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Report of Investigation
of the Monroe County Public Safety Laboratory

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I. EXECUTIVE SUMMARY

An investigation by the New York State Inspector General identified significant failures in the management of the Monroe County Public Safety Laboratory. The Monroe County Laboratory provides scientific examination and analysis of forensic evidence for law enforcement and public safety agencies in Rochester, Monroe County, and the surrounding region.

The Inspector General found that a Forensic Biologist III at the Monroe County Laboratory erroneously reported that a microscope slide bearing evidence in a sex offense investigation was negative for sperm cells. The Laboratory properly identified the error and provided the Forensic Biologist with remedial training and proficiency testing. The Inspector General, however, also found that the Laboratory failed to adequately review the Forensic Biologist's past work for similar errors. Additionally, the investigation found that Janet Anderson-Seaquist, the Laboratory Administrator, provided the New York State Commission on Forensic Science with inaccurate information regarding the review and retesting of the Forensic Biologist's past work.

The Inspector General also determined that Monroe County Laboratory Forensic Biology Section Supervisor Laura Ascroft failed to properly document the results of her audit of the Forensic Biologist's prior casework. The Inspector General found that this improper documentation was due in part to deficiencies in the Laboratory's corrective action policy. Accordingly, the Inspector General recommends that the Laboratory review this policy to better address similar occurrences in the future.

The Inspector General further found that the Monroe County Laboratory, without having conducted any testing, returned evidence in 270 cases which were more than five years old to the law enforcement agencies which had submitted the evidence for DNA analysis. Along with the returned evidence, the Laboratory issued reports to the agencies stating, "No analysis performed, since the case is past the statute of limitations. Analysis upon request." The Inspector General found that in many of these cases the Laboratory's

pronouncement that the cases were past the statute of limitations was incorrect; Laboratory personnel were unqualified to make such a legal determination; and no rational reason existed for the Laboratory to include that legal determination in a scientific report. Unfortunately, at least two police agencies relied on this pronouncement, believing that it was issued in consultation with the Monroe County District Attorney's Office, and destroyed evidence as a result. The Inspector General found that the management of the Monroe County Laboratory acted irresponsibly in issuing these reports with the statute of limitations findings.

The Inspector General recommends that the Laboratory immediately implement a policy to preclude reports from including legal opinions and statute of limitations determinations without proper legal consultation. The Inspector General is referring this report to the Commission on Forensic Science and to the Monroe County District Attorney, County Executive, and Director of Public Safety.

II. INTRODUCTION AND BACKGROUND

The Role of Forensic Laboratories in New York State

Forensic laboratories serve a critically important function in the criminal justice system by conducting scientific testing of various kinds for use in investigations and prosecutions. Reliable forensic testing contributes to the just resolution of cases by providing scientifically based evidence of guilt as well as innocence. Given these significant implications, it is essential that the public has full confidence in the integrity of forensic testing, an objective which demands the careful monitoring of forensic laboratories to ensure the validity of their results.

In New York State, 15 crime laboratories and seven post-mortem toxicology laboratories perform forensic testing. Executive Law Article 49-B mandates that all public laboratories conducting forensic testing within the state are subject to the oversight of the state Commission on Forensic Science. The 14-member Commission, which is

chaired by the Commissioner of the Division of Criminal Justice Services, determines accreditation standards for public forensic laboratories in New York, and, as part of its oversight responsibilities, reviews reported instances of laboratories' non-compliance with those standards. The Commission on Forensic Science also requires that laboratories are accredited by the American Society of Crime Laboratory Directors/Laboratory Accreditation Board (ASCLD/LAB), a nonprofit professional organization of crime laboratory directors and forensic science managers which promotes the development and maintenance of optimal standards of practice in the field, or the American Board of Forensic Toxicology (ABFT) for toxicology only.

Under rules established by the Commission on Forensic Science, laboratories are inspected by ASCLD/LAB or ABFT representatives upon initial application for accreditation and thereafter at regular intervals. Laboratories must demonstrate that their management, operations, personnel procedures, equipment, physical plant and health and safety procedures meet standards. Between inspections, ASCLD/LAB relies on laboratories to maintain compliance with established standards and accreditation criteria through annual proficiency testing – an assessment of a scientist's skill in a specific discipline. ASCLD/LAB also requires that a designated percentage of scientists' case results be subject to technical review by qualified peers and administrative review by supervisors. Laboratories are required to notify ASCLD/LAB of deviations from the standards and criteria.

The federal Paul Coverdell Forensic Science Improvement Program awards grants to states and units of local government to help improve the quality of forensic science. In order to enhance confidence in laboratory operations, recipients of Coverdell grants are required to certify that there exists an independent entity with authority to investigate allegations of serious negligence or misconduct by laboratory personnel substantially affecting the integrity of the forensic results. To ensure the reliability and credibility of the forensic laboratory accreditation program in New York State and to comply with the Coverdell program, the Commission on Forensic Science has designated the New York State Inspector General's Office as the independent investigatory entity.

Allegations Concerning the Monroe County Public Safety Laboratory Referred to the Inspector General

The Monroe County Public Safety Laboratory is a regional forensic laboratory that serves the City of Rochester, Monroe County, and the seven surrounding counties. The Monroe County Laboratory provides scientific analysis of forensic evidence for law enforcement and public safety agencies within that area. The Laboratory consists of several sections including Forensic Biology, Trace Analysis and Fire Debris, Drug Chemistry, and Digital Evidence. Janet Anderson-Seaquist has served as the Laboratory's Administrator since January 2010, and is responsible for its overall management.¹ Anderson-Seaquist reports to the Monroe County Director of Public Safety.

In October 2010, the Inspector General received a complaint alleging that an analyst at the Monroe County Laboratory had erroneously reported that a microscope slide from a Sexual Assault Kit was negative for sperm and that Anderson-Seaquist provided the Commission on Forensic Science with incorrect information regarding the corrective action that was taken related to the analyst's error. Specifically, it was alleged that Anderson-Seaquist advised the Commission that, as part of the remediation process, the Laboratory determined that the analyst had reported slides as negative for sperm in three prior cases, that these three cases were reanalyzed and that the negative results were confirmed. The complaint alleged that these statements to the Commission were inaccurate: more than three negative cases existed and only one was actually reanalyzed.

