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THE NEW YORK CITY COUNCIL

"OFFICE OF THE CHIEF MEDICAL EXAMINER – OVERSIGHT AND BILLS RELATING TO RCA"

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Today marks an historic moment in forensic science history as we consider two legislative proposals which for the first time would require mandatory reporting by a forensic laboratory to a funding municipality of one of the core principles that scientific laboratories worldwide have long recognized, namely ROOT CAUSE ANALYSIS (RCA) and simultaneously mandate that the New York City Office of the Chief Medical Examiner (OCME) embrace transparency by publishing on their website their quality manuals and policies and procedures. I favor both of these bills with some suggested changes and take this opportunity to express my thanks to Chairperson Arroyo, Chairperson Ferreras and the members of the Committee on Health and the Committee on Women's Issues not only for proposing these groundbreaking changes but also for the previous hearing which considered the disturbing and frankly shocking laboratory failures which have occurred at the OCME.

It is now forty one months since the OCME discovered that something was amiss with the work of a lab technician tasked with examining physical evidence for

[1] The views I express here today are my own and do not represent those of any organizations with which I am affiliated.

signs of forensic stains such as saliva, blood semen, etc. Recent sworn testimony by Dr. Theresa Caragine, formerly the Deputy Director of the Forensic Biology Division before her recent abrupt resignation, in a pending criminal action, indicated that OCME was aware of problems with the technician's work in 2008, 2009, that new protocols were issued at the end of 2009 beginning of 2010.[2] See People v. Devon Thomas, Indictment 949/09, Bronx Supreme Court, March 21, 2013, Transcript pp. 1087, 1081. Notwithstanding OCME's own internal audits, a privately commissioned report ("Sorenson Report"),[3] FBI audits, external audits by the

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[2] OCME has previously suggested that in February, 2011, it became aware of problems with the lab technician's work, and it initiated a review process. It is unclear when the review process began. Furthermore the OCME was undergoing ASCLAD/LAB accreditatation in approximately February, 2011, but was aware in May, 2011, that it had been granted accreditation by ASCLD/LAB and that it would be seeking further accreditation by the New York State Commission on Forensic Science (CFS) on or about June, 2011. Indeed the CFS voted OCME accreditatation on or about June 27, 2011. At the time it voted, the CFS was not aware nor had it been told anything about the pending problems, incipient investigation and findings by OCME regarding the lab technician. Approximately July 7 or July 11th, 2011, OCME sent a letter to ASCLD/LAB informing them of problems with the lab technician. A copy of this letter was received by the CFS but was not, it is beloved, distributed immediately to the CFS members. Instead the letter was placed in the CFS briefing book for the October, 2011, meeting. There appears to be no internal CFS rule that requires when a notice of the kind involved herein should be sent to CFS members. In September and October, 2011, the OCME appeared for the first time before the DNA Subcommittee of the CFS and the CFS respectively to report the technician anomaly. From October, 2011, to January, 2013, the CFS did not act upon the OCME's continued reporting of the technician failures. In retrospect, this was a grievous error. As one of the CFS members I took upon faith the reports of the OCME and did not aggressively question or seek answers as to what occurred, preferring instead to await the outcome of the final OCME report. In retrospect the blind acceptance of the initial report was due to reliance on the good faith of the reporting laboratory. Doing so this was a violation of the rule that those charged with oversight ought be skeptical and aggressive in pursuing problems. I owe the City Council and the people of the state and city a profound apology for this lapse in judgment.

[3] Published accounts about the "Sorenson Report" seem to be about top management problems without allusion to the specific problems which the City

American Society of Crime Lab Directors/ Lab Accreditation Board (ASCLD/LAB), a state commission with jurisdiction over the OCME and multiple state and city prosecutorial/investigative agencies the public and this City Council still do not know the following basic essential facts of what happened:

1. What management systems were in place to ensure the accuracy of the technician's work during the nine year period she was examining evidence?

2. Who were the direct supervisors to whom the technician reported?

3. Are any of these supervisors currently working at the OCME and if so in what capacity?

4. Have any of these supervisors been interviewed by OCME management, what were the results of these interviews and have they been made public?

Council has considered in the first hearing. We do know that "Sorenson Report" did not address any review of the validity of the sciences practiced by the OCME as the result of an affirmation submitted by Mimi C. Mairs, Special Counsel to the Forensic Biology Laboratory, who unequivocally stated that the short term consultant hired by OCME was not solicited to review and evaluate any of the DNA techniques utilized and applied with the Department of Forensic Biology (i.e. Nuclear DNA testing, Mitochondrial DNA testing, High Sensitivity testing, Y-STR-typing, etc.). Further the short term consultant was not retained to review and evaluate the validation of High Sensitivity DNA or Forensic Statistical Tool. According to Ms. Mairs affirmation the short term consultant was hired to review and evaluate the Department of Forensic Biology's management and operational structure, and administrative policies (i.e., methods of communication, effective organization, information flow, team development, human resources e.g., employee retention, employee development, etc.). Also the short tem consultant was asked to evaluate the identification and scrutiny of areas for improvement, specifically the current team configuration and reporting structure. In short according to Ms. Mairs affirmation the private forensic consultant would prepare report which summarizes its review of the Department's managerial, supervisory and operational structure. See Affidavit of Mimi C. Mairs, Affirmation in Response to Notice of Motion for Judicial Subpoena Duces Tecum, People v. Collins and Peaks, Indictment Nos. 8077-2010 and 7689-2010, Kings Count Supreme Court, Part 26, April 25, 2013, paragraphs 7, 9, 10.

5. What was the chain of supervision from the technician to the very top layers of OCME management, or put another way, who in top management was responsible for knowing about the technician's work, what did they know and when did they know about it?

6. When was the first discovery made regarding the transposition of evidence in the so far discovered 35 rape kits and who was in charge of the review process of the all the technician's work? When was the final compromised rape kit discovered?

7. How was it determined that no cross-contamination of DNA evidence occurred? Was this done by scientific testing and if not what methodology was utilized?

8. Who determined how the OCME would report the lab technician's failures and to whom? Did OCME determine the wording of the notices allegedly and eventually sent by the District Attorneys' offices? Was the wording of the notices done in collaboration with the District Attorneys' offices? Who were all the OCME participants that decided when and how the reporting to outside agencies would occur? Did anyone in the OCME decide that the term "inventory control" would be utilized to inform third parties about the extent of the lab technician's failures?

9. What discussions took place between the OCME and the District Attorney's in all five boroughs regarding how reporting would occur and who were the individual District Attorneys in each borough that were the contact persons for the OCME regarding the lab technician's work and the DNA upload failure between 2003-2006? What steps have been taken by the OCME to preserve any and all emails between the OCME and the District Attorneys relating to any and all of the lab failures considered by the City Council at the prior hearing?

10. Has the OCME conducted a root cause analysis of the lab failures and if so where is it, who conducted it and when will it be released?

The goal of all legislation that regulates any forensic laboratory is to ensure conformity with recognized principles governing best practices. Further, legislation must be constructed – and these two bills are so designed – to address three basic concepts that affect how laboratories conduct their business: accountability,

management and culture. Accountability for forensic laboratories in the United States in the year 2013 is sadly lacking. Unlike New York, many states do not have forensic science commissions. Accreditation is not mandatory but the evidence suggests that even where a lab voluntarily submits to outside accreditation, the current process has largely failed. Across the United States, the primary organization which engages in "accreditation" is ASCLD/LAB. I have previously released to the City Council a memorandum which I wrote in March, 2011, which addressed the number of laboratory failures that have occurred nationwide since 2005 at ASCLD/LAB accredited laboratories. Here in New York we have had laboratory failures in the New York State Police Forensic Investigation Laboratory run by the New York State Police, in the Nassau County Police Department forensic Evidence Laboratory (FEB) and the Monroe County Public Safety Laboratory. Each of the failures has generated eye-opening reports by the New York State Inspector General (IG) of laboratory failure by ASCLAD/LAB accredited laboratories. Indeed the State Police lab failure involved a technician who for approximately ten years succeeded in faking ("dry labbing")reports before he was discovered. In that case the IG found that supervisors who investigated the matter participated in a cover-up, and the Nassau County laboratory failure which resulted in the laboratory being shuttered, resulted in an IG report which found failures of management at all levels and worse still a finding that the CFS had abdicated its oversight function and failed to utilize its statutory powers to enact rules and regulations far stricter than those required by ASCLD/LAB.

Much of ASCLD/LAB's rules and regulations which are contained in two documents – the ASCLD/LAB MANUAL (referred to as the "Legacy" program) and the ASCLD/LAB SUPPLEMENTAL REQUIREMENTS FOR THE ACCREDITATION OF FORENSIC SCIENCE TESTING LABORATORIES, 2011 EDITION (referred to as the "international Program"). The latter document incorporates changes mandated by ISO 17025 (the International Standard) which ASCLD/LAB had utilize when it received membership into two international trade groups that recognize other accrediting agencies.[4] Unfortunately ASCLD/LAB's rules and regulations are largely written as "suggestions" to laboratories regarding the practices to be utilized (thus the repeated use of the term "should"). Moreover ASCLD/LAB definitions of when to report a non-conforming event are loosely defined and despite at least 16 different iterations of its rules over thirty plus years, ASCLD/LAB has yet to instruct laboratories on a uniform system of reporting laboratory results in each of the forensic disciplines, notwithstanding a recommendation by the National Academies of Science groundbreaking report – "Strengthening Forensic Science in the United States: A Path Forward" – published in February, 2009, which recommended that the current system of laboratory result terms, such as "match," "identical," "similar in all respects tested," etc., were not only confusing but lacked transparency which made it impossible for juries, judges and attorneys to comprehend the full meaning of what was being stated.

[4] ISO 17025 is an internationally recognized consensus standard for testing and calibration laboratories with a primary focus on management and

Neither of the two ASCLD/LAB documents has a definition of "root cause analysis." The ISO 17025 under "Management: Corrective Actions" contains this provision:

> 4.11.2 Cause Analysis
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> The procedure for corrective action shall start with an investigation to determine the root causes of a problem.

All too often laboratories appearing before the CFS report a non-conforming event which sometimes is nothing more than an admission that the event occurred followed by what corrective action was taken without the searching analysis into all of the potential causes behind the event. Some agencies conduct excellent root cause analyses such as the New York City Police Department. For many however root cause analysis is confused with "corrective action." Moreover laboratories tend to view root cause analysis as problem specific without a full comprehension that failures in one area of a laboratory which are not analyzed properly often mask other related and unrelated problems affecting other working systems in the laboratory. In any case forensic laboratories under either the ASCLD/LAB Legacy or International programs have no specific guidelines, rules or regulations defining the RCA methodology to be used.

Even if a laboratory fails to repeatedly follow ASCLD/LAB rules and regulations, there is almost no danger of being placed on probation, suspension or sustaining a revocation of accreditatation. Indeed for much of its thirty plus year history ASCLD/LAB rarely imposed any sanctions on its constituent laboratories and to a large extent it dtill does not. When the Nassau County FEB failed approximately twenty-six different benchmarks in December, 2010, ASCLD/LAB

recommended probation even though five years before the same laboratory had been placed on probation, subsequently removed from probation and then between 2005 and 2010 engaged in the same failed behaviors. In San Francisco, after a DNA mix-up in which the supervisor ordered the records destroyed, ASCLD/LAB re-accredited the laboratory even though the same supervisor had previously responded to an ASCLD/LAB inquiry as to whether the event had occurred by noting no records existed of such an event. The San Francisco event was notable since the re-accreditation occurred months after ASCLD/LAB put into effect ethical guidelines which were clearly violated.

Accreditation accountability really does not exist. ASCLD/LAB's approach to "accreditation" is one of auditing a laboratory to determine if it has the appropriate manuals and written procedures, determinations as to calibration records, how reports are written and could be improved, etc. When rules are broken there seems to be no penalty that will be imposed. Recently in a Colorado federal case, a defense attorney served a subpoena on ASCLD/LAB attempting to obtain its rules and regulations which are not published and are available only to laboratories who are accredited and to members of forensic science commissions and investigative bodies. In a motion to quash, ASCLD/LAB submitted two affidavits which for the first time publically revealed the philosophy. Corrective action requests made by ASCLD/LAB are not presumptive determinations that a laboratory is liable for a failiure or that id did something wrong or deficient. In fact ASCLD/LAB goes so far as to state that if the laboratory can justify a "home grown process" as a procedure then that is totally acceptable. Far more troubling is the assertion in the affidavit

that confidentiality between the laboratory and the ASCLD/LAB inspection teams is crucial to the success of "accreditation" for without the laboratories would not participate in the process. Further, by keeping the discussions between the inspectors and the labs "confidential" the inspectors and the labs are free to engage in a process of mutual conversation "without fear of criticism or retribution." This paranoid approach to accreditation is not an accident but emanates I believe from an antipathy to regulation and discovery of what it is that ASCLD/LAB does. Both in public writings and at conferences ASCLD/LAB board members have decried court decisions which limit forensic testimony and the workings of state forensic commissions (in particular the New York State CFS).

So the primary accountability agency offers no accountability whatsoever. Nor can the City Council rely upon the CFS. As currently constituted the CFS has for over a decade repeatedly failed to exercise its authority. The CFS often sees itself as a protector of the laboratories rather than an oversight body. How else to explain the findings of the IG report regarding the Nassau County FEB failure in which the CFS was excoriated for its failure to act as the last check and balance, the final place where the public interest could be protected. The crux of CFS's problem is its constituent members. The majority of members on the CFS are from the laboratories, prosecutors and law enforcement and allied individuals associated with the laboratories including but not limited to a representative from NYCLAC which is the umbrella group for the laboratories in New York State, With a nearly impossible to overcome majority of the votes, the laboratories have successfully for over 15 years managed to thwart effective reform. There is one defense attorney

(myself) and two representatives from the Innocence Project who serve in most, though not all, cases as the driving force seeking reforms. The fact that the IG has been reporting one laboratory failure after another since 2008 is telling proof that the CFS is unable for the moment to exert its jurisdiction over the laboratories.

The RCA bill addresses many of the problems recounted. First it requires mandatory reporting without equivocation pursuant to specific definitional elements. Second the bill introduces specific timelines for the report of a non-conforming event thus putting an end to the laboratories reluctance to give an early warning to outside parties that an investigation is underway.[5]

The bill timelines are too lengthy before a report is issued. When forensic problems arise that affect results it is crucial that defense counsel and prosecutors be notified by the laboratory immediately for the simple reason that the cases which can be affected are occurring on a daily basis. It is not unheard of for a felony matter to proceed from arraignment to a plea within two weeks. Thus those in the criminal

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[5] It should be noted that under the "Rights and Obligations of ASCLD/LAB accredited laboratories" among the listed laboratory obligations is the following:

> As a condition of accreditation, each ASCLD/LAB accredited laboratory shall inform ASCLD/LAB, without delay, of significant changes to relevant its accreditation, in any respect of the laboratory's status or operation relating to:
>
> .....
> .....
> scope of accreditation
> other such matters that may affect the ability of the laboratory to fulfill requirements for accreditation

See ASCLD/LAB website under RIGHTS AND OBLIGATIONS OF ASCLD/LAB LABORATORIES.
Given what is known at present, OCME's interpretation of its obligations to report non-conforming events defies explanation.

justice system most in need of the information would not receive it under this bill. By shortening the timelines so as to require a completed report within 60 days of the discovery of a significant event and permitting no extensions beyond a total of 90 days from discovery, a genuine balance could still be achieved between the laboratory producing a meaningful report and the necessity of counsel having information which could affect the progress and outcome of a criminal matter.

