



**REPORT ON THE
NEW YORK CITY POLICE DEPARTMENT
CRIME LABORATORY
MICROSCOPIC EXAMINATION UNIT INCIDENT**

**AUGUST
2007**

STATE OF NEW YORK
COMMISSION OF INVESTIGATION

REPORT ON THE
NEW YORK CITY POLICE DEPARTMENT
CRIME LABORATORY
MICROSCOPIC EXAMINATION UNIT INCIDENT

ALFRED D. LERNER
Chairman

HENRY J. NAHAL
VINCENT F. NICOLSI
ROBERT PRICE
GEORGE FRIEDMAN
JOHN P. CAHILL
Commissioners

ANTHONY T. CARTUSCIELLO
Deputy Commissioner/
Chief Counsel

ANTHONY HELLMER
Assistant Commissioner/
Chief Investigator

RAFFAELA PETROCCIONE
Executive Assistant

JEROME LIGHTFOOT
Deputy Chief Investigator

STAFF FOR THIS INVESTIGATION AND REPORT

ANN E. RYAN
Supervising Senior Assistant Counsel

KENNETH MICHAELS
Senior Assistant Counsel

LAURENCE SNYDER
Senior Special Agent

DEIRDRE FRAZIER
Secretary to the Chief Counsel

STEVEN GREENBERG
Media Consultant

This report is also available on the Internet at www.sic.state.ny.us

Report on the New York City Police Department Crime Laboratory Microscopic Examination Unit Incident

In response to a request from the New York State Commission on Forensic Science (“CFS”), the New York State Commission of Investigation (the “Commission”) conducted an investigation into a number of procedural and substantive mistakes made by a New York City Police Department (“NYPD”) detective, formerly assigned to the NYPD Police Crime Laboratory (the “Laboratory”) as a firearms microscopy examiner, and the NYPD’s response to the mistakes.

During its investigation, the Commission met with several NYPD members, including Deputy Chief Denis McCarthy (the Commanding Officer of the Forensic Investigations Division at the time of the incidents in question), Laboratory Director Peter A. Pizzola, former Director W. Mark Dale, and Quality Assurance Manager Vincent Crispino. Commission staff also reviewed relevant documents. Finally, the Commission analyzed the Laboratory’s procedures for reviewing casework performed by microscopy examiners.

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 assignment was performed in conjunction with the State’s application for federal funds under the U.S. Department of Justice Paul Coverdell Forensic Science Improvement Grant Program.

On November 6, 2006, CFS requested that the Commission review issues related to the casework of NYPD Detective Peter Liota, a microscopy examiner in the Laboratory. With its request to investigate, CFS provided the Commission with an anonymous letter that had been sent to the American Society of Crime Laboratory

Directors' Laboratory Accreditation Board ("ASCLD/LAB"), the entity that accredits the Laboratory, and the record of NYPD's response to issues relating to Liota's work since September 2003 when he was assigned to the Microscopic Examination Unit of the Laboratory's Firearms Analysis Section ("FAS").¹ On November 28, 2006, the New York State Division of Criminal Justice Services' Office of Forensic Science provided the Commission with additional information about Liota's work and NYPD's response to problems stemming from that work.

Liota's Casework Issues and NYPD Review

Detective Liota joined the FAS in late 1997. In 2001, he was trained in firearms identification and microscopy. In November of that year, he successfully completed his competency testing. Shortly thereafter, he began performing casework. In June 2003, Liota received a commendation for his work that resulted in the linking of a series of shootings in Manhattan and Brooklyn. In September 2003, however, James Gannalo, a consultant hired by NYPD to train firearms examiners, reported concerns about Liota's casework to the commanding officer of the FAS, Lt. James Kenny.

Gannalo then reviewed fifty-six microscopy cases that had been assigned to Liota since the beginning of that year. Gannalo found clerical and practical deficiencies in Liota's casework that he determined were not readily correctable, and that Liota had improperly marked evidence.² In nine cases, Gannalo found that Liota had "misidentified" evidence or that there had been a "misidentification" in his casework.³ Specifically, Laboratory procedures required that, where evidence size and other characteristics permitted, evidence marking include the examiner's initials, the sequential item number, and the case number including the year. According to Gannalo, in almost

¹ FAS is composed of three units: the Operability Testing Unit, the Microscopic Examination Unit, and the Computerized Ballistic Identification Unit.