In November 2011, while investigating these complaints, the Inspector General received another allegation about the Monroe County Laboratory from the New York State Division of Criminal Justice Services. The complaint alleged that the Laboratory had returned evidence in certain rape and burglary investigations that were more than five

¹ Prior to her appointment as Monroe County Laboratory Administrator, Anderson-Seaquist served as the Supervising Forensic Scientist for the Ventura County Sheriff's Crime Laboratory in Ventura, California. She previously worked as a Criminalist for the City of Phoenix Crime Laboratory in Phoenix, Arizona. Anderson-Seaquist received a bachelor's degree in biology from Arizona State University and a master's degree in forensic toxicology from the University of Florida.

years old to the submitting police departments without performing the requested DNA testing, claiming that no testing was necessary because the statute of limitations for the criminal charges had lapsed.

This investigation involved allegations related to the Forensic Biology Section of the Monroe County Laboratory. The Forensic Biology Section, which is supervised by DNA Technical Leader Ellyn Colquhoun, is responsible for analyzing evidence that may be stained with biological fluids such as blood, saliva or semen. Forensic Biology Validation Manager Laura Ascroft and an Assistant DNA Technical Leader also supervise within the Section. The Section currently consists of 13 forensic biologists including three supervisors who are Forensic Biologists Is, seven Forensic Biologist IIs, one Forensic Biologist III, and two Forensic Biologist Trainees.² All of the forensic biologists, including the supervisors, perform forensic examination and analysis of submitted evidence. Forensic Biologist Trainees do not perform independent casework.

The Forensic Biology Section consists of two subsections: Serology and DNA testing. Items that are received for analysis are first screened in the serology laboratories. During screening, an analyst tests the submitted items for the presence of biological material, and once found identifies any such materials by type or types, i.e. blood or semen.

When biological material is detected following initial serology screening, DNA analysis may be performed to obtain a DNA profile of the biological material. This DNA profile may then be compared with a suspect in a given case, and may ultimately be entered into the Federal Bureau of Investigation's Combined DNA Indexing System (CODIS) for comparison to DNA of convicted offenders, as well as other forensic cases. The profiles submitted to CODIS are compared to DNA profiles of convicted offenders and profiles generated in other cases by laboratories across the United States. In this

² The Laboratory's Quality Assurance Coordinator is a former member of the Forensic Biology Section and, on occasion, also conducts DNA casework.

way, law enforcement officers may be able to identify possible suspects when no prior suspect existed.³

III. INSPECTOR GENERAL FINDS DEFICIENCIES IN MANAGEMENT OF THE MONROE COUNTY LABORATORY

March 2010 Erroneous Result

A. Analyst's Misidentification

On March 11, 2010, a Monroe County Laboratory Forensic Biologist III submitted a report to a supervisor which stated that microscopic slides submitted to the Laboratory as part of a Sexual Assault Kit were negative for the presence of sperm. As part of routine Laboratory procedure, a second analyst performed a subsequent independent reanalysis of the same slides and found three sperm cells on one of the slides.

The Forensic Biologist III began employment at the Monroe County Laboratory on January 5, 2009. As part of initial training, the Forensic Biologist III received serology training to identify the presence of bodily fluids, such as blood, saliva or sperm on submitted evidence. In addition to this serology training, the Forensic Biologist III completed supervised casework satisfactorily, as required, prior to being allowed to conduct independent casework. A review of casework shows that the Forensic Biologist III first issued a report based on independent work in December 2009.

A Forensic Biologist III at the Monroe County Laboratory commonly analyzes evidence submitted by law enforcement in a Sexual Assault Kit. These kits, which are

³ On March 19, 2012, Governor Andrew M. Cuomo signed into law a bill that makes New York State the first "all crimes DNA" state in the nation, by requiring DNA samples be collected from anyone convicted of a felony or Penal Law misdemeanor. Convicted offender samples are processed only at the New York State Police Forensic Investigation Center; therefore, the expanded law will have no impact on case workloads in other forensic laboratories. In addition, the new law significantly expands defendants' access

provided to law enforcement agencies by the New York State Division of Criminal Justice Services, were developed to standardize protocol for hospital personnel to follow in the collection of evidence from persons involved in any criminal incident involving a sexual offense. The kits contain, among other items, a number of microscope slides which are prepared by hospital personnel from swabs taken from various parts of a victim's body. If an analyst finds bodily fluids on the submitted evidence, the results are reported and sent to a second analyst who conducts a DNA analysis of the evidence.

In March 2010, the Forensic Biologist III conducted an analysis of items that had been submitted to the Monroe County Laboratory on February 1, 2010, from a Sexual Assault Kit. Specifically, the Forensic Biologist III analyzed the slides contained in the kit for the presence of bodily fluids, primarily sperm. After the analysis, the Forensic Biologist III generated a written report indicating that all the slides were negative for sperm.

A review of the case file by the Inspector General shows that the Forensic Biologist III followed standard operating procedures in conducting this analysis. The Forensic Biologist III started with a microscopic examination (microscopy) of the slides from the kit. In the examination, the Forensic Biologist III failed to notice sperm cells on any of the slides. The Forensic Biologist III then performed a chemical (acid phosphatase) test on the items, which turns purple when acid phosphatase – a chemical contained in sperm – is present. A dark purple result indicates a high concentration of sperm. This chemical test, however, is not conclusive when there is a small amount of sperm, because vaginal secretions also contain a small amount of acid phosphatase and can produce a light purple result. The Forensic Biologist III obtained a light purple result from the test. In the event of such a result, Monroe County Laboratory policy and procedures require that an analyst use swabs taken directly from the victim, which are also contained in the kit, to create their own slides and examine those. The Forensic Biologist III properly did so and again found no sperm cells.

to DNA testing and comparison both before and after conviction in appropriate circumstances, as well as to discovery after conviction where innocence is claimed.

The Forensic Biologist III issued a report to that effect and submitted it for review to the supervisor, Laura Ascroft. Ascroft selected the case pursuant to the Monroe County Laboratory's Evidential Reanalysis Program, which the Laboratory previously had instituted to assist it in complying with ASCLD/LAB criteria for reexamination as part of proficiency testing, and which it voluntarily continued as an additional quality assurance measure. As part of the program, supervisors select cases for reanalysis to help ensure the proficiency of the analysts. The reanalysis program focuses on serology cases in which the microscopic results are negative. One reason for this focus is the Monroe County Laboratory's concern that reanalysis of positive cases may consume part or all of the samples. Moreover, cases which are found positive for the presence of bodily fluid, pursuant to Laboratory policy, are sent to a second analyst for DNA testing and are, therefore, as a matter of course, reexamined. A DNA profile cannot be obtained unless actual bodily fluid exists from which to extract DNA. Therefore, a second analyst essentially confirms the positive serology results.