At the very least it is crucial that the bill make clear that any initial report of investigation be made not only to the mayor and the City Council but to all the parties mentioned in 1(h)(3)(ii) with the addition of the New York State Association of Criminal Defense Attorneys, the New York State Defenders Association, the New York State Inspector General and the bar associations in the five boroughs of New York. Such widespread notice will at least permit counsel to alert the courts to pending investigations and allow for appropriate adjournments pending the outcome of a final report.

Section 1(h)(3)(ii) however contains a provision regarding release of the RCA committee's report which should be struck from the final RCA bill. It states that the Chief Medical Examiner shall provide a copy of the report to the District Attorneys and various public defenders "provided that the findings and or the conclusions in such report may be reasonably found to have an impact on a criminal investigation, whether ongoing or complete." Such a decision, which involves complicated legal principles, should not be left in the hands of the chief medical examiner. As written the provision can and will be interpreted by District Attorneys as one which mandates no release of significant event findings since <u>all cases</u>

involve ongoing investigations through a jury verdict. The better practice would be for individual and affected defense counsel to be notified by the chief medical examiner and the convening of a court proceeding before a court *in camera* but on the record with an appropriate protection order prohibiting the parties from revealing the information and permitting them to litigate the issues under seal.

The decision on what effect a laboratory failure has or will have on a criminal proceeding should never in any instance be made by forensic laboratory officials since they are not in a position to evaluate or even understand the infinite number of possibilities affecting a criminal matter. Motion practice, trial strategies, witness preparation, appellate proceedings and post conviction proceedings are just a few of the ways that laboratory errors can affect legal proceedings. To permit laboratories to make a final determination about whether a report should be released would be to give legal imprimatur to a system that has already failed, namely the reluctance of laboratories to contact the defense attorneys and simply rely on notices to District Attorneys with the hope that they will contact the defense bar. In fact at the first hearing the City Council heard testimony from William Gibney of the Legal Aid Society regarding not only the lack of notice to the Society's attorneys of the OCME lab technician's failures but more importantly the purposeful obscuring of the true extent of what had occurred by forwarding a notice that spoke to "an inventory control" problem.

Finally the RCA bill in Section h(1)(B) defines "root cause analysis" as a system for investigating causal factors that primarily will focus on systems and processes but "not on individual or human error." Such language should be struck

from the bill since the very nature of RCA requires looking at all possible causes of error behind a significant and sometimes one of those may be human error or performance. In fact this prohibition make no sense in view of the language contained in h(1)(F) which defines a "significant event" and includes repeated references to acts by employees which are intentional or result from a pattern of significant errors. Since the two sections have language at cross purposes and it is crucial to any valid RCA that human cause be reviewed, the language should be eliminated.

Management is the key to proper lab functioning. When management fails, then the science produced by the laboratory suffers. The OCME lab technician's failure coupled with the DNA upload problem are symptomatic of serious management failure at the OCME, and by that I a not referring to internal politics, backbiting, acts of personal disrespect and/or mis-communications. Instead laboratories and their managers are supposed to be aware of the proper systems needed to function effectively. That is one reason why laboratories have Quality Assurance Managers that report to higher management entrusted with making the appropriate changes so that the laboratory can operate in a better fashion either because of new methodologies or changing laboratory conditions. Let me be clear that the recent events at the OCME should be cause for great concern not because the errors occurred, but more so because of the nature of the errors, namely the violation of one of the most basic rules of any laboratory that prohibits a technician from having more than one case on the bench at the same time and secondly that the errors went undetected for a decade.

That no system was in place to review the work of the lab technician and that the same escaped detection for so long despite yearly ASCLD/LAB inspections is strong evidence that both the lab management and its accrediting agency were ineffectual. In the ASCLD/LAB Legacy Manual, the very first section deals with LABORATORY MANAGMENT AND OPERATIONS. Some of the concepts that inform ASCLD/LAB's thinking are:

1. Having administrative practices that are clearly developed so that employee performance will improve.

2. The necessity for having clearly written procedures for the handling and preservation of evidence.

3. Organizational structure will be more effective when variables such as the numbers of personnel , degree of interaction level of decision making, etc have been fully considered.

4. There must be someone assigned responsibility for the efficient and effective performance.

5. Good supervision contributes to critically evaluating programs.

6. Supervisors have a responsibility to critically an objectively review laboratory activities and personnel.

7. Among myriad duties the quality manager should propose corrections and improve the quality system.

8. There should be periodic audits which should utilize checklists which in turn should include evidence handling procedures.

9. There should be an annual quality review the findings from which should inform changes in the quality system.

Since all of the above are part and parcel of what ASCLD/LAB expects laboratories to do, then several key questions are raised in the context of the OCME lab failures. First just what was ASCLD/LAB reviewing during its accreditatation inspections for 10 years? It would appear that the interplay between management

systems and procedures that are supposed to be in place and the personnel who are in charge are inextricably intertwined. If that is so then how did ASCLD/LAB and OCME management miss the lab technician's errors? What exactly does ASCLD/LAB inspect when it supposedly goes over management systems that are mandated by their very own accreditatation manual? Additionally why if management systems are specifically denoted in ASCLD/LAB regulations and are subject to inspection would there be a need for OCME to retain the services of an outside vendor to review its management systems and operations paid for by taxpayer's money? It simply defies explanation that OCME needed an outside consultant unless they were dissatisfied with the ASCLD/LAB findings of the last ten years.

Given what we now know, limited though it is for the moment, it is clear that whatever ASCLD/LAB is doing, is not working. I would strongly suggest to the City Council that the obvious answer is that ASCLD/LAB is not qualified to review management systems in laboratories. It is one thing to audit a laboratory by checking off if the necessary manuals exist, have been updated, if protocols are in place and an entirely different matter to conduct interviews of laboratory personnel which do not address or even uncover problems with the management systems in place. If any part of the "Sorenson Report" findings which have been reported by the press are half true then the question the City Council must ask itself is how did ASCLD/LAB miss these problems over a ten year period? The requirement of the RCA bill that the OCME must report RCA findings may well have the intended effect of causing management to focus with greater earnestness on fundamental

laboratory problems, but it cannot fully solve the problem of what appears to be a chaotic management scheme in the laboratory.

In the world of forensic science, laboratory culture can mean the difference between a laboratory that conducts its science by adhering to proper scientific principles and a commitment to transparency and a laboratory that views itself as an arm of the prosecution with the goal of keeping its work hidden from discovery by the public, the press and defense counsel. While the OCME will upon request with an accompanying subpoena release its forensic materials to defense counsel, it does not follow the same procedures when it comes to the release of electronic raw data which underlies its DNA analyses. In many laboratories around the nation a simple request will yield the release of underlying electronic data. In fact the number of agencies that do so is well over a hundred and includes some of the following:

Albuquerque Police Department Crime Laboratory
Arizona Department of Public Safety
Colorado Bureau of Investigation
Illinois State Police Crime Laboratory
Florida Department of Law Enforcement
Georgia Bureau of Law Enforcement
Connecticut State Forensic Laboratory
Minnesota Department of Public Safety
New Jersey State Police Crime Laboratory
Pennsylvania State Police Crime Laboratory
San Diego Sheriff's Department
South African Police Force
Massachusetts State Police Crime Laboratory

Laboratories engaged in scientific research have no problem releasing such information since scientific investigation is furthered by appropriate challenges whether at scientific conferences or in courtroom litigation. Moreover, laboratories

are ever mindful that strict adherence to the most basic scientific procedures, such as the recording of validation procedures which can later be subjected to inspection and scrutiny.

Recent developments here in New York suggest that the OCME no longer sees itself as an independent entity serving the cause of science but rather a partisan party aligned with the Kings County District Attorney attempting to have a particular forensic technique accepted by the court whose results could be used to prove the defendant's guilt. Thus in the currently pending case of Jaquan Phoenix, Legal Aid Society attorney Jessica Goldwaite (Goldwaite) had to obtain an order to show cause as to why the OCME should not be held in contempt for failing to honor a so ordered subpoena requesting underlying data, protocols and validation studies employed by the OCME to reach conclusions that certain DNA evidence recovered from a bicycle could be that of the defendant. Goldwaite contended that the OCME had overstated the results of its testing and sought the materials so she could properly cross-examine and prepare for trial. After Goldwaite noted in her show cause order that the proper method for contesting the so ordered subpoena would have been to move to quash, the OCME and the defense then reached agreement on the release of the data.

Far more troubling is the testimony of Dr. Adele Mitchell (Mitchell)of the OCME's Forensic Biology Laboratory. During a Frye Hearing challenging a newly developed forensic tool used only by the OCME Mitchell was repeatedly cross examined about how she conducted her testing and research with respect to the new forensic methodology (known as FST). It is important to remember that both

the prosecution and defense may strongly litigate and disagree on the validity of a forensic method in a court of law, but regardless of the opposing views or even the final decision by a court, what cannot be denied is sworn testimony which reveals a departure from accepted principles of science. Thus in People v Collins (Collins), Mitchell testified that underestimating allelic drop-out rates was conservative and she did studies to that effect, but these were unrecorded. See Collins, May 1, 2013, Tr. p. 117. With respect to FST Mitchell testified that she did a proper validation summary to determine the quantitation size of a sample tracked the drop-out rate for that sample. However these studies were not recorded and not reported to the DNA Subcommittee of the CFS. See Collins, May 21, 2013, Tr. pp 28-32. As to calculations of "standard deviations" Mitchell testified that she did not record her testing and her information was not reported to the DNA Subcommittee of the CFS. See Collins, May 1, 2013, Tr. pp. 137-138. Thought the subject matter is very technical, the elicited testimony reveals what can be fairly interpreted as a series of deviations from the scientific practice of recording one's research so it can late be examined.

The refusal to yield scientific materials that other laboratories readily release, the litigious stance of the OCME and its ignoring of a subpoena, the necessity for defense counsel to obtain a contempt order by way of an order to show cause and deviations from proper scientific research practices are all indicia of a different kind of laboratory than we have previously known or seen in New York City. This is not a laboratory interested in transparency. Quite the opposite, OCME has become a

repository for obtuseness and a reluctance to yield information about itself or its failures.

The Transparency Bill is a good first step in bringing the OCME out into the open where its documents can be seen and examined. The mere mandating of such may have a salutary effect on how the OCME conducts itself in the future with respect to revealing the underlying information behind its research. While OCME currently posts online its technical manuals it does not publically share its quality manuals nor its laboratory policies and procedures. The Transparency Bill would benefit from requiring that OCME publish its accreditation audit reports, the annual surveillance visit reports and any other documents dealing with the accreditatation program. The more that is published regarding how the laboratory operates the more the public and litigators will know how well the laboratory is being managed and it overall effectiveness. A main reason I believe that laboratories have resisted "letting the sunshine in" is their fear that the information will be utilized by defense attorneys who will use the materials in case preparation. Yet that is precisely the goal all of us should be interested in achieving. A laboratory that knows its work will be subjected to scrutiny will function and operate at a more effective and higher level of efficiency and produce a better product. If in a court of law the OCME's work is found unassailable then the jury will be able to make an accurate evaluation of all the evidence against an accused.

One last recommendation I would ask the City Council to consider and that would be the establishment of a Forensic Advisory Committee. Such a committee could function to address issues which arise in the forensic disciplines and prepare

reports which could educate Council members on the key issues involved in making policy determinations. No great costs need be incurred. The Advisory Committee would consist of unpaid volunteers and the meetings could be conducted in any number of conference rooms that are available to the Council. It is important that this Advisory Committee not be dominated by prosecutors and laboratory personnel. That type of composition will only lead to gridlock and would be unproductive. It would be enough if members of the public and private defense bar, a prosecutor, an Innocence Project forensic expert and OCME manager be present along with an a scientist not affiliated with forensic science at all.

The passage of these two bills would be a step in the right direction and would signify that New York City is committed to providing the best possible forensic science that can be done. We should however not think for a moment that the task ahead will be easy. The laboratory community is resistant to change and regards regulation as an unnecessary intrusion upon its domain preferring instead the comfort of a discredited accreditatation system. In time however the changes which have begun with this proposed legislation will be seen as heralding a more open and better system of forensic practice which can only contribute to the betterment of our criminal justice system.

Good Morning

My name is Lawrence Kobilinsky and I am a Professor and Chairman of the Department of Sciences at John Jay College of Criminal Justice, CUNY. My area of interest for the past 2 decades has been the use of DNA for human identification. I have never worked for the OCME laboratory nor for any law enforcement agency. I am primarily employed as an academic. However, I also provide consultation to attorneys who have DNA cases and who need to better understand the procedure and the significance of experimental findings and official reports and testimony.

I testified at the first hearing regarding the problems at the OCME DNA lab and now I am back at this hearing to talk about the two proposed laws that are meant to provide more oversight and more transparency for procedures conducted at the OCME. These bills if passed will amend the New York City Charter. I support both bills for a number of reasons. In any institution or agency significant problems and issues arise from time to time. It is important that such issues be dealt with in a systematic manner so that issues are not resolved on an ad hoc basis.

I first became aware of the problem at the OCME DNA laboratory in early June when the New York Times published an article entitled "New York Examines Over 800 Rape Cases for Possible Mishandling of Evidence" written by Joseph

Goldstein. I was quite surprised to learn about these problems since this laboratory has an excellent reputation with forensic practitioners, is fully accredited, has a quality control and quality assurance program and requires well educated and well trained personnel to do casework. It uses only technology that they have validated and maintain every form of required documentation regarding their equipment, facilities, personnel and procedures. This is the largest DNA testing laboratory in the United States. It processes approximately 1500 sexual assault cases each year. In 2011 the laboratory issued around 11,000 official reports involving DNA collected from crime scenes. About 1/3 of these reports relate to property crimes (burglaries and robberies). Homicides make up only 6% and sexual assaults are approximately 20%. Recovered weapons (guns, rifles, knives, etc) make up about 10% of the caseload. The remaining 30% involve DNA testing of suspects, elimination samples, arson cases, missing person cases etc.

I have had the opportunity to read the report prepared by Sorenson Forensics which was hired last February to review and evaluate management, operational and administrative practices of the Forensic Biology Department. They have made several recommendations regarding department leadership, changes in organization structure, change in management, increases in salary to improve employee retention and other suggested changes. Many of these recommendations make

practical sense and I support them. I have also read the proposed bills before the City Council.

The establishment of a root cause committee and procedures that are meant to deal with any problem once it is recognized as a significant problem makes good sense. Protocols and guidelines can be examined, a study of the violation of a documented procedures can be made and the factors that caused or contributed to the event can be identified. Finally guidelines for identifying corrective action can be developed. I firmly believe that forensic laboratories must be transparent. Because the reported results are critical to what happens to defendants in criminal legal proceedings, the analysis of evidence must be reliable and understood by prosecutors and defense attorneys as well as by the triers of fact. These reports impact not only on the defendant but also on the victim and victim's family. Procedures must be validated and consistent with the science and technology recognized by scientists in the field of molecular Biology and forensic DNA analysis. The utilization of the scientific method to resolve legal issues is an excellent way to establish facts for jurors to incorporate into their decision making. However, it is critical that there be no bias on the part of those doing the analyses or the results may be incorrectly interpreted. Transparency helps minimize or eliminate any bias that may enter the process. I therefore support both bills that are before the City Council today. Unfortunately, these bills are not going to be

able to eliminate or minimize the root cause of serious issues that may arise at the DNA testing labs of the OCME. I would like to make the following recommendations to be incorporated into OCME policies.

Recommendations:

- Hire personnel with a good foundation in basic science including coursework in biology, chemistry, statistics, and physics. This coursework should have a strong component in ethics. Candidates should also have excellent written and oral communication skills.
- After candidates are hired, they should be given training for at least 6 months by experts who are skilled in educating about science and ethics. Only after passing a laboratory proficiency test should they start to process casework. They should begin their work experience with evidence handling, serology and eventually move on to DNA analysis procedures including extraction, amplification, electrophoretic analysis and interpretation of electropherograms.
- Maintain good quality control procedures in the laboratory. Reports must be signed by the analyst. There should always be a second reader with technical expertise to provide technical review. There should also be administrative review of the case and this must be documented.

