

7. Removal of completed hard copy case files will be documented by scanning the case file barcode or by inserting a piece of card or paper, labeled with the case number, examiner's initials and date of removal, in the specific location from which the file was removed.

F. Disposal of Records

1. Hard copy records may be disposed of once converted to an electronic format for archiving.

2. With the exception of drug and toxicology records, technical records will be retained in either hard copy or electronic format, indefinitely. Drug and toxicology technical records will be maintained in hard copy or electronic format for a minimum of six years. After six years, the documents listed below may be disposed of and not retained in either hard copy or electronic format.

   a) any subpoenas that have been placed in the file

   b) officer reports and information, with the exception of the officer affidavit and consent to test blood for toxicology cases

   c) any duplicate documents

3. When disposing of quality and/or technical records, the documents will be shredded or otherwise disposed of in a manner that ensures the confidentiality of the information within the documents is protected.

G. Electronic Storage of Records

Electronic records will be stored utilizing the BEAST Laboratory Information Management System (LIMS), the LaserFische system, or on a network server.

1. Documents stored in the BEAST will be protected in the following manner:

   a) Access to the documents will be limited through the use of a user name and password with appropriate permissions specified.

   b) Alterations to completed documents will be tracked through the system's audit log.

c) Information in the system will be replicated between servers at each CSD facility and backed up on a regular basis.

2. Documents stored on a network server will be protected in the following manner:

a) Access to the folder(s) will be limited to the appropriate individuals through permission settings.

b) Files will be backed up on a regular schedule.

c) Records stored in this fashion will be saved as pdf files or another file format which prevents unintended and/or unauthorized alteration.

III. Attachments

None

I. Scope

This procedure details the administrative and technical documentation which must be maintained for all forensic analyses performed.

II. Procedure

A. Documentation Required for Case Records

The following documentation is considered a technical record of analysis performed and must be maintained.

1. Administrative Documentation

   a) submission information
   b) evidence inventory
   c) conversations and communications
   d) copies of reports
   e) documentation of administrative and technical review

2. Examination Documentation

   a) Examination documentation includes notes concerning the analysis of evidence, scans, chromatographs, and all other documents produced and used to derive conclusions in the analysis of the case. The following details must be included in the examination documentation or another appropriately specified location in the case record:

      i. The method used for analysis.
      ii. The condition of the item, as it was received.
      iii. If applicable, a reference to the sampling plan used for analysis and date and location of sampling.
      iv. The date(s) that analysis was conducted or the start and end dates of analysis, at a minimum. The discipline quality manual or protocols must define how this requirement is met (e.g. where start and stop dates of analysis are documented in the examination records).

   b) Examination documentation must be sufficient to establish an audit trail and identify relevant documentation (calibration records, staff records, etc.).

   c) At a minimum, the case record examination documentation must be sufficient to support the reported results, conclusions, interpretations, or opinions. However, each discipline should define in the discipline quality manual or protocols what documentation is required to support conclusions and what happens to any

additional documentation or data. The procedure should clearly define the following factors:

i. Whether raw instrument data is retained in addition to analyzed or derived data
ii. If documentation is retained for data not used for interpretation such as an initial scan that was rejected (e.g. sample required further concentration or dilution, controls were not acceptable, etc.)
iii. Location of any additional retained data or documentation
iv. Procedure for protecting any additional retained data or documentation that is not kept in the case record (e.g. method for limiting access, method for back up, retention time, etc.)

d) When test results or observations are rejected, it is recommended the examination documentation document the reason for the rejection.

e) Examination documentation will include information identifying factors affecting uncertainty of measurement, where possible. This includes the identity of instruments used, personnel conducting each step of analysis, software used, etc.

f) Observations, data, and calculations will be recorded and appropriately identified at the time they are made.

3. Supporting Technical Documentation

a) Quality control results, including standards, ladders, calibrators and positive and negative controls are considered technical documentation/records.

b) Supporting technical documentation may be stored in the case file or in an alternate designated location.

B. Guidelines for BEAST Case Files

1. All administrative documentation should be maintained in the BEAST case file.

2. Any examination documentation which can be readily documented electronically should be maintained within the BEAST.

3. The BEAST audit log will track who accessed the case record and made modifications to certain portions of the record. Information regarding changes required as a result of administrative or technical review shall be identified through the use of the "route for corrections" feature in accordance with **QP 31**. Other changes made to completed examination records or additional detail regarding changes made may also be reflected using case narratives/events, a method that is

an electronic equivalent of a single line strike-through, or in accordance with a discipline specific policy or procedure.

4. Examination documentation which is generated in an electronic format and stored in the BEAST does not require page numbers. When multiple pages of examination documentation are prepared in hard copy format and then scanned into the BEAST, the pages shall be numbered prior to scanning.

5. When **manually** saving electronic documents to the image vault in the BEAST, each file shall be given a unique description which includes the case number. In the event that documentation from one CSD file needs to be added to a separate CSD file, both case numbers should be included in the description.

C. Guidelines for Hard Copy Case Files

1. Any administrative or technical documentation which is required to be retained but is not readily incorporated into the BEAST case file should be maintained in the hard copy case file. For example, documentation received in hard copy format (faxes, instrument printouts) must be maintained in the hard copy file if they are not imaged into the BEAST case file.

2. No evidence items should be stored in the Criminalistics case file, with the exception of latent lifts, photos, and/or negatives. Latent lifts will be placed into a sealed manila envelope that is clearly marked with case number, examiner's initials, barcode, and date. The items may then be placed into the case file, providing the case files are located in a secure evidence storage location.

3. All notes, forms, and documents generated by OSBI personnel (with the exception of latent evidence) shall be utilized on one side only. No two-sided forms or yellow sticky notes will be used.

D. Maintenance of Hard Copy Case File Documentation

1. All paperwork in the case file will be clearly identified with the Criminalistics' case number and handwritten initials.

2. Additionally, all Criminalist generated paperwork will be clearly identified with the examiner's initials, date, and item numbers if applicable. In some circumstances it may be acceptable for the date not to be printed on each page, provided the date the work was generated can be determined through other documentation in the file.

3. Notes generated by analysts shall be sequentially numbered for each assignment completed. When analysts conduct analysis at a later time on a separate assignment, the subsequent notes may be sequentially numbered (starting with page

1) or added to the sequence of notes already in the file. The first page of notes will be labeled to indicate the total number of pages in the set. (e.g. 1 of 5)

4. The case file will be orderly, complete and concise, thus facilitating administrative and technical review. Notes will be neat, readable, and written in ink. Notes may be typed.

5. Any corrections to notes will be made by an initialed single strikeout. Nothing in the handwritten information should be obliterated or erased and additions to notes (interlineations) must be initialed by the person making the entry.

6. It will be the responsibility of the examining Criminalist to ensure the contents of the case file are in compliance with the above sections.

7. It will be the responsibility of the unit supervisor to oversee case work and case files completed by their unit to ensure they are in compliance with all existing policies and analytical protocols.

E. Documenting Limited Samples

All evidence received of insufficient quantity to allow a representative sample after testing should be documented in the following manner.

1. The District Attorney involved in the case will be advised by the examining Criminalist prior to limited quantity samples being analyzed and consumed. A letter from the appropriate prosecuting attorney authorizing the consumption of those samples will be placed into the case record.

2. The evidence will be photographed. A ruler or size standard will be included in the photograph, if possible.

3. Photographic documentation will be made as necessary according to the appropriate discipline protocol.

4. Every reasonable attempt will be made to comply with any special request regarding the analysis of limited quantity evidence. Any special requests should be documented in an appropriate fashion (memo, e-mail, narrative, etc.) in the case record. The Division Director should be notified of any special requests.

III. Attachments

None

I. Scope

Internal audits of the OSBI CSD facilities and functions will be conducted according to this procedure.

II. Procedure

A. Scheduling Audits

1. The OSBI CSD will conduct internal audits annually for each of the following facilities:

   a) Forensic Science Center (FSC)
   b) Northeast Regional Laboratory
   c) Northwest Regional Laboratory
   d) Eastern Regional Laboratory
   e) Southwest Regional Laboratory

2. If necessary, audits of facilities may be further sub-divided into specific units/functions, provided all units of each facility are audited annually.

3. A schedule of audits including the Unit/Program and audit dates for the following calendar year will be issued by the Quality Manager (QM) during the fourth quarter of each calendar year.

4. Audit schedules may be adjusted depending on conflicts with auditors or lab staff. All changes must be requested through the appropriate Criminalistics Administrator (CA) and approved by the QM.

B. Conducting Audits

1. Prior to the audit, the QM, or designee, will assemble an audit team.

   a) The audit team at a minimum will consist of a lead auditor (normally the Quality Manager or designee) and other auditors responsible for specific areas or disciplines as assigned by the lead auditor.

   b) Each auditor shall have training in the audit process. Training may be provided by an approved external source or conducted by the QM or designee.

   c) Additional interagency or outside personnel may be requested to help in the audit process. These individuals will be included on the audit team at the approval of the CSD Director.

2. Once the audit team has been identified, the QM, or designee, will prepare a checklist of assignments indicating which criteria each individual will assess.

3. At the scheduled time of the audit, the audit team will assemble at the designated location. An opening meeting may be conducted if appropriate. Each auditor will review the appropriate documentation and/or conduct interviews in order to determine whether the work/operations conform(s) to the standard and applicable policies and procedures.

4. After completing the review and/or interviews, each auditor will report to the lead auditor and provide a summary of what was reviewed. In addition, each auditor will list or describe the objective evidence observed for any findings or non-conformances.

5. An exit meeting will be conducted to inform the supervisor(s) and/or laboratory director of the results of the audit.

6. The QM, or designee, will compile the information provided by auditors into an audit report. The audit report will be in the appropriate format as indicated below.

   a) All OSBI CSD audits will be reported referencing the most current accreditation standards. Findings will be reported in the following manner:
      i. Issues which are on the level of a simple correction, recommendations, and observations will be summarized in memo format.
      ii. Findings which require corrective action will be reported on the corrective action request (CAR) form (**CSD QPA 14.2.1**).
      iii. Findings which bring into question the reliability of reported results and require a consideration of work suspension and recall of reports will be addressed through the Nonconforming Results procedure (**QP 14.3**).

   b) For OSBI CSD facilities conducting DNA analysis, an audit report will also be completed using the most current version of the Quality Assurance Standards audit document. At the discretion of the QM, the QAS audit document does not need to be completed if an external QAS audit has been or will be conducted in the same year.

7. The audit report(s) should be completed and provided to the appropriate supervisor(s) and/or lab director within 2 weeks of the audit.

8. Within 30 days of receipt of the audit report, the appropriate supervisor(s), TM(s), and/or lab director will send a response to the QM. Responses to any CAR's will be documented according to **QP 14.2**. A response will also be required to address any minor issues or recommendations as indicated in the audit memo. This response should address what corrections and/or preventive measures have been taken and why.

9. If the root cause and corrective action cannot be completed within 30 days, the response will include a plan for completing these steps and (a) projected completion date(s).

10. The QM, or designee, will monitor the progress of corrective action plans submitted until all corrections and corrective actions are completed.

11. When necessary, the customer will be informed of non-conforming work and work will be recalled. The QM, or designee, will monitor non-conformances arising from audits to ensure that customer notifications and work recalls are conducted in an appropriate and timely fashion.

C. Submitting Annual Audit Reports

Each OSBI CSD laboratory must submit an Annual Accreditation Audit Report to ASCLD/LAB within 30 days of the laboratory's accreditation anniversary date.

D. Notifying NDIS

Each year, the CODIS Supervisor will prepare appropriate documentation to notify the NDIS Custodian of internal and external audits as required by the current NDIS Procedures. Biology and CODIS Supervisors will prepare responses to external DNA audit findings and forward them to the Biology Technical Manager. The Technical Manager, with assistance from the CODIS Supervisor if needed will forward a copy of external audit reports to the NDIS Custodian in the manner and timeframe required by NDIS Procedures.

E. Conducting Line Inspections

1. Unit Supervisors and regional laboratory Supervisors will conduct a line inspection annually.

2. Line inspections will be documented on the Line Inspection Form (**CSD QPA 17.1**).

3. Line inspections should be submitted no later than November 30th each year.

4. Supervisors conducting line inspections are to note any deficiencies and take corrective action as appropriate.

5. The Supervisor will provide copies of all line inspections to the CSD Director and the appropriate Criminalistics Administrator.

III. Attachments

OSBI CSD QPA 17.1, Rev. 4 Line Inspection Form

I. Scope

The following procedure will be used to conduct management reviews. A list of topics covered by management reviews is included in section **4.15.1** of the Quality Manual.

II. Procedure

A. Committee Structure

The following committees are established for the purpose of conducting management reviews.

1. The primary committee for conducting management review is the Quality Improvement Committee (QIC).

    a) All CSD supervisors, technical managers, and the administrative staff will serve as members of QIC.

    b) The Quality Manager (QM), or designee, will chair QIC.

i. The following subcommittees are established for the purpose of assisting the management review process as needed. The QM may assign tasks to sub-committees to facilitate the management review process.

    a) Chemistry Subcommittee

        i. CSD Supervisors and Technical Managers (TM's) that have been or will be trained in drug, trace, or toxicology analysis will serve as members of the Chemistry subcommittee.

        ii. The Controlled Substances and Toxicology TM's, or designees, will co-chair the Chemistry Subcommittee.

    b) Biology Subcommittee

        i. The Forensic Biology TM, CODIS Administrator, and any CSD Supervisor that has been or will be trained in forensic biology casework or database analysis will serve as members of the Biology subcommittee.

        ii. The Forensic Biology TM, or designee, will chair the Biology Subcommittee.

    c) Identification Subcommittee

i. The Latent Evidence TM and any CSD Supervisors and Criminalistics Administrators that have been or will be trained in the disciplines of Firearms and Latent Evidence will serve as members of the Identification Subcommittee.

ii. The TM of the Latent Evidence Discipline, or designee, will chair the subcommittee.

d) Evidence Subcommittee

i. The Evidence APO, FSC Forensic Biology Unit Supervisor, Specialized Forensic Biology Unit Supervisor, FSC Forensic Chemistry Unit Supervisor, and Latent Evidence Supervisor will be regular members of the Evidence Subcommittee.

ii. The Evidence APO, or designee, will chair the subcommittee.

iii. The Evidence APO can select additional members for the Evidence Subcommittee (e.g. Toxicology, Firearms, and Regional Lab representatives) as needed.

iv. The Evidence Subcommittee will routinely review the suitability of the Evidence Collection Manual and applicable evidence acceptance and tracking policies and provide feedback for revision of these documents as needed.

3. Subcommittees may solicit assistance from other qualified analysts as necessary to complete tasks assigned to them. Subcommittee chairs are responsible for avoiding conflicts of interest when completing tasks assigned to the subcommittee. For example, chairs should ensure that subcommittee members do not review their own proficiency tests.

B. Meeting Schedules and Agendas

1. QIC will meet at least quarterly.

2. QIC schedules and agendas will be coordinated by the QM.

3. Subcommittees will meet as needed.

4. Subcommittee meeting times and agendas will be coordinated by the subcommittee chairperson(s).
5. The QM will be notified of subcommittee meeting times and may attend at his/her discretion.

C. Documenting Management Reviews

All aspects of the OSBI CSD Management System will be reviewed at least annually according to the schedule and procedure listed below.

1. Lab management will initiate the management review process through the completion of quarterly, calendar year (CY) and fiscal year (FY) reports. Supervisors, Technical Managers, Lab Adminsitrators, Grant Program Managers, the Research Committee Chair, and designees will complete the applicable sections of the report template (**OSBI CSD QPA 18.1, Rev. 0**) located at \\pm-fsc13000s\qa\Management_System_Reviews.

2. During the scheduled review of the ASCLD/LAB Guiding Principles of Professional Responsibility for Crime Laboratories and Forensic Scientists, supervisors will be responsible for reviewing the Guiding Principles with their staff. This review should be conducted during a unit/lab meeting. It is each supervisor's responsibility to ensure that the Principles are reviewed with all staff members who are his/her direct reports. Each supervisor must maintain documentation of the review and will report to his/her subcommittee once the review has been conducted with all staff.

3. The following topics will be reviewed according to the schedule indicated. The quarters listed correspond to the calendar year quarter when the activity will be conducted. Discussion and documentation of the review of the activity will be conducted and reported in the following quarter. For example, all supervisors will review the Guiding Principles with their staff during the first quarter of the calendar year (January to March). Supervisors will report the status of this activity in the first quarter CY report that is conducted shortly after the end of the quarter.

    a. Review of **ASCLD/LAB Guiding Principles -** first quarter;
    b. An evaluation of **laboratory objectives**, indicating whether they are still appropriate for the unit and/or lab – second quarter;
    c. The status of **annual policy/procedure/training manual review**, including whether or not the policies and procedures are deemed suitable – third quarter;
    d. A review of any **reports** made by the supervisor or managerial staff during the year, which might include legislative changes that have impacted the unit/lab, staffing levels, etc. – fourth quarter;
    e. A review of the outcome of **internal audits, line inspections, property room inventories, and safety audits**, including the status of any corrective action that was required – each quarter;
    f. A review of **corrective and preventive actions** submitted or performed by the unit/lab during the reporting period and the current status of those actions – each quarter;
    g. A review of any **external assessments** conducted during the reporting period,

including the status of any necessary corrective actions – fourth quarter;

h. A review of the results of any inter-laboratory comparisons or **proficiency tests** completed during the reporting period – each quarter;
i. An evaluation of the volume and type of **work submitted and performed** by the unit/lab that highlights any changes during the reporting period – each quarter;
j. A review of any **customer feedback** received during the reporting period – each quarter;
k. A review of any **complaints** received during the reporting period including the status of any improvements implemented as a result of the complaint(s) – each quarter;
l. Any recommendations for **improvement** – each quarter;
m. Any other **relevant factors** (which might include quality control activities, resources, and staff training) – each quarter.

4. All sections of the report will be completed by the deadline specified by the CSD Director.

5. Following the completion of the quarterly reports, a full QIC meeting will be held.

6. Each QIC agenda will consist of the following items, at a minimum:

   a. Reports on past action items;
   b. Discussion points selected by the QM based on the quarterly, CY or FY reports;
   c. Summary of new action items identified;
   d. Ethics presentation/discussion;
   e. Quality standard presentation/discussion.

7. During QIC discussion, items which require action will be noted and assigned a tracking number. Action items will be logged onto a spreadsheet saved in the following directory: \\pm-fsc13000s\qa\spreadsheets. Whenever practical, each action item should be assigned an "owner" who is responsible for ensuring the item is completed and a deadline.

III. Attachments

OSBI CSD QPA 18.1, Rev. 0

I. Scope

OSBI CSD employees will be properly trained and qualified prior to performing independent or unsupervised testing.

II. Procedure

A. Training Program Structure

Each discipline will have a written training program as outlined below.

1. Each discipline's training manual/program must include the following sections:

    a. Application of ethical practices in forensic sciences
    b. General knowledge of forensic science
    c. Applicable criminal and civil law and procedures
    d. Overview of quality system
    e. Applicable Safety Topics (blood borne pathogens, chemical hygiene, etc.)
    f. Discipline specific topics
    g. Presentation of evidence in court (when applicable)

2. Each section of the training manual/program will include a list of goals which must be met for the trainee to have the skills necessary to complete the duties listed in the trainee's job description.

3. Each section of the training program will also establish the tasks or activities that will be completed by the trainee in order to meet the stated goal.

4. Successful completion of the training program will be assessed through the use of competency tests as indicated below.

5. The training program must be reviewed annually. The discipline Technical Manager (TM) and the CSD Director must approve any changes.

B. Conducting Training

1. The TM will be responsible for the assignment of training for any new employee assigned to that discipline.

2. Prior to training any individual, an assessment should be done to identify his/her specific training needs. This assessment may include a review of his/her education, experience, and/or a quiz or other competency evaluation to assess his/her knowledge/skill level.

3. Based on the results of the assessment, the training program can be modified according to the knowledge, skills, and abilities of the trainee.

4. OSBI Criminalists competent in the assigned discipline may act as trainers, at the request of the TM.

5. New training goals will not be assigned until both the trainer and trainee are satisfied that current goals are understood.

C. Documenting Training

1. Training Records

The FSC administration will maintain training records for each CSD employee. This includes information concerning the job description, education, training, and continuing education of the employee. Individual training records will be stored in the appropriate folder located at \\Pm-fsc13000s\qa\Individual_Records. Each CSD employee is responsible for placing a copy of the following documents in his/her folder:

a) all transcripts indicating any degrees conferred
b) certificates or agendas for continuing education/professional development classes attended
c) updated transcripts when additional courses are completed
d) all memos approving individuals to perform analysis

2. Supervisory Training File

The supervisor and/or appropriate TM will be responsible for maintaining a file for each trainee which includes:

a) A copy of a completed checklist of the knowledge and skills for each trainee.
b) Copies of all evaluation tools used (written tests, sample lists, etc).
c) The expected and reported results for any/all competency test(s).

3. Monthly Training Updates/Memos

The progress of each trainee will be documented in the form of a monthly update stating what training was completed during the previous month. The trainer will provide the monthly update.

a) A copy of the monthly training update will be provided to the trainee, Supervisor, Technical Manager, and appropriate CA.
b) The monthly update is in addition to any documentation or evaluation required by OSBI Human Resources.

c) The update should be submitted to the appropriate individuals by the 5th working day of the month.

D. Competency Tests

1. Regardless of education, qualifications, or past experience, each analyst must demonstrate competence in each **category of testing** through the successful completion of a competency test(s) prior to release for casework or crime scene duties.

2. In order to successfully complete a competency test, the analyst must achieve the intended results. Any discrepancies must be reviewed and re-training conducted as necessary to achieve the expected results, prior to the test being accepted as satisfactory.

3. The minimum components and objectives of a competency test are as follows:

   a. Analysis of an adequate number of unknown samples:

      Unknown samples should be prepared and assigned under the direction of the TM. The samples should encompass the range of samples which the employee will be expected to test upon successful completion of the test. The number of samples should be sufficient to evaluate an employee's ability to select and perform proper testing methods in accordance with laboratory policy.

   b. Written report:

      Results of competency tests should be reported in the same fashion as casework or database analysis. The report should then be reviewed to evaluate the employee's ability to accurately and clearly convey testing results and the significance of the results.

   c. Written and/or oral examination:

      Each employee must also demonstrate an adequate knowledge of the area being tested through the completion of a written and/or oral examination. This portion of the competency test should include a mock trial, when appropriate. Prior to the assignment of a written and/or oral examination, the TM or designee should identify the knowledge necessary to perform testing (e.g. specific technical knowledge necessary to perform testing, conduct trouble-shooting, etc. and/or specific knowledge and ability to convey the knowledge clearly to lay-people), develop questions to assess the knowledge level of the individual, prepare a scoring mechanism and/or key, and set the minimum score that will be accepted

as passing.