Another scientist in the Laboratory performed the independent reanalysis, and, contrary to the Forensic Biologist III's findings, found three sperm cells on the cervical slide in the kit. With regard to the remaining items in the kit, the scientist confirmed the Forensic Biologist III's negative results.⁴ The scientist verbally reported the results to Ascroft and also prepared a written report. Ascroft reported the contrary results of the reanalysis to her superiors, including Administrator Anderson-Seaquist. As required, Anderson-Seaquist then made a timely report of the incident to ASCLD/LAB and the Commission on Forensic Science. Consistent with Laboratory procedure, the Forensic Biologist III's initial report had not been issued pending the reanalysis; instead the report prepared after the reanalysis was issued. Therefore, the Laboratory reported accurate results to the submitting agency.

⁴ The Laboratory's Forensic Biology Validation Manager, Laura Ascroft, stated that three sperm cells likely would be an insufficient number from which to obtain a DNA profile. When asked if the Laboratory was able to obtain a DNA profile in this case, Ascroft stated that the submitting agency had advised the Laboratory that DNA testing was no longer necessary.

B. The Corrective Action

Pursuant to Monroe County Laboratory policy, Ascroft, in consultation with Anderson-Seaquist, DNA Technical Leader Colquhoun, and the Quality Assurance Coordinator implemented a corrective action plan to address the Forensic Biologist III's error. As policy required, the Forensic Biologist III was removed from casework pending completion of the corrective action.

Monroe County Laboratory Policy QM-16 Quality Action sets forth the relevant procedures. The policy includes definitions of different classes of incidents (Class I – III Discrepancy), with Class I the most serious. The Laboratory correctly categorized the Forensic Biologist III's error as a Class I Discrepancy. Class I Discrepancies are defined as: "The nature and cause of the discrepancy raises immediate concerns regarding the quality of the laboratory work product." The policy requires that a Corrective Action Form be completed for Class I Discrepancies setting forth the root cause of the problem and the corrective actions taken. The policy further states:

2.3 When a case file review indicates an analytical and/or interpretive problem, the Technical Supervisor is responsible for recommending, documenting and conducting any corrective actions that are needed.

2.3.1 The Technical Supervisor will determine the specific methods employed and the length of the correction action period based on the type of deficiency encountered.

2.3.2 If it is determined that the problem is attributable to the analyst, the corrective action may consist of supplemental training, close technical supervision and/or proficiency testing.

2.3.2.1 An audit of the analyst's prior casework may be required.

2.3.2.2. The analyst will not be allowed to continue casework in the affected discipline until the cause of the problem has been determined and the corrective actions taken.

2.3.2.3 The analyst may again resume casework duties when the Technical Supervisor, Quality Assurance Coordinator and Laboratory Director have

been assured that the problem has been corrected and the analyst has successfully completed an appropriate proficiency test.

2.3.3 Copies of the CAF and all related documents will be maintained at the laboratory.

2.3.3.1 A copy of the CAF form will be retained in the relevant case file(s).

* * *

2.5 If the corrective action is considered a Type I action, ASCLD-LAB and DCJS shall be notified. In addition, if the corrective action may affect the results of casework then the appropriate submitting agency and District Attorney's Office shall be notified.

2.6 A CAF will not be considered complete until the Technical Supervisor, Laboratory Director and Quality Assurance Coordinator are satisfied that the problem has been resolved.

Pursuant to the policy, the Forensic Biologist III was required to complete remedial training which included re-reading applicable standard operating procedures and successful examination of 10 unknown slides for the presence of sperm. The Forensic Biologist III was then allowed to return to modified casework in which the results of the next five Sexual Assault Kits were verified by a senior analyst. Subsequently, the Forensic Biologist III was allowed to return to independent casework. The corrective action was closed May 21, 2010. Ascroft prepared a Corrective Action Form documenting these corrective actions.

In addition to implementing the retraining program for the Forensic Biologist III, the Laboratory conducted an audit of the Forensic Biologist III's prior casework, as referenced in Section 2.3.2.1 of the Quality Action policy. The purpose of this audit was to determine if similar results reported by the Forensic Biologist III warranted review and/or reanalysis. Ascroft conducted this audit by reviewing a computer-generated list of all of the Forensic Biologist III's prior cases. From this list, Ascroft identified three cases in which the Forensic Biologist III analyzed and reported negative results for a Sexual Assault Kit. Ascroft then selected one of the three cases, reanalyzed it, and confirmed the Forensic Biologist III's results in that case. Ascroft stated that she annotated her findings

on the case list. Ascroft, however, did not retain this list, and did not create any record of the cases she identified, other than the one she reanalyzed.

C. The Retraining and Proficiency Testing

The Inspector General found that the Monroe County Laboratory's reanalysis program properly identified the Forensic Biologist III's microscopy error and that the Laboratory implemented reasonable remedial retraining of the Forensic Biologist III prior to reinstatement to independent casework. Specifically, the Laboratory, as required by its policy, determined that the problem was attributable to the analyst and instituted "supplemental training, close technical supervision and/or proficiency testing." The Forensic Biologist III was required to re-read applicable standard operating procedures and to successfully analyze 10 slides prepared by the supervisors as part of supplemental training and proficiency testing. In addition, the Forensic Biologist III's first five case results were verified by a senior analyst as part of modified casework prior to returning to independent casework.

D. Failure to Adequately Reanalyze Past Work

The Inspector General, however, also found that the Monroe County Laboratory did not reanalyze the three prior cases in which the Forensic Biologist III also identified the contents of Sexual Assault Kits as negative. Ascroft reported the results of her findings in a memorandum to Laboratory management dated April 6, 2010. Ascroft reported, in part:

3.) Verification of negative microscopy results in previous casework by supervisor:

a.) [The Forensic Biologist III] had analyzed six Sexual Assault Kits with negative results prior to the start of the remediation. Of those, 3 had been part of supervised casework and the negative results had already been verified by a second analyst.

b.) One of the remaining 3 kits was selected for verification. For case #2203-09, the negative results for the vaginal, cervical, and anal slides were verified by the supervisor (LRA).⁵

Although Ascroft identified three cases in which the Forensic Biologist III had independently analyzed Sexual Assault Kits with negative results prior to the remediation, she retested only one case. Asked by the Inspector General why only one case was reanalyzed, Ascroft explained that she had asked the Laboratory's Quality Control Manager if 100 percent reanalysis was required, and the Quality Control Manager advised that a representative sample is generally sufficient. Ascroft related that they then decided that reanalysis of one of the three cases was sufficient, especially given that three others of the total six cases had been conducted under supervision and confirmed. The Inspector General asked Ascroft why she selected the one case for re-examination. Ascroft initially reported that she chose that case randomly. However, in a later interview, Ascroft advised that, upon subsequent review of the files, she noted that records indicated that the evidence in the other two cases had been returned to the submitting agencies. The Laboratory, however, took no action to ascertain the availability of that evidence.