- Transparency of testing can be improved by including the real time PCR quantitative analysis calibration curves in the bench notes. These notes should be made available to prosecutors and defense attorneys in a timely manner.
- OCME experts should have an open door policy so that defense attorneys have the same access to lab procedures and reports that prosecutors have. OCME experts should be able to discuss their experimental findings with defense attorneys as well as with prosecutors.
- Continuing Education – the laboratory should make available to their science employees short intensive courses on an ongoing basis to assure that personnel are aware of the latest developments in their respective fields of practice and that they learn about best practices in their discipline. Participation in these courses should be mandatory. Such training should be conducted in house and at seminars and symposia which are regularly held at regional and national professional forensic meetings. For example, NEAFS and AAFS. DNA analysts should be able to attend a regional or national meeting at least once every two years.
- Proficiency testing is essential and is normally done every 6 months. If problems are noted, employees should be retrained or removed from testing

casework. Defense attorneys as well as prosecutors should have access to these results of proficiency testing.

- Seminars on Ethics should be routinely offered by the laboratory using external consultants. These sessions should be mandatory for all employees of the Forensic Biology Department.
- Redundancy of Testing: Do the test twice (or even three times). This is an important concept that could result in more accurate test results. The analyst is made aware that another person will be testing the same evidence and developing independent conclusions. This does not mean that every specimen is tested twice. It does not mean that every rape kit is tested twice. Perhaps every tenth rape kit would be sent to a second analyst who will independently do the same testing. Supervisory personnel and/or quality control personnel can review results to determine if the second finding is consistent with the first. It is important that the second analyst not be told the results of the first analyst and also not know the identity of the first analyst. The knowledge by the analyst that samples will be retested by an independent examiner will strongly decrease the chances that the test is done carefully and according to established laboratory protocol. No shortcuts will be taken lest the wrong conclusion may be drawn. Redundancy of testing could work within a lab or between labs.

Lawrence Kobilinsky Ph.D.

Chairman Department of Sciences

John Jay College of Criminal Justice

The City University of New York

Dr. Lawrence Kobilinsky has been at John Jay College since September 1975 when he joined the interdisciplinary forensic science department as its forensic biologist. He received his B.S. and M.A. degrees from The City College of The City University of New York in 1969 and 1971 respectively and his Ph.D. degree from The City University of New York. His doctoral work was performed at Mt. Sinai School of Medicine in the department of Biochemistry. After receiving his doctorate he became a postdoctoral fellow at the Sloan-Kettering Institute in New York City. While there he became a research associate and eventually a visiting investigator.

At John Jay College he was promoted to the positions of assistant, associate and full Professor and served in an administrative capacity as Acting Dean of Graduate Studies and subsequently as Undergraduate Dean and Associate Provost. He has also served as Science Advisor to the College President and is currently Chair of

the Department of Sciences. He is a member of the doctoral faculties in biochemistry and criminal justice at the Graduate Center of The City University of New York. He has served as a consultant to CBS and other network news programs on issues related to forensic science. He also served as an advisor to the U.S. State Department regarding forensic science laboratories in The Ukraine.

He is a member of 18 professional organizations and serves on the Board of Directors of the Eastern Analytical Symposium.

As an internationally renowned forensic scientist he has served as advisor to criminalistics laboratories in several countries including Mexico, China, Brazil, the Dominican Republic and others. He is a Fellow of the American Academy of Forensic Sciences and a Diplomate of the American College of Forensic Examiners and is a Board Certified Forensic Examiner. He has received numerous grants for both research projects and institutional development projects. He has received numerous honors including the Federal Law Enforcement Officers "Civilian Award." He has published extensively on the subject of forensic DNA analysis and has made many presentations at regional, national and international meetings. He has also published the following books: DNA: Forensic and Legal Applications published by John Wiley and Sons and Forensic DNA Analysis published by Chelsea House. He is series editor for Inside Forensic Science by the same publisher. His most recent books are: Forensic Chemistry Handbook by John

Wiley and Sons, and Forensic Science Advances and their Application in the Judiciary System, CRC Press; Taylor and Francis Group, both 2012.

Michael Coleman
Executive Director of NYCDS
Supervisor of LAS for twenty years

I'll be brief.

I'm not saying ME's office isn't doing a good job. But honestly it is not perceived as being neutral but as an arm of prosecution.

My organization defends 18,000 people in Manhattan every year where the D.A. still withholds discovery until after trial starts and trial by ambush is the norm. It goes hand in hand with the issue of loss of trust in the system. Lack of discovery and lack of transparency in the ME's office can only lead to wrongful convictions and injustice.

The old argument that if we give the defense too much information is a faulty one. It is a very dangerous one and is a slippery slope that can lead to disastrous results.

I was a village justice in Nassau County for eight years where the police lab has operated under a cloak of secrecy while we were all assured that it was the finest in the state.

Of course we found out that proper procedures and protocols were not being followed and kept secret and that 9,000 drug and alcohol test results were possibly erroneous. This has led to the overturning of many convictions and resulted in hundreds of law suits which are still pending. They will eventually cost the county a lot of money. This could have all been avoided by having a more transparent office.

Addressing these bills, it's extremely important for us to have the kind of openness and transparency in the ME's office that will alleviate our fears. It should not be perceived as a prosecutor's office. Whether or not they are doing or not doing a competent job is not the issue.

Trust is the issue.

People have to have confidence that results are accurate and most of all that justice is being done.

Transparency breeds trust and credibility and that by far is the most important issue.

We support both bills.

New York University
School of Law
A private university in the public service

Testimony of Professor Erin Murphy
Given by Elizabeth Daniel-Vasquez
NYU School of Law

Oversight: Examining the Need for Meaningful Transparency, Review and Reporting in the Office of the Chief Medical Examiner

Int. No. 1050 – In relation to procedures for conducting a root cause analysis by the office of the chief medical examiner.
Int. No. 1058 -- In relation to transparency of the office of the chief medical examiner.

New York City Council
Joint Hearing of the Committees on Heath and Women's Issues

June 24, 2013

Preface

Good morning. My name is Elizabeth Daniel-Vasquez, and I am here on behalf of Professor Erin Murphy of NYU School of Law. Professor Murphy apologizes that she cannot be here in person to give this testimony, but she asked me to read this prepared statement on her behalf, because she feels these important bills deserve comment. As you may recall from Professor Murphy's testimony this spring at the oversight hearing on these matters, she is an internationally-recognized scholar of forensic science who focuses particularly on DNA evidence, and her work has been cited numerous times by the U.S. Supreme Court. Prior to my graduation from NYU this spring, I worked closely with Professor Murphy on issues related to forensic DNA testing. It is my pleasure to share with you the following statement.

Testimony

It is with great pride in my local city council, and with special acclaim for Members Arroyo and Ferreras, that I testify in support of these two critical and visionary bills for oversight of the Office of the Chief Medical Examiner.

The last time we gathered in this room, we undertook the somber task of attempting to discern how a flagship laboratory such as OCME had allowed a forensic technician to make significant and uncorrected mistakes in roughly 1 in 10 of her cases over a period of 10 years. At that time, I pointed out in my testimony that this lapse was particularly troubling given that New York state has one of the most robust forensic oversight systems in the country, and lamented that OCME's problems were representative of greater structural infirmities in the administration and management of forensic laboratories nationwide. Observing that existing processes and institutions had proven systematically incapable of conducting truly meaningful supervision, I closed my testimony by comparing the city's strict procedures for regulating its food establishments with its relatively lax approach to its forensic labs.

Today's hearing, happily, is an occasion for celebration. The two proposed bills constitute innovative and bold steps toward establishing a DNA laboratory system that will be the pride of the city and a model for governments everywhere. I'd like to comment briefly on each bill.

First, the transparency bill represents a long overdue effort to shift the culture of forensic science practice from that of a partisan in the adversarial battle to neutral scientific participant in the criminal justice process. As the 2009 National Academy of Sciences report on *Strengthening Forensic Science in the United States* observed, all forensic laboratories should have established protocols, regular proficiency testing, and meaningful accreditation in order to safeguard the integrity of their results. This bill simply makes those important documents readily accessible. Such a move is consistent with the American Bar Association's Standards on DNA Evidence, which *require* a prosecutor to disclose: "reports of all proficiency examinations of each testifying expert and each person involved in the testing..."; "reports of laboratory contamination and other laboratory problems affecting testing procedures or results relevant to the evaluation..."; and comprehensive

documentation of accreditation, protocols, and quality assurance procedures. ABA Standard 4.1(vi), (v) and (ix). Unfortunately, New York's Criminal Procedure Law lags behind the ABA's detailed rule, and contains only a vague reference to disclosure of scientific tests, but that seems more a product of the time of its enactment rather than deliberate choice. *See* N.Y. C.P.L. 240.20.1(c). After all, the CPL is more comprehensive in its disclosure rules in section *k*, which deals with testing and equipment used for traffic violation enforcement, and it is hard to imagine that legislators made a conscious decision to privilege breathalyzer or speed gun calibration over DNA instrumentation. Regardless, there is no justification for keeping secret or making difficult to review the material covered by the proposed bill, as OCME itself in part recognized just before the February hearing, when at its own initiative it posted some of this material on its website.

In fact, the ready availability of these critical items is essential for two reasons. First, mandating that the OCME make this material public in turn gives the institution a strong incentive to keep its protocols current and its proficiency test scores high. Importantly, the National Academy of Sciences report found that labs often lacked accountability when it came to adhering to their own guidance documents, finding that protocols and quality assurance manuals were all too often "vague and not enforced in any meaningful way." 2009 NAS Report at S-5. That very finding is apparent in the case that brought the Council's attention to this issue, given among other things that the technician had apparently repeatedly failed the tests that qualified her to do her work and there were questions about fidelity to internal rules. A rule requiring the OCME to make such information public might have led management to act more aggressively, and in a more timely fashion, to address such patently inadequate work.

Second, even if public transparency does not prompt OCME toward more rigorous self-policing, it at least will enable other actors in the criminal justice system to better fulfill their institutional roles. The Supreme Court has repeatedly affirmed that the adversarial process is the time-honored way to guarantee the integrity of evidence, but sophisticated scientific evidence can pose challenges even for enthusiastic litigants. Consider how bulky and cumbersome the documentation

cited in the American Bar Association's rule can be; it is hardly the kind of material that can be readily handed over in a tidy discovery packet, particularly given the rushed and congested atmosphere of the criminal courts. But as the New York Court of Appeals has acknowledged in affirming the right of trial courts to exclude expert testimony where late disclosure of expert material "create[s] logistic problems," without such material an opposing party is "unable to engage the proffered testimony." *People v. Almonor*, 93 N.Y.2d 571 (1999). Accordingly, open access to protocols, proficiency tests, and accreditation documents helps to ensure that all stakeholders are able to raise challenges when appropriate. This is true not just of the defense, but also the prosecution. For example, the Nassau County lab scandal provides a stark illustration of how poor communication between a lab and its "customers" can be; in that case, the district attorney learned by accident through informal channels that the laboratory had been placed on probationary status by its accreditor.

This brings me to the second bill, which establishes practices and personnel for a root cause analysis. The requirements of transparency in the first bill go far to prevent against an incident like the one that brought us here today, but no laboratory is perfect. Inevitably there will be shortcomings or mistakes, and in such cases, the provisions of the second bill exist to ensure that the laboratory takes a hard look at the structural features that led to the problem, rather than treat each incident as an isolated case of "one bad apple." As my earlier testimony noted, the accreditation and oversight mechanisms in place at the time of the incident here obviously failed, in part because those mechanisms lack some of the requirements found in this bill. As members of your honorable committees well know, root cause analysis practices are considered standard among clinical laboratories because they constitute an essential safeguard of the integrity of laboratory processes. Enactment of this bill simply places the testing we perform to make decisions about human liberty on par with that done to make decisions about prescribing antibiotics.

In addition, this bill contains additional critical components that will enhance the reliability of forensic DNA testing. First, by linking the trigger for such an

analysis to the standards already used for accreditation, this bill ensures that any serious incident will be addressed in a meaningful way. Second, the mandatory deadlines impose a duty of prompt and timely investigation, which forecloses the delay that occurred in this case -- which took several years to investigate and come to light – from happening again. Finally, the disclosure provisions – especially the requirement that local district attorneys and representatives of the defense bar receive notice – guarantee that any such investigation will not occur without full awareness on the part of those that regularly rely on OCME's services.

In closing, these bills represent swift and significant responses to the crisis that occasioned these hearings, and the Council should move without hesitation to adopt them. With these bills, the N.Y. City Council will restore the OCME to its proper place as a leader and model provider in the field of forensic science, while at the same time reassuring the people of New York City that no offender will evade justice, and no person be wrongfully accused, as a result of faulty forensic testing.

Local 375 testimony for Monday, June 24th on Proposed Legislation on RCA at the OCME NYC

Michael McCasland – Criminalist III OCME and Chapter 39 Union President

Local 375 would like to thank you for allowing us to give testimony on the proposed legislation. Specifically, Local 375 represents the scientists at the OCME, the criminalists and city research scientists. These Criminalists are the individuals who perform casework, who testify in NYC criminal court to the DNA results, and as such, have the potential for public scrutiny. The union would like to give our conditional support for the legislation, along with specific suggestions for improvement. I want to make it clear that our aim is to help promote a quality system that better guarantees accountability and transparency while protecting workers from undue scrutiny or blame. We believe that proper root cause analysis can achieve this aim.

First, I would like to explain why we support this legislation at its core application. Mandating that a root cause analysis be performed when a significant event occurs ensures accountability and follow-through, and of course has the potential to improve OCME operations. Requiring the OCME draw up a policy that defines the root cause analysis procedure will help ensure that the process is executed in a consistent fashion. Defining what individuals are to be on the committee sets the framework for a balanced and independent fact finding operation, although I have a recommendation to this point that I will discuss later.

The OCME's DNA lab is the largest DNA lab in the county. We do amazing work. Our results are critical to NYPD investigations and cases pursued by the District Attorney's Office. Our work affects the lives and operations of thousands of New Yorkers, if not the safety of all New York City. Naturally, these realities place a Criminalist performing DNA analysis under the highest level of public scrutiny.

Alongside this scrutiny is that fact that the Criminalists are the first line of quality. We actually do the work, perform the DNA analysis, and testify in court. We are the primary source material to the analytical results, the day to day operations, and the foundation of any root cause analysis on DNA at the OCME.

Under these two premises, that the Criminalists performing DNA tests are under the highest level of public scrutiny, and that they are in fact most vital in ensuring transparency and quality, the union has four recommendations:

1) We would like to see more accountability written in the legislation for the root cause analysis officer. They are the gate keeper to the creation of the committee and we want to make sure that their threshold for determining a significant event is balanced and applied consistently case to case. This concern is understandable. Given the investigation and reanalysis of DNA evidence stemming from an employee that worked for the OCME for over 10 years, it is clear that critical mistakes can be overlooked. This legislation helps, but the threshold is still ultimately determined by one individual, the RCA officer. So, we recommend that the law require the RCA officer to document their rationale each time he or she makes a decision to form the RCA committee, or not to form such committee. This will add a level of accountability and help ensure consistency.

