



**REPORT ON THE NEW YORK CITY POLICE
DEPARTMENT CRIME LABORATORY LATENT PRINT
DEVELOPMENT UNIT INCIDENT**

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STATE OF NEW YORK
COMMISSION OF INVESTIGATION

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Report on the New York Police Department Crime Laboratory Latent Print Development Unit Incident

In response to a request from the New York State Commission on Forensic Science (“CFS”), and in conjunction with the New York State Commission of Investigation’s (“the Commission”) designation under the U.S. Department of Justice Paul Coverdell Forensic Science Improvement Grant Program, the Commission conducted an investigation into the failure by a latent print development analyst to find and report latent prints on evidence at the New York City Police Department (“NYPD”) Laboratory (“the Laboratory”) in Queens, New York. Through its investigation, the Commission sought to identify the cause of the analyst’s failure and to examine and assess the NYPD’s response to this problem.

During its review, the Commission met with several NYPD members, including Deputy Chief Denis McCarthy, Commanding Officer, Forensic Investigations Division,¹ Laboratory Director Peter A. Pizzola, and Quality Assurance Manager Vincent Crispino. The Commission also reviewed the Laboratory’s procedures for reviewing casework performed by latent print development analysts.

Background

In July 2005, the Commission was designated by the State to conduct investigations into allegations of serious negligence or misconduct substantially affecting the integrity of forensic results committed by employees or contractors of any forensic laboratory system, medical examiner’s office, coroner’s office, law enforcement storage facility, or medical facility in the State. This investigation was conducted in conjunction with the State’s application for federal funds under the U.S. Department of Justice Paul Coverdell Forensic Science Improvement Grant Program.

¹ Subsequent to meeting with the Commission, Deputy Chief McCarthy was transferred to another division.

At the November 6, 2006 CFS meeting, members of CFS discussed three incidents of possible misconduct at laboratories in Suffolk County and New York City and requested that the Commission review those incidents. On November 28, 2006, the Commission received correspondence from the New York State Division of Criminal Justice Services Office of Forensic Science concerning the failure of a latent print development analyst to find and report prints on evidence at the NYPD Laboratory.

NYPD Latent Print Development Unit Incident

On August 5, 2004, an analyst in the Laboratory's Latent Print Development Unit ("the Latent Print Unit") was assigned to examine a firearm for the presence of fingerprints. The analyst was able to develop two fingerprints from the firearm and forwarded them to the Latent Print Identification Unit, where developed fingerprints are compared to fingerprints of known persons. Pursuant to Laboratory procedures, after concluding her examination, the analyst marked her initials on the firearm and prepared a laboratory report. The firearm was then forwarded to the Laboratory's Firearms Analysis Section, where it was tested for operability.

On August 16, 2004, unaware of the prior examination, an Assistant United States Attorney requested that the firearm be examined for fingerprints. On August 18, 2004, the case was assigned to Officer Phyllis Martin, another analyst assigned to the Latent Print Unit. During her examination of the firearm, Officer Martin failed to notice the prior analyst's initials and the two fingerprints that had been developed previously. After concluding the examination, she prepared a report reflecting her findings that no latent prints were developed from the firearm. On September 29, 2004, an administrative aide notified Latent Print Unit Supervisor Richard Herlihy about the two conflicting reports. On October 4, 2004, Herlihy re-examined the firearm, found one latent fingerprint, and then notified his supervisor, Judy O'Conner, about the problem. Together, they notified then-Laboratory Director W. Mark Dale. Laboratory officials subsequently issued an amended report indicating that Officer Martin's report was void.

Laboratory officials decided to review all cases assigned to Officer Martin for the next thirty days. That review revealed that, in three of the twenty-one cases assigned to her, Officer Martin failed to report all the prints that she had developed on evidence she had examined. Additionally, in one case, she failed to report the presence of trace evidence.² On or about November 24, 2004, Officer Martin was removed from casework pending further investigation by her supervisors. In January 2005, following a review of sixteen additional cases assigned to Officer Martin that revealed four additional deficiencies, Officer Martin was permanently barred from performing casework in the Latent Print Unit.

Response by NYPD Laboratory Officials

As a result of this incident, Laboratory officials took steps to address the immediate problems caused by Officer Martin's deficient work, and to identify and correct systemic problems that might have contributed to her failures. First, to determine whether there were similar deficiencies in the work performed by other analysts in the Latent Print Unit, the officials re-examined cases assigned to each analyst. Five cases assigned to each analyst were randomly selected and re-examined. No deficiencies were found in any of these cases.