The Inspector General also inquired of Laboratory Administrator Anderson-Seaquist why the other two cases had not been reanalyzed. Anderson-Seaquist responded, "We decided this was the best course of action." When asked the reasoning for the decision not to reanalyze all three cases, Anderson-Seaquist asserted, "I guess we didn't see a reason to go and retest all of them."

While reanalysis of a percentage of an analyst's past casework may be appropriate when the analyst has produced a significant volume of casework, such is not the case here. The Forensic Biologist III was a relatively new analyst with a small body of work. The Inspector General can discern no rational reason why all three cases that were found

⁵ LRA are the initials of Laura R. Ascroft.

to be similar to the case in error were not reanalyzed, or, at least, why an attempt to reanalyze them was not made.

E. Erroneous Information Provided to the Commission on Forensic Science

In a letter dated June 28, 2010, Anderson-Seaquist made required notifications regarding this incident and the remedial measures to ASCLD/LAB and the Commission on Forensic Science. In the letter, Anderson-Seaquist identified the likely causes of the error, stating, “Probable causes may include that Analyst A did not examine the entire stained surface of the slide, was distracted during analysis or somehow rushed through the procedure.” The letter also set forth the corrective actions taken. In addition, Anderson-Seaquist advised in the letter, “It was determined that [the Forensic Biologist III] reported negative microscopy results on a total of three independently analyzed cases. The slides for one of those cases were re-examined by the supervisor, who confirmed the negative results.”

At its regularly scheduled September 14, 2010 meeting, the Commission on Forensic Science discussed, among other matters, the Forensic Biologist III’s erroneous negative finding. Anderson-Seaquist participated in the meeting by telephone. As part of standard practice, Anderson-Seaquist’s June 28, 2010 letter was provided to the each Commission member prior to the meeting. While New York State forensic laboratories are required to report testing errors to the Commission, the instant matter was placed on the Commission’s meeting agenda because it had been deemed a deficiency of the most serious type, a Class I deficiency, whereby “[t]he nature and cause of the discrepancy raises immediate concerns regarding the quality of the laboratory work product.”

During the discussion about Anderson-Seaquist’s letter, the letter was introduced on the record and portions of it were read aloud. Onondaga County District Attorney William Fitzpatrick, a Commission member, then asked Anderson-Seaquist about the Monroe County Laboratory’s rechecking of the three independently analyzed cases

referred to in the June 28, 2010 letter. According to a recording of the meeting, the following exchange occurred:

Fitzpatrick: Janet, this is Bill Fitzpatrick from Syracuse. Could you do me a favor? You say [the Forensic Biologist III] here only did three cases and you rechecked one. Could you just recheck the other two just for the heck of it?

Anderson-Seaquist: Actually, we rechecked all of them.

Fitzpatrick: Okay, it's not what the letter says, but I'm glad you did.

Anderson-Seaquist: Yes, we did.

When asked by the Inspector General what he meant when he asked Anderson-Seaquist to recheck all three cases completed by the analyst, Fitzpatrick referred to Anderson-Seaquist's June 28, 2010 letter, in which she had stated that the analyst had reported negative microscopy results on a total of three analyzed cases, and that the "slides" from one of those cases were "re-examined" and confirmed as negative. Indeed, only moments before Fitzpatrick's questioning of Anderson-Seaquist, the relevant portions of the letter had been read aloud for all, including Anderson-Seaquist by telephone, to hear. Fitzpatrick stated that, upon reading Anderson-Seaquist's letter, he did not understand why all three cases had not been reexamined, and as a result, he asked Anderson-Seaquist to recheck all three. Fitzpatrick related that he relied on Anderson-Seaquist's response that all three cases had been rechecked, and was satisfied with her answer. Fitzpatrick advised the Inspector General that he left the meeting with the "crystal clear" understanding that each of the three cases reported by the Laboratory as negative had been retested.

The Inspector General found that Anderson-Seaquist's representation to the Commission on Forensic Science that the Laboratory had "rechecked all" the cases was inaccurate. In fact, as detailed earlier in this report, only one of three cases was rechecked. During an interview with Anderson-Seaquist, the Inspector General played the recording of her exchange with Fitzpatrick from the September 14, 2010,

Commission meeting. The Inspector General then questioned Anderson-Seaquist as follows:

Inspector General: In your letter to ASCLD dated June 28, 2010, you stated that, “[i]t was determined that Analyst A reported negative microscopy results on a total of three independently analyzed cases. The slides for one of those cases were re-examined by the supervisor, who confirmed the negative results.” Now, Mr. Fitzpatrick asked you to recheck all three. Your response to him was that you did. He asked you to do it as you had done it for the one.

Anderson-Seaquist: No, he did not. He just asked if they had been reviewed, and they had been reviewed.

At this point, the Inspector General replayed the recording from the Commission meeting and further questioned Anderson-Seaquist:

Inspector General: Well, Mr. Fitzpatrick said . . . that you rechecked one and asked you to recheck all three.

Anderson-Seaquist: To recheck all three and we did recheck all three.

Inspector General: You rechecked them? You didn’t reanalyze them?

Anderson-Seaquist: No.

Having conceded that she did not reanalyze them, Anderson-Seaquist would not admit that her answers may have been misleading to the Commission:

Inspector General: Do you think that Mr. Fitzpatrick, when he said, recheck all three, do you think he could have taken your answer to mean that you reanalyzed all three? Do you think that could have been misleading?

Anderson-Seaquist: I don’t think it was misleading. I answered the question as it was phrased directly. I can’t tell you what his interpretation was.

The Inspector General then queried Anderson-Seaquist on what she meant by the use of the word “recheck.” When pressed to delineate what steps were taken to support her representation that the two remaining cases had been “rechecked,” Anderson-Seaquist claimed to have to defer to Supervisor Ascroft who actually conducted the review of the Forensic Biologist III’s cases:

Inspector General: And by recheck, what did you mean?