Local 375 testimony for Monday, June 24th on Proposed Legislation on RCA at the OCME NYC

Michael McCasland – Criminalist III OCME and Chapter 39 Union President

2) If the significant event involves a union member, we would like the legislation to require that a union representative working in the lab sit on the RCA committee. As I stated before, the Criminalists who perform the work are the primary source for what is actually done. Importantly, a union representative who works in the lab knows what is going on at the lab bench; Criminalists come to the union rep with their issues; the union rep is aware of workers' grievances. Therefore, the union rep has a perspective unique to a regular lab worker or employee, something that will enhance the fact finding operation of a root cause analysis. Having a union rep on the committee will also hold the committee to task - that the root cause analysis performed looks at systems, not particular individuals.

3) We have real concerns with privacy. Workers in the lab must work in an environment that they feel comfortable, not only so that they can perform their duties, but also so that they are willing to report mistakes and nonconformities. We recommend that the legislation explicitly state that names cannot be included in the proficiency summary report posted on the OCME website, similar to how it is address for the root cause analysis report, section 6, Int 1051-2013.

4) Lastly, we would like the legislation to add that the RCA committee's results cannot be a substitute for an employee's disciplinary procedure. Root causes analysis is designed to focus on systems and not individuals. Still yet, it is the employee who performs the work. As such, you cannot do a root cause analysis without looking at individuals. That is why we want to project civil servant rights by asking that you define the RCA committee be absolutely exclusive of disciplinary hearings. Additionally, we want the law to indicate that the findings of the RCA committee may not be used in a disciplinary hearing. Just as RCA focuses on the processes, a disciplinary focuses on the employee. We want this boundary to be firm.

June 24, 2013

OFFICE OF CHIEF MEDICAL EXAMINER TESTIMONY BEFORE CITY COUNCIL: HEALTH AND WOMEN'S ISSUES COMMITTEES

Re: Int.No.1050 and Int. No. 1058

Chairpersons Arroyo and Ferreras, thank you for inviting us to speak before you today. I am Dr. Barbara Sampson, Acting Chief Medical Examiner. To my right is Barbara Butcher, Chief of Staff and Interim Director of the DNA Laboratory, and to my left is Mimi Mairs, our attorney for DNA matters.

I would like to briefly review for you the scope of work performed by the New York City Medical Examiner's office before I discuss the details of the proposed legislation. The Agency has two major functions: death investigation and DNA analysis. You are aware that, as dictated by the City Charter, we investigate all deaths that are sudden, violent or unexpected. We work cooperatively, though independently, with many entities including law enforcement and the criminal justice and medical communities, to ensure that family members of decedents are served with compassion and technical excellence. Equally important but less well known is our role in public health: monitoring disease and accidents. The Department of Health and several Federal agencies routinely use our data to improve the lives of citizens.

Our work in this area is regulated by Federal, State, and local government, as well as by professional medical authorities.

No area of our work, though, is more highly regulated or overseen than that of our Forensic Biology laboratory. As the largest public forensic DNA lab in the country, we are closely regulated by Federal authorities as well as our accrediting bodies. Additionally, New York State highly regulates all of its Forensic labs, making us subject to scrutiny of the highest order.

Our oversight bodies include the New York State Commission on Forensic Science, the DNA subcommittee, the Department of Criminal Justice Services, the FBI, the American Society of Crime Laboratory Directors Laboratory Accreditation Board (ASCLD/LAB), the International Organization for Standardization (ISO), the New York City Council, and the Mayor's Office.

We have studied the proposed Charter amendments carefully to understand the Council's suggestions and concerns. We share and indeed fully embrace the Council's goal of ensuring a high level of transparency and accountability. We are cautious, however, about many of the specific provisions of the bill, and we would like to bring them to your attention.

First, it is already a requirement of the DNA accrediting bodies that we perform a root cause analysis in the event of any incident which affects casework. This is described in standard number 4.11.2 of ISO/IEC 17025, as well as the FBI DNA Quality Assurance Standard 14.1.b. The bill also contains a provision that we designate a Root Cause Analysis Officer, which we already have in the person of our Technical Leader and Quality Assurance Director, Eugene Lien.

Root cause analysis is a part of our internal culture at OCME. We are concerned, though, that the proposed bill's detailed requirements for composing a Root Cause Analysis committee could frustrate our ability to perform a quality incident review. The bill states that we must convene the committee within 48 hours of discovering an error. The committee must contain at least 7 members of varying credentials relative to the incident in question, and a consultant employed by the Health and Hospitals Corporation must be engaged as a member of said committee. Gathering 7 members for a committee is unwieldy, likely slowing the process of a good investigation, and achieving all this within 48 hours would be difficult if not impossible. Further, HHC's participation in the committee, as apparently required by the bill, would likely be voluntary and at their discretion, as HHC is an independent public benefit corporation. If the bill requires that this

"consultant" be retained outside of his or her normal work for HHC, then this would seem to be a highly unusual legislative contracting requirement, which might in any event require HHC's consent.

As this Committee may be aware, there are many different types of Root Cause Analysis applicable in differing circumstances. We are unclear if under the bill we would retain the discretion to choose the type of analysis we think best suited, or if we are limited to using only one methodology, and if so, which one? The language in a Root Cause Analysis report can be quite technical and not likely to be of benefit to the general public.

The reports may also be explicit in characterizing errors and mistakes made by identified individuals, and we fear that the publication of RCA reports on the Internet might discourage some from embracing a culture of reporting mistakes or writing openly and frankly about errors. This is precisely why hospital root cause analyses are internal and not made public. Although the legislation states that no individual shall be named when describing errors in a case, we believe based on our experience that some will seek to publicize those names in an effort to impugn testimony that is unrelated to the incident being reviewed. It has long been our practice to notify criminal justice entities of any error in a specific case; that practice is part of our protocols and is codified by our regulatory bodies. To protect the quality and integrity of our review procedures, as well as the confidentiality of the identities of those involved, we believe it to be essential that these reports are not unnecessarily widely distributed beyond those who have a direct interest in the matter.

Efforts to maintain the anonymity of OCME employees and the subjects of our work may not always be able to be achieved merely by striking their names from a published root cause analysis report. The particular facts and circumstances of an incident could identify someone even if his or her name is not mentioned. In matters where an incident may have stemmed from employee misconduct, wide

distribution of a root cause analysis might seriously frustrate or even prejudice the City's effort to investigate and potentially discipline our employee, while not furthering the purpose of ensuring meaningful review of our lab's practices and procedures.

Perhaps our greatest concern is how publishing these reports in a public forum might affect the judiciary and other investigative bodies. It may take years to investigate and adjudicate any given case, and we fear that publishing the results of a root cause analysis may interfere with the ongoing criminal justice process. Although the bill describes investigation of the systemic framework from which mistakes arise, it is often necessary in a sound RCA to identify those individual cases which lead back to the system failure. As stated earlier, we immediately notify the relevant parties of a mistake in any particular case.

The amendment requires that we provide these reports to the Mayor, City Council, accrediting bodies of the State and Federal government, District Attorneys, Legal Aid Society, all public defenders under contract to the City, and representatives of the 18-B assigned counsels for New York, in addition to publishing the reports on the website. It is already our required practice to provide the relevant information to members of the criminal justice bar whose cases were involved in or affected by a mistake. This is accomplished through the affected district attorneys, who are mandated by law to notify defense counsel in a relevant matter. We are not in a position to know who the defense counsel is at the time this bill requires our action, and notifying virtually the entire criminal defense bar would in almost all cases be vastly disproportionate to the particular matter at issue, while discouraging in practice the kind of internal scrutiny that creates real improvements.

With respect to the second bill directing publication of proficiency test results, we do not object in principle but do have some comments on the specific requirements. First, proficiency tests are given to each and every criminalist

twice a year, and are graded on a pass/fail basis, so we cannot provide an average score. We can provide aggregate data that we believe would satisfy the bill's intent, and that is in the same format as the report that we already provide each year to ASCLD/LAB as part of our accreditation requirements.

The bill also directs us to publish all of our manuals and protocols and certificates of accreditation on our website, which we already do, far in advance of any other lab in the state.

We urge the Council to take time to reconsider specific provisions of these amendments, so that we can achieve our mutual goal of transparency while avoiding unintended consequences.

We would also like to bring you up to date on our search for a new DNA Laboratory Director. We have completed a nationwide search for this position, and are pleased to tell you that we have decided upon Tim Kupferschmid, pending the usual vetting processes of the city. We are especially fortunate to have him, as he is aware of the recent problems of the laboratory and understands the structure and systems that gave rise to those problems.

His credentials are exactly what we had hoped for — in addition to holding 2 Masters degrees - in Forensic Science and Business Administration – he is extremely well-regarded in the forensic community for his management acumen and leadership skills.

Mr. Kupferschmid has been a laboratory director of both public and private forensic laboratories - the Maine State Police Crime Lab and Myriad Genetics Laboratory. In addition, Tim was the laboratory manager for the Armed Forces Institute of Pathology. As a founder and Director for Sorenson Forensics, Tim consulted for the Department of Criminal Justice and other government agencies,

teaching Root Cause Analysis, Lean Six Sigma process mapping, and management techniques for forensic laboratories nationwide.

Mr. Kupferschmid is a Director of the Board of American Society of Crime Lab Directors and Chairman of the Ethics Committee, the Commissioner of the Forensic Science Education Commission, and an active member of the American Academy of Forensic Sciences.

Tim is the author of numerous articles on laboratory management as well as forensic and DNA science, and speaks often at national conferences. We look forward to building further on the reforms we have made in the laboratory under his experienced leadership.

We thank you for your consideration.

TESTIMONY

Before

The Council of the City of New York

Sponsored by:

Committee on Health and the Committee on Women's Issues

Int. No. In Relation to Procedures for Conducting Root Cause Analysis by the Office of Chief Medical Examiner

Int. No. In Relation to Transparency of the Office of Chief Medical Examiner

Oversight: Examining the Need for Meaningful Transparency, Review and Reporting in the Office of Chief Medical Examiner

June 24, 2013

250 Broadway
New York, New York

Submitted by:

The Legal Aid Society
199 Water Street
New York, NY 10038

Presented by:

Steve Banks, Attorney-in-Chief

Good morning. I am Steve Banks, Attorney-in-Chief of The Legal Aid Society and I thank the Committee on Health and the Committee on Women's Issues for inviting our comments regarding a bill that requires root cause analysis of errors by the Office of Chief Medical Examiner (OCME), a bill that increases transparency within the OCME and suggestions regarding better oversight of OCME. I appreciate your attention to these important issues.

The Legal Aid Society is the nation's largest and oldest provider of legal services to low-income families and individuals. From offices in all five boroughs in New York City, the Society annually provides legal assistance to low-income families and individuals in some 300,000 legal matters involving civil, criminal and juvenile rights problems. The Society operates three major practices: the Criminal Practice, which serves as the primary provider of indigent defense services in New York City: the Civil Practice, which improves the lives of low-income New Yorkers by helping families and individuals obtain and maintain the basic necessities of life – housing, health care, food and subsistence income or self sufficiency; and the Juvenile Rights Practice, which represents virtually all of the children who appear in Family Court as victims of abuse or neglect or as troubled young people facing charges of misconduct.

During the last year, our Criminal Practice handled some 220,000 trial, appellate, and post-conviction cases for clients accused of criminal conduct. In recognition of the increasing importance of role of DNA in the criminal justice system the Criminal Practice recently created a DNA Unit, which trains and works with the criminal defense staff in the defense of DNA-related cases. Through this work we are familiar with the vital

importance of accurate and reliable forensic testing in the criminal justice system. Because of the breadth of The Legal Aid Society's representation, we are uniquely positioned to address the issues regarding OCME.

The Legislative Proposals

In response to the recent revelations of significant problems within the OCME and in the wake of the February 15, 2013 City Council hearing "The Mishandling of DNA in Sexual Assault Cases by the Office of Chief Medical Examiner," Councilmembers Arroyo and Ferreras have introduced two bills that are intended to improve the quality and transparency of the OCME.

The Council is considering an amendment to the New York City Charter that requires a root cause analysis of serious errors by OCME. The bill would require a review of systems and processes that contribute to an error whenever a "significant event" occurs that implicates the reliability or accuracy of the OCME or its employees. Significant events would include internal fabrications by lab workers, workers who demonstrate patterns of significant errors, lab workers with patterns of failure to follow lab protocol, and misrepresentations or significant errors by lab employees. The occurrence of a significant event would trigger a root cause analysis review of the problem within the lab. The reviews would be governed by guidelines and procedures issued by OCME. OCME would have 90 days to issue a report on the cause of the problem or explain why more time is necessary to complete the report. Final root cause analysis reports would be distributed to the Mayor, the City Council, the Commission on Forensic Science, the District Attorneys Offices, The Legal Aid Society and other defense attorneys throughout the City.

The second proposed law would require the posting on the OCME website of all manuals, guidelines and scientific procedures, protocols, quality control procedures and materials for training of lab workers, evidence and case management procedures, the most recent proficiency testing reports and certificates of accreditation issued to the OCME lab.

The Legal Aid Society supports these proposals as reasonable steps that are intended to prevent the recurrence of significant problems within the OCME. At the February hearing it became clear that OCME had no clear plan to cope with a problem that it knew had existed for about two years. We see the root cause analysis proposal as a way to require OCME to analyze, recognize and confront the existence of a serious problem in a timely way.

We have several additional suggestions. The requirement of a report to the defender offices in the root cause analysis bill is conditioned on an OCME finding "that the findings and/or conclusions contained in such report may be reasonably found to have an impact on a criminal investigation, whether ongoing or completed." See §1(f)(3). The recent history of OCME causes concern about this requirement. In January of this year, before OCME had even completed its review of the problematic cases it had identified, Dr. Mechthild Prinz, the former Director of Forensic Biology at OCME, assured the public that "we do know that nobody was wrongfully convicted."[1] Given the defensive reaction of this lab to past errors we urge that full disclosure be required whenever a significant event occurs in connection with a criminal case. The

[1] Joseph Goldstein, *New York Examines Over 800 Rape Cases for Possible Mishandling of Evidence*, N.Y. TIMES, Jan. 10, 2013.
2. Id.

judgment call as to whether the error reasonably had an impact on an investigation or case is better left to the courts to decide.

We have an additional suggestion for the root cause analysis bill. Whenever the type of serious errors at the DNA lab occurs so as to meet the standard for a "significant event" there is a potential that the erroneous analysis has caused or contributed to an unjust charge or conviction. In addition to the requirement of a report, we propose that the requirement of an "impact statement" be added to root cause bill so that an analysis of the potential for unjust charges or convictions and a plan for a remedy is included in any root cause report. This analysis may help curtail the impact of serious lab errors.

OCME now posts the most recently enacted protocols on its website. We believe this was done as a crisis management tool during the recent discoveries of mismanagement. The Council proposal, which requires expansion of the present posting, is a good idea that should bring greater transparency to the OCME. Right now the website posts only protocols that are currently in effect. However, there are many criminal cases pending where the analysis was performed under the old protocols. We suggest that any protocol that was utilized for pending criminal cases should be required to be posted on the website.

Oversight

At the February 2013 City Council hearing OCME reported that it had retained an outside consultant and as a result it did not have in place a remedial plan for the problematic technician problem that it first learned about in 2011. Around the same time OCME was asserting that it had conducted "a rigorous two year investigation and

corrective action process."[2] We now have more information from the outside consultant review, the Forensic Laboratory Management Consulting Services report.[3] The Council should note that the initial solicitation for this external review did not occur until February of this year, around the same time that OCME was preparing for the City Council hearing on the mishandling of DNA.

The consultant report paints a disturbing picture of the management at OCME. Management at the lab is described as "weak," "top-heavy" and in need of "transformational change."[4] When problems with employees were encountered the pathway for corrective action was not clear. Directors were concerned more about productivity numbers and they "have lost what is most important in a forensic lab – timely quality reports released to the customers; effective supervision, quality of work product and employee development."[5]

In direct contradiction to this finding, however, Forensic Laboratory Consulting Services also reported that "the forensic science practiced at the Forensic Biology Laboratory is excellent."[6] The fact is, however, that while the consulting agency did review the manuals and protocols at OCME and they were found to adhere to sound scientific practices, it never reviewed the actual forensic work done by the lab. Its report focused mainly on management practices at OCME.