Second, Laboratory officials continued to re-examine Officer Martin's cases. By January 2006, 132 of her cases had been re-examined and, in twenty-six of them, her work was found to be deficient. In twenty-five of those cases, Officer Martin had either failed to report or under-reported the number of latent prints she had developed during her examination. In the remaining deficient case, she failed to report the presence of trace evidence. Amended laboratory reports were prepared and forwarded to the police commands that had submitted the evidence for analysis. The Laboratory's Quality Assurance Manager was later assigned to notify the District Attorney's Offices about the deficient cases and to forward the amended laboratory reports where appropriate.

² Trace evidence is a small or hard to visualize substance, such as fiber, hair or blood, found at a crime scene or on evidence from a crime scene.

Laboratory officials determined that they would be unable to re-examine all of Officer Martin's cases expeditiously.³ Instead, they decided to focus initially on those cases that had resulted in a conviction. Commanding officers in units that had submitted evidence that was examined by Officer Martin were directed to review the status of their cases and report those which had resulted in a conviction. This process revealed that Officer Martin's cases involved 176 convictions.⁴

In August 2006, Laboratory officials notified all five New York City District Attorneys about convictions that may have been impacted by Officer Martin's work. In September 2006, members of the NYPD also met with representatives of each District Attorney's Office.⁵ The Commission contacted assistant district attorneys in each borough to confirm that they had been notified about this matter.⁶

Next, Laboratory officials reviewed and revised the technical review process utilized in the Latent Print Unit to ensure quality control in the analysts' work. Prior to this incident, the technical review process required that six cases per month per analyst be reviewed. Each analyst determined which of his or her completed cases were to be reviewed. The review was conducted by another latent print analyst, who reviewed the notes and documentation in the case file, examined the evidence at the end stage of the processing, and determined whether there was a proper basis for the original analyst's conclusions. As a result of this incident, the Laboratory's technical review process has been amended. Currently, the process requires verification of the analysts' work at each step of the examination process in a minimum of six cases per month. Although the

³ Officer Martin was assigned to the Latent Print Unit in June 1998. She began independent Laboratory casework shortly after concluding her training in late October 1998. Laboratory records revealed that she had processed approximately 1400 cases between January 1999 and 2004.

⁴ The convictions included 144 guilty pleas and 32 convictions after trial.

⁵ Since then, Laboratory officials have been holding periodic "customer" meetings with representatives of the District Attorneys' Offices. These meetings are held approximately every three months and help to facilitate communication between the Laboratory and the District Attorneys' Offices.

⁶ Assistant district attorneys from New York and Queens Counties requested that the evidence be re-examined in eleven cases. In nine of those cases, Officer Martin's results were found to be accurate. In one case, she had reported that sixteen latent prints had been developed. Upon re-examination, five additional latent prints were located. In the remaining case, the evidence is unavailable for re-examination. The Commission has been informed that logbooks within the Property Clerk's Office indicated that the property has been auctioned off. The Bronx, Kings and Richmond County District Attorney's Offices have not requested any re-examination of evidence.

analysts still determine which of their cases are to be reviewed, they must designate a case for review prior to examining the evidence involved. The reviewing analyst then shadows each step during the examination process and must be in agreement with all conclusions reached by the case analyst. Additionally, either a supervisor or another analyst reviews all notes and documents prepared by case analysts for each of their cases. Lastly, the Latent Print Unit supervisor randomly selects and reviews one to three cases per analyst per month.

Conclusion

The Commission concludes that, prior to the discovery of Officer Martin's failures, the technical review process utilized in the Latent Print Unit was deficient and contributed to the inability of Laboratory officials to uncover those failures, which were not found through an internal review process but, rather, by a fortuitous set of circumstances. The Commission finds, however, that, once the problem was uncovered, NYPD Laboratory officials reacted appropriately. Steps were taken to identify the extent of Officer Martin's deficiencies and to determine whether the same failures were being committed by other analysts as well. Officer Martin was removed from conducting examinations and all of her cases were identified so that they could be re-examined if needed. When the volume of her cases proved too large for an expeditious re-examination, Laboratory officials correctly prioritized those cases that had already resulted in a conviction to ensure that action could be taken to correct any wrongful convictions. Finally, the NYPD amended the Latent Print Unit's technical review process to help prevent a recurrence of this same problem and to ensure that similar incidents are uncovered more quickly.

The Commission also concludes, however, that Laboratory officials took too long to notify the District Attorneys about this problem and should have notified them earlier in the process. The Commission recognizes that it took time to identify the extent of the problem and that none of the District Attorneys have since reported that any of their cases had been compromised. Nevertheless, notifying the District Attorneys that there was an

apparent problem with some of Officer Martin's work would have allowed them to take appropriate action more quickly. The Commission recommends that, in the future, Laboratory officials notify prosecutors as soon as possible regarding any problems that might affect their criminal cases, particularly those that have already resulted in a conviction. Continuing the recently initiated periodic meetings between Laboratory officials and representatives of the District Attorneys, which are noted above, will help to address this concern.