Anderson-Seaquist: We went through and looked at everything that she had done to make the determination on what was the best direction to take on remediation.

Inspector General: And the two cases . . . what steps were specifically taken with regard to the other two, to recheck them? What did you mean by recheck?

Anderson-Seaquist: I would have to refer to Laura [Ascroft] because it was her responsibility to check the cases. And that we made a determination on the best direction to take the remediation. We had to make a decision on what would be appropriate and how to proceed. And I support that.

Inspector General: In our previous interviews you said that the decision was made to reanalyze just one.

Anderson-Seaquist: Correct

Inspector General: Why was only one reanalyzed?

Anderson-Seaquist: One was fully reanalyzed.

Inspector General: And what was done with the other two is my question?

Anderson-Seaquist: They were reviewed.

Inspector General: And by review, what do you mean?

Anderson-Seaquist: Again, I would have to refer to Laura [Ascroft].

Inspector General: If they were reviewed, by Laura [Ascroft] or whoever the reviewer is, would they have generated some sort of report about their review.

Anderson-Seaquist: I don’t know.

In fact, as noted earlier, Ascroft had prepared a memorandum to Laboratory management, dated April 6, 2010, detailing her review process. In pertinent part, she wrote: “One of the remaining 3 kits was selected for verification. For case #2203-09, the negative results for the vaginal, cervical, and anal slides were verified by the supervisor.” When questioned on this exact issue, Ascroft advised the Inspector General that she reanalyzed one of the three cases at issue and, took no actions to review or “recheck” the findings in the remaining two cases other than reading the reports to confirm their negative findings for Sexual Assault Kit cases issued independently by the Forensic Biologist III.

In conclusion, Fitzpatrick’s inquiry as to whether all three negative results had been reanalyzed does not appear ambiguous. While the possibility exists that Anderson-Seaquist misunderstood the query, her representation to Fitzpatrick that “we rechecked all of them,” is inaccurate. Neither Ascroft nor any other analyst at the Monroe County Laboratory rechecked the remaining two cases in any meaningful way to support Anderson-Seaquist’s response to the Commission on Forensic Science.

F. Failure to Properly Document the Audit Results

The Inspector General also found that Ascroft failed to properly document the results of her audit of the Forensic Biologist III’s prior casework. As detailed above, Ascroft explained to the Inspector General that she conducted the audit by retrieving a printed list of all of the Forensic Biologist III’s prior cases from the Laboratory’s computer system. Ascroft then reviewed the list to identify cases in which the Forensic Biologist III had reported evidence negative for sperm; she found six prior cases in which the Forensic Biologist III analyzed Sexual Assault Kits and reported negative results, three of which were conducted independently without supervision.

Ascroft then annotated that information on the computer-generated case list. However, she neither retained the list nor documented the six case numbers and the

findings that she identified in the memorandum as being “negative results prior to the start of remediation,” other than the case that she verified by reanalysis.

The Inspector General found the Monroe County Laboratory’s Corrective Action policy, Lab Policy QM-16, to be deficient. Specifically, with regard to reviewing an analyst’s past work as part of a corrective action, Lab Policy QM-16 simply states, “An audit of the analyst’s prior casework may be required.” The policy does not require that the methodology or results of such an audit be documented or that such documentation be retained. When asked about this apparent deficiency, both Ascroft and DNA Technical Leader Colquhoun agreed that audit results and methodology should be documented and retained. In fact, Ascroft, on her own initiative, recreated her previous audit work and documented the results.

In addition, the Laboratory’s Corrective Action policy fails to identify in any way situations when an audit “may be required,” or the scope of such audit. Ascroft noted that Corrective Actions such as the one at issue are rare, and admitted that she had little experience in dealing with them.

The Monroe County Laboratory’s Return of Untested Evidence

In November 2011, while investigating the false negative determination and its attendant issues, the Inspector General received another allegation about the Monroe County Laboratory from the Division of Criminal Justice Services. The complaint alleged that the Laboratory had returned evidence in certain rape and burglary investigations that were more than five years old to the submitting police departments without performing the requested DNA testing, claiming that no testing was necessary because the statute of limitations for the criminal charges had lapsed.

A. Decision to Return 270 Cases to the Submitting Agencies

Between February 28, 2011, and March 14, 2011, Laboratory Administrator Anderson-Seaquist sent letters to law enforcement agencies and District Attorneys in the area the Laboratory services. These letters advised these agencies of the following:

The Forensic Biology Section has retained evidence for possible DNA analysis from cases in which the statute of limitations has expired. In anticipation of our impending move to our new facility, we are issuing a 'No Analysis' report and the retained evidence will be returned to the submitting agency.

Should you consider the cases still active or feel that DNA analysis would provide additional information to other cases which are currently active (e.g. serial burglary), please feel to contact me or the DNA Technical Leader, Ellyn Colquhoun. We can then discuss and make arrangements for DNA analysis after we are established in the new facility.

The Monroe County Laboratory then issued laboratory reports to the submitting agencies which stated in the Results/Conclusions Section, "No analysis performed, since the case is past the statute of limitations. Analysis upon request." In addition, the Laboratory returned the evidence in each of these cases to the submitting agencies. A review of reports revealed that the Laboratory returned evidence to the submitting agencies, in this manner, in 270 cases. The evidence was purported by Laboratory management to have been returned, at least in part, in anticipation of the Laboratory's impending move to a new facility (the Laboratory moved into the new facility in stages from March to April 2011). During this move, the remaining evidence was transported from the old facility to the new, escorted by Monroe County Sheriff's Office deputies.

B. The "No Analysis" Reports Issued by the Monroe County Laboratory

The Inspector General asked DNA Technical Leader Colquhoun why the Monroe County Laboratory returned evidence to the submitting agencies without conducting testing. Colquhoun explained that one of her analysts came to her in either 2010 or 2011 and said that the Laboratory had yet to test a significant number of cases that were

beyond the statute of limitations. The analyst asked Colquhoun whether it was reasonable to work on these cases. According to Colquhoun, the analyst proposed that the Laboratory return the cases to the submitting agencies, along with a report indicating that the Laboratory will perform analysis upon request. The agencies could then return the cases (which they had sent to the Laboratory in the first instance) if they deemed these cases still viable.

When asked by the Inspector General what she thought of this proposal, Colquhoun replied: "I was a little nervous about it at first, it felt like failure to me." She explained that, "Because we had cases that had expired the statutes, to my understanding it was five years, cases that sat there for five years. I was embarrassed by that." Colquhoun stated that these cases included rape cases in which Sexual Assault Kits had been submitted and serology screening had determined to be positive for sperm.