4. The trainee must successfully complete all phases of the competency test before being released to perform independent testing.

5. Upon the successful completion of a competency test, an Authorization to Work (ATW) memo shall be issued or updated by the TM to reflect the release to begin work.

E. Competency Evaluations

On some occasions, additional evaluations of competency are needed after a competency test has been given. This may be due to the training of qualified analysts in a new method, instrument, or other significant modification to protocol, or after re-training of analysts as described in section II.F. Competency evaluations must be tailored to ensure that the training was effective in providing the necessary skills and knowledge base to the analyst.

1. The TM or designee shall document the procedure and criteria for successful completion of the competency evaluation prior to assignment.

2. Upon successful completion of a competency evaluation, the TM shall update the analyst's ATW to reflect the release to begin work.

F. Re-training

Re-training is occasionally needed for various reasons including transfer of employees into a section or discipline where they have previously been authorized to work or where there has been an indication that training was not effective (e.g non-conforming work or unsuccessful completion of competency test).

1. Re-training should begin with an assessment of the training needs of the individual. This may include completing a cause analysis related to non-conforming work or evaluating contributing factors for incorrect responses on competency tests. For employees re-training in an area of prior competence, this should also include an evaluation of changes to the methodology since the analyst last conducted work in the discipline.

2. Re-training may be conducted using specific portions of the discipline training manual, or may be developed and tailored to the needs of the individual being re-trained. Modified or newly created training programs used for re-training must be documented and approved by the TM before use. When modifying an existing training program for use in re-training, the TM shall document justification for eliminating or significantly reducing specific training requirements.

3. Any re-training conducted should be documented in the same fashion as initial training.

4. All re-training must be followed by an evaluation to determine the effectiveness of the re-training. This evaluation may or may not include a full competency. The decision of the method used to determine the effectiveness of the re-training shall be made and documented by the TM.

G. Authorizations to Work

Upon successful completion of appropriate competency test or evaluation, the TM shall authorize analysts to conduct work (e.g. casework, database analysis, access to and operation of individual characteristic databases, etc) in an Authorization to Work (ATW) memo. The CODIS Administrator shall be responsible for issuing the ATW for access to and operation of the CODIS database. ATW memos will be maintained as a single document per discipline and will be updated as needed to reflect additional authorizations to work. ATW memos shall include the following information:

1. A description of the training and competency test or evaluation that has been completed. (e.g. blood alcohol analysis, sexual assault serology testing, latent print processing, etc.)

2. The date the authorization and/or competency is confirmed. Whenever possible reflect the date the authorization is made (e.g. when the individual is released for casework). Otherwise, specify the date that their authorization/competency was verified/confirmed.

3. List types of testing (include any sampling procedures, if applicable) the individual is authorized to perform: List specific protocols or categories of protocols. For example, TX-4 ELISA, TX-5 Ethanol Analysis by headspace GC or all approved Toxicology methods related to ELISA, blood alcohol analysis, and qualitative identification of drugs in whole blood.

4. List types of equipment/instrumentation the individual is authorized to operate: List specific instruments or reference instruments through protocols. For example, "Tecan Freedom EVO75 (ELISA), Headspace GC, GC/MS, GC/FID, LC/MS/MS" or "all equipment referenced in the currently approved toxicology protocols governing ELISA presumptive screening for drugs, blood alcohol analysis, and qualitative identification of drugs in whole blood."

5. Describe what the individual is authorized to report and testify about. Be sure to specify results, interpretations and/or opinions as appropriate.

H. Continuing Education

Employee development is critical to the quality program of the laboratory. Laboratory employees must keep current on the latest techniques and technologies. The OSBI CSD supports the continuing development of its employees through various methods, including the following.

1. Attendance at professional meetings is encouraged. Employees should refer to OSBI Agency Policy 202.1 for more information on regulations concerning attendance at professional meetings. Required materials concerning the course must also be turned in to the training office.

2. OSBI CSD employees are also encouraged to recommend training classes which can be hosted in the FSC training rooms. Recommendations for training classes should be forwarded through the supervisory chain to the CSD Director.

3. The OSBI encourages attendance at local colleges and universities in areas related to the job description of the employee by offering tuition assistance when funding is available as outlined in OSBI Agency Policy 202.2. A copy of a completed transcript for any course related to professional development should be forwarded to the QM.

4. An employee development plan is a part of each annual evaluation as required by Oklahoma law and OSBI Agency Policy 214.

5. Other sources of training and development include:

   a) Courses offered by the Council on Law Enforcement Education and Training (CLEET)
   b) Courses offered by the Office of Personnel Management
   c) In-house seminars, employee conferences, training and technical meetings
   d) FBI, DEA, or other outside training

6. An evaluation of any grant funded training or meeting will be documented on form **OSBI CSD QPA 19.1** and submitted to the CA responsible for overseeing grants.

7. Current literature review is important to the development of employees. The TM (or his/her designee) of each discipline will assign/and or circulate articles of interest for their discipline. The TM will make sure each analyst has had an opportunity to read each article.

III. Attachments

OSBI CSD QPA 19.1, Rev. 0

I. Scope

The OSBI CSD maintains the integrity and prevents contamination of evidence and ensures the confidentiality of records by limiting access to restricted areas to authorized personnel.

II. Procedure

A. Facilities

1. Access to laboratories, file rooms, and evidence rooms will be limited to employees assigned to the laboratory unit, evidence technicians assigned to the physical facility, Criminalistics Administrative personnel, and other personnel as authorized by the CSD Director on a limited or permanent basis. All other personnel including service/maintenance personnel will only have access to the laboratory and evidence room areas when accompanied by employees authorized to have access.

2. Laboratories and evidence rooms will remain locked. Any exception must be authorized by the laboratory administration. At the end of each workday, the last person leaving is to ensure the unit and building are secured and alarmed.

3. No exterior or lab access door shall be propped open under normal circumstances. If an exterior or lab access door is propped open (e.g. while moving equipment), the employee propping the door open will ensure that appropriate OSBI personnel are present to monitor who enters and exits, until the door is closed. It will be the responsibility of any employee opening an outside door during normal work hours to ensure that door is locked at the end of that activity.

4. Access to quality and technical records will also be restricted. Access may be limited by maintaining these records in a location that is in a secure space. In addition, keys, proximity devices, and access cards which provide access to quality and technical record storage areas will only be issued to individuals who are authorized by the CSD Director to access these records.

B. Lock Security

Keys, proximity devices, and access cards which provide access to laboratory spaces or evidence storage areas will be tracked as indicated below. Each key, proximity device, and access card, should be engraved or stamped with a unique identification if not already provided. Excess keys which are not issued for use may not require a unique identification. However, these keys should be maintained in a secure location and be labeled in a manner that they can be associated with the coordinating lock.

1. Tracking Keys

   a) Key control logs (**OSBI CSD QPA 20.2**) will account for the number of assigned keys to a laboratory unit and a sign out log will document who has keys to each door, locking refrigerator, freezer, or work area drawer. A master key log will be maintained (**OSBI CSD QPA 20.4** or **OSBI CSD QPA 20.4b**) for all keys within a unit or regional laboratory. The total number of keys will be verified annually and recorded on the Master Key Log.

   b) Laboratory units having proximity access devices (key fobs, etc.) will use OSBI **CSD QPA 20.2** to document the issue and receipt of proximity access devices, excluding identification badge proximity access devices which are handled according to section II.B.2.a, below. Cipher lock codes will be maintained on **OSBI CSD QPA 20.3**.

   c) Assigned keys will not be copied or loaned. Proximity access devices will not be loaned. Cipher lock combinations, access codes, and alarm codes will not be further disseminated by the individuals receiving the combination or code.

      i. Loss of assigned keys and proximity access devices will be handled as per OSBI Directive 211. The employee shall immediately report the loss to their Supervisor.

      ii. Previous key control log forms must be archived by the responsible person(s) designated in II.B.2. When key control log forms are revised, the older revision may be used until a change in key assignment occurs.

   d) Occasionally, a common key is issued to a Supervisor or a key is needed for only a short period of time. In those instances, the person checking out the key must sign and date when the key is removed and when it is returned using **OSBI CSD QPA 20.1**.

   e) The drying stall key control log (**OSBI CSD QPA 20.5**) may be used when temporarily issuing drying stall keys to individuals outside the OSBI CSD.

2. Issuing Keys, Proximity Access Devices, and Lock Codes

The following individuals are responsible for issuing keys, proximity access devices, and lock codes and maintaining their corresponding logs:

a) Forensic Science Center (FSC)–

i. Identification Badge Proximity Access Devices: Human resources personnel or a designee will issue an identification badge/proximity access device to each CSD employee and assign the employee a personal identification number (PIN). New or modified FSC access privileges should be requested through the supervisory chain to the CSD Director for approval. The CSD Director or designee will then forward approved requests to the FSC Building Manager, who will be responsible for programming the identification badge proximity access device with the authorized level of access to FSC.

ii. The FSC Building Manager will issue FSC building entry keys and maintain records documenting the issuance of those keys.

iii. Unit Supervisors are responsible for unit keys used for temporary evidence storage areas within their assigned sections.

b) Regional Laboratories – The Laboratory Supervisor is responsible for tracking keys and access codes.

3. Changing Access Codes/Privileges

At a minimum, cipher lock combinations, access codes or privileges and alarm system codes will be changed or deleted under the following conditions:

a) When necessary to prevent unauthorized access to a laboratory or unit by a former employee.

b) When a situation or circumstance involving a potential security breach occurs as determined by the Unit Supervisor or Criminalistics Administrator over the unit.

c) Employee PIN's should also be changed when necessary due to technical difficulties, such as repeatedly and inadvertently entering duress code.

4. Responsibilities for Updating Codes

Updating access codes for cipher locks and alarm systems will be the responsibility of the following individuals:

a) Forensic Science Center – The FSC Building Manager will be responsible for controlling the levels of access granted to employees for FSC. Modifications to access privileges should be requested, approved, and routed as indicated in section II.B.2.a above.

b) Regional Laboratories - Laboratory Supervisor will be responsible for updating access codes.

C. Evidence Storage and Security

1. Each laboratory site shall establish a secure and organized evidence storage room(s) and/or building.

2. Evidence rooms will be kept neat and clean and will have limited and controlled access. Evidence rooms will have fire and security alarm systems.

3. Each laboratory evidence room or building shall at a minimum meet the following standards:

   a) An inside room or building with no windows, or, if windowed, the windows must be covered with secure steel bars or grate; or the room must be on an upper floor not easily accessible; or monitored by suitable motion detectors or other devices.

   b) Doors must have secure locks.

   c) Sufficient shelving or floor space must be available so that all evidence can be stored in a safe and orderly manner.

4. Prior to being logged in and labeled, evidence may be held in a secure, approved designated temporary evidence holding area or in an Evidence Room. The evidence or the holding area should be labeled to identify it as pending log in. All other evidence placed in an evidence room shall be marked for identification with a Criminalistics case number, the submitting agency, and barcode.

5. No CSD personnel may store evidence at home, in their vehicle, in their office/work area, or at any other such place. This does not apply to latent lifts, impressions, or images of latent prints/impressions which may be maintained by Latent Evidence analysts in their desk areas. CSD personnel may also temporarily maintain custody of evidence while working with the evidence, transporting the evidence, traveling to and from court, or for any other short-term investigative or prosecutorial purpose.

D. Alarm Systems

1. All buildings in which laboratories and evidence rooms are located will have security alarm systems. The security alarm will monitor the facility when it is not occupied. This approval will be documented by a memorandum from the CSD Director to the respective laboratory facility and will be archived at the FSC. Changing and redistribution of access codes/levels will be done as described in sections II.B.3 and II.B.4.

2. Each laboratory facility will maintain a call list for the alarm system. The list is maintained by the person responsible for maintaining keys, magnetic cards, and keypad lock codes in II.B.2 and updated as outlined in II.B.4. Copies of the call list shall be forwarded to the alarm monitoring company in the event the alarm company does not provide the list. The call list will be kept on file with the Regional Laboratory Supervisor in regional laboratories or Administrative Office at the FSC. These same individuals are responsible for archived lists when changes are made.

E. Enforcement

It will be the responsibility of the immediate unit Supervisor to ensure and monitor compliance with this policy.

III. Attachments

OSBI CSD QPA 20.1, Rev. 1 Temporary Key Control Log
OSBI CSD QPA 20.2, Rev. 1 Key Control Log
OSBI CSD QPA 20.3, Rev. 1 Keypad Control Log
OSBI CSD QPA 20.4, Rev. 1 Master Key Log
OSBI CSD QPA 20.4b, Rev. 1 Excel Master Key Log
OSBI CSD QPA 20.5, Rev. 1 Drying Stall Key Control Log

I. Scope

This procedure will outline the process for recommending and evaluating research projects. Research projects may be more informal evaluations of potential new or modified methods and/or instruments. Research may be proposed and conducted by OSBI CSD employees or by volunteers such as students completing a practicum study, internship, or student research project.

II. Procedure

A. Research Committee

CSD employees may volunteer to serve on the Research Committee. Individuals interested in serving on the committee must notify the CSD Director. The CSD Director will select individuals to serve on the committee based on the needs of the CSD. The CSD Director will appoint a committee member to chair the committee.

B. CSD Employee Research Proposals

OSBI CSD employees will use the following steps to propose and obtain approval to conduct research.

1. Obtain approval and guidance for purchasing, storing, and using any new reagents. Refer to OSBI Policy 121.1 concerning proper procedures for procuring new reagents.

2. Prepare a written research plan including the following information:

   a) goal(s), objective(s), and relevance of the research
   b) description of research project(s) to be performed
   c) list of employees that will participate, including their roles
   d) description of sample types to be used (use of evidence for research must be evaluated and conducted in accordance with **QP 6.2**)
   e) financial impact, including:
      i. a list of additional equipment, reagents, and supplies necessary to complete the validation and projected cost
      ii. a projected cost per sample, including a comparison to any existing method used
   f) project timeline, which must include start and end dates and deadlines for major milestones

3. Route the research plan to the CSD Director.

4. The CSD Director will solicit feedback from the Research Committee and the

administrative staff as necessary.

5. The CSD Director will notify the Research Committee chairperson if the plan was approved or denied.

C. Student Research Proposals

Students or other individuals who would like to conduct research in collaboration with OSBI CSD employees or utilizing OSBI CSD resources should contact the Research Committee Chair. Student and any other non-OSBI CSD research projects should be evaluated, approved, conducted, and documented in accordance with procedures established by the Research Committee.

If student research is performed on CSD equipment used for casework analysis, the equipment may need to be checked for proper function and calibration prior to resuming casework analysis. Refer to section **5.5.9** of the QM.

D. Reporting Research Results

Following the completion of an OSBI CSD research project, a summary should be prepared and routed in the same fashion as the research proposal.

1. The summary should indicate whether the research was successful and what further action, if any, is recommended.

2. When enough data from research has been obtained to determine that it is desirable to introduce a method for use in casework, the research should be summarized with a recommendation to proceed to validation. A more thorough and detailed validation plan should then be submitted according to section **QP 21.2**.

III. Attachments

None

I. Scope

All analytical methods utilized by the OSBI CSD will be validated prior to use to ensure each method is fit for its intended use. This procedure explains the process for validating and approving methods used by the CSD.

II. Procedure

A. Proposing and Reporting Validation Studies

Any new or modified method, or method to be used in a fashion outside the original intended scope, will be validated prior to use in testing.

1. Obtain approval and guidance for purchasing, storing, and using any new reagents. Refer to OSBI Policy 121.1 concerning proper procedures for procuring new reagents.

2. Prepare a validation plan and route the plan to the appropriate QIC subcommittee. The subcommittee will review the merit and completeness of the validation plan. The subcommittee may approve the validation plan or return for corrections/modifications. Once approved, the subcommittee will forward the validation to the CSD Administration (CA's and CSD Director) for a final review and approval.

3. The plan should include the following sections and/or attachments:

   a) goal(s) and objective(s)

   b) financial impact, including:

      i. a list of additional equipment, reagents, and supplies necessary to complete the validation and projected cost
      ii. a projected cost per sample, including a comparison to any existing method used

   c) study descriptions, including:

      i. purpose/type of study (precision, sensitivity, etc.)
      ii. validation parameters for testing (e.g. temperature, time, volume, etc.)
      iii. types of samples (pristine, simulated forensic, non-probative) and approximate numbers of sample
      iv. controls and any standard reference materials
      v. method for evaluating data

d) references, including:

i. any applicable recommendations/requirements from a Scientific Working Group
ii. any applicable peer reviewed literature
iii. draft protocol

4. Following the completion of the validation study, the results will be summarized for review. Validation reports should include the following sections/attachments:

a) range and accuracy of values obtainable (this may include uncertainty of measurement, detection limit/sensitivity, selectivity/specificity, reproducibility, etc.)

b) quality control measures which must be incorporated with the method

c) final draft of the technical protocol and any quality control/calibration protocols required

d) final cost/benefit analysis (this should summarize both the technical and financial benefits and liabilities)

B. Review of Validation Reports

1. The initial review of validation reports will be conducted by the appropriate QIC subcommittee.

2. The subcommittee should ensure that the report is complete and then, based on their review, recommend the method be approved or recommend further validation.

3. In addition to reviewing the validation report, the subcommittee will also review the associated draft protocol. The subcommittee should review the protocol to determine if each of the applicable aspects outlined in **QP 2** section II.G.5 have been clearly addressed by the protocol and are properly supported by the validation results. The subcommittee should document any aspect which it deems not applicable and the reasons supporting that determination.

4. Completed validation reports which are recommended for approval should be forwarded to the appropriate CA, the Quality Manager (QM), and the CSD Director. A summary of the subcommittee recommendation, including any dissenting opinion(s), should be attached to the validation report.

5. If the CA, QM, and CSD Director unanimously agree with the subcommittee then the validation will be approved.

6. If the CA, QM, and CSD Director do not unanimously agree, they may return the validation for additional action. Alternately, the Quality Manager may forward the report to all QIC members including all comments and recommendations.

7. The Quality Improvement Committee can then approve the technique or remand the validation for additional study.

8. QIC review and approval may be conducted and documented via e-mail if necessary.

9. The validation plan and all related documentation are to be archived with the Technical Manager of the discipline.

10. Approval of validation summaries may be documented by writing on a copy of the validation summary. It may also be further documented through the issuance of an approved protocol.

C. Performance Checks

A performance check will be conducted to verify that a validated method works as expected on additional or new instruments of the same kind. Performance checks may also be appropriate when other minor modifications are made. Performance checks will be conducted under the instruction of the appropriate Technical Manager. The Technical Manager and/or the appropriate Supervisor will be responsible for maintaining the appropriate documentation.

III. Attachments

None

I. Scope

This procedure will be used for the estimation and documentation of uncertainty of measurement for applicable testing methods. Uncertainty of measurement will be estimated and reported in compliance with the current policy issued by ASCLD/LAB and posted to their website (www.ascld-lab.org). In the event that ASCLD/LAB rescinds or suspends the policy, uncertainty of measurement will not be reported, but work to estimate the uncertainty of measurement will continue following the most up to date guidance available from ASCLD/LAB. When new or updated policies are issued by ASCLD/LAB, the OSBI shall comply with the new policies by the deadline established by ASCLD/LAB.

II. Procedure

A. Tests Which Require Estimation of Uncertainty of Measurement

The OSBI CSD shall have and shall apply a procedure to estimate the uncertainty of measurement when values are reported for:

1. Weight of controlled substance evidence
2. Concentration of drugs in toxicology samples
3. Barrel length and/or overall firearm length

The OSBI CSD does not currently report the following types of test results: volumes of controlled substance evidence, quantitation (purity) of controlled substance evidence, or calibration of breath alcohol instruments or reference materials. In the event that OSBI CSD policy is modified to provide these services, a procedure for estimating uncertainty of measurement will be developed and applied to these areas as well.

B. Procedure Requirements

The Toxicology, Chemistry, and Firearms Units will each issue a discipline specific procedure detailing the process to use for estimating and reporting the uncertainty of measurement. These procedures must include a process for rounding the expanded uncertainty and must require a minimum coverage probability of 95.45%. In addition, the policy must ensure the following information is recorded:

1. The measurand.

2. Description of how traceability is established for the measurement.

3. The method for measurement, including the equipment or instrument used to take the measurement.

4. List of all uncertainty components considered.

5. List of all uncertainty components of significance and how they were evaluated.

6. Data used to estimate repeatability and/or reproducibility.

7. All calculations performed.

8. The combined standard uncertainty, the coverage factor, the coverage probability, and the resulting expanded uncertainty.

9. The schedule to review and/or recalculate the measurement uncertainty.

C. Documenting Uncertainty Calculations

1. The TM or designee will be responsible for maintaining documentation of any uncertainty of measurement calculations conducted. Documentation must include the data elements listed in section II.B above.

2. Analysts must document in the case record those factors which impact the uncertainty of measurement. This may include the identification of the instrument or measuring device used or an indication of the size or capacity of the measuring device.

D. Reporting Uncertainty of Measurement

1. Reporting uncertainty of measurement will be conducted as indicated in the discipline specific procedure. At a minimum, uncertainty of measurement must be reported in the following circumstances:

   a. The uncertainty of measurement will be reported upon request by the customer.

   b. The uncertainty of measurement will also be reported when the measurement and applicable uncertainty of measurement overlap an established and applicable legal threshold. For example, if the legal threshold for trafficking methamphetamine is 20 grams, the reported measurement is 20.02 grams and the uncertainty of measurement is +/- 0.03 grams, then the uncertainty of measurement should be reported.

   c. When necessary for interpretation of test results.

2. When the uncertainty of measurement is reported, it must be reported using the same units of measurement and the same number of significant figures as the reported measurement. The rounded expanded uncertainty should be reported using up to two significant digits. In the event it is necessary to report using more than two significant figures, the discipline specific procedure must document the

reason(s) for using more significant figures. The associated confidence level of the estimated uncertainty of measurement must also be reported.