In litigation that is now pending The Legal Aid Society has been reviewing the forensic science surrounding OCME's low copy DNA testing procedures and its

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[2] Letter from Barbara Butcher, Interim Director, OCME Department of Forensic Biology to Quality Assurance Manager, ASCLD/LAB, February 7, 2013.
[3] Kupferschmid, Green, Dearing, *Forensic Management consulting Services, Observations and Recommendation Final Report,* Sorenson Forensics, LLC, May 2, 2013.
[4] Id. Executive Summary and Recommendations, at p. 2.
[5] Id. Final Report at p. 8.
[6] Id. at p. 3.

Forensic Statistical Tool (FST), which was developed in-house. The Forensic Statistical Tool is a statistical program that provides a likelihood ratio statistic when the crime scene sample contains a mixture of DNA of more than one individual and that mixture cannot be separated out completely into individual profiles. In the course of that litigation we have learned that a number of key studies done by OCME that should support the science behind the approach OCME is using went unrecorded and were never reported to the DNA Subcommittee or the Forensic Science Commission.[7] The problem of lack of transparency within OCME goes to the very heart of the scientific work done by the lab. It hinders understanding and meaningful review of the methods employed by OCME by outside scientists.

We support the City Council resolutions, but we think the recent history also calls for broader reform, and the period of reorganization at OCME provides an opportunity for such reform. In our February 15, 2013 testimony, we discussed the inherent conflict between the goal of science to produce the most scientifically accurate results possible and the more limited goal of the prosecution to identify a criminal and produce a conviction. The idea that the scientific product of a lab is owned by only one party of the criminal justice system, the prosecution, creates inevitable problems for the accuracy of the findings. The over-identification with only one of the parties in the criminal justice

[7] In the cases of People v. Collins and People v. Peaks, cross examination of OCME employees and former employees has shown that work/analyses OCME scientists claimed was done as part of the validation studies were unrecorded by OCME and not reported to the DNA Subcommittee or the Forensic Science Commission. This included analyses of how conservative the testing was so as to prevent wrong conclusions, the effect of the quantitation value or size of the amplified DNA sample on the final likelihood ratio, the effect of going one standard deviation below the mean rather than the standard two, the effect of altering the minimum and maximum dropout rates on the final likelihood ratio, the comparison of the OCME procedure to another likelihood ratio computer program, and the fixing or flattening out of certain data.

system allows a partisan bias to enter the culture of the laboratory.[8] In recognition of this problem, in 2009, the National Research Council drafted a report, *Strengthening Forensic Science in the United States: A Path Forward*, which urged that "forensic science . . . must be equally available to law enforcement officers, prosecutors, and *defendants* in the criminal justice system." (Emphasis in original.)

The outside consultant Forensic Laboratory Management Consulting Services report provides a good illustration of the fact that OCME identifies itself with the prosecution. During the course of the review scientists in the lab were reported as being concerned about the limited communication with their "direct customers (NYPD and the DA office)."[9] The fact is that DNA can be as useful to the defense as it is to the prosecution. In an age when the utility of DNA to exonerate innocent people is repeatedly demonstrated the concept that the lab exists to service the needs of a few "direct customers" from one part of the criminal justice system is disturbing. New York is all too familiar with the problems caused when a poorly functioning scientific lab is too closely associated with the police and prosecution.[10]

The criminal defense bar and the criminal justice system should be viewed as the final quality control mechanism for OCME. The concept that it is proper to hide the evidence or hide mistakes from the defense and the criminal justice system has directly contributed to the poor state of affairs we see today. With that principle of equal access in mind we propose the following rules for to the operation of OCME.

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[8] The example of Massachusetts, which confronted a laboratory scandal at the Hinton State Laboratory Institute in Jamaica Plain, should be a reference point for remedial action here. The lab scandal was caused by a chemist who falsified drug test results during the period between 2003 and 2012.

[9] Kupferschmid, Green, Dearing, *Forensic Management consulting Services, Observations and Recommendation Final Report,* supra at p. 7.

[10] See N.Y. Off. Insp. Gen., *Investigation into the Nassau County Police Department Forensic Evidence Bureau*, Nov. 2011.

1) **OCME should be required to provide to the defense disclosure of all materials relating to DNA evidence, including, but not limited to all electronic raw data produced during testing at the earliest opportunity.**

The principle of full and fair disclosure must become the keystone of the criminal justice system. The American Bar Association Standards on DNA Evidence support this view.[11] When no suspect has been arrested on a case involving DNA evidence that is tested as part of the investigation, OCME should make a complete folder of discovery materials, including the electronic raw data, on a disk or disks, numbered with an index of the contents of each disk. OCME should hold and preserve the "defense disks" until the individual is represented by an attorney and then it can forward the disk to the attorney.

The file turned over should be an exact duplicate of all materials turned over to the prosecutor, including any and all emails between the OCME Department of Forensic Biology ("DFB") and the DA's office and notes of telephone conversations between DFB employees and members of the prosecutor's office or NYPD. The OCME should also be required to promptly update the defense file by emailing new additions to the OCME case file (i.e., additional laboratory reports; telephonic/email requests from the DA's office) to defense counsel.

2) **OCME should provide access to the various databases maintained and relied upon by OCME in its casework, including the database of individual genotypes which OCME uses to assess allele frequencies, the resulting allele frequency tables, and the races of the individuals whose genotypes are included in the database. These databases should be "open source," meaning publicly available on the internet. Additionally, the FST program and the source code shall be made available to the defense, preferably in open source format.**

[11] See American Bar Association Standards for Criminal Justice: DNA Evidence, Standard 4.1.

A proper review of OCME's methodologies includes analyzing OCME's calculation of allele frequencies, as this value is factored into the statistics which accompany all conclusions which are not exculpatory (or inconclusive) (i.e., when the profile deduced from a crime scene sample matches that of the suspect; when a suspect cannot be excluded from contributing to a mixture and the FST is run, etc.) Additionally, this information allows analysis of any systemic under-representation of certain races in the database.

Other scientific bodies make this information publicly available. For example, the National Institute of Standards and Technology (NIST) maintains a database of genotypes, allele frequencies, and race which is publicly available at http://www.cstl.nist.gov/strbase/NISTpopdata/JFS2003IDresults.xls.[12] OCME should be required to release this information as well.

3) **Liaisons from the defense community and the district attorney offices in all counties of New York City should be created that will work with the OCME on issues related to laboratory analysis, accreditation, and matters before the City Council and New York State Forensic Commission, including the DNA Subcommittee.**

OCME should be required to notify defense and district attorney contacts concerning issues of laboratory accreditation, inspection dates by accrediting and other bodies, inspection results, and remediation. Anything that must be reported to an accrediting body should also be reported to the liaisons. The OCME should disclose this information contemporaneously with its discovery.

[12] In response to the recent DNA scandal the Commonwealth of Massachusetts' Executive Office of Public Safety and Security set up a database of information to identify individuals whose cases may have been impacted. see http://www.massbar.org/media/1286464/non%20disclosure%20form.pdf.

The defense community should establish a liaison committee similar to the liaisons established by the District Attorney offices. Representatives from The Legal Aid Society, other organizations, 18b Counsel, the Innocence Project, the Association of Criminal Defense Attorneys and the County Bar Associations could form a representative committee that would assure delivery of individual case material to the proper defense counsel. The 2011 recommendation of the New York Office of the Inspector General could serve as a model.[13]

4) To improve quality OCME should implement of a blind proficiency testing program.

Proficiency testing is designed to ensure that lab analysts are able to carry out their jobs competently. As currently implemented, OCME's proficiency testing program can and does catch errors. But it was inadequate to flag in a timely way the problems with the performance of the analyst who mishandled the sexual assault evidence. As we testified in February, OCME should implement a policy of blind proficiency testing. Initially, once a month a particular analyst could be selected and test-evidence be submitted for testing and analysis within the regular flow of casework, without the analyst's knowledge. Implementation of this blind proficiency testing will require coordination with an outside vendor, but should not be overly burdensome and is necessary to better screen the competency of the criminalists working at OCME. A more comprehensive blind testing protocol could be implemented in stages.

We thank you for this opportunity to testify and we are available if you have any questions or concerns.

13. N.Y. Off. Insp. Gen., *Investigation into the Nassau County Police Department Forensic Evidence Bureau*, Nov. 2011, pp. 165-66.

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Written Testimony of The Bronx Defenders

New York City Council

Committee on Health and Committee on Women's Issues

June 24, 2013

Int. No. - In relation to procedures for conducting a root cause analysis by the Office of the Chief Medical Examiner

Int. No. - In relation to transparency of the Office of the Chief Medical Examiner

Oversight: Examining the Need for Meaningful Transparency, Review and Reporting in the Office of Chief Medical Examiner

Introduction

My name is Marika Meis and I am the Legal Director of the Criminal Defense Practice at The Bronx Defenders. I submit these comments on behalf of The Bronx Defenders, and thank the Committees for the opportunity to testify.

The Bronx Defenders is a community-based public defender that provides fully integrated criminal defense, civil legal services, and social services to indigent people charged with crimes in the Bronx. We serve 28,000 Bronx residents each year.

As defenders on the front lines representing clients, we see firsthand how the OCME's lack of transparency and accountability impair the integrity of the criminal justice system, impede the ability to provide zealous advocacy to our clients, and result in a fundamental lack of fairness to those accused of crimes.

Although we believe that more needs to be done to address the problems at the OCME, these bills provide much-needed transparency and oversight. We applaud the Committees for their efforts and support these bills.

As defenders of accused individuals at the trial level, our office is in a unique position to observe and catalogue OCME's lack of transparency and accountability on individual cases and litigants as well as on the

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criminal justice system more generally. We hope that by providing specific examples we will illustrate the inadequacy of the OCME's current procedures for dealing with internal problems and the need for these bills as well as additional reforms.

We have witnessed first hand the myriad ways in which the OCME's lack of transparency impedes defense attorneys' ability to zealously represent their clients, restricts an accused's ability to present a defense, and ultimately impacts the OCME's ability to function as an independent agency.

Specific Examples of Problems With a Lack of Transparency

1) Until recently, the OCME's Department of Forensic Biology was one of the only labs conducting DNA analysis in this country that did not provide their protocols absent subpoena. Those protocols have only recently become available on the OCME website, presumably due to the involvement of the City Council and the prior hearing in February 2013, but this disclosure was long overdue and it is not enough. The OCME has only disclosed the current protocols even though in many DNA cases, the DNA testing was performed years ago when the current protocols were not in place. If the OCME were truly transparent, then it would provide access to all protocols past and present. Further, the OCME does not provide access to proficiency tests or accreditation reports. The transparency bill will thus provide much-needed enhancement by requiring annual proficiency testing reports and the posting on the website of all manuals, guidelines, and documents relating to scientific procedures and/or protocols, quality assurance and quality control, materials used for the training of lab workers, case management procedures, proficiency testing reports and certificates of accreditation. We urge even further disclosures, including broad disclosure of past protocols, guidelines and proficiency tests for DNA testing and criminalists in older cases that are only now heading to trial.
2) The OCME changes its policy and procedures without notifying the defense bar or the public. For example, the OCME used to have a policy of taking three swabs of every gun and analyzing each

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swab separately. They then switched to a policy of combining those three swabs into one analysis, but when they realized that policy was possibly creating mixtures, they switched back to the original policy. Yet, the defense community was not informed of these policies or the change. Our office only learned of it by asking a criminalist the right question during a trial preparation meeting.

3) In developing and using the Forensic Statistical Tool (FST) to provide likelihood ratios for DNA mixtures and using high sensitivity testing to test very small amounts of DNA under the Low Copy Number DNA analysis (LCN) – both unique to OCME and on the cutting edge of accepted DNA analysis, OCME has done only internal validation and will not allow outside forensic experts to examine the computer code for the FST algorithm. If these advancements are good science that should be trusted by the criminal justice system and admitted in court, they should be open to robust external review, whereas at present, they are not subject to any external review. The spirit of the NAS February 2009 report "Strengthening Forensic Science in the United States: A Path Forward" and the National Research Council's Commission on DNA Forensic Science (NCR II) report support more information sharing. DNA testing has been recognized by the NAS Report as the gold standard among scientific disciplines, therefore, the OCME should treat it that way.

4) The OCME's lack of transparency has negatively impacted its independence. The functioning of the OCME is shrouded in secrecy for those in the defense bar. However, it is not so for those in the District Attorney's Office. For example, the OCME routinely provides the entire forensic biology case file to the Office of the District Attorney, while we, as defenders, are forced to request it from the assigned Assistant District Attorney. If we are unable to obtain the file from the Assistant District Attorney, we must subpoena the file from OCME. Yet, the OCME often responds that the entire file was already turned over to the District Attorney's Office and, therefore, cannot be subpoenaed form the OCME. Similarly, when defense attorneys meet with an individual criminalist, the OCME informs the District Attorney's Office. However, the defense bar is never informed when

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someone from the District Attorney's Office meets with a criminalist. In one specific case, we discovered a note in the forensic biology case file written by a criminalist to the ADA expressing concern about a possible defense argument. Such investment in the outcome of a criminal case obviously undermines the OCME's independence, but sharing it with the ADA all but eviscerates it. The OCME's selective transparency substantially jeopardizes one of its most important attributes – its independence.

5) In yet another case, a criminalist was aware that our client had been re-swabbed by a second police officer because the police officer who took the first swab had been indicted on criminal charges. However, the criminalist we met with and who knew why our client had been re-swabbed was ordered not to disclose the information to us. While the OCME is not bound by the Brady obligations of prosecutors, the keeping of secrets and revealing information only to one side certainly reflects a lack of transparency that compromises independence.

6) The OCME routinely fights our office when we request raw data. The OCME claims that the electronic data is provided in the electropherograms and that the National Research Council's Commission on DNA Forensic Science (NCR II) "recommends retesting the samples, not rerunning the raw data, as the best method to determine whether or not a public laboratory performed the tests at issue properly, recommends testing the evidence in order to eliminate any possibility of error, and has concluded that independent retesting is the best way to ensure testing accuracy." But the ABA Standards for DNA Evidence explicitly address the issue of electronic data and require disclosure.[1]

[1] **Standard 1.2 General Principles**
(a) Consistent with rights of privacy and due process, DNA evidence should be collected, preserved, tested, and used when it may advance the determination of guilt or innocence.
(b) DNA evidence should be collected, preserved and tested, and the test results interpreted, in a manner designed to ensure the highest degree of accuracy and reliability.
(c) The policies and procedures employed for testing DNA evidence should be available for public inspection.
(d) Test results and their interpretation should be reported and presented in an accurate, fair, complete, and clear manner.
(e) A person charged with or convicted of a crime should be provided reasonable access to relevant DNA evidence and, if it has been tested, to the test results and their interpretation.

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The contention that independent testing is a substitute for seeing the electronic data makes no sense. The review of electronic data has served to be a very valuable check on labs. In each individual case, reviewing the electronic data provides us the opportunity to see the data that analysts may ignore below threshold or wish to characterize as important or unimportant to their analysis.

7) The OCME will not permit public tours of actual DNA testing areas or permit defense attorneys or their experts such tours or the opportunity to actually observe DNA testing.

Specific Examples of Problems With a Lack of Accountability

As defenders on the front lines we also see how the lack of accountability impairs the integrity of the criminal justice system, impedes our ability to provide zealous advocacy to our clients, and results in a fundamental lack of fairness to those accused of crimes.