Colquhoun discussed the proposal with Laboratory Administrator Anderson-Seaquist, who approved implementing the proposal. When asked by the Inspector General where the idea to issue "No Analysis" reports originated, Anderson-Seaquist asserted that the idea was hers. Anderson-Seaquist opined, "The reality is that's not our evidence. We're a separate entity from them" (referring to the submitting agencies). When asked by the Inspector General how the cases from the Forensic Biology Section were selected for return, Anderson-Seaquist explained: "I left that decision with the supervisory staff as to which cases. I just tried to make it clear that I wanted to move [to the new Laboratory facility] as few as possible because I wanted the evidence to remain secure and I felt it would be more secure if it went back to the agencies."

Anderson-Seaquist reported to the Inspector General that prior to issuing the "No Analysis" reports because "the statute of limitations had passed," she had advised local law enforcement agencies of the Monroe County Laboratory's plan at meetings of the Law Enforcement Council, which includes chiefs of police, the District Attorney, and other law enforcement representatives from the area. Anderson-Seaquist explained that this was her primary method of informing law enforcement of the Laboratory's intent to

return evidence. Anderson-Seaquist stated that she “kept them (submitting police agencies) very well abreast” of the progress of the move and that the evidence would be returned with the qualification of “Analysis upon request.” The minutes of the March 31, 2011 council meeting show that Anderson-Seaquist advised that the Laboratory was in the process of sending letters requesting that submitting agencies pick up “old evidence” in anticipation of the Laboratory’s move. The minutes, however, do not reflect any discussion of the Laboratory issuing reports with the legal conclusion that “the statute of limitations had passed.”

At Anderson-Seaquist’s direction, Colquhoun then reviewed Laboratory records to identify cases in which the statute of limitations had expired. Colquhoun advised the Inspector General that she determined that the applicable statute of limitations was five years for felonies by reading the relevant statute.⁶ She added that no homicide cases were returned, as she understood that no statute of limitation exists for those crimes. Colquhoun conceded that she did not consult with an attorney in making this legal determination. Colquhoun specifically acknowledged that she did not consult with the Monroe County District Attorney’s Office, the Monroe County Attorney’s Office, or other attorneys for legal advice.

In fact, the applicable statute of limitations law includes many caveats and must be interpreted in the context of relevant judicial decisions. Colquhoun admitted to the Inspector General that it has since been brought to her attention that the statute of limitations calculation is more complicated than simply being five years. She also acknowledged that she now understands that no statute of limitation exists for the charge of Rape in the First Degree.

Based upon Colquhoun’s review, the Monroe County Laboratory issued the 270 reports with the results stating: “No analysis performed, since the case is past the statute of limitations. Analysis upon request.” The Laboratory then returned the evidence in those cases to the referring agencies. These “No analysis” reports were issued by the

⁶ New York Criminal Procedure Law § 30.10.

Laboratory in February 2011 and March 2011. Initially, the Laboratory issued “No Analysis” reports for burglary and criminal mischief cases; then, at a later date, the Laboratory issued “No analysis” reports for additional cases, including sexual assault cases.

Anderson-Seaquist conceded that the Laboratory could have contacted the submitting agencies rather than just issuing the “No Analysis” reports. Upon presentation of the ramifications of the Laboratory’s actions in the 270 “No Analysis” cases, Colquhoun similarly admitted as much to the Inspector General. While Anderson-Seaquist stated that the main reason for the “No Analysis” reports was to reduce the amount of evidence that the Laboratory would need to transport to a new facility, the Inspector General questions the soundness of this rationale offered by the administrator of a public forensic laboratory.

C. The Monroe County District Attorney’s Response to the “No Analysis” Reports

Kelly Christine Wolford, the Monroe County First Assistant District Attorney, advised the Inspector General that she was appointed to her current position in July 2011. At that time, staff brought to her attention two packages in the office containing a large number of Monroe County Laboratory reports. Each report in these packages stated in the Results/Conclusions sections that, “No analysis performed, since the case is past the statute of limitations. Analysis upon request.” Because arrests had not been made in these cases, this was the first time the District Attorney’s Office had seen the majority of these cases. Indeed, Wolford explained that the District Attorney’s Office generally does not become involved in a case prior to an arrest.

Upon receipt of these reports, Wolford, with the assistance of a paralegal and another attorney, obtained and reviewed the police reports related to the Monroe County Laboratory’s “No analysis” reports to ascertain the status of each case, *i.e.*, if the case was within the statute of limitations or otherwise prosecutable. Wolford could not recall the exact number of cases reviewed. However, Wolford’s and her staff’s review

determined that the statute of limitations had not expired in 41 of the cases, and that prosecution remained viable.

As part of this review, Wolford contacted the submitting agencies, and found that, in some cases, the agencies had already destroyed evidence as a result of having been advised by the Monroe County Laboratory that the statute of limitations had expired. Wolford advised the agencies to cease destroying evidence pending a full review of the cases. Wolford related to the Inspector General that when she advised the submitting agencies that she was reviewing the statute of limitations issue in these cases, “The hardest thing for them (the submitting agencies) to come to grips with was that this seemingly legal conclusion that was put forth in the report did not come as a result of discussion with us (the District Attorney’s Office). That was something they weren’t aware of when they got the (Monroe County Laboratory) letter.”

During its review, the District Attorney’s Office identified a rape case from the Town of Brighton which required immediate DNA testing. The District Attorney’s Office contacted the Laboratory and requested that this case be tested.

After this review, Wolford sent a letter to Anderson-Seaquist, dated September 16, 2011. Wolford’s letter advised that it was the District Attorney’s opinion that the statute of limitations had not expired in the 41 cases which were attached to the letter. Wolford’s letter stated:

I am in receipt of a large number of certifications from DNA analysts, sent to the District Attorney’s office from your laboratory, which state in the “RESULTS/CONCLUSIONS” portion “No analysis performed, since the case is past the statute of limitations. Analysis upon request.” **On initial review of these documents, it was immediately apparent that the prosecution of many, if not most, of the cases would not be barred by the statute of limitation at this time.** It is unclear from the reports why the evidence in these cases has not been tested as requested by the submitting police agencies, but these cases should not have been closed based on what appears, at best, to be an erroneous interpretation of the New York Criminal Procedure Law.