3. If the uncertainty of measurement is reported without a customer requesting it, the reporting analyst should ensure that the customer understands what the uncertainty of measurement is. This can be accomplished by calling the customer and explaining the new reporting language prior to or shortly after releasing the report. Alternately, the TM or designee may prepare and have approved by CSD Administration a written explanation of uncertainty of measurement that can be attached as an appendix to reports or e-mailed to customers as necessary.

III. Attachments

None

I. Scope

The OSBI CSD will use the following procedure to ensure adequate traceability of measurements where measurement uncertainty is estimated or when the measurement result has a significant impact on the final test result.

II. Procedure

Any OSBI CSD discipline which conducts measurements requiring an estimation of uncertainty of measurement or which significantly impact results must have a written procedure for calibration which complies with the current Measurement Traceability Policy issued by ASCLD/LAB. A list of current ASCLD/LAB documents and policies is located at http://www.ticr.us/clients/ASCLDWEB97q4b8/accreditation-policies/.

A. Internal Calibrations

The OSBI CSD shall not perform calibrations of equipment or reference standards without first obtaining accreditation in the necessary field of calibration from an accrediting body with an appropriate scope of recognition from IAAC or ILAC.

Any instruments operated by the OSBI CSD which are capable of performing an internal self-calibration shall be addressed through discipline protocol/policy which incorporates appropriate guidance or requirements established in applicable ASCLD/LAB policy on Traceability and Uncertainty of Measurement. The discipline policy shall identify whether the instrument internal calibration will be utilized or not. If instrument internal calibrations are permitted, the discipline policy shall identify any performance checks which may be required by ASCLD/LAB policy.

B. External Calibrations

In order to ensure that external calibrations of measuring equipment/instruments and reference standards provide adequate traceability, the following steps will be used to select an appropriate vendor and maintain adequate documentation of the calibration. When used for establishing or maintaining traceability, calibrations (of equipment, reference materials, or reference standards), reference standards, and reference materials are considered critical supplies and services as referenced in ISO/IEC 17025:2005 standard 4.6.4. As a result, the evaluation of the vendors used to provide these calibrations and/or supplies must be conducted and documented in accordance with **QP 9**.

1. The vendor conducting the calibration must demonstrate and provide documentation of **competence** and adequate **measurement capability** and **traceability**.

a. **Competence** will be demonstrated by selecting a calibration laboratory which is ISO/IEC 17025:2005 accredited. The accreditation should be from an IAAC or ILAC MRA signatory when possible. Listings of current IAAC MRA and ILAC MRA signatories may be found on the internet at http://www.iaac.org.mx/English/Members.php and http://www.ilac.org/documents/mra_signatories.pdf respectively.

b. **Measurement capability** should be verified by determining that the calibration laboratory's scope of accreditation includes a measurement range applicable to the instrument or measuring equipment being calibrated.

c. **Measurement traceability** should be verified by obtaining documentation from the calibration laboratory which documents traceability to NIST standards.

2. The calibration certificates received from outside calibration laboratories should include:

   a. the measurement results and the associated uncertainty of measurement, and/or

   b. a statement of compliance with a metrological specification.

3. Instruments, equipment, reference standards, and reference materials which have been externally calibrated to obtain appropriate traceability will not be adjusted by OSBI CSD personnel. If intermediate checks are performed and results indicate that the item is no longer within the calibrated range, the item will be taken out of service until an appropriate external calibration can be performed.

4. If the only supplier available for calibration used for measurement traceability is accredited to ISO/IEC 17025:2005 by a non-IAAC MLA or non-ILAC MRA signatory accrediting body, then the discipline TM shall **verify and document** the competence (accreditation), measurement capability, and traceabilty.

C. Intermediate Checks

Each discipline shall determine if intermediate checks are necessary to maintain confidence in the calibration (and associated traceability) status of equipment, reference standards and reference materials. If intermediate checks are needed, they shall be conducted according to discipline specific protocols or policy and schedule. Once a calibration schedule has been established, calibrations and/or intermediate checks shall not be conducted less frequently without documented empirical data supporting the change in frequency.

D. Calibrations to Alternate Reference Standards or Materials

If calibrations cannot be made in SI units, the OSBI CSD will provide confidence in reported measurements by:

1. establishing traceability to a certified reference material (see **QP 26**), or

2. using a specified method or consensus standard agreed on by OSBI CSD management and the customer.

III. Attachments

None

I. Scope

The OSBI CSD will furnish CSD facilities with equipment and instrumentation which will provide the correct performance for the analysis conducted. This procedure will be used to track, maintain, and verify calibration of equipment and instruments. This may include computers or automated equipment used to process, record, report, or store test data. This procedure will also be used to ensure safe handling, transport, storage, use, and maintenance of measuring equipment.

II. Procedure

A. Inventory

1. The Supervisor of each unit and of each regional laboratory must have access to an inventory of their instruments/equipment and analysis software.

2. The inventory for instruments/equipment should include the following information:

   a) Name

   b) Manufacturer, model number, and serial number

   c) OSBI asset number

3. As each unit or laboratory receives new instruments/equipment, the Supervisor or designee will send information concerning the new instruments/equipment to the FSC Administrative Office.

4. A file containing original paperwork (manufacturer's information, etc.) for instruments/equipment should be readily accessible by the Supervisor.

B. Calibration and Maintenance Procedures

1. Equipment procedures (protocols) will be established as necessary to ensure the following criteria are met:

   a. Each discipline shall have a written procedure or program for the calibration of equipment. The procedure shall identify:

      i. a list of equipment which requires calibration
      ii. specifications for the calibration laboratory (must comply with **QP23** if applicable)
      iii. specified requirements for the calibration
      iv. required frequency of calibration

b. Equipment will be checked (e.g. function verification) or calibrated before being placed into service to ensure it meets the necessary specifications established in OSBI CSD protocols.

c. Equipment used for tests which has a significant impact on accuracy or validity of tests results shall be calibrated before being put into use.

d. For measuring equipment (or test equipment with measuring functions) that has a significant impact on the accuracy or validity of a test result or the total uncertainty of the test result, the calibration procedure must ensure that any calibrations and measurements made are traceable according to **QP 23**.

e. For equipment where the calibration does not have a significant effect on the test result or the total uncertainty of the test result, the discipline TM shall determine whether a calibration will be performed and establish requirements for a reliable calibration laboratory, if calibration is performed.

2. Equipment procedures will require and specify the maintenance of the following records for equipment and software which has a significant effect on the accuracy or validity of test results:

   a. **user's manuals** or manufacturer's instructions or a reference to the location of the manuals/instructions (if they are not in located at or near the equipment);
   b. **calibration records** which include the dates, results, and copies of calibration reports/certificates, as well as records of any adjustments, acceptance criteria, and the due date for the next calibration;
   c. **results of function verifications** (at a minimum the record should include the date of the verification, initials of the person conducting the verification, a description of the verification activity, and identification of any reference standards or materials used);
   d. **maintenance plan and records** of maintenance (at a minimum maintenance records should include the date of the maintenance, initials of the person conducting the maintenance, and a description of the maintenance activity);
   e. **records of any damage, malfunction, modification, or repair**.

3. Maintenance procedures should include a maintenance plan, maintenance contract information, and routine preventive maintenance.

4. Whenever an applicable laboratory instrument/equipment is taken out of service, an entry will be made in the logbook including the "out of service" date and again the "in service" date. Additionally, the instrument/equipment must have an "out of service" sign placed on it or be otherwise isolated and/or identified to prevent use until it is placed back into service.

C. Measuring Equipment

1. At a minimum, measuring equipment, such as pipettors, balances, pH meters, etc., will be handled, transported, stored, used and maintained according to manufacturer's recommendations in order to prevent deterioration and/or contamination. If additional procedures are necessary to adequately prevent deterioration and/or contamination, the discipline Technical Manager will issue a protocol detailing the appropriate additional steps.

2. The manufacturer's user's manual should be maintained for all measuring equipment. In the event that the manufacturer's user's manual is not available, the discipline Technical Manager will be responsible for issuing a protocol detailing proper handling, transportation, storage, use, and maintenance of the equipment.

III. Attachments

None

I. Scope

This procedure will be followed to ensure traceability of reported measurements, when applicable, and to ensure proper calibration and handling of reference standards.

II. Procedure

A. Calibration of Reference Standards

1. Disciplines which use reference standards shall have a written procedure which identifies the following factors:

   a) A list of reference standards which require calibration
   b) Specifications for the calibration laboratory (must comply with **QP 23**)
   c) Specifications for the calibration
   d) How frequently the reference standard(s) must be calibrated

2. Calibration Requirements

   a) Reference standards shall be calibrated in a manner that ensures compliance with **QP 23**.

   b) Calibration certificates will be maintained at the CSD unit using the reference standard. The original calibration certificates for reference standards used by multiple units will be maintained with the standards. Units using the standards should maintain a copy of the calibration certificate for easy reference. Expired certificates will be maintained by the appropriate unit Supervisor or Technical Manager.

B. Transport and Storage

1. Calibrated reference standards will be stored separate from evidence in a secure location that does not invalidate their performance as reference standards.

2. The current location of calibrated reference standards used by multiple units will be tracked through the use of a sign out sheet or equivalent tracking mechanism.

3. Calibrated reference standards will be used for their intended purpose only, unless it can be demonstrated that alternate uses do not invalidate their performance as reference standards.

4. Manufacturers' recommendations will be followed for the handling, storage, transport, and use of reference standards to ensure that they are protected from damage.

III. Attachments

None

I. Scope

This procedure outlines the legal, safety, transportation, storage, handling, and use requirements for reference materials, such as drug standards and certified reference materials (CRM's). These requirements will be followed to prevent contamination or deterioration of reference materials and in order to protect their integrity.

II. Procedure

A. General Requirements

When it is not possible or appropriate to trace reported results to SI units, the OSBI CSD will ensure the reliability of reported results, wherever practicable, through the use of certified reference materials.

1. Certified reference materials are considered to have valid measurement traceability when supplied by a National Metrology Institute or from an Reference Material Producer (RMP) that is accredited to ISO Guide 34:2009 by an accrediting body that is a signatory to a mutual or multilateral recognition arrangement in an ILAC recognized regional accreditation cooperation or the ILAC Mutual Recognition Arrangement, with a scope of accreditation covering the CRM. In order to ensure appropriate traceability, CRM's should only be ordered from suppliers which meet this clause, if available.

2. If a CRM is used to establish measurement traceability but can only be obtained from an RMP that does not meet the criteria listed above, then the TM shall be responsible for confirming and documenting the competence and traceability.

3. Certificates of analysis from manufacturer's will be maintained in a location designated by the Supervisor and/or Technical Manager.

4. Reference materials will be labeled with the date of receipt and receiving analyst's initials, date opened, initials of the individual opening the reference material, and expiration date, if applicable.

5. Reference materials should not be stored with evidence samples.

6. Whenever possible, only one lot number of standards will be open and in use at a time.

7. The safe handling, transport, storage, and use of reference materials will be conducted according to the manufacturer's instructions or an approved discipline protocol to prevent contamination, deterioration and to protect the integrity of the reference material.

8. If a CRM is changed in a way that alters the traceable measurement value, then the equipment used to alter the CRM shall be evaluated according to **QP 24**. Specifically, if the equipment used to alter the CRM has a significant impact on the accuracy or the validity of the test result or on the total uncertainty of the test result, then the equipment shall be calibrated by a vendor that is accredited to ISO/IEC 17025:2005 with a scope of accreditation covering the calibration.

B. Drug Standards

Drug standards are considered reference materials and will be received, handled, and logged according to applicable discipline Quality Manuals. Requirements for the suppliers of drug standards **which are not used to establish traceability** shall be determined and documented as necessary in applicable discipline Quality Manuals.

III. Attachments

None

I. Scope:

This procedure provides for assistance by criminalists at crime scenes. This procedure will be followed to ensure proper notification of crime scene requests and responses and documentation of activities conducted at a crime scene. This procedure will apply to crime scene response/activities at remote locations and crime scene response/activities at CSD facilities (e.g. processing a vehicle in the FSC vehicle bay).

II. Procedure:

A. Requests for Crime Scene Assistance:

The OSBI CSD provides crime scene assistance through two groups, the Latent Evidence Unit (LEU) and the Crime Scene Response Team. Requests for response by any other criminalists must be evaluated and approved by the CSD Director. Requests for assistance by a Criminalist in one of these groups will be routed as indicated below.

1. Latent Evidence Unit

    a. The supervisor or designee will be notified of the request and determine if the scene warrants the use of a criminalist.

    b. In the event that the supervisor or designee is unavailable, the Criminalistics Administrator (CA) responsible for LEU will be contacted and make assignments as needed.

    c. The Division Director should be notified (via phone, blackberry, e-mail, etc.) when criminalists attend a crime scene.

2. Crime Scene Response Team

Participation in the Crime Scene Response Team is voluntary. Individuals interested in participating may express their interest to the CSD Director who will make the final determination whether an individual is eligible to participate.

    a. Individuals seeking assistance from the Crime Scene Response Team will contact the CSD Director who will notify the appropriate individual(s) from the Team.

    b. If the CSD Director is not available, the CA assigned to FSC Biology, Firearms, Latent Evidence, et al, will be contacted.

3. Miscellaneous Requests for Assistance

Any CSD employee who receives a request for assistance that is not covered by the LEU or Crime Scene Response Team must notify his/her supervisor. The supervisor

will verify that the employee has received appropriate training, successfully completed a competency test, and received written authorization to conduct the type of crime scene work that was requested. The supervisor must also notify the CSD Director prior to authorizing the employee to respond to a scene.

B. Crime Scene Memorandum:

1. All crime scene responses require a Crime Scene Memorandum (**OSBI CSD QPA 27.1**).

2. Copies of the crime scene memorandum will be distributed as follows:

   a. One copy each will be forwarded to the CSD Director and the LIMS Administrator. At the latest, this copy should be turned in by 10:00 A.M. on the following Monday.

   b. The original will be placed in the criminalistics case record, if applicable.

   c. A copy may be retained by the responding criminalist(s) and/or supervisor.

3. If the responding OSBI Criminalistics personnel did not leave together, travel together in the same unit and return together, separate crime scene memos must be completed.

4. Separate crime scene memos will be filled out when a Criminalist responds to different locations (scenes) on the same case.

C. Crime Scene Narrative Report:

1. Any criminalist collecting, preserving, diagramming, photographing, or analyzing evidence at a crime scene will complete a Crime Scene Narrative Report. Morgue calls do not require a crime scene narrative.

2. Crime scene response team members are provided for support only. While they may assist with photographing or diagramming the scene, the report regarding crime scene activities will remain the responsibility of the investigative personnel on scene.

3. The narrative report will include a general description of the Criminalist's activities at the crime scene, an itemized list of what was inventoried or collected, and if testing was performed at the scene. The narrative report can be included with the Criminalistics Examination Report and issued as one document. A copy of a Crime Scene Narrative Report can be distributed to district attorneys, investigating officers and other appropriate parties. The original Crime Scene Narrative will be retained in the case file.

III. Attachments

OSBI CSD QPA 27.1, Rev. 2

I. Scope

This procedure establishes consistency in the format, content, style, and distribution of analytical reports.

II. Procedure

A. Generating Analytical Reports

OSBI CSD analytical reports will be generated in the BEAST Laboratory Information Management System (LIMS). Although the procedure may vary some from discipline to discipline, this is typically done in the following manner:

1. The analyst will click on the "Analysis" button from the "Assignments" tab in the BEAST.

2. This should open exam log and/or matrix panels that the analyst can use to document the analysis.

3. Once the necessary data has been entered, clicking on the "Send to Word" button should open a draft report. Analysts should verify that the information in the report is complete and properly formatted.

4. Analysts will not modify the laboratory name or address on the report in the Word document/draft report. If the lab name or address is incorrect in the report, the analyst will need to correct the lab code for the assignment found on the "Assignments" tab.

B. Correcting Reports

On occasion, mistakes are noted in reports after a report has been approved. If the mistake impacts the findings or results of the report, a corrected report will be issued using the applicable procedure listed below. If the mistake does not impact the findings or results, then the need to issue a corrected report will be evaluated on a case by case basis and corrected reports will be issued at the discretion of the Unit Supervisor.

1. When a report has been approved, **but not distributed (hard copy or pdf via website)**, it may be corrected with assistance from a LIMS administrator using the following **reset** process:

    a. Reset the report – this creates a new assignment and the matrix data is still in place.

    b. Delete the reset report – this deletes the current report number along with the

report.

c. From the matrix, regenerate the report. The analyst can then proceed to sign, route for review, and approve the report.

2. When a report has been distributed and needs to be corrected, the following process will be used to issue an **amended report**:

a. Create an assignment with the same items selected for the assignment that were included in the report being corrected.

b. In the lower right corner of the "Assignments" tab, indicate the report number that is being corrected in the "Amended From" field.

c. Click on the "Analysis" button, navigate to the proper "Send to Word" button, and create a report. All of the exam log and matrix panels should be blank, so the report generated should not include any results.

d. Copy and paste the necessary content from the report being amended into the new report document. Do not copy the signature block. This can be accomplished through the BEAST by placing the cursor on the desired report, pressing the Shift key and clicking print on the BEAST reports tab together. This will generate an unsigned report in Word with "uncontrolled copy" labeled on the report which can be used for copy and paste.

e. Make the necessary corrections to the content of the report, identify the report as an amended report according to section II.E below, and then conduct review and approval of the report according to applicable procedures.

f. Changes made to amended reports should be identified whenever practical. This can be done by putting the changed text in bold or italics, underlining the change, etc. A statement should be placed on the report indicating how the changes are identified.

C. No-Analysis or Partial Reports

1. Occasionally, case circumstances will change and requested analysis will no longer be necessary. When this happens and notification is received before the analysis begins, the following procedure will be used to issue a **"no-analysis" report**.

a. First, enter a narrative in the BEAST case file.

i. From the "Case Info" tab, click on the "Narrative" button.
ii. Click on the "Add" button in the lower left corner. Then enter details of the

conversation, including the first and last name of person, the agency, and what analysis is no longer needed.

iii. Select "NA" for no analysis communication in the "Type" field.

iv. When all information has been entered, click "save."

b. Next, generate the no analysis report.

i. From the "Assignments" tab, highlight the appropriate assignment, and click the "Edit" button at the bottom of the screen.

ii. In the "Lab/Format" field in the lower left corner of the screen, select "NOAN" and, if necessary, select the appropriate analyst in the "Analyst" field. Click "Save."

iii. Click on the "Notes" button and enter the amount of time spent on the "no analysis."

iv. Click on the "Analysis" button and navigate through the exam log/matrix panels and click on the appropriate "Send to Word" button. Verify the information is correct, and then save the report. Print a sufficient number of reports for mailing, if necessary.

c. Finally, close the assignment.

i. Back on the "Assignments" tab, click on the "No Analysis" button.

ii. Click on "Yes" in the next window.

d. The analyst closing the assignment is responsible for ensuring that the evidence is moved or routed appropriately so that it can be returned to the proper agency in a timely fashion.

2. In the event that a request for analysis is canceled after analysis has started but before it has been completed, a **partial analytical report** will be issued. At a minimum the report should address the partial results in one of the following two ways:

a. The report can be issued indicating that analysis was started but then canceled at the request of the customer or due to case circumstances (suspect pled guilty, DA declined to file charges, etc). The report should include the name (first and last) of the customer who canceled the service request or confirmed that analysis was no longer necessary. The report may then indicate that results of testing are not reported since the analysis was not completed. This type of report must be administratively reviewed, but no technical review is required.

b. Alternately, the report may include results from any testing/items which were completed and a statement similar to that described above to address any testing which was not completed.

D. Sub-contracting Reports

When evidence is sent to a contract laboratory for analysis, an OSBI report is not required. However, the requesting agency shall be notified in writing (e.g. report, letter, or memo) that the evidence was sent to a private lab for analysis. At a minimum, this written notification should include the requesting agency case number, OSBI Lab case number, a description of the evidence and/or packages sent, and the name of the laboratory the evidence was submitted to.

E. Numbering Reports

1. Reports and notifications generated in the BEAST will be assigned a sequential number by the BEAST. This number will not be modified by analysts.

2. On amended reports, the analyst will indicate below the report number, "Amended From Report X" where X is the number of the report that was amended.

3. When issuing an amended report for a report that was generated prior to the implementation of the BEAST, the analyst will indicate in the report what report was amended. If the report does not have a number, the issuing analyst and date of issue will be referenced for identification purposes.

4. Similarly, if a case has been worked both before and after the implementation of the BEAST and a duplicate report number is assigned by the BEAST, it is recommended that the analyst place a statement of explanation in the report.

F. Report Content

The format of analytical reports will include the following information. The following requirements do not apply to reports or notifications which do not contain results of analysis. This includes no-analysis reports and CODIS Database Entry Notifications.

1. All OSBI CSD analytical reports will have the title, "Criminalistics Examination Report."

2. All OSBI CSD analytical reports will include the date the report is issued.

3. The name and address of the OSBI Laboratory issuing the report will be reflected in the header of the report. If part or all of the analysis is conducted at another location, this shall be documented in the case record.

4. All OSBI CSD analytical reports will contain and be uniquely identified by the case number and a report number.

5. The name and agency and/or address of the requesting officer will be located in the report header.

6. All OSBI CSD reports will reflect the date evidence was first received by the CSD. For evidence that has left the custody of the OSBI CSD and then been resubmitted, the first date that the evidence was received back into CSD custody will be reflected in the report.

7. All OSBI CSD reports will include a description of the evidence submitted and an unambiguous identification of the items tested.

8. When available and practical, department item numbers (from the requesting agency) should be included in the report as part of the item description. This may not be required if the department item number cannot be clearly associated with an item. In addition, department item numbers are not required if a more unique and unambiguous descriptor is used (e.g. kit number, etc).

9. All current OSBI CSD reports, with the exception of no-analysis reports, shall include a signature block showing the type-written name and title of the analyst issuing the report and an electronic signature.

10. Requesting agency case numbers should be listed on the first page of the report immediately below the header. Be sure to indicate the agency number by using the initials or title of the agency with the agency case number. Agency case numbers will be reported as they have been entered into the BEAST. If the case number appears to include additional information (e.g. property receipt number), it will be reported as entered.

