ANNUAL ACCREDITATION AUDIT REPORT FROM 4-29-11 to 4-29-12

Indicate the period of activity above. The period should include a full year from accreditation anniversary to the next anniversary. The Annual Report is due on or within 60 days after the laboratory’s anniversary date.

Accreditation Certificate Number (Submit a separate form for each certificate number): 316

Laboratory Name: Pasadena Police Department Regional Crime Laboratory
Agency Name: Pasadena Police Department

LABORATORY DIRECTOR: Check if changed since the last report [ ]
Name: Pamela J. McInnis
Title: Laboratory Director

Street / Mailing Address: 923 E. Shaw Avenue
City: Pasadena
State/Province: Texas
Zip/Postal Code: 77506
Telephone: 713-475-7866
Fax: 713-475-2022
E-mail: pmcinnis@ci.pasadena.tx.us

NAME OF SYSTEM DIRECTOR (if applicable):

QUALITY MANAGER: Check if changed since the last report [X]
Name: Azell Carter
Title: QA/QC Manager

Telephone: 713-475-7866
Fax: 713-475-2022
E-mail: acarter@ci.pasadena.tx.us

LABORATORY DELEGATE (Check one)
[ ] The Laboratory Director listed above is the Delegate.
[ ] As Laboratory Director, I have named the following individual as the Delegate for this laboratory:
Name:
Title:
Telephone:
Fax:
E-mail:

SELF-EVALUATION OF COMPLIANCE

Using standards and criteria in the most current Accreditation Manual, a self-evaluation of your laboratory operations should form the basis for completing the following table.

<table>
<thead>
<tr>
<th></th>
<th>Total Number Possible</th>
<th>Total Yes</th>
<th>Total No</th>
<th>Total N/A</th>
<th>Percentage Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential</td>
<td>91</td>
<td>66</td>
<td>0</td>
<td>25</td>
<td>100</td>
</tr>
<tr>
<td>Important</td>
<td>45</td>
<td>40</td>
<td>2</td>
<td>3</td>
<td>89</td>
</tr>
<tr>
<td>Desirable</td>
<td>16</td>
<td>16</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

While the current manual should always be used for annual audits, laboratories which were accredited under the standards and criteria of an earlier version of the manual are not required to be in compliance with new standards which were added or raised to essential after their accreditation. However, laboratories must include a statement concerning such standards, which they do not meet, to indicate the steps that are being taken to move toward compliance with those standards and criteria.
This report must include explanations of any essential criteria scored “No” during the self-evaluation.

PERSONNEL

Total number of employees subject to proficiency testing (including vacancies): 6

The total number of employees subject to proficiency testing (including vacancies) is an important number and should be accurately determined. This is the number used to calculate your laboratory’s shares for the annual administrative fee. The number should not include administrative or clerical personnel. The number does include all laboratory positions subject to proficiency testing, whether in training, providing technical support or currently vacant.

IMPORTANT . . . If the response to any of the following is YES, please attach an explanation

During the past year:

• Did the annual audit reveal any instance of substantive non-compliance with any Essential criteria? ................................................................. □ Yes □ No

The primary purpose of the Annual Accreditation Audit Report is to document that the laboratory has made at least an annual determination that operations continue to be in compliance with accreditation standards, with a particular focus on Essential criteria. Laboratories must report substantive occurrences of non-compliance with essential criteria. “Substantive” means potentially having a significant bearing on the quality of the work of the laboratory, even if for a short period of time. With the expectation that a laboratory will always react internally and appropriately to instances of known non-compliance, it is not necessary to report every isolated occurrence of non-compliance. For deciding upon inclusion in this report, factors such as significance, substance and time-span of non-compliance should be evaluated. When in doubt, include the finding in your report.

• Was any discipline or sub-discipline added, reinstated, or suspended? ............. □ Yes □ No

List the discipline(s), action(s) taken and date: ____________________________________________________________

• Did an inconsistency or error on a proficiency test occur that required corrective action to be implemented? .................................................. □ Yes □ No

• Did an inconsistency or error on casework occur that required corrective action to be implemented? ............................................................ □ Yes □ No

IMPORTANT . . . If the response to the following is NO, please attach an explanation

• Did the laboratory meet the external proficiency testing requirements of each discipline, including the submission of all test results by the test provider’s deadline? ................................................................. □ Yes □ No

SIGNATURE (A typed name should be inserted for reports submitted via E-mail)

__________________________________________________________  ________________________________
Laboratory Director                                               Date

INSTRUCTIONS

• Reports may be submitted electronically to tdolin@ascld-lab.org or mailed to: ASCLD/LAB
  139 J Technology Drive
  Garner, NC 27529

• Questions about the completion of the Annual Accreditation Audit Report may be addressed to
  ASCLD/LAB at 919-773-2600 or mcreasy@ascld-lab.org

Every laboratory must submit an Annual Accreditation Audit Report to ASCLD/LAB on or within 60 days of the anniversary date of the laboratory’s accreditation. This report and supporting documentation can serve as proof of an annual audit (1.4.2.3). Laboratories applying for accreditation must conduct an audit in order to complete the Grade Computation Sheets and other supporting documents required with the application. Those documents may serve as proof of an annual audit.
proof of an audit for the purpose of the accreditation inspection. Laboratories having an inspection for renewal of accreditation, may utilize the application documents and inspection report as supporting documentation of an audit for the year in which the inspection is conducted. While appropriate as supporting documentation, neither the application for renewal, nor the subsequent inspection report replaces the required Annual Accreditation Audit Report.
A Quality Review was conducted for the whole laboratory during January 2012. Changes were made to various sections of the laboratory based on the review. The findings are summarized here. The appropriate notes and documentation will be maintained in the Audit 2012 notebook.