* * *

I am attaching the Laboratory Report for each case we believe is still viable. We are strongly urging you honor the request of the various police agencies made at the time the evidence was submitted to you and immediately test the samples submitted. As you will see from the notations on the reports, some of these cases involve serious offenses, such as forcible rapes, committed by complete strangers. Entry into CODIS of a profile could solve these crimes. Your failure to test the evidence submitted to your laboratory long ago by the arresting agency may result in an inability to arrest and convict violent criminals. Obviously this could result in these offenders continuing to roam the streets, free to prey on additional victims. I am sure you share my concern that this not be allowed to happen by the failure to conduct DNA testing.

* * *

Please feel free to contact me if you have any questions. In addition, I would hope that you are communicating with the original submitting agencies on each case before you make decisions not to test evidence submitted by an agency in connection with any given case. I would hope that this issue can be handle (sic) with great expediency given the gravity of the situation. [Emphasis supplied]

In a letter dated September 30, 2011, Anderson-Seaquist responded on behalf of the Monroe County Laboratory to Woford's letter. However, Anderson-Seaquist's correspondence did not address the major issues raised by the District Attorney's September 16, 2011 letter. Instead, Anderson-Seaquist's response questioned Woford's faith in DNA testing, stating, "the perception of power demonstrated in your transmittal regarding DNA analysis and CODIS entry may be unwarranted."⁷ When the Inspector General questioned Anderson-Seaquist about this seemingly inappropriate response from a laboratory director, she claimed that her point in making the statement was to show that DNA does not solve everything; "It's just a tool to be used."

In her response to the District Attorney's Office, Anderson-Seaquist also stated:

⁷ In support of her position, Anderson-Seaquist in her letter referred to a National Institute of Justice's presentation at the Los Angeles County Sheriff's Department Crime Laboratory in which it was found that of 6,732 cases analyzed, only 305 CODIS profiles were obtained, of which only two were prosecuted (both unsuccessfully).

The Crime Lab will continue to honor analysis requests made by our criminal justice community. The enclosures were released to the District Attorney's office in February; your request of the Laboratory to expedite resolution is duly noted and will be respected. Unless priority requests are received from the District Attorney's office delineating reasonable target dates, I will assume your office supports the direction provided by investigators from our law enforcement partners as we move forward.

Notably, Anderson-Seaquist failed to address in her correspondence the District Attorney's concerns that in "many, if not most, of the cases" the Laboratory was incorrect in asserting that the statute of limitations had lapsed.

As a result of Woford's letter, Colquhoun began contacting the submitting police agencies at issue to determine if they wanted the cases analyzed, and if so, to resubmit the evidence. Specifically, Colquhoun contacted the Rochester Police Department, the Brighton Police Department, the Gates Police Department, the Greece Police Department, and the Monroe County Sheriff's Office.

The Monroe County Laboratory subsequently provided the Inspector General with applicable case files, and reported in a February 16, 2012 memorandum to the Inspector General that the agencies that had been contacted had requested analysis in 13 of the cases returned by the Laboratory. These 13 cases came from the Rochester Police Department, the Monroe County Sheriff's Office, the Brighton Police Department, and the Gates Police Department. Indeed, the Laboratory advised the Inspector General that the Gates Police Department indicated that it did not understand why the cases submitted for testing by their agency had not been tested in the first place, and requested that it be done.

The Laboratory also reported that the evidence in three of these cases (each a burglary investigation), in addition to the rape case that the District Attorney's Office had requested testing of prior to the issuance of its letter, had been tested. In these four cases, DNA profiles were obtained which were entered into CODIS and resulted in matches to prior offenders in the database.

The Laboratory also reported in its February 16, 2012 memorandum to the Inspector General that no response had been received from the Monroe County Sheriff's Office regarding three other cases in which "No analysis" reports had been previously issued. During this investigation, the Sheriff's Office provided the Inspector General with documents indicating that the evidence in those cases had been destroyed after receipt of the report from the Laboratory stating that the cases were "past the statute of limitations." Two of the cases involved burglary charges; the other involved a rape investigation.⁸ The documents also showed a fourth case that had been earmarked for destruction, but was recovered from the trash after the Laboratory contacted the Sheriff's Office to ask if the case should be analyzed. This evidence, also from a rape case, is listed in the Laboratory's memorandum as one where testing was requested by the Sheriff's Office.

The Rochester Police Department also advised the Inspector General that, relying on the Laboratory's pronouncement that the statute of limitations had passed, it destroyed evidence in a burglary case.

In addition, evidence was destroyed in the Brighton rape case, which the District Attorney's Office had requested be tested following its review. In that case, the assailant left a beer can, from which he had drunk, in the victim's car. A swab was taken from that can and submitted to the Laboratory in 2003. On December 1, 2011, the Laboratory tested that swab for DNA at the District Attorney's request, which resulted in a CODIS hit to an offender specimen. Brighton Police advised the Inspector General that the beer can and other evidence in the case had been destroyed in 2005. Although this evidence was not destroyed as a result of the "No analysis" reports, it is clear that it would not have been destroyed if the Laboratory had performed the DNA testing prior to 2005.

⁸ The Monroe County Sheriff's Office advised the Inspector General that after the destruction of this evidence it determined that the evidence consisted of cigarettes smoked by a suspect in a Brighton Police Department rape investigation. The Sheriff's Office, to assist in that investigation, submitted the cigarettes for comparison to evidence obtained by Brighton. However, after the submission Brighton obtained a DNA match to another individual.

The Inspector General inquired of Anderson-Seaquist if, based on the above-described results, she thought that Monroe County Laboratory personnel should have made the statute of limitations determinations. She responded, “If they were wrong, the report says ‘Analysis upon request’ and they can return it.” The Inspector General advised Anderson-Seaquist that at least one agency destroyed the evidence due to the notation. Anderson-Seaquist said that she takes responsibility for the reports. However, she denied responsibility for the destruction of the evidence, claiming that the evidence destroyed was in the agencies’ custody. Incredibly, Anderson-Seaquist further asserted that the police agencies should not have relied on the Laboratory’s legal determinations, as “we are not attorneys.” Anderson-Seaquist’s assertion is undermined by her own previous explanation that the statute of limitations language was included in the Laboratory reports because it “might provide assistance in determining whether it (referring to the evidence in the case) should be returned or not.”