G. Reporting Results

Care must be taken when reporting results to ensure that the results are clear and not confusing to any lay person (attorney, DA, juror) who will ultimately read the report. The following criteria are provided as guidance to provide clear and unambiguous report language. However, the reporting Criminalist bears the ultimate responsibility for ensuring the report language accurately reflects the analysis performed in the case.

1. All results of tests or series of tests must be reflected in the report.

2. Analysis of evidence or results sections will include identification of the item tested and test results. In some circumstances, test results may encompass a series of tests performed, provided that results are consistent. For example, if presumptive and confirmatory tests are performed on the same item and both are positive, then one statement could be used to communicate the results (e.g. blood

was detected). However, if test results are not consistent (one was positive, and one negative or inconclusive) then results from both tests should be communicated in the report.

3. Where relevant, OSBI CSD reports should include a statement indicating that the reported results apply only to the items tested and that yielded the reported result. For example, if 10 tablets are received, three are tested with no CDS detected in two tablets and hydrocodone confirmed in a third tablet, report wording should be:

   Item 1: 10 white oval tablets, marked M365

   Result – Three tablets were tested. Hydrocodone was confirmed in one tablet. Two other tablets were negative for controlled substances.

4. All DNA reports will include qualitative or quantitative interpretive statements; the amplification system or loci used for analysis; and a disposition of the evidence, as applicable.

5. When associations are made, the significance of association shall be communicated clearly and properly qualified in the report.

6. When comparisons are made and result in an elimination, the elimination shall be clearly stated in the report.

7. When results are inconclusive, the report shall clearly communicate why no definitive result can be made.

H. Analytical Report Format

1. All OSBI CSD reports will be numbered to indicate the page number and total number of pages in the report.

2. OSBI CSD reports will follow proper rules of grammar and correct spelling in the Criminalistics Examination Report.

3. For DNA reports, the method of analysis used will be included in the report.

4. All Criminalistics Examination Reports will be in Times New Roman font. The preferable font is size 10 or 12. Only the certification block and any report footer should have a font size of less than 10 (with a minimum font size of 7).

5. All OSBI CSD reports will reflect the results of analysis, including units of measurement, where appropriate.

6. The signature block will be located on the right side at the bottom of the report.

7. The report certification block will be placed next to or above the signature block.

8. Opinions and interpretations reported will be appropriately identified in the report.

9. Multiple submittals should be listed in a paragraph format immediately preceding the description of those items of evidence.

10. With the exception of the Drug and Toxicology reports, the "Analysis of Evidence" should be written in semi-narrative style. Item numbers and analytical results are included under this section.

III. Attachments

None

I. Scope

Criminalists will accurately document the number of items submitted, the number of examinations performed, and the time expended analyzing items of physical evidence in each sub-case worked.

II. Procedure

A. Criminalistics statistics will be recorded by clicking the "Notes" button on the "Assignments" tab in the BEAST. Criminalists may, at their discretion, maintain a personal log book.

B. Each Criminalist who inventories and/or analyzes items in a sub-case will record the appropriate numbers in the BEAST.

C. It is the responsibility of each Criminalist to accurately record their statistics at the conclusion of the analysis.

D. Worksheets can be utilized to document the kinds and numbers of examinations made on all items of a sub-case analyzed. Worksheets will be retained in accordance with **QP 16.1** and **QP 16.2**.

E. It is acknowledged that some analytical procedures utilize reference standards, controls, or both and these shall be counted as examinations as well.

F. It is not the intent of this policy to mandate standard analytical procedures for Criminalists to follow for the analysis of specific kinds of items. However, each Criminalist shall perform sufficient analytical procedures to support the opinion rendered by the report. The following procedures are not all-inclusive. Any additional procedures to be used for statistical purposes must be approved by the appropriate Criminalistics Administrator.

G. ANALYTICAL PROCEDURES: Any of the following listed analytical procedures performed on an item will be counted as ONE examination. Items inventoried for report purposes only (no analysis cases) will not be counted as items analyzed or counted as examinations.

1. Drug analysis

    a. Any measurement to determine quantity of an item (i.e., weight, volume, count).
    b. Macroscopic or microscopic examination for a specific purpose.
    c. Reference/literature search.
    d. Spot/color test (includes Duquenois-Levine test).
    e. pH determination.
    f. Thin layer chromatography examination.

g. Wet chemistry extraction.
h. Individual instrument analysis.

2. Toxicology

a. Alcohol (Volatile) Analysis.
b. Immunoassays – Immunoassays for each individual drug assay will each be considered one examination.
c. Blood Drug Screen – Each screen for different classifications of drugs (bases, acid – neutral) will be considered one examination.
d. Quantitations for Blood Drug Concentrations – Quantitations which require separate extractions due to drug classifications will each be considered one examination.
e. Reference/literature search.

3. Forensic Biology

Forensic biology examinations will be counted using the spreadsheet "Biology_Number_of_Exams_Stats_Calculator_v1.0" which can be found on the DNA server (\\pm-fsc13000s\biology).

4. Firearms & Toolmark

a. Visual examination.
b. Determination of class characteristics.
c. Determination of individual characteristics.
d. Comparison of individual known samples to individual unknown sample.
e. Firearm function examination.
f. Reference/literature search.
g. Any distance determination procedure.
h. Chemical procedure to identify obliterated serial number.
i. Shot cup or wad examination.
j. Comparison of cutting or pry tool to individual cut or pry mark.
k. Comparison of any two individual fractured items.

5. Latent Print

a. Macroscopic examination.
b. Light source examination.
c. Image enhancement.
d. Use of any development or processing technique.
e. Electrostatic dust lifter.
f. Comparison of unknown latent impression to any known impression.
g. Casts and Photographs.

i. Visual examination for comparison suitability.
ii. Comparison to physical items for class characteristics.
iii. Comparison to physical items for individual characteristics.

6. Trace Evidence

a. Sample preparation.
b. Macroscopic or microscopic examinations for a specific purpose.
c. Specialized light examination (either macroscopic or microscopic).
d. Spot/color test.
e. Microcrystal examination.
f. Thin layer chromatography examination.
g. Melting point determination.
h. Solubility determination.
i. Density determination or comparison.
j. Refractive index determination or comparison.
k. Individual instrument analysis.
l. Reference/literature search or comparison.
m. Any physical measurement or comparison.
n. Arson
   i. Macroscopic or microscopic examination for a specific purpose.
   ii. Sample preparation or isolation.
   iii. Burn tests.
   iv. Individual instrument analysis.
   v. Reference/Literature Search.

III. Attachments

None

I. Scope

Proficiency tests will be used to monitor the quality of results provided by OSBI CSD analysts. This procedure will be used to conduct external and internal proficiency testing, including re-analysis of casework samples.

II. Procedure

A. Scheduling Proficiency Tests

Each year, the Quality Manager (QM) or designee will coordinate with Technical Managers to prepare a draft proficiency test schedule that meets the following guidelines:

1. If possible, each analyst working in a discipline containing multiple categories of testing, will be administered a proficiency test, annually, for each category of testing in which he/she performs analysis. At a minimum, each analyst and technician performing analysis shall complete a proficiency test for each category of testing in which he/she performs analysis once per five year accreditation cycle.

2. Each year, every OSBI laboratory (FSC, NERL, NWRL, SWRL, ERL) shall complete at least one external proficiency test per discipline in which they provide service.

3. When practical, a minimum of one external proficiency test should be completed per category of testing performed per laboratory. Some categories of testing, such as GSR or general Trace analysis, may be more effectively addressed through internal proficiency tests, such as re-analysis casework.

4. Each analyst and technician performing analysis shall complete one proficiency test (internal or external) per discipline in which he/she performs casework, annually.

5. Each Forensic Biologist conducting DNA analysis must complete two external proficiency tests per year. One proficiency test must be completed in the first six months of the calendar year and the second in the last six months of the calendar year. The time between tests must be at least four months, but not longer than 8 months. For calculating time periods between tests, the vendor due date will be used.

6. Forensic Biologists who are qualified for multiple DNA methods or technologies must complete proficiency tests as follows:

   a) Forensic Biologists must complete a test on each method at least once per

year. Examples of different methods are Identifiler Plus for casework, Identifiler for database samples, manual extraction or setup, automated extraction or setup, etc.

b) Forensic Biologists must complete at least two tests approximately 6 months apart for each technology they are qualified to use for casework or database samples. Examples of different technologies are STR analysis, Y-STR analysis, and mitochondrial DNA analysis.

c) Results from different technologies, but not different methods, may be reported on the same test. For example, Identifiler Plus casework results and Y-STR analysis may be reported on the same test.

B. Ordering External Proficiency Tests

1. The QM or designee will then prepare an internal purchase request to order a sufficient number of external tests as indicated by the schedule.

2. External proficiency tests will be obtained from ASCLD/LAB approved test providers, where available.

C. Assigning External Proficiency Tests

1. Upon receipt of test samples from an external provider, the QM or designee will determine which employee each test will be assigned to and what analysis the analyst will need to conduct. The QM will also retain the "Release of Data to Accreditation Bodies" form for proficiency tests from Collaborative Testing Services.

2. The QM or designee will then log the proficiency tests into the BEAST as follows:

   a) Open the BEAST receive.exe program.
   b) From the main screen click on the "New Lab Case" button.
   c) Click on the manual submission button on the screen that comes up. This icon looks like a hand on top of a piece of paper.
   d) Click OK on the screen that opens next.
   e) Enter PT as the case type, 00 as the county, and 3 as the priority.
   f) Enter the appropriate test provider in the "Department" field.
   g) Enter "Quality Manager" in the case officer field.
   h) Enter "UPS" or the most appropriate submission type in the "Submission Type" field.
   i) Enter the UPS or other tracking number from the box or package that the proficiency tests were received in. This can also be done by scanning the

barcode on the shipping label.

j) Enter the proficiency test number, including an abbreviation for the provider and the letter designator for the participant code, in the "Department Case" field.
k) Enter a name in the "Submitted By" field. For example, C.T. Services can be used as the "Submitted By" name for a CTS proficiency test.
l) Enter the date that the proficiency tests were received as the "offense date."
m) On the "Names" tab in the Quick Create screen, enter names based on the proficiency test scenario.
n) On the "Containers" tab, enter the appropriate container designator, package type, item number(s) and service request(s). Refer to **QP 5** if necessary.
o) On the "Items" tab, enter a description of what was submitted in the "Description" column.
p) Complete the case creation process by clicking the "Quick Create" button at the bottom of the screen.

3. After the case has been logged in, the QM or designee will attach the evidence barcode generated to the sample packet or container and the file folder barcode will be attached to the proficiency test data sheets.

4. Next, the QM or designees will assign the proficiency test "case" to the appropriate analyst.

   a) From the main BEAST screen, click on the "Assignments" button at the top of the screen.
   b) Use the search tab to bring up the list of recently created proficiency test cases. This can be done by searching on a Case Type of "PT" or a Priority of "3."
   c) From the list of cases that comes up, highlight the appropriate case and click on the "Assign" button in the lower left corner.
   d) Select the appropriate analyst, priority, and status.
   e) Enter in the "Comments" field when the test must be returned to the QM and, if necessary, any specific analysis instructions and click "OK."
   f) Repeat this process until all proficiency tests are assigned.

5. Once all proficiency tests have been logged in and labeled with barcodes, the QM or designee will scan the barcodes for the case files to the FSC File Room location. The data sheets will be provided to the appropriate analyst and no further custody transactions will be tracked for the data sheets.

6. The sample packs will be transferred to the custody of the appropriate analyst or transferred to/routed to the appropriate property room location.

D. Preparing Internal Proficiency Tests

Internal proficiency tests may consist of re-usable, expired external proficiency tests, external proficiency tests which can be analyzed multiple times, internally prepared proficiency tests, or re-analysis casework.

1. Internal proficiency tests may be prepared from re-used external proficiency tests by following these steps:

   a) The samples will first be packaged in a fashion which precludes associating the samples with the original manufacturer test number.
   b) The samples will be assigned a proficiency test number in the following format IPT-QM-YY-NNN, where YY is a two digit representation of the year the proficiency test will be assigned, and NNN is a chronological number assigned to the test.
   c) The test number and the expected results associated with the test must be recorded.

2. An external proficiency test may be assigned to one or more analyst(s) as an internal proficiency test when the test samples lend themselves to multiple examinations (e.g. comparison of latent print images ordered on a DVD). In these situations, the test will be assigned in the same fashion as an external proficiency test and must be completed prior to the release of the manufacturer's results. The department case number for an external test that will not be submitted to the manufacturer will include a suffix with "IPT" and a letter to designate the participant. (e.g. CTS11-518-IPT-A)

3. Internal proficiency tests prepared "from scratch" in-house will be prepared by the appropriate Technical Manager or designee using the following guidelines:

   a) The composition of the proficiency test will be determined based on the type of procedure and samples tested.
   b) All proficiency tests should be prepared using samples, materials, and methods that ensure the uniformity, integrity, and identity of the proficiency testing samples.
   c) Duplicate testing samples should be prepared and retained when possible. Alternately, test samples should be prepared in a fashion that will facilitate re-testing, in the event of a potential discrepancy.
   d) Proficiency test samples that use comparisons or produce qualitative results should be prepared in such a way that they contain sufficient class/individual characteristics for meaningful analysis and comparison.
   e) For those proficiency tests that evaluate procedures which produce quantitative results, samples should contain an amount of testing material sufficient to enable a conclusion to be drawn from the results of the analysis.

f) Proficiency tests should include appropriate controls among the samples submitted, where appropriate or necessary. Standard reference materials may be used as part of the control system if available for a particular examination.
g) Each set of proficiency samples must be labeled with a test set identifier using the format IPT-TMD-YY-NNN, where TMD is a designator for the discipline or the individual preparing the test (e.g. CDS, TM's initials, etc.), YY is a two digit abbreviation of the year the test will be assigned/created, and NNN is a chronological number assigned to the test.
h) After analysis, any remaining portion of each proficiency test sample will be returned to the QM or designee for possible reassignment and/or re-analysis and comparison if circumstances dictate.

4. Cases may be selected for re-analysis at the discretion of the Technical Manager, following the guidelines set forth in section II.J, below.

E. Assigning Internal Proficiency Tests

1. Re-used external proficiency tests will be assigned by the QM or designee, using the procedure outlined in section II.C, with the following exceptions:

   a) II.C.2.f - In the department field, enter IPT to indicate the case is an internal proficiency test.
   b) II.C.2.h and i – For the submission method, choose hand delivered no signature.
   c) II.C.2.j – Enter the internal proficiency test case number.
   d) II.C.3 – The barcode for the case file may be placed on a hard copy of the RFLE and routed to the appropriate analyst.

2. Internal proficiency tests created in-house will be assigned by the appropriate TM or designee, using the procedure outlined in section II.C, with the same exceptions listed in II.E.1. TM's or a designee must provide the QM a record of the test number, method of preparation, and the expected results at the time the test is assigned to an analyst.

F. Analysis of Proficiency Tests

1. Proficiency tests will be analyzed using the same analytical protocols as casework. This includes all verifications and administrative and technical reviews required by current OSBI policy.

2. All proficiency tests will be handled in compliance with the OSBI CSD QM and QP's. This includes policies regarding itemization and evidence handling.

3. Proficiency tests will be analyzed to the full capability of the analyst assigned. Each analyst will conduct all appropriate examinations for which he/she is qualified

based on the case information provided with the test.

4. The same examination documentation generated during testing will be generated during the analysis of proficiency tests.

5. Results of proficiency tests will be reported to the QM in an OSBI report or according to the normal protocol documentation for any discipline which does not issue a standard OSBI report (e.g. database units).

6. External proficiency test data sheets will be completed by the analyst in their entirety. This includes any section which requires the analyst to list a narrative statement of how their conclusions would be reported. It is not acceptable to put "See Attached Report," since only the data sheets are submitted to the vendor.

7. Upon completion of the proficiency test, the analyst will turn in all hard copy documentation to the QM.

8. If all proficiency test documentation is electronic, the analyst will e-mail the QM to notify him/her that the test is complete.

9. Remaining samples will also be returned to the QM, or they may be archived according to the unit's standard procedures for database proficiency samples. When multiple analysts in the same lab or unit have participated in the same proficiency test, all sample packets from the unit/lab should be returned at one time to the QM.

G. Review of Proficiency Tests

Proficiency tests will be reviewed to determine if they have been successfully completed. Proficiency tests are considered successfully completed under two sets of circumstances. First, tests are successful when the results obtained are consistent with the expected, manufacturer's, and/or consensus results. However, in some circumstances, results do not match the expected results. This can indicate that improvements may need to be made to the quality system, such as improved procedures/instrumentation, clarified protocols, or more thorough training programs. After laboratory policies are followed and any necessary corrective action is successfully completed, then the proficiency test that may have yielded discrepant results may be considered successfully completed. The following steps will be used as a guide for reviewing proficiency tests and routing for corrective action when necessary.

1. Upon receipt of a completed test, the QM will review the following documentation to determine if the expected results were obtained.

    a. External tests – manufacturer's results and consensus results (once received)

b. Re-used external tests – manufacturer's results and consensus results
c. Internal tests created in-house – expected results provided by TM
d. Re-analysis cases – memo from TM indicating whether second results were consistent with original analysis.

2. Provided that results are consistent, the QM will mark the results page/memo as satisfactory, initial and date the page and forward the page to the analyst, any other participants, and the TM (if necessary) for notification. Each individual will initial or sign and date the page to document his/her notification and return the page to the QM for archival.

3. The QM will ensure any test with discrepant results is routed for corrective action as needed. This may include forwarding the test to the appropriate QIC sub-committee or a designee for a more detailed review. Potentially non-conforming work will be evaluated according to **QP 13**.

4. When necessary or practical, notifications of analysts or TM's may be done via e-mail or an alternate method, provided that adequate documentation is maintained to demonstrate that the notification has been received.

H. Review of DNA Proficiency Tests

It is the responsibility of the Biology TM to evaluate DNA proficiency tests in accordance with the current revision of the Quality Assurance Standards (QAS) for DNA Testing or Database Laboratories. This includes grading the analyst's performance on the test as satisfactory or unsatisfactory based on a review of the electropherograms and the analyst's compliance with current OSBI interpretation guidelines. The procedure below provides a guide for facilitating this review.

1. For DNA proficiency tests, the QM will route the results page(s) to the Biology TM and the following information will be noted by the TM:

   a. Are results satisfactory or unsatisfactory?
   b. Are all reported inclusions correct (if applicable)?
   c. Are all reported exclusions correct (if applicable)?
   d. Are all reported genotypes and/or phenotypes correct or incorrect according to consensus results or within the laboratory's interpretation guidelines?
   e. Are results reported as inconclusive or not interpretable consistent with written laboratory guidelines?

2. For any DNA proficiency test identified with non-administrative discrepancies that affect the typing results and/or conclusions, the TM will inform the appropriate CODIS Administrator at the time of discovery. The CODIS Administrator will sign/initial and date the pages to indicate he/she has been notified.

3. The TM will sign/initial and date the page(s) and then forward them to the appropriate analyst and any other participant for him/her to sign/initial and date to indicate he/she received notification of test results.

4. The Biology TM and QM will work together to ensure any DNA test with discrepant results is routed for corrective action as needed. This may include forwarding the test to the Biology sub-committee or a designee for a more detailed review. Potentially non-conforming work will be evaluated according to **QP 13**.

5. When necessary or practical, notifications of analysts, other participants, TM's, or the CODIS Administrator may be done via e-mail or an alternate method, provided that adequate documentation is maintained to demonstrate that the notification has been received.

I. Documentation of Proficiency Tests

The following documentation should be maintained for each test completed:

1. Test set identifier
2. How the samples were obtained (test provider for external) or created
3. Identity of analyst and other participant(s), if applicable
4. Date of analysis
5. Date of completion
6. All data sheets, notes, and work products (scans, electropherograms, etc.)
7. Report of results
8. Provider's proficiency test evaluation, for external tests
9. Review of any discrepancies noted, if applicable
10. Notice to the analyst/participant of the proficiency test results and review
11. Notification to TM of results and review, for DNA proficiency tests
12. Notice of any deficiencies and corrective action (if needed)

J. Re-examination

Re-examination casework may be assigned to meet an internal proficiency test requirement or as an additional quality control measure, at the discretion of the TM. The guide for re-examination cases is as follows:

1. Re-examination cases will be selected and issued by the TM of each discipline. Re-examination cases may be selected from evidence already authorized for destruction, if appropriate.

2. If possible and practical, the original analytical results will be unknown to the second analyst.
3. Re-examination results will be reported in the same fashion as original analysis

with the following exceptions:

a) Provided that the re-examination results are consistent with the original results, the report header will be edited to reflect that it is reported to "case file" instead of a requesting agency or district attorney's office.
b) A statement or footer will be placed on the report indicating that the results reported were generated from a re-examination of the evidence conducted as part of a routine OSBI quality control process.

4. Upon completion of the re-examination, the re-examining analyst will provide his/her results to the TM for review **prior to approving his/her report of analysis**.

5. Once completed, all documentation of the re-analysis will be placed in the original case file.

6. The Technical Manager will issue a memo stating the case number, analysts involved in retesting, whether the test was assigned as an internal proficiency test or additional QC, and a summary of results indicating whether results were concordant or discrepant to the QM.

7. Inconsistent results will be evaluated as non-conforming work according to **QP 13**.

8. The QM will retain re-examination documentation memos.

III. Attachments

None

I. Scope

All case record documentation is subject to review. Review assists in ensuring the quality of the work product. Two types of review will be used: administrative review and technical review.

II. Procedure

A. General

1. The review process does not shift responsibility for an analyst's findings to the reviewer. Each Criminalist has the ultimate responsibility for their casework.

2. Prior to submitting case files for administrative or technical review, each criminalist will thoroughly review his/her own reports and case records. Upon completion of this review the analyst will click on the "Sign" button on the right side of the assignments window. This will lock the report and documentation in the BEAST and prevent unintentional changes.

3. Administrative and technical reviews may be done consecutively in either order (AR-TR or TR-AR) or concurrently (at the same time).

4. Additional administrative or technical reviews (above the minimum required by policy) may be done as necessary or desired by CSD Management.

5. Cases requiring correction will be routed in the BEAST to the appropriate analyst for correction. When routing cases for correction, the reviewer must include an explanation in the comments field describing what must be corrected. **Changes made during or after the review process must be recorded.**

B. Technical Review

Technical reviews will be performed according to the procedure below to ensure that reported conclusions are correct and reasonable, in accordance with validated scientific knowledge, and supported by the examination documentation in the case record.