² Specifically, Gannalo found that Liota has used an old technique, and had marked evidence with permanent ink marker rather than engraving the evidence.

³ In the field of firearms identification, the term "misidentification" is normally used to describe a false positive or false exclusion. According to ASCLD/LAB inspectors who later performed an interim inspection, the errors that Gannalo described did not constitute misidentifications.

all of Liota's cases, the evidence was marked only with Liota's initials and a sequential number.

Gannalo also found other errors. These included the incorrect description or improper identification of bullet and cartridge case evidence, administrative errors in recording evidence received or the results of an examination, and errors in determining the class characteristics of fired rounds that were evidence. Gannalo concluded that none of Liota's errors appeared serious enough to threaten the prosecution of a case.

Nevertheless, on October 13, 2003, Liota was removed from casework, and received eighty hours of retraining, which he completed in February 2004. Between February 25 and March 16, 2004, Gannalo administered four tests to Liota to determine whether Liota was competent to perform casework independently. As a result of Liota's poor performance on these competency tests, effective March 22, 2004, his duties were limited to testing firearms for operability and working in the Laboratory's computerized ballistic identification unit. In April 2004, Gannalo recommended that Liota receive additional training.

The fifty-six cases that Gannalo had reviewed were reviewed again by other examiners in April and May 2004. Detective First Grade Kevin Barry, a senior examiner in the unit, was assigned to review all of the cases,⁴ and Edward Hueske, an independent firearms consultant, reviewed a number of the cases. Barry and Hueske returned different conclusions, both from each other and from those submitted by Gannalo.⁵ Barry concluded that the deficiencies he found did not significantly affect the reliability of Liota's or the Laboratory's work product. Hueske concluded that Liota had not misidentified materials in any of the cases he had reviewed, and stated that "perhaps" the phrase "improper description" would be more appropriate. FAS commanding officer

⁴ Former Laboratory Director Dale was aware that Barry had performed the peer review on many of the cases that Gannalo had audited, but nevertheless felt that Barry was the best qualified examiner in the unit to review the cases.

⁵ ASCLD/LAB's inspectors later determined that the major difference was on a case in which Liota and Barry concluded that four cartridge cases were fired from one firearm. Gannalo and Hueske concluded that three of the cartridge cases were fired from the one firearm but that the fourth was inconclusive.

James Kenny concluded that the three reviews “revealed a pattern of incomplete note taking, evidence improperly marked, and minor errors.”

As a result of reviewing Liota’s cases, in addition to finding Liota’s individual mistakes, the Laboratory found a number of institutional problems and took steps to address them. It determined that a number of examiners did not fully understand their role in performing technical peer review of others’ work. Although technical review is supposed to include the review of notes, reports, data and other documents that serve as the basis for the scientific conclusions, as well as the checking of evidence markings, the Laboratory determined that some examiners had incorrectly thought that such review was limited to the verification of a peer examiner’s conclusions after a quick viewing of evidence through a microscope.⁶ As a result of this determination, the examiners in the section were retrained on the procedures for verification and technical review. Additionally, the Laboratory determined that examiners were choosing which peer would review their cases. Accordingly, then-Laboratory Director W. Mark Dale instituted a weekly rotation system specifying which examiner would perform technical review of another’s work.

In May 2005, Nicholas Mattia, who had been hired as a new firearms consultant, was assigned to develop an additional training program for Liota. Mattia administered the retraining and three competency tests to Liota, who successfully completed them. In late August 2005, Liota was returned to microscopy case work. In total, it took twenty-one months to complete Liota’s retraining process.⁷

ASCLD/LAB Issues

In October 2004, the Laboratory was inspected by ASCLD/LAB as part of the Laboratory’s ongoing accreditation review. Liota’s performance issues, however, were

⁶ ASCLD/LAB also reported that conclusion.