The Inspector General also noted Anderson-Seaquist’s lack of knowledge regarding the cases returned by the District Attorney’s Office. When asked to comment on the Laboratory’s errors in determining the statute of limitations in the cases identified in Woford’s letter, Anderson-Seaquist claimed that she was not aware that the Laboratory had made errors in its determinations of the statute of limitations. Apparently, she either did not read or failed to understand the import of Woford’s letter. Anderson-Seaquist told the Inspector General that New York’s statute of limitations law is “a gray area.” Notwithstanding this qualification, the “gray area” was obviously not contemplated by Anderson-Seaquist when she instructed her staff to render an opinion as to the timeliness of hundreds of cases without any consideration to either facts or law. Indeed, Anderson-Seaquist’s acknowledgement of this “gray area” should have prompted the Laboratory to obtain legal counsel prior to making such a determination.

IV. FINDINGS AND RECOMMENDATIONS

The Inspector General's investigation identified significant failures in the management of the Monroe County Public Safety Laboratory. The Inspector General found that the Laboratory's reanalysis program properly identified a microscopy error committed by a Forensic Biologist and that the Laboratory implemented reasonable remedial retraining of the Forensic Biologist prior to her returning to independent casework. However, the Inspector General also found that the Laboratory did not reanalyze all three prior cases in which the Forensic Biologist also identified the contents of Sexual Assault Kits as negative, and instead only reanalyzed a percentage of her work, in this instance, one case. While reanalysis of a percentage of an analyst's past casework may be appropriate when the analyst has produced a significant volume of casework, such is not the case here. The Inspector General can discern no rational reason why all three cases that were found to be similar to the case in error were not reanalyzed, or at least attempted to be analyzed. The Inspector General also found that Laboratory Administrator Anderson-Seaquist's representation to the Commission on Forensic Science that all three cases were rechecked to be inaccurate.

The Inspector General also found that Forensic Biology Section Supervisor Laura Ascroft failed to properly document the results of her audit of the prior casework of the Forensic Biologist III who had made the microscopy error. The Inspector General found that this improper documentation was due in part to deficiencies in the Laboratory's Corrective Action policy. Accordingly, the Inspector General recommends that the Laboratory amend existing policy to better address similar occurrences in the future. At a minimum, audit results and methodology should be documented and retained to ensure that the Laboratory accurately reports the results of such an audit and to allow a meaningful review of the audit results if necessary.

The Inspector General also found that the Laboratory's Corrective Action policy provides no guidance on when an audit may be necessary or its scope. The Inspector General acknowledges that every incident requiring corrective action will be both unique

and require that Laboratory personnel exercise professional judgment in determining how to best address the issues involved. However, the policy should be strengthened to include, at a minimum, criteria to be considered in determining when an audit of an analyst's past work is necessary, as well as the scope of that audit. The criteria could include, among other things: the severity of the error; the frequency of the error; the likelihood of the error being repeated by the analyst or others; and the effect of the error on any criminal prosecutions or potential prosecutions.

The Inspector General determined that both the Monroe County Laboratory's designation without legal consultation of cases as "beyond the statute of limitations," and their issuance of the "No analysis" reports were both ill-advised and improper. Indeed, in light of the remarkable result of the destruction of case evidence, these actions were irresponsible and inexcusable. The Inspector General recommends that the Monroe County Laboratory immediately implement policy that precludes reports from including legal opinions, including statute of limitations determinations.

The Inspector General's investigation also identified the large backlog of cases awaiting DNA testing in the Monroe County Laboratory as an important matter. The Inspector General notes that backlogs in DNA testing are not unique to the Monroe County Laboratory, but are a nationwide concern. This investigation did not directly examine the backlog issue. However, backlogs in the testing of DNA cases give rise to concerns relative to the integrity of a laboratory's forensic results, thereby warranting the Inspector General's examination. Consequently, the Inspector General is inquiring into testing backlog in forensic laboratories across the state to assess the extent of the backlogs and the adequacy of the actions laboratories are taking to address them. The goal of the Inspector General's inquiry is to determine and recommend best practices for laboratories in dealing with this serious issue.

Finally, the Inspector General recommends that the Laboratory establish and maintain regular communication with the law enforcement agencies it serves regarding

evidence submitted for analysis. The designation of a specific employee of the Laboratory for this purpose is encouraged.

The Inspector General is referring this report to the Commission on Forensic Science, the Monroe County District Attorney, County Executive, and Director of Public Safety for appropriate action.

V. RESPONSE FROM THE MONROE COUNTY EXECUTIVE

In a letter dated June 5, 2012, Monroe County Director of Public Safety Stephen C. Bowman responded to this report. Initially, Bowman noted that Anderson-Seaquist has been placed on administrative leave from her position as Laboratory Administrator pending a full review of the issues identified in this report.

In response to the Inspector General's finding that Laboratory Administrator Anderson-Seaquist's representation to the Commission on Forensic Science that all three cases were rechecked was inaccurate, the letter states, "we have made it clear to [Anderson-Seaquist] that she should not have permitted any confusion – or even potential for confusion – in communicating with the Commission." The letter adds that the same is required of all Laboratory personnel and a policy amendment to that effect has been proposed. The Inspector General notes that by reducing Anderson-Seaquist's response to the Forensic Commission as mere "confusion," Monroe County discounts the full import of her misrepresentation and minimizes her responsibility and accountability to the Forensic Commission, Monroe County and the Laboratory itself.

In response to the recommendation that the Monroe County Laboratory strengthen its Corrective Action Policy with regard to audits, a proposed policy amendment was provided to the Inspector General which requires an audit as part of every Corrective Action Plan involving an analytical error; provides guidance as to the scope of the audit; and mandates written documentation of the audit procedure.

In response to the Inspector General’s recommendation that the Monroe County Laboratory implement policy that precludes reports from including legal opinions, including statute of limitations determinations, Monroe County has proposed a policy amendment that states, “reports will not contain any legal determinations without consulting legal counsel.”

Finally, as to the Inspector General recommendation that the Laboratory establish and maintain regular communication with the law enforcement agencies it serves regarding evidence submitted for analysis, and designate a specific employee of the Laboratory for this purpose, the Laboratory has proposed a policy amendment requiring the designation of a liaison to law enforcement agencies, and mandating a Laboratory representative attend all Law Enforcement Council meetings.

The County Executive also noted her intention to form a Crime Laboratory Advisory Panel to “provide an opportunity for members to address concerns and offer suggestions for improvement of Laboratory services.” The Panel will include representatives from the Monroe County District Attorney’s Office, Monroe County Sherriff’s Office, Rochester Police Department, Law Enforcement Council and law enforcement official from outside Monroe County.