(f) The collection and preservation of, access to, and use of DNA evidence should be regulated to prevent inappropriate intrusion on privacy rights.
(g) Funding necessary to achieve these principles should be provided.

Standard 4.1 Disclosure
(a) The prosecutor should be required, within a specified and reasonable time prior to trial, to make available to the defense the following information and material relating to DNA evidence:
(i) laboratory reports as provided in Standard 3.3;
(ii) if different from or not contained in any laboratory report, a written description of the substance of the proposed testimony of each expert, the expert's opinion, and the underlying basis of that opinion;
(iii) the laboratory case file and case notes;
(iv) a curriculum vitae for each testifying expert and for each person involved in the testing;
(v) the written material specified in Standard 3.1(a);
(vi) reports of all proficiency examinations of each testifying expert and each person involved in the testing, with further information on proficiency testing discoverable on a showing of particularized need;
(vii) the chain of custody documents specified in Standard 2.5;
(viii) all raw electronic data produced during testing;
(ix) reports of laboratory contamination and other laboratory problems affecting testing procedures or results relevant to the evaluation of the procedures and test results obtained in the case and corrective actions taken in response; and
(x) a list of collected items that there is reason to believe contained DNA evidence but have been destroyed or lost, or have otherwise become unavailable;
(xi) material or information within the prosecutor's possession or control, including laboratory information or material, that would tend to negate the guilt of the defendant or reduce the punishment of the defendant.
(b) The defense should be required, within a specified and reasonable time prior to trial, to make available to the prosecution the information and material in subdivision (a)(i) through (ix) of this standard for each expert whose testimony the defense intends to offer.

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1) In January 2013, our office was in the middle of representing a man on trial where a key piece of evidence against him was DNA. After the criminalist had testified on direct examination and asserted the utmost confidence in the lab and those who worked at OCME, the New York Times published an article about Serita Mitchell. Serita Mitchell had been involved in the DNA testing in our trial case, yet no one from the OCME or the District Attorney's Office had informed us of the problems with her work. Had the lawyer trying the case not read the article, she never would have known about the problems at the lab, and neither would the judge or the jury. When questioned about the failure to disclose, we were told by the Bronx District Attorney's office that they did not inform us of her involvement in the case because the OCME has a "procedure" where they inform the defense attorney during the defense attorney's pre-trial meeting with the criminalist. We were later told by the OCME criminalist that no such policy exists. As this example illustrates, the OCME did not have clear procedures at the lab because they have such little accountability to the City, the public and the criminal justice stakeholders. Such procedures are critical to ensuring the integrity of the criminal justice system, the ability to provide a zealous defense and fairness to the accused. We understand that the "root cause analysis" addresses these concerns by focusing on the underlying source of the problem, not individuals, and we agree that doing a thorough and prompt inquiry into not just the individual, but the underlying cause of the problem is a valuable way to ensure a thorough analysis of a significant event and a way to prevent such a problem in the future. In order to zealously defend our clients and to ensure fairness to the accused, however, we in the defense bar must also be alerted to actual individuals involved in a "significant event," so that we can fulfill both our constitutional obligation to properly advise our clients and our client's constitutional right to confront each person involved in DNA testing.[2]

2) Another example of the problem with the OCME's lack of accountability arose recently in the

[2] Williams v. Illinois, 566 U.S. __, 132 S.Ct. 2221 (2012).

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midst of litigation over the issuing of a protective order. The defense had moved to limit the use of a court-ordered DNA swab, and a Bronx Supreme Court Judge requested that someone from OCME appear to give their position on whether they are subjected to Executive Law Article 49. However, the OCME refused to obey the judge's request and did not send a representative to answer the court's questions. While the root cause analysis bill does not specifically address an instance like this, we believe that greater accountability will result in greater communication and responsiveness to criminal justice stakeholders.

Increased transparency and accountability will improve the integrity of the criminal justice system, the ability to provide zealous advocacy to our clients and the fairness to those accused of crimes, as well as increase public confidence in the OCME. The bills will also help preserve the finality of convictions by ensuring that problems will not come to light after the conclusion of a case when they are much more costly and difficult to resolve. The public, courts, prosecutors, victims and defenders should all share this goal.

Although beyond the scope of this hearing and these bills, the area of DNA criminal litigation is also in need of discovery reforms. In this regard, broad disclosure of past protocols, guidelines, and accreditation reports as noted above would serve an important role for defenders who are currently handling cases where the DNA testing was done some time ago. The mandatory disclosure of raw data as supported by ABA Standard 4.1 would also greatly benefit defenders and improve the criminal justice system. If we do not get this vital information until the last minute, we cannot possibly comply with our obligation to provide effective assistance to our clients by evaluating weight of the case against them and providing a meaningful discussion of a plea offer and the risks of going to trial, as the Supreme Court of the United States recently made clear is part of our constitutional obligation to provide effective assistance of counsel.[3] Slow and incomplete disclosure of DNA evidence also leads to delays in the already backlogged court system.

Conclusion

[3] Lafler v. Cooper, __ U.S. __, 132 S.Ct. 1376 (2012); Missouri v. Frye, __ U.S. __, 132 S.Ct., 1399 (2012).

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We applaud the City Council and the Committees on Health and Women's Issues for the two City Council Bills and we urge the Council to pass this crucial legislation immediately. We are also optimistic that more can be done to provide even further transparency and accountability in the areas of discovery and disclosures that will further increase public confidence in the OCME, add to the integrity of the criminal justice system, enhance our ability to provide zealous advocacy to our clients, and result in more fundamental fairness to those accused of crimes. We look forward to working with our partners in the City Council to accomplish these important goals.

TESTIMONY

Before

The Council of the City of New York

Committee on Health and Committee on Women's Issues

Oversight: Examining the Need for Meaningful Transparency, Review and Reporting in the Office of Chief Medical Examiner

Monday, June 24, 2013

City Hall
New York, New York

OAD | OFFICE OF THE APPELLATE DEFENDER

Submitted by:

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Presented by:

Alexandra Keeling, Deputy Attorney-in-Charge
Anastasia Heeger, Director, Reinvestigation Project

Good morning. My name is Anastasia Heeger, I am the director of the Reinvestigation Project at the Office of the Appellate Defender ("OAD"). Also with me today is OAD's Deputy Attorney-in-Charge, Alexandra Keeling. We welcome this opportunity to testify about what are – as recent headlines make clear – vitally important issues about the role of DNA in our criminal justice system.

OAD is – as many of you know – one of the oldest providers of appellate representation to indigent persons convicted of felonies in New York City. In addition to its appellate practice, OAD's Reinvestigation Project focuses on wrongful conviction cases before post-conviction remedies are exhausted. For obvious reasons, we are extremely concerned not only about the integrity and reliability of testing at OCME, but also in ensuring transparency and accountability at OCME.

Just this month, the *New York Times* reported that police departments, including the NYPD, have been amassing vast DNA data banks of thousand of potential suspects.[1] And, in the wake of the Supreme Court's recent decision in Maryland v. King,[2] which sanctioned the collection of DNA samples from people arrested for serious crimes, we

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[1] See "Police Agencies Are Assembling Records of DNA," N.Y. Times, June 12, 2013, available at: http://www.nytimes.com/2013/06/13/us/police-agencies-are-assembling-records-of-dna.html?hpw

[2] The full text of Maryland v. King is available at: http://www.supremecourt.gov/opinions/slipopinions.aspx.

expect such collections to grow exponentially. In turn, more collection means more testing.

The stakes are high – DNA is viewed as the gold standard of evidence – it can be extremely persuasive to juries and a critical consideration in plea negotiations. In a DNA symposium at New York University this past March, Jonathan Lippman, chief judge of the Court of Appeals, extolled DNA typing as having "revolutionized criminal justice" and lauded its expansive use to identify the guilty and exonerate the innocent.

With that as background, we would like to highlight three points.

First, as we have seen in the past two years, the process of handling and testing DNA and reaching conclusions about this testing is not infallible. Potential cross-contamination of evidence, and other problems arising from testing employees' failure to follow correct procedures are real and they are serious.

Professionalism and high standards are critical, of course, but it is equally important for any entity such as OCME to have external quality assurance.

The defense bar is uniquely situated to provide such a check. As defense attorneys, first and foremost, of course, we represent the interests of our clients, but in doing so, we are also a constant check on the police, on prosecutors, and – in New York City – the OCME. The role of the defense attorney, both at the trial and appellate level, includes facilitating transparency and helping to ensure the legitimacy of criminal proceedings.

Regardless of good intentions, any organization that serves the public needs outside eyes looking in. As the committee knows, with the 800 plus rape kits, OCME believed – at several points over nearly two years – that they had figured out the extent of the technician's error – only to find out there was more. Of concern, of course, is not only that a criminalist potentially botched testing in an unknown number of cases, but also that OCME's internal quality assurance mechanisms did not catch the problem sooner. This criminalist did not work in a vacuum. Notifying the defense bar of "significant events" as defined in the bill can help ensure that problems are identified and investigated in a timely manner.

Second, there is an expectation of finality in our criminal justice system and we can tell you, as post-conviction counsel, the critical importance of doing things right the first time. It is not easy to "fix" things after a conviction – the law severely restricts what can be reviewed after a criminal conviction. It is vitally important that evidence be handled properly, disclosed in a thorough and timely manner, and meaningfully tested in a court of law. When there are questions or uncertainty about the veracity of DNA evidence, the more time that goes by, the more problems it creates for all parties involved – victims, prosecutors and criminal defendants. It also imposes a significant financial burden on this City. Post-conviction litigation that entails a re-examination of the evidence is costly and time consuming. And, in the worst case scenario – a wrongful conviction – an innocent person has lost years of lives.

Patterns of lab error and significant errors or failures at OCME should be and must be disclosed to the defense and OAD is in support of the models for disclosure presented earlier to the committee. Moreover, OAD supports, as a first step, the legislation to require OCME guidelines, procedures and protocols to remain public. As other panelists have noted, OCME is very much a black box to the defense bar.

Finally, and most importantly, it cannot be left to prosecutors alone to be the gatekeepers of information about problems at OCME. As it was suggested at the February hearings, the scientific output of OCME needs to be "the product of the entire criminal justice system and not just law enforcement and the District Attorneys."

A prosecutor may not believe that a criminal conviction needs to be re-examined because that prosecutor believes there is sufficient other evidence to sustain the conviction. But we know – and the public is beginning to be educated about this – many kinds of evidence – including eyewitness identification, confession or informant testimony – that we once believed was strong evidence is, in fact, often very unreliable.

Related to this point is a provision in the law that gives us concern – the trigger provision of subsection (3) of the root cause analysis bill – which mandates that disclosure be made to prosecutors and defense attorneys where the findings and/or conclusions of a root cause analysis report may "be reasonably found to have an impact on a criminal investigation, whether ongoing or completed."

A root cause analysis is triggered by a "significant event," which, under this bill,

includes acts of "intentional fabrication or falsehood" with regard to work product, analysis or test results, incidents by employees who have engaged in a "demonstrated pattern of significant errors" which may have resulted in or risked an erroneous identification, false identification, false negative or false positive, incidents involving "a lab employee who has engaged in a demonstrated pattern" of failing to follow protocols, or incidents involving employees who have testified falsely.

It should go without saying that any such event could "be reasonably found" to have an impact on a criminal investigation. In other words, the very occurrence of a "significant event" should trigger disclosure to all parties of the root cause analysis. We are concerned that any such a determination of impact on criminal investigation would be made outside of the judicial process – this is what our adversarial system is for. It is beyond the mandate of the OCME to be concluding that a significant event did not have an impact on a criminal investigation.

In sum, we believe that it is imperative for problems to be disclosed to both prosecutors and the defense bar regardless of an outside determination of whether the underlying event could have affected the criminal investigation.

Now is the time to ensure that systemic problems at OCME are timely identified and effectively and timely disclosed to oversight bodies as well as to all the parties in our adversarial system.

Thank you.

Mark L. Taff, M.D.

FORENSIC PATHOLOGIST
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Re: Oversight hearing on the Office of Chief Medical Examiner (OCME); Examining the Need for Meaningful Transparency, Review and Reporting in OCME. Committee Room, City Hall, New York, NY, Monday June 24, 2013, 10 a.m.

To: The Health Committee/Committee on Women's Issues of City Council

From: Mark L. Taff, M.D., presently a Board-certified Forensic Pathologist, Clinical Associate Professor of Pathology, Mount Sinai School of Medicine, New York, New York and consultant to Assigned Counsel Plan, Legal Aid Society of New York, New York City Transit Authority, New York City Housing Authority, New York City Law Department, New York State Attorney General's Office, and New York State Police; and former Deputy Medical Examiner of Nassau County, Coroner's Pathologist for Ulster, Green, Orange, Putnam and Sullivan Counties and Chief Medical Examiner of Rockland County, Co-Chairperson, Inspection & Accreditation Committee, National Association of Medical Examiners, President & Founder, New York Society of Forensic Sciences at Lehman College, Bronx, New York and Feature Editor, American Journal of Forensic Medicine and Pathology.

Good morning. I am Dr. Mark L. Taff, who has been a student and practitioner of forensic medicine and pathology in the Greater Metropolitan area for the past 40 years. My credentials are summarized above on this handout.

OCME is basically a government medical laboratory or "hospital for the dead" which employees two types of professionals of equal importance. One group is made up of physicians (skilled autopsy surgeons), who oversee sequential and interdependent 6-stage death investigations. The 6-stages are: 1) history; 2) scene findings; 3) autopsy (external and internal examinations); 4) ancillary laboratory tests (e.g. toxicology, DNA, etc.); 5) creation of the report; and 6) signing of the death certificate. The other group is composed of civil service/union members who have specialized training in the performance of forensic laboratory, investigative and clerical work. The dead are our patients and they should be treated with the same respect and dignity as we would want for a sick friend or relative. Medical examiners are licensed physicians and, like all other doctors, they must abide by the same codes of medical practice and ethics in the treatment of patients. The same rules regarding physician-patient confidentiality apply to the dead unless, of course, a death is contested in open court. Employees of OCME are ambassadors of government agency and should comport themselves accordingly at all times. Like others employed in civil service, medical examiners serve the public - both living and dead.

During the past 1-2 years, OCME experienced an institutional crisis regarding the handling of human remains and performance of DNA testing. City Council is to be commended for their efforts in trying to get OCME back on track. I am here today to assist City Council in doing so.

I must first remind everyone that no person or organization ever walks a straight line in the field sobriety test of life. Due to the tumultuous and tragic nature of the death business, medical examiners are no strangers to controversy. Between 1976 – 1988, four different Chief Medical Examiners had to contend with a variety of unpredictable and uncontrollable events, including: soaring homicide rates, inadequate manpower and financial resources, charges of incompetency institutional racism, and malfeasance. One chief medical examiner even had to deal with the unimaginable problems stemming from a prostitution ring being run out of the city morgue (This event was memorialized in a movie called "Night Shift"). In true New York fashion, the City was able to get through the so-called "good ole' days". If we continue to work together now, I am confident that we will be able to resolve the current problems shortly.

As a tribute to Dr. Charles Hirsch, there were no major problems at OCME during his tenure from 1989 until just before his retirement in February, 2013. Hopefully, New York City will be lucky enough to find a replacement for Dr. Hirsch with equal, or even better, professional and administrative skills. As City Council knows, the selection of the Chief Medical Examiner is a mayoral appointment that historically has involved the vetting process. Before making any permanent changes in the standard operating procedures at OCME, City Council should take into account that OCME is going through a leadership transition period that should be resolved within 6-8 months. I think it would be in the best interest of all parties that the next Chief Medical Examiner be given the opportunity to participate in the decision-making policies which will affect OCME.