1. Qualifications of Technical Reviewers:

   An individual performing technical reviews must meet the following requirements:

   a. He/she must be a qualified individual who is not the author or co-author of the report **or examination records** being reviewed.

   b. He/she must have received authorization from the discipline Technical Manager (TM) to conduct the technical review based on experience gained through training **and casework experience** in the category of testing he/she is reviewing.

Analysts may not be authorized to perform technical reviews until they have performed some casework in the category of testing being reviewed.

c. He/she must have knowledge of the discipline protocols/quality manual applicable to the case he/she is reviewing.

2. Scope of Technical Reviews:

A technical review is a thorough review of the entire case file/record including the Criminalistics Examination Report. Verifications of latent evidence identifications and firearms/toolmarks identifications do not constitute a technical review.

Technical reviews are not required for reports which do not contain the components described in section II.B.3 below (e.g. analytical results, conclusions, associations, etc). Some examples of reports which may not contain these elements include CODIS Database Entry notifications and amended reports, if the correction made does not impact the results, conclusions, or associations of the original report.

For technical reviews, a legible photocopy or fax of the entire file, including the signed report, are to be sent for review only when the original case file cannot be examined on site. **ORIGINAL CASE FILES WILL NOT BE MAILED.**

3. Parameters for Technical Review Process:

Discipline protocols and/or quality manuals may describe more specific portions of examination records which must be checked to complete a technical review. However, any discipline specific review procedures must include a verification of the following, at a minimum:

a. compliance with all applicable sections of the discipline quality manual and protocols and CSD policies and procedures;
b. accuracy of the report and that all reported results and/or conclusions are supported by the data in the case record;
c. any associations are properly qualified in the report;
d. report contains all information required by discipline quality manual and protocols.

4. Documenting Technical Reviews:

Technical reviews will be documented using one of the following methods:

a. Using the BEAST to complete the following steps:

i. click on the “Tech Rev” button from the assignments tab
ii. complete the checklist in the window that opens (if applicable)

iii. click the "Tech Rev" button in the lower right corner
iv. enter your password and click "yes"

b. Completing a hard copy version of the checklist and signing and dating the hard copy. Hard copy technical review forms will be obtained by accessing the "Reports" button from the main BEAST screen. Run the "TECH_REVIEW: Hardcopy Tech Review form" report and print the discipline appropriate form. The hard copy must then be placed in the case file or scanned and saved to the image vault in the BEAST. This method should only be used for documenting additional technical reviews or if technical difficulties with the BEAST necessitate an alternate method.

5. Handling Technical Review Discrepancies

If an analyst and technical reviewer disagree whether a report and case file meets the criteria listed in section II.B.3, the following steps will be taken to resolve the discrepancy or disagreement.

a. The analyst and the technical reviewer will discuss the issue and attempt to resolve the issue together.

b. If the criminalists cannot resolve the issue together, they will seek input from the appropriate Supervisor(s) and/or the Technical Manager.

c. Any disagreements which cannot be resolved by the Supervisor and/or Technical Manager will be brought to the attention of the Criminalist Administrator assigned to that discipline for further evaluation.

Any non-conforming work identified during review will be handled according to **QP 13**.

6. Frequency of Technical Reviews:

a. All case files of Criminalist I's will be technically reviewed until the Technical Manager of the discipline feels that the Criminalist is fully competent and no longer requires 100 percent technical review. The Technical Manager of the discipline determines the level (within policy) of technical review for employees within their discipline.

b. The minimum level of technical review for all Criminalists will be at least six cases per month or 20 percent of the cases worked per month, whichever is less.

c. The Technical Manager of each discipline will determine the number or percentage of cases and the types of cases which must be technically reviewed.

d. The Technical Manager of the discipline is responsible for designing a system to monitor the number of cases technically reviewed ensuring that the minimum number specified are reviewed.

C. Administrative Review

1. All OSBI case files, with the exception of BEAST generated no analysis reports, will be administratively reviewed by an individual other than the reporting analyst in accordance with the following procedure, prior to being released to an outside agency.

   a. Administrative reviews may be performed by any casework qualified analyst or supervisor. A casework qualified analyst or supervisor may conduct administrative reviews for any discipline, not just the discipline for which he/she is qualified to perform casework.

   b. Administrative reviews may also be performed by a properly trained laboratory analyst or laboratory technician. Administrative review training for these employees must include a review of QP 31 and the discipline specific case documentation which they will be responsible for reviewing. The appropriate supervisor and/or technical manager will be responsible for documenting the training completed and the date that the individual has been approved to conduct administrative reviews.

2. Administrative reviews will include the following:

   a. a review of the report(s) for spelling and grammatical accuracy;

   b. a review of all administrative and examination records to ensure they are labeled with the case number and initials of the appropriate individual(s) and/or any alternate or additional identification required by discipline or laboratory policy/procedure;

   c. a review of the report to ensure that all key information required by **QP 28** is included;

   d. a review of the evidence described in the report compared to the evidence described on the original RFLE and/or submission paperwork;

   e. a review of the report (for DNA reports) to ensure that it includes a description of the technology and loci or amplification system used and a disposition of the evidence.

3. Documentation of administrative review will be done by one of the following

methods:

a. Completion of the technical review documentation process for an AR/TR conducted concurrently. It must be documented in the discipline procedure or checklist that the review includes both administrative and technical review.

b. Completion of a similar BEAST method developed for a specific discipline with the LIMS Administrator's assistance/guidance which has been written into the discipline quality manual or protocol.

c. Completion of a hard copy or electronic version of **OSBI CSD QPA 31.1**. A hard copy should be signed and dated by the reviewer and placed in the case file or scanned and saved to the image vault in the BEAST. Alternately, if the form will be placed in the image vault in the BEAST by the reviewer, it may be completed electronically with the analyst's typed name and date.

III. Attachments

OSBI CSD QPA 31.1, Rev. 1

I. Scope

Each OSBI CSD employee will use this procedure to actively solicit feedback regarding testimony he/she provides.

II. Procedure

A. Procedures for Using the Witness Critique Form

1. Whenever possible, testifying employees shall give a Witness Critique Form (**OSBI CSD QPA 32.1**) to judges, prosecutors, defense attorneys, and other persons in a position to evaluate their testimony. Employees will actively encourage them to objectively complete the form and mail it to the OSBI CSD Quality Manager (QM). Employees may directly accept a completed form to return to the QM.

2. Supervisors and peers will use the Witness Critique Form when observing and evaluating the testimony of laboratory employees.

3. The QM will document all Witness Critique Forms received and forward them to the immediate supervisor of the evaluated employee.

4. The supervisor shall review each evaluation with the employee. Strengths and deficiencies will be noted and discussed, and recommendations for improvements may be made. Both the supervisor and employee will sign the form after the review and discussion. The supervisor shall then ensure that an imaged copy of the signed review form is placed in the employee's training file located on the quality server in the following directory: \\pm-fsc13000s\qa\Individual_Records.

5. The QM will maintain a spreadsheet summarizing all completed Witness Critique Forms. The spreadsheet will track who has been evaluated and the numerical rating. The QM may provide access to the spreadsheet to supervisors and administrators as necessary and appropriate.

6. The completed Witness Critique Forms and summaries may be used for annual performance evaluations.

7. Supervisors shall ensure that all their testifying employees are evaluated with a Witness Critique Form at least once each calendar year.

8. Supervisors are strongly encouraged to personally observe the testimony of each of their testifying employees. Once a year is recommended. More frequent intervals are encouraged for less experienced personnel. It is desirable that employees testifying for the first time be observed by their supervisor or a senior peer.

B. Other Methods of Monitoring and Evaluating Employee Testimony

1. It is recommended that supervisors periodically read the transcripts of testimony given by their employees when such transcripts are readily available, and discuss the testimony with the employee.

2. It is recommended that supervisors periodically telephone or personally contact one or more officers of the court to solicit feedback on the testimony of their employees. The information obtained should be recorded on the Witness Critique Form, discussed with the employee, and forwarded to the QM.

C. Corrective Action

When the rating received on a witness critique form is less than satisfactory (average score less than 2 and/or any individual rating of 0), the Supervisor will coordinate with the Technical Manager to review the circumstances of the testimony to determine whether the analyst needs additional training. The supervisor will document the review in the appropriate section of **QPA 32.1**.

In the event that it is determined that erroneous or misleading testimony was provided, the Supervisor of the testifying employee will follow **QP 13** to evaluate the non-conforming work.

III. Attachments

OSBI CSD QPA 32.1, Rev. 1 Witness Critique Form

I. Scope

Laboratory analysis reports and other information concerning OSBI CSD work product are made confidential by State Statutes. Case information may only be provided as allowed by law.

II. Procedure

A. Persons or Agencies Authorized to Receive OSBI Analytical Reports

1. Title 74 O.S., § 150.2, paragraph 1 states the OSBI shall "maintain a nationally accredited scientific laboratory to assist all law enforcement agencies in the discovery and detection of criminal activity."

2. Title 74, O.S., § 150.5(D) states: "all records relating to any investigation being conducted by the Bureau, including any records of laboratory services provided to law enforcement agencies pursuant to paragraph 1 Section 150.2 of this title, shall be confidential and shall not be open to the public…." and "the person or entity authorized to initiate investigations (laboratory services) in this section shall receive a report of the results of the requested investigation." Therefore, a copy of an OSBI laboratory analysis report can be provided to the following requestors of forensic laboratory services:

   a) Governor
   b) Attorney General
   c) Council on Judicial Complaints
   d) A Legislative Committee with Subpoena Powers
   e) Chief Medical Examiner
   f) Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control
   g) Law Enforcement Agency or Officer
   h) District Attorney

3. Title 74, O.S., § 150.5(D) further states: "The person or entity requesting the investigation (forensic laboratory services) may give that information only to the appropriate prosecutorial officer or agency having statutory authority in the matter..." therefore, the requestor of forensic laboratory services may provide, or authorize the OSBI Laboratory to provide, a copy of a laboratory analysis report to a prosecutor or prosecutorial agency with jurisdiction in the case.

4. Title 74, O.S., § 150.5(D) also states "officers and agents of the Bureau may disclose, at the discretion of the Director, such investigative information (laboratory analysis reports) to officers and agents of federal, state, county, or municipal law enforcement agencies and to district attorneys, in the furtherance of criminal investigations within their respective jurisdictions." The OSBI Director has given

authority over laboratory report dissemination to the CSD Director. Unless specifically requested not to by the submitting agency, the CSD Director has authorized that prosecuting attorney offices with jurisdiction may always receive copies of laboratory analysis reports.

5. Regarding the provision of laboratory reports and information to OSBI Investigative Division personnel, authority is provided in two areas. First, intra-agency sharing of forensic laboratory and criminal investigative information in furtherance of criminal investigations or prosecutions is not prohibited by the confidentiality statute, and is desirable and beneficial. Second, the state statute provides for, at the discretion of the Director, the disclosure of records of laboratory services to officers and agents of state law enforcement agencies in the furtherance of criminal investigations within their respective jurisdictions. The person granting the information will document all requests and disseminations in the respective laboratory case file as to the information provided.

B. Criminalistics Analysis Report Dissemination

1. The appropriate number of reports will be made and distributed as follows:

   a) A minimum of one signed report should be issued to the prosecuting authority having jurisdiction and/or the requesting agency. In some circumstances it may be appropriate to send a report to the requesting agency only. For example, some case types such as property crimes where no suspect has been identified do not need to be distributed to the prosecuting authority.

   b) No hard copy report needs to be distributed if the receiving agencies have already been issued access to the reports on-line. The list of agencies which don't require hard copy reports will be issued at the discretion of the LIMS administrator.

   c) An electronic copy of each report prepared using the BEAST Laboratory Information Management System (LIMS) will be maintained in the BEAST.

   d) Reports will not be distributed via e-mail without the express permission of the CSD Director.

   e) When reports or other case related information containing confidential information are disseminated by fax, they shall be sent using **CSD QPA 33.1** as a fax cover sheet so that a notice of confidentiality is included with the fax transmission.

2. One copy of the report can be retained with the evidence.

3. The only exception to the above is in a situation noted on the RFLE limiting report distribution at the request of the submitting officer, or with the permission of the

appropriate Criminalistics Administrator or CSD Director.

C. Inquiries Concerning Case Related Information

1. Occasionally, calls are received requesting information on laboratory cases from the news media, family members, and others.

   a) All calls from the news media will be routed through the Oklahoma State Bureau of Investigation Public Information Office.

   b) Other calls from families, friends or others interested in information concerning a CSD case should be directed to the original submitting agency in the case.

   c) The CSD Director must approve any exceptions to the release of case information.

2. Discovery orders will be handled as per OSBI Policy 226.

III. Attachments

OSBI CSD QPA 33.1, Rev. 0

Rev. #	Effective Date	History
0	10-4-11	Original issue. Combined past QM and QP's into one document with single history and approval. Replaces QM Rev 3, QP 1 Rev 3, QP 2 Rev 1, QP 3 Rev 2, QP 4 Rev 1, QP 5 Rev 4, QP 6 Rev 4, QP 7 Rev 4, QP 8 Rev 3, QP 9 Rev 1, QP 10 Rev 1, QP 11 Rev 3, QP 12 Rev 3, QP 14 Rev 4, QP 15 Rev 2, QP 16.1 Rev 2, QP 16.2 Rev 1, QP 17 Rev 1, QP 18 Rev 1, QP 19 Rev 1, QP 20 Rev 2, QP 21 Rev 1, QP 22 Rev 1, QP 23 Rev 0, QP 24 Rev 2, QP 25 Rev 1, QP 26 Rev 1, QP 28 Rev 2, QP 30 Rev 3, QP 31 Rev 2, QP 32 Rev 1, and QP 33 Rev 1. QM updates- Added organizational chart back as OSBI CSD QMA 1, Rev 1. Updated 4.1.5.e,f,i, and 4.1.7 to reference QMA 1. Added 2nd sentence to 4.5. QP 1 – Revised section II.A.2.a,b,c to match administrative re-organization. QP 5 – Revised section II.A and II.F to require RFLE. Revised section II.C.1 re: documentation of unloaded firearms. Revised section II.D.1 & II.D.4 for clarification. Added RFLE as OSBI CSD QPA 5.1. Added "or other identifying mark" to section II.B.2. QP 6 – Renamed as QP 6.1. Added section II.B.5.c to clarify when evidence has been subdivided. Added language to section II.F.4 and 5 regarding proper storage of evidence (toxicology samples and DNA extracts). QP 6.2 – Inserted new policy re: using evidence for non casework purposes (e.g. training, research, validations, etc). Added notice to customers as QPA 6.2.1. QP 7 – Incorporated deviation into section II.B. QP 8 – Added section II.E. 2 to clarify that reagents/supplies are continually evaluated through controls/standards. QP 10 – Incorporated deviation (deletion of 2nd portion of II.E.1). QP 11 – Updated QPA 11.1 (Rev. 4) to new contact person for complaints. QP 16.2 – Revised section II.C.1 to clarify police reports are not required to be retained. QP 18 – Minor grammatical changes to clarify subcommittee assignments. QP 19 – Revised section II.D.1 to reflect storage of training records on QA server. Added section II.F.6 and training evaluation form (OSBI CSD QPA 19.1). QP 21 – Split into QP 21.1 (Research) and QP 21.1 (Validations).

		QP 27 – Inserted Operations Policy 400, Rev 3. Revised to match current practices. Added crime scene memo as QPA 27.1. QP 28 – Added II.A.4.d to prompt return of evidence for no-analysis cases. Revised section II.B.1 and II.C to clarify different requirements for analytical and no-analysis reports and CODIS notifications. Corrected typo in II.C.14. Added "Analytical to header of II.D. Added "and any report footer" to II.D.4. QP 29 – Inserted Operations Policy 600 Rev 1. Major revision to incorporate use of BEAST and match current testing methods. QP 30 – Added language to II.D. and II.D.2 to clarify that external proficiency tests may be assigned to multiple analysts with subsequent analysts' tests considered as internal. Inserted sections II.F.2 and II.F.4. Major revision to section II.J. QP 31 – Added 2nd paragraph in II.B.2. Added language to II.C.1 re: who can conduct AR's and appropriate training. QP 32 – Deleted "the original or" from last sentence in II.A.4. Replaced "will" with "may" in 1st sentence of II.A.6. QP 33 – Revised section II.B to better match current report distribution practices.
1	12-28-12	QM Updates – Incorporated deviation to glossary (replaced definition of critical reagent with new definition for critical consumable, supply, and service); Updated org chart to QMA 1 Rev 2; made minor grammatical changes to QMA 3 (now rev 4); deleted controlled substance quantitations and trigger pull analysis from QMA 4 (now rev 2). QP 1 – Updated CA responsibilities (II.A.2); added responsibilities of LIMS Administrator (II.A.3); revised responsibilities for APO over evidence (II.A.4); added responsibilities for FSC Facilities Manager and Safety Coordinator (II.A.5 and II.A.6); revised language of II.A.7 to identify Biology, Drug, and Trace TM's through org chart; Moved II.B.2.c to II.B.3. QP 2 – Added location for archiving controlled documents to II.E; deleted "or designation" from 1 in both lists in II.F; revised last sentence of II.G.2 to remove option to document protocol/policy review in quarterly memo. QP 5 – Added II.A.3; revised language in II.C.1 to clarify responsibilities for documenting unloaded status of weapons; deleted II.D.7.b (changing value in "Qty" column for blood alcohol kits). QP 6.1 – Incorporated deviation changing "should" to "must" in II.F.5.

QP 6-3 – All new language. Policy added to detail requirements for evidence room inventories and conducting custody inquiries on a regular basis.
QP 6.4 – All new language. Policy replaces protocol PET 01. All CSD employees must follow QP 6.4 for monitoring temperatures of refrigerators and freezers used to store evidence.
QP 7 – Added note at top of section II; added II.2.b.vi; added "the agency receiving the evidence and" to II.C.2.c; deleted "the FSC Evidence Unit Supervisor or" from II.C.3.f; deleted "with the exception of pharmaceutical items" from 1st sentence under II.D; revised II.D.5 to show CA over evidence responsible for coordinating drug destruction.
QP 8 – Inserted language regarding labeling kits (II.C.2); revised language in II.F.3 thru II.F.6 to incorporate deviation removing chem. formulation worksheet; removed QPA 8.1.
QP 11 – Incorporated deviation revising point of contact for lab surveys (QPA 11.1 updated to revision 5).
QP 12 – Updated language in II.A regarding responsibilities for handling complaints; changed language throughout to reflect QM or designee in place of CA responsible for tracking complaints.
QP 13 – Incorporated deviation changing "will" to "may" in last sentence of II.B.3; changed II.C and following sections to move procedures for simple corrections to QP 14.1 and non-conforming results to QP 14.3.
QP 14.1 – New section number – language inserted from QP 13.
QP 14.2 – New section number – language originated from QP 14 in last revision; added sentences 2-4 of first paragraph under II.B; changed corrective action form number to 14.2.1 rev 0.
QP 14.3 – New section number – language originated from QP 13; minor grammatical changes; changed form number to 14.3.1 rev 0 (was 13.1).
QP 16.1 – Revised II.E.3 to reference compliance with administrative rules; removed option in II.F.2 to dispose of instrument scans.
QP 16.2 – Incorporated deviation by adding second sentence to II.A.2.a.iv.
QP 17 – Added "or e-mail" to II.C.2; revised line inspection form (rev 2) to remove questions regarding updated policy manuals and conducting case reconciliation.
QP 18 – Incorporated deviation regarding schedule of management review, use of discussion points and action items, and required QIC agenda items; made minor changes to update subcommittee membership/structures.
QP 19 – Changed "should" to "must" in II.A.5.

		QP 21.2 – Incorporated deviation regarding routing validation plans for review and approval (II.A.2); incorporated deviation regarding review of draft protocol (II.B.3). QP 22 – Added sentences 2 thru 4 to scope to require compliance with current ASCLD/LAB policy and clarify UOM not reported if ASCLD/LAB policy is suspended/rescinded; added "or designee" to II.B.5 thru II.B.7, II.C.1, and II.D.3. QP 24 – Added "or designee" to II.A.3. QP 27 – Added last sentence to scope; changed "Trace" to Latent Evidence" in II.A.2.b; Changed routing of crime scene memo to CSD Director and LIMS administrator (II.B.2.a); updated form to rev 1 to reflect change in routing. QP 28 – Incorporated deviation regarding not changing lab name/address in report header (II.A.1.d); inserted language in II.C.8 regarding department item numbers. QP 29 – Replaced forensic biology stats guidelines with requirement to use discipline developed spreadsheet for counting exams (II.G.3). QP 30 – Inserted "or designee" in II.D.3; replaced Technical Manager with "the individual preparing the test" in II.D.3.g; inserted "method of preparation" in 2nd sentence of II.E.2; inserted intro paragraphs under II.G and II.H; revised language in II.G.3 and II.H.4. QP 31 – Inserted "in the BEAST" in II.A.5. QP 32 – Revised II.A.4 thru II.A.6 to match current practice for documenting and retaining records of witness reviews; revised last sentence of II.C to reference QP 13 only. QP 33 – Incorporated deviation limiting e-mailing of reports (II.B.1.d)
2	12-31-13	QMA 1 (org chart) updated to revision 4. QMA 5 (list of alternate service providers) updated to rev. 3 - added more service providers. QM Section 2 – Added references to ASCLD/LAB policies on Measurement Uncertainty and Traceability. Updated link to ASCLD/LAB Guiding Principles. QM Section 5.2.5 – Added reference to QP 19 for guidance on issuing Authorizations to Work (ATW). QM Section 5.2.7 – Inserted reference and link to Oklahoma Department of Libraries. QM Section 5.5.9 – Changed "outside of the laboratory" to "outside the direct control of the CSD" and added reference to QP 21.1. QM Section 5.7 – Removed references regarding quantitation of controlled substances samples.