⁷ In his interview with the Commission, Dale could not fully explain why the retraining took so long. He told the Commission that Liota’s training was not a priority for the Laboratory, that there were scheduling conflicts between Gannalo and Liota, and that Liota “was needed elsewhere,” namely to perform firearms operability testing in a different FAS unit.

not brought to the attention of ASCLD/LAB inspectors at the time. Former Laboratory Director Dale told the Commission that he “made a judgment” not to notify ASCLD/LAB because an internal investigation was ongoing, and the problem did not “involve misidentification and was not systemic.”

A year later, in October 2005, Laboratory Director Pizzola learned that ASCLD/LAB had received an anonymous, undated letter that alleged a “cover-up” in the investigation of Liota’s work. The letter alleged that Liota had not followed Laboratory procedures, that he had improperly identified evidence, and that he would “shop around” for peer examiners who were more likely to approve his work. The letter also alleged that Gannalo’s audit confirmed the concerns about Liota’s work, that Liota was still being retrained twenty-one months later, that Barry and Liota had tampered with evidence, and that the matter had been kept from the ASCLD/LAB inspectors during their October 2004 inspection.

In response to the allegations in the letter, the NYPD conducted an internal investigation, which concluded that the allegations in the letter were unsubstantiated. Specifically, the NYPD found that no examiner had had knowledge of another examiner committing improper acts or violating Laboratory procedures; no examiner had observed Liota or Barry improperly altering evidence; and no examiner had been told to hide or not disclose information to the ASCLD/LAB inspectors.

ASCLD/LAB also reviewed the matter, conducting an interim inspection in response to the allegations in the letter and found that that “no sanctions or other actions [were] appropriate in this matter.” In a report dated March 2006, it concluded that, with the exception of NYPD’s failure to disclose the Liota issues in a timely fashion, the Laboratory had taken appropriate action.⁸

⁸ The ASCLD/LAB report also found, in contrast to NYPD’s finding that no examiner had been told not to disclose information, that one examiner told the ASCLD/LAB inspectors that he was told “what happens in-house, stays in-house.”

In February 2006, the NYPD hired George Krivosta, an independent consultant, to conduct a technical audit of randomly selected Laboratory cases. Krivosta randomly selected and examined nine of Liota's cases and thirteen cases from other examiners, including two examiners who had already left the Laboratory. On February 27, 2006, before the audit was completed, Krivosta notified Laboratory director Pizzola by telephone that Liota had failed to mark evidence properly in one case. Laboratory officials reviewed the case that day, found additional problems⁹ and removed Liota from performing casework. Liota was transferred to another command in April 2006.

Krivosta found deficiencies – procedural mistakes – on three of Liota's cases, including the storage of an item from one case with materials from another case, failure to properly mark evidence, and failure to note the possession and return to storage of evidence in the appropriate log. In two of the three cases with deficiencies, he found discrepancies – substantive errors. In both of those cases, where Liota had made a positive identification of either expended bullet casings or a bullet, Krivosta found that he had insufficient cause for the findings, and should have reported the result of his tests as “inconclusive.”

Laboratory officials took steps to determine whether other similar examination failures had been made by other FAS examiners. First, Laboratory officials re-examined cases to determine if the evidence was properly marked. Approximately eighteen cases that had been assigned to each examiner during a three month period were re-examined. Some deficiencies were found in these cases and were corrected.¹⁰

Laboratory officials also continued to re-examine Liota's cases. An audit of those cases from years 2000 through early 2006 was conducted in April and May 2006,¹¹ and

⁹ The problems found by Laboratory officials included: a bullet that had not been marked; a container that lacked required markings; two containers that were marked incorrectly with the wrong number; and an envelope with incorrect information written on it. Moreover, no entries had been made in the chain of custody logs for the case in question.

¹⁰ Of 233 gun operability cases examined, there were two cases where the evidence was not properly marked. Of 230 microscopy cases, there were twenty-three inconsistencies. The inconsistencies were corrected and the entire section was retrained.