As you know, Dr. Hirsch began his job as Chief Medical Examiner in January, 1989. This was around the same time that I started one of the first private practices of Forensic Medicine and Pathology in the United States. Many of my clients were lawyers, law firms, insurance companies, private citizens and government agencies who asked me to review and evaluate mostly homicides and accidents investigated by OCME. Although OCME conducts about 12-15,000 death investigations each year, a much smaller number of cases climb the "ladder of death litigation" which are contested in courts of law. Although the majority of deaths investigated by the medical examiner are due to natural causes, homicides and accidents seem to count more in the legal adversarial system. In my capacity as an independent forensic pathologist expert, I have reviewed hundreds of high-profile homicides and wrongful death cases originally handled by OCME since 1989. I am happy to report that, up until about 2-years or so ago, OCME did an overall very good-to-excellent job. However, in recent times, several lawyers, other forensic experts and I all have seen a steady decline in the quality of death investigation and autopsy reports. Autopsy, toxicology and forensic consultant reports are taking longer to be completed and, when they are issued, they raise more questions than they answer. The reports are neither integrative nor interpretative. Many reports are confusing to lay readers and open to interpretation. The reports are not written with the consumers of medical examiner information in mind. The primary consumers of medical examiner reports are the next-of-kin, insurance companies, lawyers, and the justice system. Medical examiner reports and rulings are, in effect, the fuel that drives the litigation industry. Because of the service role of medical

examiners in society, they must interact closely with other physicians, law enforcement, funeral directors, politicians, policy makers, the public and the media.

Death investigation is an assembly line of truth production reflected in autopsy reports and death certificates. The quality of reports and opinions contained therein rests in the hands of the Chief Medical Examiner and his/her designated Borough Deputy Chief Medical Examiners. These individuals must multi-task and act as teachers, consultants, supervisors, editors, and overseers of the OCME medical and non-medical staff. The Chief Medical Examiner must be cautious and surround him/herself with competent, well-trained, dedicated individuals. The hiring of good people today will result in fewer problems tomorrow. Such individuals will adhere to the recommended guidelines and protocols governing the practice of the forensic sciences.

I have read the proposed amendments to the New York City Charter regarding procedures for conducting a root cause analysis. It seems that all the effort going into the correction of the current problems can be easily remedied with the appointment of an experienced Chief Medical Examiner. I realize that OCME medical and staff behavioral problems have created political problems for City Council who is now obliged to restore public confidence. I am not so sure, however, if all these emergency layers of legal regulations are needed just yet. Good leadership and the hiring of the right people in the very near future should achieve the improvements sought after.

DNA technology became a reliable way of identifying people in the 1980's and 1990's. Prior to the use of DNA, medical examiners identified the majority of badly decomposed bodies and human skeletal remains through circumstantial, visual, fingerprinting, dental, and anthropological analyses. The method(s) used depends on the condition of the corpse at the time of discovery. Ever since "9/11", OCME has become more dependent on DNA evidence for the proper identification of dead persons. Nowadays, the bulk of DNA testing is performed on burglary and rape cases at the request of law enforcement. In general, OCME reserves DNA analysis for badly decomposed bodies/skeletonized remains and victims of apparent sexual homicides, child abuse and bite marks. In preparation for this presentation, I spoke to the Pathology Department Chairpersons of all the medical schools in New York City about the current problems at OCME's DNA lab. The general consensus was that OCME should divest itself from overseeing the DNA lab. Instead, the DNA lab should be an independent laboratory headed by a physician with Board-certification in clinical pathology and molecular pathology. The DNA lab should be part of the Department of Health with the Director of the DNA lab and the Commissioner of Health as the overseers of the lab and responsible as the "Designated Root Cause Analysis Officers". OCME's involvement with the DNA lab should be limited to a consultative relationship on a case by case basis. The Chief Medical Examiner and his/her physician staff would, of course, remain responsible for integrating and interpreting all of the tests ordered and performed in establishing the cause, manner, and time of death and identification of the deceased (final stage of the standard 6-stage death investigation).

Aside from the recent problems, several other issues may confront OCME in the near future, including:

1. Manpower Shortage: If homicide rates ever go up again or some mass disaster occurs, these events will have a tremendous impact on OCME. In light of Dr. Hirsch's recent retirement and the imminent departure of five other senior experienced medical examiners, the increased work load will have an adverse effect on OCME's quality of work. OCME would need more money in the budget to attract qualified physicians to pursue careers in forensic pathology in New York City. Financial incentives will be needed to attract experienced forensic pathologists to relocate to New York City.
2. Brain Drain: With the retirement of Dr. Hirsch as the Director of the Forensic Pathology Post-Graduate Training Program, OCME will have a difficult time attracting young physicians to train in New York City and keep them here after they successfully completed the 1-2 year training program.
3. Term Limits for the Chief Medical Examiner: Even if the Chief Medical Examiner is doing what appears to be a good job, the job should not be an automatic lifetime appointment. The Chief Medical Examiner, like other OCME employees, should be evaluated annually. The job performance of the Chief Medical Examiner should be fair and reasonable. The evaluation should be based on specific professional standards and community expectations.
4. Evaluation Process for OCME Employees: As a form of institutional quality control, OCME employees should also be subjected to fair and reasonable annual reviews similar to the evaluations recently recommended for New York City Public School teachers.
5. Creation of a Fundraising/Donation System: Nowadays, several medical institutions encourage and depend on private sector donations to help improve the quality of patient care. The time has come that a fundraising/donation system earmarked for OCME be established to facilitate the financial support and professional advancement of the forensic sciences in New York City.
6. Quality of Autopsy Reports & Courtroom Testimony: Autopsy reports are prepared by medical examiners that basically deconstruct 3-dimensional corpses and reconstruct them into 2-dimensional paper people. The reports must be written in a clear and concise manner for all to understand. Integrative and interpretative reports must be issued in a timely fashion. The reports should be in narrative form and not just "laundry lists" of findings open to interpretation. Well-trained, experienced medical examiners must be future-oriented and write reports that anticipate medicolegal issues that are frequently contested in courts of law. Medical examiners should realize that homicide and accident autopsy cases rapidly ascend the hierarchy of death litigation and the documents will eventually serve as the basis ("script") of medical examiner testimony. Well-written autopsy reports should result in more effective courtroom testimony and overall improvements in the administration of justice.

Mark L. Taff, M.D.
Forensic Pathologist

INNOCENCE PROJECT

Benjamin N. Cardozo School of Law, Yeshiva University

Testimony of Sarah Chu

Forensic Policy Advocate, Innocence Project

THE NEW YORK CITY COUNCIL

"OVERSIGHT: EXAMINING THE NEED FOR MEANINGFUL TRANSPARENCY, REVIEW AND REPORTING IN THE OFFICE OF THE CHIEF MEDICAL EXAMINER"

- ***Int. No. 1050,*** *a Local Law in relation to procedures for conducting a root cause analysis by the Office of the Chief Medical Examiner*
- ***Int. No. 1058,*** *a Local Law in relation to transparency of the Office of the Chief Medical Examiner*

JUNE 24, 2013

Thank you, Chairperson Arroyo, Chairperson Ferreras, and members of the Committee on Health and the Committee on Women's Issues, for holding this hearing to discuss ongoing events at the Office of the Chief Medical Examiner and the proposed legislation that addresses transparency and root cause analysis (RCA). We support these bills because, if enacted, they would once again elevate the DNA laboratory at the New York City Office of the Chief Medical Examiner as a national leader and an exemplary model among forensic science providers. The Innocence Project appreciates the invitation and thanks you for the opportunity to share our thoughts on these issues.

My name is Sarah Chu and I am the Forensic Policy Advocate for the Innocence Project. The project is a national litigation and public policy organization dedicated to exonerating wrongfully convicted people through DNA testing and reforming the criminal justice system to prevent future miscarriages of justice. To date, post-conviction DNA testing has exonerated 309 innocent people who had been wrongfully convicted of serious crimes. That number continues to grow.

Overturned wrongful convictions proven by post-conviction DNA testing free innocent people

from prison and, in roughly half the cases, identify the true perpetrator of the crime. They are especially important to the criminal justice system because each of the 309 DNA exonerations to date provides the system with a unique and crucial opportunity to understand what causes wrongful convictions. By deconstructing the sequence of events that produced a wrongful conviction, various contributing factors that negatively impact the criminal justice system can be identified, researched, and understood. Through this work, we hope to aid stakeholders in the criminal justice system in developing systems and approaches to mitigate the contributing factors that lead to wrongful convictions. True reform builds upon that research by implementing measures that reduce the likelihood of error and ensure reliability in processes embedded in the criminal justice system. By limiting the chance of repeat errors, public safety and the criminal justice system are both enhanced.

The Innocence Project's policy agenda consists of reforms we have found through rigorous research that can identify, prevent, and remediate the factors which cause wrongful convictions. The top priorities informed by our findings address systemic problems in eyewitness identification, forensic science, false confessions, incentivized jailhouse informant testimony, and unnecessarily limited access to post-conviction DNA testing.

In our review of the contributing causes of the nation's first 300 post-conviction DNA exonerations, reliance on unvalidated, improper, or flawed forensic evidence (such as bite mark identification, microscopic hair comparison, improper serology, etc.) has proven to be the second most frequent contributing factor, having played a role in approximately 51% of those cases (See Table 1).

These cases, however, are not the only proof of the need for fundamental improvement in forensic practice. The need for scientific improvements to the forensic system was clearly outlined in the National Academy of Sciences' report *Strengthening Forensic Science in the United States: A Path Forward.* This report, authored by some of the nation's most prominent research scientists, engineers, forensic practitioners, legal experts, and criminal justice stakeholders, identified the roots of the problems in forensic evidence and how those problems should be addressed. The report concluded that the scientific foundation of most forensic science disciplines have not yet been determined and require research to improve their validity, reliability, and to develop standards and best practices. The NAS report noted that unlike all

other pattern impression or subjective interpretation disciplines, nuclear DNA analysis benefits from statistical underpinnings and population studies. Yet the report also noted that this does not give DNA evidence a free pass in analysis or in court:

> "[N]uclear DNA analysis has been rigorously shown to have the capacity to consistently, and with a high degree of certainty, demonstrate a connection between an evidentiary sample and a specific individual or source. Indeed, DNA testing has been used to exonerate persons who were convicted as a result of the misapplication of other forensic science evidence. However, this does not mean that DNA evidence is always unassailable in the courtroom. There may be problems in a particular case with how the DNA was collected [or] examined in the laboratory."[1]

The Innocence Project clearly supports using DNA evidence within the courtroom and recognizes the New York Office of the Chief Medical Examiner (OCME) as one of the premier forensic DNA laboratories in the country. The pivotal role that forensic DNA plays in criminal cases requires that the OCME be held to very high standards, run a laboratory with the highest regard for quality control, and pursue thorough introspection in the wake of an error. The OCME sets itself apart from other DNA laboratories by employing researchers in addition to forensic practitioners. As a result, significant advances in DNA science originated at the laboratory on 26th Street in Manhattan. Some research highlights include identifying 9/11 remains, advancing high sensitivity DNA testing, and understanding secondary and tertiary DNA transfer. The OCME is a source of pride for the citizens of New York City and deserves its excellent reputation.

In February of this year, the Committees on Health and Women's Issues convened a joint hearing to understand the circumstances under which a crime lab technician at the OCME missed critical evidence that led to the review of nearly 900 rape cases and how the lapse in uploading DNA profiles analyzed in the laboratory to the state DNA database occurred. The NAS report forewarned that forensic labs – including DNA labs – often lack systematic and routine feedback

[1] Strengthening Forensic Science in the United States: A Path Forward, Committee on Identifying the Needs of the Forensic Science Community, The National Academies Press (2009), p.100 (Hereafter, NAS report).

loops that engender self-correction and allow the profession to discover, and then learn from, past mistakes.[2] Although such quality assurance and quality control processes are a fundamental element of practice in clinical labs and diagnostic medicine, forensic laboratories have not yet adopted many of these controls. Despite the NAS report's notification of the likelihood of such an event, the criminal justice system was still startled by what transpired at the OCME.

Root Cause Analysis

In clinical laboratories, one important quality control process is root cause analysis. The OCME is accredited by the American Society of Crime Lab Directors Laboratory Accreditation Board (ASCLD/LAB) to its "International" program which is based on ISO/IEC 17025:2005 (ISO 17025) standards. ISO 17025 is an internationally recognized voluntary consensus standard for testing and calibration laboratories and primarily focuses on management and technical requirements. Under this standard, laboratories are required to respond to nonconforming work or departures from the policies and procedures with a root cause analysis:

> **4.11.2 Cause analysis**
>
> The procedure for corrective action shall start with an investigation to determine the root cause(s) of the problem.
>
> NOTE: Cause analysis is the key and sometimes the most difficult part in the corrective action procedure. Often the root cause is not obvious and thus a careful analysis of all potential causes of the problem is required. Potential causes could include customer requirements, the samples, sample specifications, methods and procedures, staff skills and training, consumables, or equipment and its calibration.[3]

Root cause analyses are important in response to nonconformances or departures from policies and procedures because these occasions signal gaps in the quality control system(s) that failed to register small issues in the preceding series of events. Such nonconformance or significant events occur when systems and processes fail to catch the accumulation of errors – often from various individuals throughout multiple points in a series of events. Simply suspending or terminating

[2] NAS report, p. 25
[3] ISO/IEC 17025:2005(E) International Standard, General requirements for the competence of testing and calibration laboratories, p. 8.

the employment of the person responsible for their role in the nonconformance or departures from policies and procedures does not eliminate the problem.[4] Without addressing the higher level root causes and addressing the system as a whole, the weaknesses of the laboratory's quality control system will continue to persist.

The OCME is ASCLD/LAB accredited and should conduct a cause analysis under 4.11.2. Unfortunately, it is unclear how ASCLD/LAB enforces this standard and how it defines a root cause analysis. Additionally, neither ASCLD/LAB nor the underlying international accreditation standard ISO 17025 provides specific language or guidance on how to carry out a root cause investigation or prescribe a methodology. ASCLD/LAB accreditation standards are inadequate in this respect and the root cause analysis bill introduced by Chairpersons Arroyo and Ferreras will serve as an important guidance for the OCME in reviewing future significant events.

Comprehensive root cause analyses to understand the sources of the issues involving the lab analyst and the DNA profiles are the best practice in response to these oversights and there is no evidence that such an analysis was conducted by the OCME. We are only aware of the internal review that the OCME described at the February hearing[5] and the external management review conducted by Sorenson Forensics as it was described in the local media.[6] The former was a corrective action report addressed to ASCLD/LAB and the latter appears to be a management study commissioned by the OCME. While the Sorenson report focused on higher-level problems at the management level, it did not seem to tie them to the specific events that initiated the review. If the OCME has conducted a root cause analysis, it would be important for the report to be disclosed so the stakeholders in the criminal justice system that rely on the OCME can understand who conducted the analysis, the methodology applied, and to whom the analysis was shared. Until a root cause analysis is conducted, or at least released publicly so the rigor of its review can be verified, defendants in NYC courts and the public will not have confidence in the work of the OCME and the excellent scientific methodology practiced at the OCME will be questioned.

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[4] The Innocence Project does realize that individuals can participate as bad actors in a laboratory and there are various legitimate reasons for termination. However, when the actions of one individual, especially a technician at the beginning of a process, go unnoticed throughout the process, it proves a quality control system has gaps or flaws.

[5] Testimony of Dr. Barbara Sampson, "Testimony of the Office of the Chief Medical Examiner Before for the new York City Council Committees on Health and Women's Issues," February 15, 2013.

[6] Daniel Beekman, Shayna Jacobs, and Rich Schapiro, *EXCLUSIVE: 'Leadership must change' at city's DNA lab: report,* N.Y. Post, May 18, 2013. Available at http://www.nydailynews.com/new-york/leadership-change-city-dna-lab-article-1.1347616 (last accessed, 6/16/2013).