QM Section 5.8.4.6 Moved requirements for procedures governing use of individual characteristic databases (ICD) to subsections 5.8.4.6.1 through 5.8.4.6.3 and added section 5.8.4.6.4 to delegate authority for approving access to ICD's.
QM Section 5.10.1 – Added language to require evidence collection be reported when it is not already part of a reported result. Added last sentence referencing QP 28.
QP 1 – Revised II.A.6 to indicate Safety Coordinator will be identified on org chart. Revised II.A.7 to indicate TM's will be identified on org chart. Added II.A.7.a, II.A.7.h, and II.A.7.i as TM responsibilities. Deleted sentence from II.A.8.g requiring supervisors to monitor administrative reviews. Added "laboratory analyst" to II.A.11.
QP 2 – Added "training manuals, quality manuals, major deviations" to II.A. 1. Added statement requiring archival of policy notifications to II.D. Section II.E revised to establish procedure for consistent storing/archival of controlled documents. Inserted section II.G (II.G.5 came from QP 21.2) and II.I.
QP 5 – Added reference to QMA 5 in section II.A.1. Major revision of section II.D to provide better instruction for data entry of evidence intake. Removed II.D.12 regarding recording OBN seal numbers. Inserted II.D.8 and updated QPA 5.1 to revision 2 to incorporate changes made by deviation to the RFLE and to add a line for officers to provide a court date if it is known upon submission, added check box for previous evidence submittals, re-ordered columns in names tables to match BEAST fields, modified check boxes for submission of reference samples.
QP 6.1 – Added language re: noting discrepancies in evidence inventories to II.A.2. Added II.E.1.a.
QP 6.3 – Incorporated deviation in section II.E that custody inquiries are not required if no evidence transactions have been conducted during the applicable time period.
QP 7 – Modified language of II.B.2.c.i to allow taping transfer forms to buckets. Added sentence regarding dog drugs to II.D. Corrected reference in II.D.3 to refer to QP 5 section II.F. Added reference to Physical Evidence Technician Training Manual to II.D.6.
QP 14.1 – Revised to shift primary responsibility for simple corrections to TM's.
QP 14.2 Revised method for initiating and routing CAR's. Initial review by TM then QM responsible for assigning designees to complete CAR. Added 1st paragraph to II.G to

ensure supervisors and TM's are notified even if not assigned to complete part of the CAR.
QP 14.3 – Revised to have QM notified of NCR and then QM will assign designees to complete various portions of the NCR report. Added 1st paragraph to II.D to ensure supervisors and TM's are notified.
QP 16.2 – Inserted sections II.B.4 and II.B.5.
QP 17 – Added 2nd sentence to II.B.6.b. Changed II.B.8 to include TM's for audit responses and to require audit response be sent to QM instead of CSD Director. Changed II.C to give responsibility for closing audits back to QM. Modified section II.F to require line inspections annually by November 30th and removed reference to conducting line inspections ~6 months after audit. Revised QPA 17.1 to revision 3 which shortened checklist to 1 page.
QP 18 – Minor changes made to include new TM positions on QIC subcommittees. Changed II.B.3 to require quarterly meeting of subcommittees.
QP 19 – Re-ordered sections. Revised II.D.5 to reference ATW memo. Added section II.E re: competency evaluations. Revised section II.F to include more language on re-training due to transfers back and forth between disciplines. Added II.F.4. Added II.G for ATW's.
QP 20 – Inserted "file rooms" to II.A.1. Removed requirement for CSD Director's approval in II.C.1 and II.D.1.
QP 21.1 – Revised to provide better guidance of Research Committee role and include additional requirements for research plans. Modified budget requirements in section II.B to match the financial impact requirements of QP 21.2.
QP 21.2 – Moved list of recommended info for protocols from section II.B.3 to QP 2 section II.G.5.
QP 22 – Revised to incorporate info from ASCLD/LAB Policy on Measurement Uncertainty.
QP 23 – Revised to incorporate info from ASCLD/LAB Policy on Traceability.
QP 24 – Revised section II.B.1 to include guidance from ASCLD/LAB Policy on Traceability.
QP 25 – Revised section II.A to incorporate guidance from ASCLD/LAB Policy on Traceability.
QP 26 – Inserted II.A.1, II.A.2, and II.A.8. Combined what was II.B.1 and II.B.2 into first sentence under II.B. Added second sentence under II.B.
QP 27 – Revised QPA 27.1 to revision 2, adding a check box for use of controls at the scene.

		QP 28 – Re-structured content. Added 1st paragraph under II.B detailing when to issue an amended report. Added info to II.B.2.d to tell how to open a Word copy of report. Created section II.G and added info (through section II.G.3) to try to clarify reporting requirements. Inserted II.B.2.f regarding identifying changes made in amended reports. QP 29 – Removed reference to quantitative analysis from section II.G.1. Significant update to latent section II.G.5. QP 31 – Inserted II.C.2.d. Added "laboratory analyst" to II.C.1.b. QP 33 – Inserted II.B.1.e. Added QPA 33.1 Rev 0 (Fax cover sheet with notice of confidentiality).
3	6-16-14	Glossary – removed references to evidence without container under definition of proper seal. QMA 1 – removed org chart as a controlled document. Replaced references to QMA 1 with appropriate language referencing updated location of org chart. QMA 1.1 – Updated to Revision 1 changing reference to QMA 4 to QMA 4.1. QMA 2 – Updated to Revision 2 – Added reference to Evidence Collection Manual (#7), changed language in #8 to refer to QMA 4.1 and 4.2, added #10 to incorporate previously approved deviation requiring biology evidence to be submitted in person. Inserted #11. QMA 3 – updated to revision 5. Removed language re: weapons not requiring a container. QMA 4 (rev 2) – renamed as QMA 4.1 revision 0. Deleted "SWRL" from Biology header. QMA 4.2 – Inserted new document with additional guidance on services which cannot be provided or require certain limitations. QM 4.1.4 – Inserted note. QM 4.1.7 – Changed reference to Safety Coordinator from "CSD" to "OSBI." QM 4.2.2 – Inserted "and procedures." QM 4.2.5 – Changed "should" to "may amplify but shall" in last sentence. QM 4.4.2 – Inserted "received according to QP 5" after "RFLE." QM 4.4.4 – Inserted "unless the modification . . ." in the last sentence. QM 5.2.5 – Inserted "that it is confirmed" after "date". QM 5.6.3.4 – Changed reference from QP 26 to QP 25. QM 5.8.4 – Inserted 3rd sentence with reference to QP 6.4. QP 1 - Replaced references to QMA 1 with appropriate language referencing updated location of org chart. Updated CA

responsibilities in section II.A.2 to reflect change to SWRL and creation of SFBU. Deleted "in effect" from II.A.4 before "the Technical Manager . . ." Added last two sentences to II.B.5.
QP 2 – Changed II.A.5 from "should" to "shall" and added reference to section II.E.4. Change "should" to "must" in last sentence of II.E.4.
QP 3 – Changed II.B to have minor deviations approved by TM or designee instead of supervisor.
QP 4 – II.A – Inserted reference to QP 5. Changed II.A.3 to reference QMA 4.1. Inserted II.A.4. Inserted "and the evidence will not be accepted" to II.B.3.
QP 5 – Changed 2nd sentence of II.A form "should" to "shall" and included the exception. Changed language in II.D.8 to have tracking labels copied and scanned into BEAST instead of mailing containers retained. Added sentences 2 & 3 to II.D.9 to incorporate previously approved deviation. Replaced "signed submittal form" with "BEAST generated submittal receipt" in II.E.3. Added "or RFLE" to II.G.1. Added reference to folders and updating folder location in II.H.
QP 6.4 - Added reference to alternate temperature log in II.D.2 to incorporate previously approved deviation.
QP 7 - Revised language in II.D to incorporate previously approved deviation regarding dog drugs. Inserted "or which are authorized for destruction" to II.C. Revised language II.D.1 to improve accuracy. In II.D.6 replaced "on page 24 of 40" with "in the appropriate section."
QP 8 - Renamed as QP 8.1. Revised II.F.6 to reference QP 8.2 and made minor grammatical change to last sentence of II.F.6.
QP 8.2 - Inserted new procedure for use of Chemical Inventory System.
QP 13 – Inserted sentences 2-5 and graph to II.B.
QP 15 - Added last sentence to Scope (I).
QP 16.2 - Inserted language – II.A.2.c and II.A.2.d. Modified language in II.B.3 to better reflect how changes are tracked and in II.B.4 to clarify page numbering requirement.
QP 17 – Changed language of II.B.6.a to better reflect addressing and documenting findings consistent with QP 13. Deleted section re: closing audits. Updated QPA 17.1 to revision 4 – removed reference to phone card and inserted reference to CPR/AED training.
QP 18 – revised language to incorporate previously approved deviation (created evidence subcommittee, subcommittees meet as needed, use of report template QPA 18.1 Rev 0 for quarterly reports).

QP 24 – Inserted 3rd sentence in Scope section (I). Inserted "if they are not . . ." in II.B.2.a.
QP 28 – Corrected reference in II.B.2.e according to previously approved deviation. Changed "should" to "shall" in II.D regarding notifying agency of subcontracting. Added last sentence under II.F.10 to incorporate previously approved deviation.
QP 30 – Deleted reference to QIC subcommittee from II.I.9.
QP 31 – Modified language in II.B.4.b to incorporate previously approved deviation re: hard copy TR's.
Minor grammatical and formatting corrections made through document.

Quality Manager_____ Date__6-12-14_____
Erin N. Henry

Division Director_____ Date__6-12-14_____
Andrea R. Swiech

Notice to Customers

ASCLD/LAB-*International* accreditation requirements state that laboratories must notify customers (investigators, prosecuting attorneys, etc.) in certain circumstances listed below. ASCLD/LAB has established that labs may conduct these notifications on a case by case basis or through a general notification made available to all customers. This notice will serve as a general notification to customers for these areas. Submitting evidence to the OSBI Criminalistics Services Division (OSBI CSD) indicates consent with these terms.

Review of Requests for Analysis (ISO/IEC 17025:2005 Std. 4.4.1):

Each request for forensic analysis is reviewed by OSBI CSD personnel. The OSBI CSD will use the review process to ensure:

1. that the customer's needs are understood (ex: which items need to be processed by the Latent Evidence Unit, etc.), and

2. that the OSBI CSD can meet those needs.

However, the OSBI CSD will determine the most appropriate method(s) of analysis (ex: which chemical processing would best develop latent prints on an item submitted for latent processing) based on the information provided by the customer. Once the OSBI CSD accepts a request for analysis, the accepted request is considered a contract between the requestor and the OSBI.

Changes to Contracts (ISO/IEC 17025:2005 Std. 4.4.4):

In addition, the OSBI CSD may select the item(s) most appropriate for analysis and/or elect to not analyze all items submitted based on the needs and circumstances of the case. The OSBI does not consider this a change to the "contract," and this may be done without additional notice to the customer.

The OSBI CSD does strive to provide the highest quality and most valuable forensic analysis possible. For that reason, if analysts conducting testing identify alternate and/or additional testing that may prove beneficial to our customers, the OSBI CSD may notify the customer on a case by case basis. This notification will always be done if the proposed analysis will require consumption of the evidence and/or limit future examinations.

Subcontracting Analysis (ISO/IEC 17025:2005 Std. 4.5.2):

The OSBI CSD will transfer evidence between OSBI CSD laboratories in order to accommodate efficient analysis.

In limited circumstances, the OSBI CSD may subcontract analysis, if the OSBI CSD cannot provide the service necessary. This includes sending out samples for mitochondrial DNA (mtDNA) analysis and for the DNA identification of human remains and/or associated reference samples.

Any unidentified human remains and/or any reference samples associated with missing persons or unidentified remains that are subcontracted will be sent to the University of North Texas Missing Persons/Unidentified Remains program. Any other evidence requiring mtDNA analysis will be sent to the Federal Bureau of Investigation (FBI) or one of their regional mtDNA labs.

Deviations from Analytical Procedures (ISO/IEC 17025:2005 Std. 5.4.1):

The OSBI CSD utilizes analytical methods that are generally accepted in the forensic science community and that have been validated by OSBI CSD personnel and documented in written protocols. In addition, the OSBI CSD maintains a policy to allow for suggesting, evaluating, approving, and documenting deviations to policy and procedure when necessary. These deviations are not communicated on a case by case basis, but are documented according to policy and can be discussed with customers upon request.

Selection of Methods (ISO/IEC 17025:2005 Std. 5.4.2):

OSBI CSD analytical methods are documented in written protocols and in some circumstances the analytical method used is also referenced in the case file and/or case record. In some circumstances, the analytical methods used may be listed in the examination report, as required by accreditation and quality standards. In any case in which a report does not list the analytical methods used, the OSBI CSD will provide this information upon request. In addition, a list of current services and/or analytical methods currently in use by the OSBI CSD is located in **OSBI CSD QMA 4.1**.

Oklahoma State Bureau of Investigation - Criminalistics Services Division (OSBI CSD)
Evidence Acceptance Requirements

The following requirements must be met for the OSBI CSD to accept evidence for analysis:

1. The evidence must be submitted by an individual or agency authorized to request services from the OSBI CSD. The agencies and individuals authorized to request services are listed in Title 74, Sections 150.2 and 150.5. The OSBI CSD cannot accept evidence from private citizens or other individuals/agencies not listed in statute.

2. The evidence must be relevant to an investigation which is expected to result in criminal charges being filed. Evidence relevant to civil investigations or non-criminal product cases such as food or drugs suspected of being old, faulty, etc., will not be accepted for analysis.

3. The evidence must not include any explosive devices, explosive samples, or post-blast samples.

4. The evidence must not include syringes, which under normal circumstances will not be accepted for analysis. Exceptions to this will be evaluated on a case by case basis and exceptions must be approved by a Criminalist Supervisor, Criminalistics Administrator, or designee.

5. Evidence must be submitted in person or through a delivery service such as the United States Postal Service (USPS), United Parcel Service (UPS), or Federal Express (FedEx). Evidence in digital form (images of latent prints, etc.) will not be accepted by e-mail.

6. Evidence must be collected and packaged in a manner that preserves the integrity of the evidence. Evidence which is packaged in a manner that would invalidate the results of testing will be refused. Refer to the OSBI Evidence Collection Manual for information regarding appropriate collection and packaging of evidence.

7. Evidence must be properly collected, packaged, and sealed. Refer to the OSBI Evidence Collection Manual located in the Law Enforcement section of the OSBI website at http://www.ok.gov/osbi/Forensic_Laboratory/Law_Enforcement_Training/index.html for evidence collection guidelines. Refer to **QMA 3** for evidence sealing guidelines.

8. The evidence must have a legitimate associated service request which complies with policies outlined in **QMA 4.1** and **4.2**. A listing of available services is detailed in **QMA 4.1**. A listing of services which are not provided or which may be limited is included in **QMA 4.2**. Evidence will not be accepted for the purpose of long-term storage or if the OSBI CSD cannot meet the needs of the customer.

9. Evidence samples submitted for the purpose of comparison (paints, fibers, projectiles, DNA, etc.) must be accompanied by the appropriate reference samples. In most cases, comparison samples will not be accepted unless both the questioned and reference samples are provided. However, this does not apply to samples submitted for comparison to a database. For example, DNA cases with no suspect identified may be submitted with the evidence sample(s) and victim reference sample.

10. Evidence submitted for Forensic Biology analysis must be submitted in person. Forensic Biology evidence received in any other way will be shipped back to the submitting agency without analysis.

11. Weapons submitted for analysis must be submitted in person.

Oklahoma State Bureau of Investigation - Criminalistics Services Division (OSBI CSD)
Evidence Packaging and Sealing Guidelines

Evidence submitted to the OSBI CSD must be stored in an appropriate container under proper seal. The seal must be sufficient to prevent item(s) contained from being lost, removed, or contaminated by outside sources. A container is considered "appropriate" and "properly sealed" only if its contents cannot readily escape and only if entering the container results in obvious damage/alteration to the container or its seal.

1. All evidence must be packaged in a suitable container that protects the evidence from loss, cross-transfer, or contamination.

    a) Other evidence, such as liquids may require multiple containers. For example, containers of liquid samples must be stored in a plastic bag, bucket, or other container that will contain the liquid if the immediate container leaks.

    b) Glass containers should be placed inside a container that will also protect the glass from breaking.

    c) Containers used to protect the immediate evidence package from leaks or breakage may be treated as convenience packages. However, only one item should be in each "convenience package" to prevent contamination in the event of a leak.

2. All evidence must bear a proper seal. A proper seal includes the initials or other unique identification of the person sealing the evidence and an acceptable evidence container seal. The following should be used as a guide for acceptable evidence container seals:

    a) Boxes: A box container seal includes the long seam at both the top and bottom of the box. Boxes should be sealed with two-inch tape, IPG N8315 or equal/better. Evidence tape may also be acceptable.

    b) Paper sacks, bags: All sack-like containers should be sealed by folding down the flap of the sack across the top and placing a continuous piece of 2 inch tape, IPG N8315 or equal/better, across the fold and around the sack edges. Evidence tape may also acceptable.

    c) Envelopes: The top (unsealed) flap of the envelope should be sealed along or across the seam using two inch tape, IPG N8315 or equal/better, or using evidence tape.

d) Cans: One continuous piece of evidence tape across the top and down the sides of the container (including buckets with lids) or two separate pieces of evidence tape across from each other are to be used to seal all can-like containers. The seal must be marked or initialed. No clear adhesive tape is to be used on cans if it can be peeled off without evidence of removal.

e) Kits: Boxed sexual assault kits, GSR kits, and other purchased kits are acceptable with the seal provided by the kit manufacturer. Envelope-style sexual assault kits shall meet the evidence sealing requirement for envelopes as listed in 2.c above.

f) Bulky Evidence: Some items of evidence do not lend themselves to a container. In those cases, the area of interest for analysis should be isolated, protected and marked or initialed. Examples are doors or car bumpers.

3. Evidence which is properly sealed and marked for identification may then be placed in unsealed containers such as boxes or bags for the purpose of grouping items of evidence or for the convenience of carrying the evidence without that container having to meet the requirements of identification and sealing, as long as evidence security requirements are otherwise met. These containers should be marked as a "convenience package" or "convenience container."

4. Heat sealing a container of an item of evidence is also acceptable. Identifying marks or initials of the person sealing the evidence must be present across the heat seal.

5. The submitting officer will be expected to correct improperly sealed evidence prior to the evidence being accepted by the lab. If evidence received by the laboratory has an acceptable evidence seal but is not initialed or marked and that individual is not available to remedy the problem, the receiving personnel will place a piece of evidence tape across the evidence seal at an approximate 90 degree angle and initial across the tape or place the entire evidence container in a heat sealed container and initial across the heat seal.

Oklahoma State Bureau of Investigation - Criminalistics Services Division (OSBI CSD)
Facilities and Available Services

FACILITIES:

The OSBI CSD provides services at the following 5 facilities:

OSBI Forensic Science Center (FSC)
800 East Second Street
Edmond, OK 73034
(405) 330-6724

OSBI Eastern Regional Laboratory
701 West Carl Albert
McAlester, OK 74501
(918) 423-6672

OSBI Northwest Regional Laboratory
1305 E. Garriott
Enid, OK 73701
(580) 242-2600

OSBI Northeast Regional Laboratory
1995 Airport Parkway
Tahlequah, OK 74464
(918) 456-0653

OSBI Southwest Regional Laboratory
5 Northeast 22nd Street
Lawton, OK 73507
(580) 355-6144

For the convenience of OSBI CSD customers, evidence may be submitted at any CSD facility. OSBI CSD personnel will transport evidence between facilities when necessary to provide the appropriate or most timely analysis.

SERVICES:

The following services/analytical methods are available. However, the OSBI reserves the right to select the most appropriate method and to select the item(s) most appropriate for analysis (see **"Notice to Customers" – OSBI CSD QMA 1.1**). If a particular test method or service is desired for a specific item, please contact a Criminalist from the discipline in question for assistance with the review of the request.

Biology (FSC and NERL):

1. **Screening**

   Evidence can be screened for biological material including blood, semen, and hair.

2. **Confirmatory Testing**

   Tests are available to confirm the presence of blood and semen.

3. **Hair Evaluation**

   Hair samples can be evaluated to determine whether the hair is animal or human and, if human, whether adequate sample is present for nuclear or mitochondrial DNA testing.

4. **DNA Analysis**

   The OSBI CSD can perform two types of Short Tandem Repeat (STR) DNA analysis – autosomal and/or Y-STR analysis. Y-STR analysis generates a DNA profile based on locations on the Y-chromosome only, which means in order to generate a profile, the sample must contain male DNA. Y-STR analysis is only available at the FSC and NERL facilities.

   The OSBI CSD can forward evidence to an FBI Regional Mitochondrial DNA Laboratory for analysis.

5. **Database Entry/Search**

   All eligible DNA profiles obtained during the analysis of casework can be entered into the state CODIS (Combined DNA Index System) database and national database (NDIS).

Controlled Substances (FSC, ERL, NERL, NWRL, SWRL):

1. **Controlled Substance Identification**

   Identification of controlled and some non-controlled substances.

2. **Clandestine Laboratory Analysis**

   Analysis can be conducted on clandestine laboratory samples to detect controlled substances, precursors, and chemicals related to the illegal manufacture of controlled substances.

3. **Poison Identification**

   Some poisons such as Strychnine can be identified by the drug lab. Other compounds such as Ethylene Glycol (antifreeze) that can be used as poisons can also be identified.

Firearms/Toolmarks (FSC):

1. **Function Test**

   Guns submitted for analysis can be tested to determine if the weapon is functional.

2. **Fired Bullet and Casing Analysis**

   Fired projectiles and/or fired casings can be compared to other fired evidence (bullets/casings) or to a suspect gun.

   In addition, fired projectiles and fired casings can also be examined and may sometimes provide information regarding potential makes and models of guns that could have fired the evidence. This is dependent on the amount and type of characteristics present on the fired evidence.

3. **Serial Number Restoration**

   When requested, analysis can be performed to attempt to restore the serial number of a gun.

4. **Distance Determination**

   In some cases, evidence can be examined to determine an approximate distance between an object and the point/location from which a gun was fired.

5. **Database Entry/Searching**

   Test fires from suspect weapons or fired evidence can be evaluated to determine suitability for entry into the Integrated Ballistic Identification System (IBIS). Items entered into IBIS will be automatically searched against the region (Oklahoma and Texas). The OSBI can request searches through other regional databases as well.

6. **Toolmark Analysis**

   Analysis can be conducted to determine, if possible, whether or not a particular tool was used to generate impressions or striations on the item submitted (padlock, window frame, etc.). In addition, analysis can be done to determine if the toolmarks on multiple evidence items were made by the same tool.

Latent Evidence (FSC):

1. **Footwear Analysis**

   Photos or casts of questioned footwear impressions can be compared to known shoe samples.