¹¹ The fifty-six cases reviewed by Gannalo were not included in this audit.

thirty-two errors were found in 510 cases. In eight cases, the audit reflected that evidence had not been marked and, in nine cases, the evidence had been marked incorrectly. In two instances, an evidence container had been marked incorrectly, and in eleven instances, an evidence envelope had been marked incorrectly. Additionally, in two cases, Liota had not prepared the proper reports. Finally, NYPD firearms consultant Mattia randomly selected and reviewed twelve cases that Liota had worked on since his return to microscopy casework, and found no problems with the results.

As a result of its investigation into Detective Liota's work, the Laboratory has instituted a series of corrective and preventive actions. All firearms personnel have been retrained in the proper marking of evidence, proper documentation of chain of custody, and verification of all evidence markings while conducting microscopy examinations. In addition, new FAS supervisors have been trained regarding the proper steps to follow when initiating and conducting a corrective action. The Laboratory Director has also requested permission from the NYPD to hire a consultant to review possible systemic problems within the Microscopic Examination Unit of the FAS by conducting random audits of the casework of assigned personnel on an ongoing basis.

In the spring of 2006, Laboratory officials determined that, of the fifty-six Liota cases that Gannalo had reviewed in 2003, five cases had been referred for prosecution. One of those five cases had been dismissed. In the remaining four cases, the defendants had pled guilty.¹²

In May 2006, management at the Laboratory requested permission from Chief McCarthy to notify the five New York City District Attorneys about the Laboratory work issues. Chief McCarthy denied that request but told the Laboratory that, if any amended reports had been prepared, they could be forwarded to the District Attorneys. At a November 9, 2006, meeting of the Commission on Forensic Science attended by members of the Laboratory and representatives of some of the District Attorneys' Offices, the Liota matter was raised and fully discussed. Since the matter was now public

¹² One case charged two co-defendants.

within the prosecutorial community, Laboratory officials decided to formally notify all five New York City District Attorneys via email, and included in that email an attached document outlining the issues in the Liota matter and the Laboratory's response to each issue.

In December 2006, members of the Laboratory discussed the Liota matter with representatives of each District Attorney's Office at a meeting.¹³ Since then, Laboratory officials have begun periodic "customer meetings" with representatives of the District Attorney's Offices. These meetings are held approximately every three months and help to facilitate communication between the Laboratory and the District Attorneys' Offices.

Conclusion

The Commission finds that, once the 2003 problems with Liota's work were discovered, Laboratory officials reacted appropriately in many ways. Liota was removed from microscopy casework pending retraining. When he did not successfully complete the series of competency tests given at the conclusion of the retraining, he remained barred from performing microscopy work. In an effort to have Liota reinstated to microscopy work, Laboratory management required Liota to receive more training and take competency tests. After he successfully completed that process, he returned to performing microscopy work. Both the NYPD and ASCLD/LAB conducted investigations into the allegations raised in the anonymous letter. Both offices determined that the NYPD Laboratory had not made substantive errors. ASCLD/LAB found that issues surrounding Liota's work should have been reported in a timely fashion. The Commission concurs with this finding.

The Laboratory took action to address the problems it faced, both those that were specific to Detective Liota and to institutional problems unearthed as a result of the Liota investigation. Examiners were retrained in proper evidence marking and in technical review procedures. Ultimately, the Laboratory also reviewed other examiners' work and

¹³ The Commission contacted representatives of each district attorney's office to confirm that they had been notified about this matter.

determined whether other examiners were not properly engraving or marking the evidence, and the Laboratory notified the District Attorney's Offices of the various issues that had been discovered and addressed.

The Commission concludes that, after learning of additional problems with Liota's work in 2006, the Laboratory appropriately removed him from casework. The Commission also concludes, however, that Laboratory officials took too long to notify the District Attorney's Offices about problems relating to Liota's cases, and should have done so earlier.

The Commission recommends that, in the future, Laboratory officials notify prosecutors as soon as possible regarding any Laboratory work issues that might affect criminal cases, particularly those that have already resulted in a conviction. The recently initiated periodic meetings between Laboratory officials and representatives of the District Attorney's Offices will serve as a good forum for open discussion of such issues if they arise.