The bill sponsored by Chairpersons Arroyo and Ferreras is essential to moving our criminal justice system forward and will be a pioneering model in the forensic science community. The implementation of a comprehensive and public root cause practice at the OCME would be, I believe, the first of its kind in forensic laboratories, and would further anchor the OCME as a leader amongst forensic science providers. The bill carefully structures the root cause analysis committee assembled in the event of a significant event in order to maintain objectivity. Its members are drawn from a broad swath of the laboratory staff, but also include an independent, external participant who is an expert in root cause analysis from the city health and hospitals community, allowing an unbiased perspective and facilitating expertise in the process.

One suggestion I would like to propose for this excellent bill is the inclusion of the New York State Office of the Inspector General (OIG) among the list of entities that will be notified when a root cause analysis report is completed. The OCME is a recipient of Coverdell Forensic Science Improvement Grants (Coverdell) through New York State. Coverdell grants are federal awards to states to support their forensic science and medical examiner services.[7] As a stipulation to receiving this grant money, New York State must certify that an independent, external government entity has been designated to receive allegations of serious negligence or misconduct and has a process in place to conduct an investigation into those allegations. In New York, the OIG serves as the Coverdell entity for all forensic laboratories. Although the New York State Commission on Forensic Science is named as a notification entity in the bill, it is important to note that the Commission does not undertake investigations and may not necessarily refer all allegations of negligence or misconduct to the OIG. As different institutions have different missions and interests, they must all be notified in order to cover the breadth of review that needs to be done.

Lastly, I believe that a healthy root cause practice within the OCME will be instrumental in maintaining scientific excellence and improving internal culture at the OCME by encouraging solutions that address the source of a problem rather than placing blame. It is unfortunate that the OCME lost its scientific leaders in the wake of the recent laboratory problems. It is my hope that this bill will create a mechanism that can improve internal culture and provide the space that

[7] The Coverdell program is authorized by Title I of the Omnibus Safe Streets and Crime Control Act of 1968, Part BB, codified at 42 U.S.C. § 3797j-3797o.

the OCME needs to continuously improve its laboratory without sacrificing its scientific talent.

Transparency

The transparency bill proposed by Chairpersons Ferreras and Arroyo will not only bring the disclosure of practices of the OCME in line with many other forensic science providers, but it will enhance the independence of the laboratory. Currently, the Virginia Department of Forensic Science[8] and the North Carolina State Crime Laboratory[9] post its policies and procedures online and many laboratories, including the OCME, post their accreditation certificates online.[10] The OCME currently posts its technical manuals online, but not its quality manuals nor other laboratory policies and procedures.[11] The provision in the transparency bill that requires that all of OCME's policies and procedures be posted online is necessary. Likewise, the preparation and posting of a proficiency testing report that will provide long-term comparison data creates a new level of transparency and accountability that will elevate OCME's transparency policies above other forensic providers across the country.

While the OCME would benefit from other transparency measures that are beyond the scope of this hearing, additional disclosure items that your committees may consider relevant to this bill are the inclusion of accreditation audit reports, annual surveillance visit reports, and any inspection reports or documents associated with the laboratory's accreditation program. Accreditation programs, like ASCLD/LAB, utilize these documents in overseeing conformance and compliance monitoring procedures.[12] These documents provide insight into a laboratory's management, operations, personnel qualifications, and the physical plant requirements including:

- procedures to protect evidence from loss, cross-transfer, contamination, and/or deleterious change;
- validated and documented technical procedures;
- the use of appropriate controls and standards;

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[8] Virginia.gov, Department of Forensic Science: Manuals, available at http://www.dfs.virginia.gov/manuals/index.cfm (last accessed, 6/17/2013).
[9] NCDOJ.gov, State Crime Lab: ISO Procedures, available at http://www.ncdoj.gov/About-DOJ/State-Bureau-of-Investigation/Crime-Lab/ISO-Procedures.aspx (last accessed, 6/17/2013).
[10] The OCME accreditation certificates are also available on the ASCLD/LAB website and can be found at: ASCLD-LAB.org, ASCLD/LAB Accredited Laboratories, available at http://ascld-lab.org/labstatus/accreditedlabs.html (last accessed, 6/17/2013).
[11] NYC.gov, NYC Office of the Chief Medical Examiner: Technical Manuals, available at http://www.nyc.gov/html/ocme/html/fbio/Manuals.shtml (last accessed, 6/17/2013).
[12] ASCLD-LAB.org, Compliance/Conformance Monitoring, available at http://ascld-lab.org/monitoring/monitoring_overview.html (last accessed, 6/17/2013).

- calibration procedures;
- complete documentation of all evidence examination;
- documented training programs that include competency testing;
- technical review of a portion of each examiner's work product;
- testimony monitoring of all who testify; and
- a comprehensive proficiency testing program.[13]

As you can imagine, the aforementioned accreditation documents are highly relevant to understanding the state of a laboratory's management system and technical operations and provide a picture of the overall health of a laboratory. Currently, these documents are generally not shared outside of the laboratory unless required by law per ASCLD/LAB's policies. Since these materials are not included in the discovery packages that defense attorneys receive, it places an additional burden on attorneys to obtain them through legal procedure. If the Councilmembers are concerned about privacy issues, they may choose to make these documents available upon demand by prosecutors and defense attorneys alike.

Together Root Cause Analyses and Transparency Measures are Synergistic

The root cause analysis bill and the transparency bill introduced by Chairpersons Arroyo and Ferreras are separately important pieces of legislation. Together, they will work synergistically to accomplish far more than what each bill can accomplish alone.

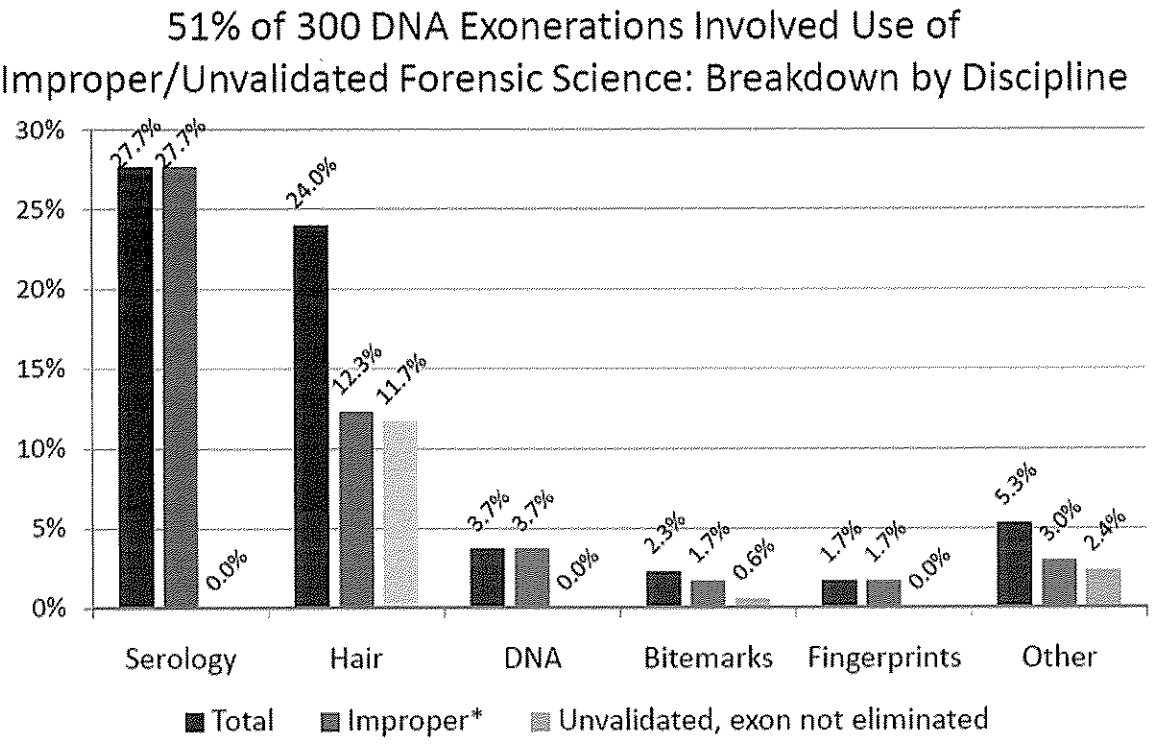
For example, proficiency testing will receive a greater level of attention and consideration since the proficiency report will be made public. The OCME may tailor the proficiency test to what will be most useful in assessing the competencies of forensic scientists in different positions. Also, the OCME can be more responsive to forensic scientists who marginally pass the exam but could use specific training to maximize performance. Consequently, root cause analysis, a layer of quality control that operates from a higher vantage point, would also benefit from proficiency testing. If a laboratory employee always maintained proficiency, and then suddenly failed a proficiency test, the root cause analysis could be applied to understand all the contributing factors that led to the failed test. Between the successful and the failed proficiency test, there could exist a number of variables such as new or faulty instrumentation, contaminated or

[13] NAS report, p. 198.

incorrect reagents used in analysis, a misunderstanding of new protocols or procedures, changes in the evidence chain of command, malfunctioning of storage facilities or environmental controls, gaps in communication due to staff, management, or supervisor changes - all of which could potentially affect results. A root cause analysis examines every angle and determines how the variables or events impact the final outcome of a proficiency test completed by one technician. While proficiency testing is a quality control system that focuses on an individual's performance, it alone would not have been able to answer those questions.

The Chief Medical Examiner has a responsibility to continually improve its methodology and policies. While the past events have shown that errors at even a prestigious lab will occur, all stakeholders in the criminal justice system should follow the lead of City Council by holding themselves accountable to reviewing these errors, understanding their causes, and implementing tangible change. Perhaps the single most unfortunate significant error in the criminal justice system is a wrongful conviction. DNA exonerees have spent time on death row, served approximately 4,135 years in prison while the best years of their lives passed them by. The Innocence Project realizes that these significant events are only possible from a confluence of contributing factors with errors that go unchecked throughout various systems beginning with the investigation through the trial in the courtroom. As the Innocence Project works to reduce wrongful convictions, it is gratifying to know that the OCME and City Council are working to reduce significant errors that occur at crime labs through additional legislation to bolster root cause analysis and transparency. Such measures will ensure that significant errors will not be reduced into single faults by specific individuals, but rather understood in a way that reflects the reality of excellent scientists working in a very difficult and stressful environment. The Innocence Project supports the transparency and root cause analysis bills proposed by Chairpersons Ferreras and Arroyo that will further improve the reliability of forensic analysis while providing stakeholders an ability to understand and monitor their world-class work.

Table 1. 51% of 300 DNA Exonerations Involved Use of Improper/Unvalidated Forensic Science: Breakdown by Discipline[14]



* Improper category includes: testimony or analysis which drew conclusions beyond the limits of science as known at that time; cases in which there was negligence in analysis, fabrications/alterations of reports and possible failures to conduct elimination testing or comparison; and withholding laboratory reports, analysis, data, or the very existence of evidence

[14] Also available at http://www.innocenceproject.org/docs/FSBreakdownDiscipline.pdf.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1050 Res. No. 1058

☒ in favor ☐ in opposition

Date: 6/24/13

(PLEASE PRINT)

Name: Sarah Chu

Address:

I represent: Innocence Project

Address: 40 North St, #701, NYC 10013

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1050 Res. No.

☑ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Jeffrey Weiss MD

Address: Montefiore Medical Center 111 East 210th ST Bronx, NY

I represent:

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. Res. No.

☐ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: MARVIN E. SCHECHTER

Address: 110 BROADWAY, SUITE 710, NY 10019

I represent: TRUTH JUSTICE

Address:

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
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Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Lawrence Kobilinsky

Address: John Jay College

I represent: Myself

Address: 524 W 59th St NYC 10019

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Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/24/13

(PLEASE PRINT)

Name: Mimi Mairs

Address: Attorney for DNA matters

I represent: OCME

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/24/13

(PLEASE PRINT)

Name: Barbara Butcher

Address: Chief of Staff & Interim

I represent: Director of the DNA Lab

Address: OCME

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: 6/24/13

(PLEASE PRINT)

Name: Dr. Barbara Sampson

Address: Acting Chief Medical Examiner

I represent: OCME

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1050 & 1058 Res. No. _____

☒ in favor ☐ in opposition

Date: 6/24/13

(PLEASE PRINT)

Name: ALEXANDRA KEELING

Address: 11 PARK PLACE 10007 1601

I represent: OFFICE OF THE APPELLATE DEFENDER

Address: SAME

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1050 Res. No. 1058

☒ in favor ☐ in opposition

Date: 6/24/13

(PLEASE PRINT)

Name: Anastasia Heeger

Address: 11 Park Pl. #1601, Ny, Ny 10007

I represent: Office of the Appellate Defender

Address: 11 Park Pl. #1601, Ny, Ny 10007

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1051/1058 Res. No. _____

☑ in favor ☐ in opposition

Date: 6/24/13

(PLEASE PRINT)

Name: Marika Meis The Bronx Defenders

Address: 360 E. 161st St. Bx, NY 10451

I represent: The Bronx Defenders

Address: same

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1050/1058 Res. No. _____

☒ in favor ☐ in opposition

Date: 6/24/13

(PLEASE PRINT)

Name: Jessica Goldthwaite

Address: Legal Aid Society 199 Water St NY, NY

I represent: Legal Aid Society

Address: 199 Water St NY, NY.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1050/1058 Res. No. _____

☒ in favor ☐ in opposition

Date: 6-24

(PLEASE PRINT)

Name: WILLIAM GIBNEY

Address: THE LEGAL AID SOCIETY

I represent: LEGAL AID

Address: 199 WATER STREET NYNY

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1051 Res. No. _____

☒ in favor ☐ in opposition

Date: 6/24/2013

(PLEASE PRINT)

Name: Michael McCasland – Chapter President

Address: 836 Myrtle Ave. Apt. 1 Brooklyn, NY 11206

I represent: Scientists & Criminalists at OCME, Union President

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1050 & 1058 Res. No. _____

☒ in favor ☐ in opposition

Date: 10/24/13

(PLEASE PRINT)

Name: Elizabeth Daniel Vasquez

Address: NYU School of Law

I represent: Professor Erin Murphy

Address: NYU School of Law

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 1050 Res. No. 1058

☒ in favor ☐ in opposition

Date: 6/24/13

(PLEASE PRINT)

Name: Michael Coleman

Address: 53 Parkland Rd Lynbrook, NY

I represent: N.Y County Defender Services

Address: 225 Broadway – Suite 1100 NY, NY 10007

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. ~~1058~~ 1050 Res. No. _____

☐ in favor ☒ in opposition

Date: Mon 6/24/13 10a.m.

(PLEASE PRINT)

Name: Dr. Mark L. Taff

Address: 511 Hempstead Avenue West Hempstead, N.Y. 11552

I represent: ~~Independent Self Employed~~ Forensic Pathologist

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Lisa Mc Govern

Address: _____

I represent: Emerald Isle Immigration Center

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: FATHER RICHARD GORMAN

Address: 4101 WHITE PLAINS ROAD THE BRONX

I represent: CHAIRMAN OF COMMUNITY BD #12

Address: SAME

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6/24/13

(PLEASE PRINT)

Name: MARY DUGGAN SHEEHAN

Address: 4280 KEPLER AV. BRONX 10470

I represent: WAKEFIELD TAXPAYERS ASSN.

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 6-24-13

(PLEASE PRINT)

Name: HUGH McMORROW

Address: 55 E 235 BRONX NY 10470

I represent: _____

Address: _____

Please complete this card and return to the Sergeant-at-Arms