   The OSBI CSD cannot examine questioned footwear impressions without known shoes for comparison purposes.

2. **Tire Impression Analysis**

   Photos or casts of questioned tire impressions can be compared to casts or photos of known tire impressions. Tires will not be accepted for comparison purposes.

   The OSBI CSD cannot examine questioned tire impressions without known tire impressions for comparison purposes.

3. **Latent Print Analysis**

   Processing:

   Items suitable for latent print development which have been properly collected and packaged can be processed to detect and lift/capture latent prints for comparison or AFIS entry.

4. **Latent Print Comparison**

   Questioned latent prints submitted or recovered from items submitted for processing can be compared to known inked impressions submitted or to known impressions from retained records when the subject's information (name, race, sex, date of birth, and SID number) is provided.

5. **Database Entry/Searching**

   All latent prints (including palm prints) of appropriate quality that are not identified to a known can be evaluated for entry into the Oklahoma Automated Fingerprint Identification System (AFIS).

   The OSBI CSD can also request a search be conducted using the Integrated Automated Fingerprint Identification System (IAFIS), which searches records from the FBI files.

Toxicology (FSC):

1. **DUI Cases**

   Blood or urine collected from individuals suspected of driving under the influence can be analyzed for the presence of alcohol or drugs.

2. **Drug Facilitated Sexual Assault**

   Blood and/or urine collected from an individual reporting a drug facilitated sexual assault can be analyzed for the presence of impairing substances.

3. **Alcoholic Content**

   Liquids suspected of containing alcohol can be analyzed to determine the presence and quantity of alcohol. (Ex: suspected moonshine)

4. **Poisons**

   Samples suspected of containing poison can be tested for select poisons, such as the active ingredient in Visine.

5. **Toxic Vapors**

   Blood may also be analyzed for other substances which cause impairment such as toxic vapors inhaled by a suspect (i.e. huffing).

Trace Evidence (FSC):

1. **Ignitable Liquids Residue Analysis**

   Properly packaged samples of fire debris can be analyzed for the presence of ignitable liquids such as gasoline, paint thinner, or diesel, etc.

2. **Primer Gunshot Residue Analysis (GSR)**

   Evidence submitted using an OSBI GSR Evidence Collection Kit can be analyzed for the presence of elements that are characteristic of gunshot residue (lead, antimony, and barium).

3. **Manufactured Fibers:**

   Questioned fibers can be analyzed and compared to reference or known samples submitted to determine if the questioned and known sample may have originated from the same source. This comparison applies to man-made fibers only.

   Analysis of questioned fibers can also be conducted to determine the composition of the fiber(s). However, this analysis is limited to the material (e.g. nylon, acetate, etc.) and color. The OSBI CSD does not have the capability to indicate what item(s) may have been a source of the questioned fiber(s).

   The OSBI CSD does not perform hair comparisons.

4. **Paint Evidence:**

   Questioned paint samples can be analyzed and compared to known samples, when available, to determine if the questioned and known samples may have originated from the same source.

   If known paint samples are unavailable, then unknown samples may be submitted for possible Make and Model determination utilizing the Paint Data Query (PDQ) database.

5. **Elemental/Chemical Analysis:**

   Evidence can be analyzed to determine its elemental composition. The most common application of this analysis is to identify the presence of poisonous materials such as lead, arsenic, and mercury. Elemental analysis can also be conducted to identify elements used in clandestine drug manufacturing, such as phosphorus and iodine.

6. **Fracture Matches:**

   Miscellaneous types of evidence that are torn or broken can be compared to a sample suspected to be the source of the evidentiary sample. For example, duct tape removed from a victim can be compared to a roll of duct tape found in a suspect's possession.

Oklahoma State Bureau of Investigation – Criminalistics Services Division (OSBI CSD)
Service Limitations

The following summarizes types of cases which cannot or typically will not be routinely accepted for analysis or which will only be accepted once certain requirements are met.

Case Requests Not Accepted:

The following types of requests will not be accepted because the OSBI does not have the capability to perform these types of analyses.

1. Animal DNA analysis
2. Plant DNA analysis
3. No suspect DNA cases which do not meet eligibility requirements for CODIS (will be determined by Biologist at submittal)
4. Identification of synthetic or aldulterated urine
5. Bite mark analysis (swabs of bite marks can be submitted for DNA)
6. Quantitation of controlled substances
7. Ejection pattern analysis of fired cartridge casings or shotshells

The following case types are typically not accepted or will only be accepted under the circumstances described. In rare circumstances, exceptions to this policy may be needed. Unless otherwise noted, requests for exceptions must be submitted to and approved by a Criminalistics Administrator or the CSD Director. Requests for exceptions to the case acceptance policy made on behalf of another agency (e.g. a District Attorney's office, etc) must be accompanied by a written request from that agency on their agency letter head.

Case Requests Typically Not Accepted:

1. DNA analysis on controlled substance evidence
2. Sexual assault cases where the suspect has admitted to intercourse
3. Felon in possession of a firearm cases for latent evidence or DNA analysis
4. Animal poisoning cases
5. Touch DNA analysis when the item is known to have been handled without gloves during or after collection
6. Contact DNA analysis on airbags
7. Requests for fingerprint confirmation of defendant identity (e.g. repeat of Interstate Identification Index)
8. Spores for drug analysis (mushrooms)

Oklahoma State Bureau of Investigation – Criminalistics Services Division (OSBI CSD)
Service Limitations

Case Requests With Special Requirements:

Forensic Biology

1. DNA analysis for property crime cases will be limited to 3 items. Items selected will be limited to cigarette butts, bloodstains, or other items that are believed to have biological fluid (blood, semen, saliva) from the alleged perpetrator. This would include items from which it is believed that the suspect ate or drank. Items that the alleged perpetrator is believed to have had prolonged contact with such as clothing or hats recovered from the scene may also be submitted.
2. Cold cases will be accepted for analysis on a case by case basis. Please contact the Specialized Forensic Biology Unit (SFBU) located at the Forensic Science Center in Edmond prior to submitting Cold Case evidence.
3. Touch DNA analysis will only be performed on evidence that would likely contain DNA resulting from the transfer of epithelial cells from the skin to an object due to extended contact. Examples of extended contact DNA evidence include some clothing, cigarette butts, items drank from, etc. DNA analysis will not be conducted on items with only brief contact which are not likely to contain sufficient transfer of epithelial cells from the skin to the object. Examples of brief contact items include door handles, counter tops, etc.
4. DNA analysis from vehicle interiors (e.g. airbag, seats, visor, etc) in serious injury or fatality accidents will be limited to bloodstains recovered from the interior of the vehicle, <u>when the driver has fled the scene</u>. Due to the vast number of unknown directional forces during vehicle accidents, in all other cases, DNA analysis will not be performed without an approved exception.
5. All requests for DNA analysis must be accompanied by an officer statement and/or police report that includes detailed information about the evidence collected (e.g. location recovered from, who the item belonged to, etc). This information is critical for ensuring DNA profiles obtained are eligible for CODIS entry.
6. All DNA requests must be submitted with known reference samples. This must include samples from the victim(s), suspect (if applicable), and exclusionary samples as needed (e.g. consensual partner, property owner, etc).

Evidence Kits

Evidence collection kits will not be accepted outside the generally accepted collection time window unless exigent circumstances exist. For sexual assault kits collected from living victims the window would be 5 days.

Latent Evidence

Digital images of latent prints or impression evidence must be submitted on physical media (CD, DVD, etc) and are not accepted by e-mail. Each disc must include only the images which require examination/analysis. General crime scene photos (e.g. showing location of scene, body, or other evidence items) should not be included on the disc. However, some crime scene photos which provide context for an image which will be analyzed may be included. For example, a photo of a door bearing a footwear impression may be included when that impression is one of the images submitted for analysis. In addition, each disc should be accompanied by a photo log which identifies the file name and a description of the image. The description should include an explanation of the item and/or location from which the print/impression was collected.

Firearms and Toolmarks

Requests for firearms distance determination will not be accepted unless the firearm, ammunition involved in the crime, and the item bearing the pattern (photos are not accepted) are ALL submitted together. Distance determination cannot be conducted on clothing that does not have bullet holes.

Toolmark cases will only be analyzed when a suspect tool is submitted. Comparisons between two unknown toolmarks will not be conducted.

Oklahoma State Bureau oInvestigation – Criminalistics Services Division (OSBI CSD)
Alternate Service Providers

In the event that the OSBI CSD cannot provide a particular service requested by a customer, OSBI CSD personnel may assist the customer in locating an appropriate agency or organization that can provide the service. The list below summarizes some of the agencies or organizations that may be able to provide service to customers. This list is intended to be used as a tool to provide assistance to customers and is not intended to serve as a guarantee of service or endorsement of the agencies and organizations listed.

Alcohol, Tobacco, Firearms:

Bureau of Alcohol, Tobacco, and Firearms (ATF):
Firearms, Explosives, Arson—1-800-283-4867
Arson Hotline—1-888-283-3473 (24 Hours)
Explosives Hotline—1-888-283-2662 (24 Hours)
Firearms Hotline—1-888-283-4867 (24 Hours)

Animal/Agricultural:

Animal Disease and Diagnostic Lab
Livestock Diseases
405-744-6623

Department of Agriculture:
Herbicides and Insecticide Poisoning, Animal Food Poisoning
405-521-3864

OSU School of Veterinary Medicine:

Animal Deaths
405-262-5291

Archaeology

University of Oklahoma
Mr. Kent Buehler
Norman, OK
405-325-7211

Aviation:

Federal Aviation Administration:
Investigations and evidence involved in airplane accidents
405-954-3011

Oklahoma State Bureau oInvestigation – Criminalistics Services Division (OSBI CSD)
Alternate Service Providers

Bomb Squads:

Agency	Jurisdiction	Phone
OCPD	All incorporated areas of OKC except for State property	405-297-3477 405-297-1000
OCSO	All unincorporated areas of OKC except for State property	405-713-1044
MWCPD	All incorporated areas of Midwest City	405-739-1388
Edmond PD	All incorporated areas of Edmond	405-354-4420
Norman PD	All incorporated areas of Norman	405-321-1444
Tulsa PD	All incorporated areas of Tulsa	918-596-9222
OHP	All areas of the State that do not have a bomb squad in their jurisdiction.	405-425-2435 405-682-4343 405-202-3763
US Army Fort Sill	Fort Sill EOD will assist any PD or FD 24/7	580-442-8885 580-442-2313

Crime Scene Cleanup:

Heartland BioClean
405-802-6246

Environmental Management, Inc. (Guthrie)
405-282-8510

Environmental Cleanup, Inc. (Oklahoma City)
405-677-0565

Aftermath
888-635-5779

AEGIS Biosystems (Edmond)
405-341-4667

Traumatix Solutions (Glen Poole)
918-605-2556

Ferguson Environmental Resources, Inc.
405-495-6336

Crime Scene Cleanup (Reimbursement and Referral):

District Attorney's Council (DAC) Victim Services
405-264-5006

Emergency Management:

Oklahoma Department of Civil Emergency Management
1-800-800-2481 or 405-521-2481

Entomology (Analysis of Insects):

Oklahoma State University
Zoology Department

Stillwater, OK
405-744-5527

University of Oklahoma
Dr. Heather R. Ketchum
Norman, OK
405-325-4354

Environmental Concerns:

Department of Environmental Quality State Lab:
Poisoning of ground water/public or private water supply/soils
405-752-1000

US EPA-ERT Environmental Response Center
2890 Woodbridge Avenue, building #18 (MS 101)
Edison, NJ 08837-3679
1-732-321-4398 http://www.ert.org

Food/Drug:

Food and Drug Administration:
Retail Food/Medication (for Human Consumption) Tampering
405-231-4544 (Oklahoma City)
214-253-5200 (Dallas, 24 Hours)

Health Departments:
Non-criminal tampering/contamination of food or over the counter medications
405-271-5243 Oklahoma State Department of Health
405-425-4348 Oklahoma County Health Department
918-595-4301 Tulsa County Health Department

Oklahoma State Department of Health
Biological contamination of foods (e.g. bacterial or viral contaminants)
405-271-5070

Forensics (Fee for Service):

The BODE Technology Group
Springfield, Virginia
703-646-9740

LabCorp
1912 Alexander Drive
Research Triangle Park, NC 27709
800-533-0567

Reliagene
New Orleans, LA
800-256-4106

Serological Research Institute
3053 Research Drive
Richmond, CA 94806
(510) 223-7374

Oklahoma State Bureau oInvestigation – Criminalistics Services Division (OSBI CSD)
Alternate Service Providers

Sorenson Forensics, LLC
2495 S. West Temple
Salt Lake City, UT 84115
800-824-3457 or 888-488-1122
www.sorensonforensics.com

Tarrant County M.E.'s Office
200 Feliks Gwozdz Pl.
Fort Worth, TX 76104
807-920-5700

Hazardous Materials:

OHP HAZMAT
405-425-2017
Level A hazmat

Phlebotomy (blood drawing for drug screening)

Entero Services LLC
580-278-4077

Poisoning Deaths:

Office of the Chief Medical Examiner
405-239-7141

Soil Analysis:

FBI Trace Analysis Unit
Attn: Bob Fram
2501 Investigation Parkway
Quantico, VA 22135
703-632-8449

Toxicology:

Bexar County Medical Examiner's Office
Bexar County Forensic Science Center
7337 Louis Pasteur
San Antonio, TX 78229-4565
210-335-4000

Northwest Toxicology (Lab One)
Salt Lake City, Utah
1-800-322-3361 or 1-801-268-2431

El Sohly Laboratories
Oxford, Mississippi
1-662-236-2609

University Toxicology Lab
University Hospital, Rm EB 400
P.O. Box 26307
Oklahoma City, OK 73126
405-271-3840

Oklahoma State Bureau oInvestigation – Criminalistics Services Division (OSBI CSD)
Alternate Service Providers

National Medical Services (Can analyze hair samples for drugs)
3701 Welsh Road
Willow Grove, PA 19090
(800) 522-6671
www.nmslab.com

Weapons of Mass Destruction/Terrorism:

63rd Weapons of Mass Destruction Civil Support Team
63rd WMD CST 405-228-5880
Note: normally dispatched via Oklahoma Dept of Civil Emergency Management for response.

FBI Counter Terrorism Unit
405-290-7770 or 405-290-3615
Explosives, radiation

State Department of Health (Biological Weapons (e.g. Anthrax))
Public Health Laboratory Services
P.O. Box 24106
Oklahoma City, OK 73214
Phone: 405-271-5070
Fax: 405-271-4850

405-271-4060	Epidemiologist on call 24 hours
405-271-4341	Security, alternate 24 hr number

OSBI Criminalistics Services Division
Deviation Request Form

I. Explanation of Request

Name: _____ Date: _____

Applies to (Policy/Procedure): _____

Describe Requested Deviation: _____

Specify the Instance/Circumstance for which the Deviation is Requested: _____

Reason for Deviation: _____

II. Technical Review and Authorization

Merits: _____

Risks/Impact: _____

Duration of Authorization: _____
Restrictions/Limitations: _____

Authorized/Rejected (signature) Date:

III. Quality Assurance Manager Authorization

Acceptability Within General Quality Assurance Principles? YES/NO
Significant Negative Impact to Division-Wide Quality Standards? YES/NO
Restrictions/Limitations: _____

Authorized/Rejected (signature) Date:

IV. Criminalistics Division Director Authorization

Authorized/Rejected (signature) Date:

Effective Date:

OKLAHOMA STATE BUREAU OF INVESTIGATION
REQUEST FOR LABORATORY EXAMINATION

Requesting Officer: _____ Badge # _____ Agency/Troop: _____
(TYPE / PRINT - OFFICER'S NAME)

Requesting Officer's Email: _____ Phone No: _____

Submitting Officer: (Person delivering evidence to the OSBI Laboratory) Evidence Delivered: ☐In Person ☐ By Mail

_____ _____ _____
(TYPE / PRINT - OFFICER'S NAME & BADGE#) **(OFFICER'S SIGNATURE)** **(AGENCY/TROOP)**

Requesting Agency Case #: _____

Type of Offense: _____

County of Offense: _____

Date of Offense: _____

Court Date, If Known_____

_____
OSBI Laboratory Number

Has evidence been previously submitted on this case? ☐Yes ☐ No
If yes, please provide the OSBI Lab Number _____

SUBJECT/SUSPECT(S):

Last Name, First Name, Middle Name	Sex	Race	DOB	SSN	Check if Knowns Submitted*
					☐DNA ☐ Fingerprint ☐ Palm Print
					☐DNA ☐ Fingerprint ☐ Palm Print
					☐DNA ☐ Fingerprint ☐ Palm Print
					☐DNA ☐ Fingerprint ☐ Palm Print

***For Biology and Print cases, if knowns have not been submitted, please attach a signed statement describing what steps have been taken to obtain knowns.**

VICTIM(S):

Last Name, First Name, Middle Name	Sex	Race	DOB	Check if Knowns Submitted
				☐DNA ☐ Fingerprint ☐ Palm Print
				☐DNA ☐ Fingerprint ☐ Palm Print

EVIDENCE SUBMITTED:

Itemized Description of Evidence (Attach additional pages if necessary)	**Type of Exam Requested**** (per item)

****For all Biology/DNA/CODIS requests, an officer statement or police report is required.**

SEND A COPY OF REPORT TO: (include address)

Copy of report to DA's OFFICE:
☐Yes ☐ No

Upon submission of evidence to the OSBI Laboratory for examination, the requesting officer agrees to the following terms:
The OSBI shall select and use the most appropriate testing method and procedure.
Evidence may be subject to methods which are destructive and may damage the evidence.

Notification Regarding Non-Casework Use of Evidence

The OSBI Criminalistics Services Division (CSD) sometimes encounters a need to use evidence for purposes beyond the analysis requested in the furtherance of criminal investigations. This notification serves to explain those circumstances and what the OSBI CSD Policy is regarding non-casework use of evidence.

Non Casework Use of Evidence

Re-analysis of Casework:

Annually, the OSBI CSD randomly selects cases to re-analyze as part of our quality assurance program. Re-analysis of casework is conducted and documented in the same fashion as the original examination. Results of re-analysis are not reported to customers unless the results are not concordant with the original examination. The OSBI CSD is in the process of transitioning to web-based distribution of reports. Re-examination reports will be available on the website, but they will be marked to indicate that the results were obtained during routine re-examination.

Research, Validation, and Training:

The other areas where evidence may be needed for non-casework use, include research, validation, and training. Research and validation projects are periodically conducted to evaluate, identify, or incorporate new methods or instrumentation which allow the OSBI CSD to improve efficiency, increase services, or make other quality improvements. Training is conducted for new CSD analysts so that they will be well qualified to analyze casework. When gathering samples for research, validation, and training, the OSBI CSD prepares “mock” evidence samples or uses samples from evidence submitted for destruction whenever possible. However, some circumstances require use of evidence from adjudicated or non-adjudicated cases.

For most cases, the amount taken for research, validation, or training will be comparable to the amount taken for the casework analysis. However, there may be occasions where a more sizable amount needs to be collected. For example, when a large amount of a controlled substance not frequently seen in casework is received, it is beneficial to the OSBI CSD to collect a larger amount to set aside for future training needs.

Notification

As described in OSBI CSD Procedure QP 6.2, the OSBI CSD has notified customers through the posting of this policy. Customers will receive a subsequent notification when samples are collected from active cases. The OSBI CSD will strive to utilize evidence from active cases as little as possible and the removal of evidence for non-casework purposes will be documented in the case record. **The OSBI CSD will not consume more than half of any sample for non-casework purposes, unless the evidence has been re-submitted or otherwise authorized for destruction.**

Submittal of evidence to the OSBI CSD for analysis or destruction indicates that the customer is aware of and accepts this policy.

OSBI WEEKLY TEMPERATURE LOG

YEAR_____

Equipment Type:_____
Brand/Model #: _____
OSBI Asset #:_____
Location:_____

DATE	INITIALS	TEMP (˚C)

DATE	INITIALS	TEMP (˚C)

OKLAHOMA STATE BUREAU OF INVESTIGATION

INVENTORY OF DRUGS SUBMITTED FOR DESTRUCTION
AND/OR
OTHER ITEMS IN OSBI CUSTODY FOR DESTRUCTION

NOTICE: THIS FORM IS SUBMITTED IN COMPLIANCE WITH TITLE 63 OKLAHOMA STATUTES, SECTIONS 2-507 AND 2-505(B). THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND SIGNED BY THE SUBMITTING OFFICER OR THE ITEMS CANNOT BE ACCEPTED FOR DESTRUCTION.

OSBI LAB NUMBER	**AGENCY CASE NUMBER**	**DESCRIPTION OF CONTAINER** (envelope, suitcase, box, etc.)	**DESCRIPTION OF ITEMS** (marihuana, pills, liquid, clothes, kits, etc.)	**COUNT OF ITEMS** (count, weight)

This is a true and correct inventory of all of the items I have submitted this date to the OSBI for destruction and all legal proceedings have been exhausted with respect to all items listed above and submitted today including, where applicable, compliance with Title 63 O.S. Section 2-505(B) which authorizes the destruction of bulk items prior to trial on the merits upon meeting certain qualifications.

OSBI LAB USE ONLY

Drug Destruction Record

Number: _____

Page _____of _____

SUBMITTED BY: _____
(Agency)

_____
(Printed Name) (Signature)

_____
(Title) (Date)

_____
(Received OSBI) (Date)

PAGE _____ of _____

OKLAHOMA STATE BUREAU OF INVESTIGATION
CRIMINALISTIC SERVICES DIVISION

EVIDENCE RELEASE FORM

These items have been tested and handled in the normal course of business by the Criminalistic Services Division of the OSBI. No warranty is made as to identity, purity, or pharmaceutical suitability for human consumption.

Chain of custody should be maintained for future legal proceedings and evidence should be maintained in a condition that would allow further forensic examination. All biological evidence must be retained and preserved for such period of time as any individual convicted of that crime remains incarcerated (Title 22 § 1372).