SAFETY

A review of the safety manual and the safety inspections for the year revealed no problems. The following videos obtained from Texas Municipal League Intergovernmental Risk Pool were viewed as part of the laboratory safety training on November 10, 2011:

- Safety First: Working with Hazardous Materials (Video #705)
- Learn From Their Mistakes: Hazcom Case Histories (Video #92)

Safety training was scheduled with Sue Baird for March 23, 2012. She will conduct training in first aid and CPR.

CORRECTIVE ACTIONS

There were three corrective actions for refrigerator/freezer equipment malfunctions. One corrective action involved confusion on evidence item numbers since the item numbers in Tiburon® do not necessarily match the item numbers in the Beast® Property Room Module. There was one Deviation from Documented Procedures involving the conversion of serum alcohol concentration to whole blood alcohol concentration.

COURTROOM TESTIMONY

Since the last inspection, only two chemists have testified. They are Sebastian Frommhold and Deborah Lind. There were no problems with any of the testimony.

PROFICIENCY TESTING

All the proficiency tests since the last inspection were satisfactory. One result is pending for the last blood drug test from CAP. Derek Sanders is writing a letter questioning one result.

LABORATORY OPERATIONS GUIDE

Several changes to the Laboratory Operations Guide were implemented: LOG 02, added correct title for the firearms examiner, removed serial number restoration from the trace list, and removed the requirement for the account balance; LOG 03, added Firearms Examiner/Forensic Chemist and QA/QC Manager/Forensic Chemist; LOG 07, changed the official manual definition to reflect that the official manual could be stored in the Conference Room or in the appropriate section; LOG 08 added a unique laboratory number on the front page of the document and the staff member’s initials may identify multipaged administrative documents that are bound together; also removed checking of ten percent of Tiburon® reports; LOG 14, addition of Laboratory Director and Section Leader as the appropriate...
personnel to sign off on training when the experienced analyst is going to be the Quality Manager; LOG 21, removal of obsolete fire extinguisher numbers; LOG 24, Calibration Documentation Notebook identified as the location for all maintenance records; LOG 26, all maintenance documentation placed in the Liebert notebook

**FIREARMS SECTION**

Several changes were made to the Firearms SOP. Under Evidence Handling, test fires, removed date of recovery, finish, firing pin and rifling pattern; In FA-IV-03, under equipment list, added compound microscope and Micrometer/Caliper.

**SEROLOGY SECTION**

The Serology Section SOP was not modified.

**TRACE SECTION**

The trace section SOP was not modified.

**TOXICOLOGY SECTION**

Several changes were made in the Toxicology Section SOP. TOX 01: add “if multiple positive responses are indicated, one procedure may be performed if all identified analytes can be confirmed in that procedure; add “Toxi-Lab A extraction – all samples deemed appropriate by the analyst (e.g. if performing Toxi-Lab will give a preliminary or secondary confirmation); add for MSTFA derivatizing reagent, expiration date will be two years from the date of purchase, for in-house controls, three years from the date of preparation; add the limit of detection for an analyte shall be defined as the concentration of the analyst required to give a signal equal to the background plus three times the standard deviation of the background. TOX 02: Add Preliminary Identification – Mass Spectrum, the mass spectrum conditionally identifies the compound; add the conditions for the confirmation extraction; expiration dates added the same as in TOX 01; limit of detection added the same as for TOX 01. TOX 04: conditions for priority sample added; the conversion factor for changing serum and plasma ethanol concentration to whole blood concentration was added. TOX 05: expiration dates added the same as in TOX 01. TOX 06: some abbreviations were added to the list.

**CONTROLLED SUBSTANCES SECTION**

The FTIR in the trace section was added to CS-TG 07 FTIR. In CS-SOP 02: convert tare weight to the same units as the pre-analysis weight. Truncate values to the appropriate number of digits, do not round up. The conditions for in-vial extractions for GC/MS analyses were added. The storage boxes used to transfer evidence to CER were added. In CS-SOP 03: the specifications for handwritten initials using the automatic numbering machine were added to this and to CS-SOP 05. In CS-SOP 06: the ATR attachment was added, the nitrogen purge gas was removed since it is not used, and examiner’s printed initials added. In CS-SOP 16: changes for reporting pharmaceutically identified tablets when only one tablet is analyzed were added.
VAULT/EVIDENCE INSPECTION

Five random cases for each chemist were inspected to verify location of evidence and proper sealing. There were no problems.

FOLDER AUDIT

The results of the folder audit showed few errors. Two reports had items left off that needed to be added. Everything was corrected the same day. The detailed list of the folder audit is available in the Quality Manager’s office in the Audit 2012 notebook.

Respectfully submitted,

Claudia Busby
Quality Manager