Re: Case Number_____

The Oklahoma State Bureau of Investigation is releasing evidence pertaining to the above Case Number to:

_____ _____

(Agency's Name) *County of Offense*

Description of Items Being Released:

Container Description	Tracking Number(s)	Item Number(s)/Description

Received by: _____/_____Date:_____
Printed Name Signature

Released by: _____/_____Date:_____
Printed Name Signature

Released at: _____
(Location)

Remarks:

OSBI
EVIDENCE TRANSFER FORM
LABORATORY USE ONLY

Requesting Criminalist: _____
(Type or Print – CRIMINALIST NAME)

From Unit: _____

LAB # _____

Container Description	Item Number(s)	Evidence Description

TARGET UNIT:

TYPE OF ANALYSIS:

Additional Instructions:

This form contains information for routing convenience only. This form should be shredded upon completion of the related assignment.

OSBI Forensic Laboratory Survey

We are dedicated to providing the highest quality services to you. To assist us in doing so, we are asking for your input. Please, take a few minutes to complete this survey. The information you provide will only be shared with the appropriate department Supervisor.

If you have a compliment, concern or complaint, we welcome the opportunity to visit with you about it. We ask that you provide your name and telephone number or email address at the end of this survey if you would like a member of our staff to contact you.

What was the nature of your visit or contact with the OSBI Laboratory?
_____

Laboratory being evaluated: _____ Forensic discipline used: _____ Name of OSBI employee who assisted you: _____

Please, rate the following based on your experience with our laboratory. Skip a section if it does not apply to your experience with us.

OSBI Staff 4 = Excellent 3 = Good 2 = Fair 1 = Poor	___ Knowledgeable ___ Accessible ___ Friendly ___ Professional ___ Appearance ___ Follow-through
Communications 4 = Excellent 3 = Good 2 = Fair 1 = Poor	___ Accuracy of written materials ___ Quality of written materials ___ Ease of understanding written materials ___ Telephone assistance (time on hold, call transfers, wait time for returned calls)
Timeliness of Responses 4 = Excellent 3 = Good 2 = Fair 1 = Poor	___ Waiting time in person ___ Waiting time by phone ___ Waiting time by e-mail/letter
Our Services 4 = Excellent 3 = Good 2 = Fair 1 = Poor	___ Turn-around time of examinations ___ Breadth of services offered by lab ___ Availability of personnel for court, etc. ___ Ability of personnel to explain test results ___ Adequacy of training courses offered
Facilities 4 = Excellent 3 = Good 2 = Fair 1 = Poor	___ Accessibility ___ Location ___ Cleanliness ___ Hours of operation
Website 4 = Excellent 3 = Good 2 = Fair 1 = Poor	___ Ease of use ___ Information on website ___ Design of website

Additional Comments

Do you have an idea to improve customer service or a comment you would like to share:

Do you have a complaint you would like to discuss:

Your Contact Information

If you would like a response to your survey, provide your name and contact information below:
Name

Email Address

Telephone Number (with area code)

Thank you for taking the time to complete this survey!
You can e-mail the completed survey to erin.henry@osbi.ok.gov or print it out and mail/fax to:

OSBI, Attn: Erin Henry
800 East 2nd Street
Edmond, OK 73034
Fax 405-330-6207

OSBI LABORATORY DIVISION
COMPLAINT TRACKING FORM

Complainant Name:	Date:
Organization:	Phone #:
Description	

Date Received	Received by:		Logged-in Date:	#:
Was the circumstance verified?	Yes	No	Date:	By:
Is the complaint valid?	Yes	No	Date:	By:
Complainant notification date:			By:	
Assigned to:	Date:		Plan received date:	
Completion date:	Final Notification Date:		By:	
Notes:				

OKLAHOMA STATE BUREAU OF INVESTIGATION
NON-CONFORMING RESULTS REPORT

Section I		
Name:	Laboratory:	Date of Observation:
Section II		
Description of Area(s) Impacted:		
Section III		
Summary of Observation: Analyst:		Date:
Section IV – Evaluation and Proposed Remediation		
Scope: Significance: Action Taken: Proposed Remediation: Supervisor:		Date:

OKLAHOMA STATE BUREAU OF INVESTIGATION
NON-CONFORMING RESULTS REPORT

Section V –Review and Approval	
Scope: Significance: Action Taken: Proposed Remediation: Technical Manager -or- Criminalistics Administrator:	Date:
Completion of Remediation	
Supervisor:	Date:
Approval to Resume Work (if applicable)	
Technical Manager -or- Criminalistics Administrator:	Date:

Attach additional pages and or pertinent documentation.

OKLAHOMA STATE BUREAU OF INVESTIGATION
CORRECTIVE ACTION REQUEST

Section I		**Tracking #:**
Name:	Laboratory:	Date:
Section II		
Description of event which requires corrective action:		
Section III – Root Cause Analysis		**Assigned To:**
Describe the steps taken to determine what the root cause(s) is/are and what is determined to be the most likely root cause.		
Section IV – Description of Corrective Action Plan		
Based on the root cause determined, list potential methods of corrective action and then determine which corrective action plan is most likely to prevent recurrence and is most appropriate to the magnitude and risk that the problem presents. Describe the steps that will be taken to prevent the problem from recurring. Include who will be responsible for various steps of the plan and deadlines for completing each step. Include steps to remediate or correct the work originally identified as non-conforming if it has not already been documented.		
Supervisor:		Date:
Technical Manager -or- Criminalistics Administrator:		Date:

Section V – Monitoring Plan

Describe the method that will be used to monitor the completion and effectiveness of the corrective action plan. Include who is responsible and deadlines for the completion of individual steps or reviews. If necessary, include attachments.

Supervisor: Date:

Technical Manager -or-
Criminalistics Administrator: Date:

Section VI – Completion of Corrective Action Plan

Sign below to indicate that the corrective action plan has been completed. Include a statement indicating whether the corrective action has been effective.

Supervisor: Date:

Technical Manager -or-
Criminalistics Administrator: Date:

Section VII – Approval to Resume Work (if applicable)

Technical Manager -or-
Criminalistics Administrator: Date:

OKLAHOMA STATE BUREAU OF INVESTIGATION
CRIMINALISTIC SERVICES DIVISION
LINE INSPECTION CHECKLIST

Laboratory Unit/Region: _____ Supervisor: _____Date: _____	Related References: Laboratory Quality Policy QP 17 OSBI Directive 230 CALEA Standard 53.1.1 Checklist Created 11-7-01 Revised 6-16-14

Line inspections are annual inspections and evaluations of each regional laboratory or laboratory unit conducted by the regional or unit supervisor. Regional and unit supervisors will note all deficiencies, take corrective action as appropriate, and archive copies of the reports. The supervisor maintains the inspection form until all corrective actions are completed and verified through a re-inspection. When completed, the original form is sent to the Division Director of Criminalistics. The unit or regional supervisors maintain a copy and a copy is sent to their Criminalistics Administrator .

Inspection Criteria	Yes	No	N/A	Comments	Corrective Action (CA) Needed	CA Due Date	CA Completion Date
Do employees have their credentials, badge, CLEET card, and valid driver's license?							
Were annual safety audits performed when required?							
Do all employees wear the appropriate PPE as required?							
If the internal audit has been conducted, has the report been received and a response provided per QP 17?							
Are PMP evaluations up-to-date on all employees?							
Are laboratory and office areas clean, safe, and orderly?							
Do employees follow time and leave policies?							
Are periodic staff meetings held with employees? List dates or schedule in comments.							
Do enough employees have current certification in first aid, CPR/AED? List # in comments.							
Do employees receive ongoing annual training?							
Is emphasis placed upon closing older cases?							
Are resources directed at reducing case turnaround times?							
Do employees understand organizational values?							
Are employees in compliance with the appearance policy?							

Unit/Region_____ Date_____ Supervisor_____

Oklahoma State Bureau of Investigation

STAN FLORENCE
Director

CHARLES D. CURTIS
Deputy Director

Memorandum

To: CSD Director

Through:

From: Lab Management (Supervisors, Technical Managers, Lab Administration, Grant Project Directors)

Date:

Subject: Management System Review

The following form will be used to collect information for the management review process. Each section shall be completed by the individual(s) designated. Sections identified with a unit or lab name shall be completed by the appropriate supervisor. Sections identified with a discipline name shall be completed by the appropriate Technical Manager.

Review of ASCLD/LAB Guiding Principles

Were the ASCLD/LAB Guiding Principles reviewed with all staff in your section/lab? Answer yes or no and provide the date the review was conducted.

QM	**ERL/SWRL**	**FSC-CHEM**	**FSC-CODIS**	**FSC-EVID**	**FSC-FA/TM**
FSC-FBU	**FSC-LEU**	**FSC-SFBU**	**FSC-TOX**	**NERL**	**NWRL**

Were there any concerns or issues raised during the review which need to be addressed or discussed further? (e.g. staff received a request which contradicts guiding principles) Answer no or yes and include an explanation if yes.

QM -

HEADQUARTERS
6600 N. Harvey
Oklahoma City, OK 73116-7910
(405) 848-6724
Fax (405) 843-3804
TDD (405) 843-7303

ERL -	

FSC-CODIS -	

FSC-EVID -	

FSC-FA/TM -	

FSC-FBU -	

FSC-FCU -	

FSC-LEU -	

FSC-SFBU -	

FSC- TOX -	

NERL -	

NWRL -	

SWRL -	

Annual Policy, Procedure, and Training Manual Review and Revision

Indicate what the current status of policy review and revision is including the date or date range of the last documented review/revision for all controlled documents you are responsible for (e.g. protocols, discipline quality manual, training manual). Indicate whether the policies are suitable or if substantive modifications are being planned/worked on. Also indicate, if applicable, if the laboratory objectives need modification.

Quality -

Biology -	

Chemistry (Drugs) -	

Chemistry (Trace) -	

CODIS -	

Evidence -	

Firearms/Toolmarks -	

Latent Evidence -	

Toxicology -	

Reports

Include any relevant information that is not addressed in other sections. For example, supervisors should comment on any general workload observations (e.g. increase in a particular case type, evidence submission/packaging trends, legislative changes that have been proposed or implemented and how they will impact the unit, etc).

ERL -	

FSC-CODIS -	

FSC-EVID -	

FSC-FA/TM -	

FSC-FBU -	

FSC-FCU -	

FSC-LEU -	

FSC-SFBU -	

FSC- TOX -	

NERL -	

NWRL -	

SWRL -	

Internal Audits, Line Inspections, Property Room Inventories, and Safety Audits

Provide a summary of any internal audit, line inspection, property room inventory and safety audit that was completed during the reporting period. Include the date of the audit, inspection, or inventory, a brief summary of any findings or discrepancies and an explanation of how the issue(s) have been or will be corrected.

ERL -	

FSC-CODIS -	

FSC-EVID -	

FSC-FA/TM -	

FSC-FBU -	

FSC-FCU -	

FSC-LEU -	
FSC-SFBU -	

FSC- TOX -	

NERL -	

NWRL -	

SWRL -	

Corrective and Preventive Actions

The Quality Manager will provide a summary of any corrective or preventive actions opened or in progress during the reporting period. Any summary of corrective action should only describe the quality issue identified. In the event that disciplinary action was incorporated as part of the corrective action plan, no specific information regarding disciplinary action shall be included in the summary.

QM -

External Assessments

The Quality Manager will provide a summary of any external assessments, including any pending applications for assessment or corrective actions/appeals.

QM -

Proficiency Tests

The Quality Manager will provide a summary of any proficiency tests assigned, in progress, or reviewed during the reporting period.

QM -

Work Submitted and Performed

The LIMS Administrator will provide statistical information regarding the volume and type of analysis requested and performed during the reporting period. Supervisors of units with an individual characteristic database (CODIS, AFIS, IBIS) will report on database use and success, including number of cases/samples entered, number of hits obtained, and number and types of investigations aided.

LIMS Admin-	

AFIS (LEU Supervisor) -	

CODIS (CODIS Supervisor) -	

IBIS (FA/TM Supervisor) -	

Customer Feedback

The Quality Manager will report on customer feedback, including lab surveys and witness critique forms, received during the reporting period.

QM -

Complaints

The Quality Manager will report on any formal complaints received or documented during the reporting period.

QM -

Recommendations for Improvement

Include any proposed recommendations for future improvement or any recommendations which were proposed and implemented in the section during the reporting period.

ERL -	

FSC-CODIS -	

FSC-EVID -	

FSC-FA/TM -	

FSC-FBU -	

FSC-FCU -	

FSC-LEU -	

FSC-SFBU -	

FSC- TOX -	

NERL -	

NWRL -	

SWRL -	

OTHER RELEVANT FACTORS

Grant Information

Grant project managers or the appropriate designee will report on the status of any open grant or grant application. Information should include the amount of funds requested or used during the reporting period and the purpose or success of the expenditure. (e.g. overtime funds used should indicate how many OT hours were worked and the number of additional cases completed using the OT)

Coverdell -

NIJ -		

OHSO -	

Cold Case -	

VOCA -	

Validation and Research

Provide a summary of any validation or research in progress or completed during the reporting period. In addition to providing a summary of any research conducted/coordinated by the Research Committee, the Research Committee Chairperson will also provide a summary of other relevant Research Committee activities, projects, and plans.

Biology -	

Chemistry (Drugs) -	

Chemistry (Trace) -	

CODIS -	

Evidence -	

Firearms/Toolmarks -	

Latent Evidence -	

Toxicology -	

Research Committee -	

Special Projects and Interesting Cases

Report on any additional projects in progress or completed during the reporting period. Also provide a summary of any unique or interesting cases.

ERL -	

FSC-CODIS -	

FSC-EVID -	

FSC-FA/TM -	

FSC-FBU -	

FSC-FCU -	

FSC-LEU -	

FSC-SFBU -	

FSC- TOX -	

NERL -	

NWRL -	

SWRL -	

Allocation of Lab Positions

The LIMS Administrator will provide a summary of lab positions, including vacancies and grant funded positions.

LIMS Administrator -	

OSBI Training Report Form

For training conferences attended, please use this form to capture the requested information. The information will be used by the OSBI Laboratory Administration and grant organizations.

Date of this report: _____ Grant number (if applicable):_____

Individual(s) who attended training: _____

Training attended, location, and dates: _____

_____

List each new technique, method, procedure, idea, and/or concept learned and implemented by you that was a direct result of the training attended.

1. _____
2. _____
3. _____
4. _____
5. _____

For each new technique, method, procedure, idea and/or concept listed above, cite **specific improvement(s)** in the quality, timeliness (improved case turn around times), and/or case backlogs of the forensic science services provided by you that were learned at the training.

1. _____
2. _____
3. _____
4. _____

Please submit this completed form within 7 working days of the completion of the training to the Lab Administration.

Thank you for your cooperation in providing this information.

TEMPORARY KEY CONTROL LOG

KEY #	DESCRIPTION (Desk, Door, etc.)	Checked Out By (Signature)	Check Out Date/Time	Check In Date/Time

KEY CONTROL LOG

Employee_____

By receiving these keys I understand they are non-transferrable and that if lost, it is to be reported immediately.

KEY # OR KEY PAD LOCK #	DESCRIPTION (Desk, Door, etc.)	ISSUED BY (Signature & Date)	ISSUED TO (Signature & Date)	RETURNED BY (Signature & Date)	RECEIVED BY (Signature & Date)

KEYPAD CONTROL LOG

BY RECEIVING THIS CODE I UNDERSTAND IT IS FOR APPROVED PERSONNEL ONLY

	Keypad #_____	**Keypad #_____**	**Keypad #_____**	**Keypad #_____**
NAME	Sign and Date	Sign and Date	Sign and Date	Sign and Date

MASTER KEY LOG

KEY SET OR LOCK NUMBER	DESCRIPTION (List the lock location or indicate what the key provides access to)	INDIVIDUAL KEY NUMBER(S)	ISSUED TO or CURRENT LOCATION	Date Verified and Initials	Date Verified and Initials	Date Verified and Initials	Date Verified and Initials

FSC BUILDING MASTER KEY LOG

OSBI CSD QPA 20.4b Rev. 1 (AΩ)

Key Set or Lock Number	Description or Door Number	Numbered Keys	Non - Numbered Keys	Total	Number Issued	Net In Storage	Key Number	Issued to or current location	Date Verified and Initials	Date Verified and Initials	Date Verified and Initials	Date Verified and Initials	Date Verified and Initials

DRYING STALL KEY CONTROL LOG

Drying Stall Location/Key #	Checked Out By (Print name)	Checked Out By (Signature)	Contact Phone Number	Check Out Date/Time	Check In Date/Time

M E M O R A N D U M

TO: Criminalistics Services Division Director

SUBJECT: ☐ Crime Scene Memo OR ☐ MORGUE

FROM:

Criminalistic Case #:

Type of Offense:

Date of Offense:

Victim(s):

Suspect(s):

Request for Assistance From:

Agency:

	DATE	TIME
Request for Assistance Received		
Left for Scene(s):		
Arrived at Scene(s)		
Left Scene(s) to Return		
Returned from Scene(s)		
Total Time Out (hrs/min)		

COMPLETE THE FOLLOWING FOR ALL CRIME SCENES

Were blood, bodily fluids or excretions present at the scene? ☐ Yes ☐ No

If Yes, were you working in the immediate vicinity of the blood, bodily fluids, or excretions? ☐ Yes ☐ No

If Yes, was the biological material ☐ wet and/or ☐ dry?

Was luminol utilized at the crime scene? ☐ Yes ☐ No ☐Unknown

If Yes, were you working in the immediate vicinity where it was used? ☐ Yes ☐ No

Which of the following personal protective equipment was utilized by Criminalists responding with your group (i.e. those that traveled together)?

Gloves: ☐ Yes ☐ No Protective Eyewear: ☐ Yes ☐ No

Respiratory Protection: ☐ APR ☐ Dust Mask ☐ None

Disposable Booties: ☐ Yes ☐ No

COMPLETE THE FOLLOWING FOR LATENT PRINT SCENES

Which techniques were utilized at the crime scene?

Dusting: ☐ Yes ☐ No

If Yes, Dusting time was ☐ Less Than or ☐ More Than 5 hrs

Reagent Spray: ☐ Yes ☐ No

If Yes, which reagent? ☐ LCV ☐ Other:_____

Control Pass? ☐ Yes ☐ No

Alternative or high intensity light: ☐ Yes ☐ No

Comments/Explanation:

SCENE INFORMATION:

Location: County

Address City

Atmospheric Conditions of Scene: ☐ Sunny ☐ Rain ☐ Snow ☐ Cloudy ☐ Night ☐ Windy ☐ Other:

Approximate Temperature: Outside Scene Indoor Scene

List of Individuals met at the scene and the agencies they represent:

Officer in Charge of Scene:

Summary of what Criminalistic Personnel did at scene (Processed house,car,etc. List serial numbers if applicable. Include brief description of scene.)

Name(s) of OSBI Criminalistics Personnel responding to scene(s), indicate which ones traveled together.

OSBI Unit # used for transportation: Total Mileage Out:

DISTRIBUTION OF COPIES OF MEMO:

1. Copy to be forwarded to Criminalistics Services Division Director
2. Copy to be forwarded to LIMS Administrator
3. Original to be placed in the criminalistics case record, if applicable
4. Copy for the Criminalist(s) personal file (Optional)

(NOTE: If the OSBI personnel responding did not leave together, travel together in the same unit and return together, separate crime scene memos must be completed for each group,)

CRIMINALIST COMMENTS:

OKLAHOMA STATE BUREAU OF INVESTIGATION CRIMINALISTIC SERVICES DIVISION

CASE FILE ADMINISTRATIVE REVIEW FORM

Analyst: _____ **Case #:** _____ **Report No.:** _____

By signing or completing this form, I verify that the following items have been reviewed and verified to be in compliance with applicable CSD policies and procedures:

1. The report has been reviewed for spelling and grammatical errors.
2. All administrative and examination records have been reviewed to ensure they are labeled with the case number and initials of the appropriate individual(s) and/or any alternate or additional information required by discipline or laboratory policy and procedure.
3. The report has been reviewed to ensure that all information required by QP 28 is included.

Corrections Required (if applicable):

_____

_____

_____

Examiner's response (if appropriate):

_____

_____

_____

Admin. Review (sign and date): _____

Second Admin Rev. (initial and date): _____

Signatures indicate any necessary corrections have been completed.

OKLAHOMA STATE BUREAU OF INVESTIGATION
800 East Second Street
Edmond, OK 73034
Fax: 405-330-6207 Phone: 405-330-6724
Attn: Laboratory Quality Assurance Manager

Witness Critique

In furtherance of our goal to provide accurate and reliable testimony in a professional manner, we have developed this questionnaire to collect information that will help the OSBI laboratory better evaluate our employees' courtroom testimony. Please take a minute to answer the questions below, then return the form. Your opinions, observations and suggestions are important to our organization, and will help us improve the quality of service we provide to you.

Thank you for your assistance.

Witness' Name _____ Court # _____
Court/County _____ OSBI Lab # _____
Testimony Date _____ Defendant _____

Please rate the examiner's testimony:	Excellent (3)	Good (2)	Fair(1)	Poor(0)
	Please leave blank if not applicable.			
1. Courtroom demeanor and appearance	☐	☐	☐	☐
2. Ability to convey information in an understandable manner	☐	☐	☐	☐
3. Poise and professionalism during direct examination	☐	☐	☐	☐
4. Poise and professionalism during cross examination	☐	☐	☐	☐
5. Use of court exhibits/visual aids (if applicable)	☐	☐	☐	☐
6. Testimony based upon scientific principles (to be rated by lab reviewers only)	☐	☐	☐	☐

Remarks/Comments/Suggestions (please explain poor ratings): _____

_____

_____

_____

Your Name (optional) _____ Judge ☐ Prosecutor ☐ Defense ☐

OSBI Supervisor ☐ Peer ☐ Other ☐

(FOR INTERNAL USE BY OSBI ONLY)
REVIEWED WITH EMPLOYEE: _____ _____
Employee Date

_____
Supervisor

Additional Training Required (circle one and initial): YES NO N/A

Oklahoma State Bureau of Investigation
Criminalistics Services Division

Andrea R. Swiech
CSD Director

Erin N. Henry
CSD Quality Manager

Fax Cover Sheet

To:	From:	
Fax:	Pages:	including this cover sheet
Phone:	Date:	

Notice of Confidentiality: The information contained in this fax transmission is confidential and may be legally privileged. If you are not the intended recipient or the employee or agent responsible to deliver this to the intended recipient, you are hereby notified that any dissemination, distribution or forwarding of this information is strictly prohibited. If you have received this fax in error, please notify the sender and shred or otherwise securely destroy this fax.

Forensic Science Center
800 E. Second St.
Edmond, OK 73034-5309
(405) 330-6724
Fax (405) 330-4732