CODE 20 SIDEBAR

This edition of the Sidebar provides notification of a 2 April 2012 Memorandum from the Department of the Army - Office of the Judge Advocate General Criminal Law Division

Memorandum:

The memorandum released by the Department of the Army, Office of the Judge Advocate General (Criminal Law Division) provides notice that in December of 2011 an inspection of the Ft. Meade Forensic Toxicology Drug Testing Laboratory (FTDTL) resulted in the discovery of two issues concerning four laboratory employees.

The Army memorandum is attached to this Sidebar, and details the two issues discovered. One issue involved a laboratory technician's failure to place a Blind Quality Control (BQC) tube in an initial screening batch for testing and her attempt to conceal this mistake. The other issue involved three lab processors who falsified timecards. The information is being released by the Department of the Army pursuant to *Brady v. Maryland*, 373 U.S. 83 (1983) and Rules for Court-Martial 701. Code 20 has confirmed that NCIS has used this lab and has requested a list from NCIS of potentially impacted cases.

******All Judge Advocates should read the attached memorandum and be aware of any notice requirements.******

Code 20 has also posted a copy of the memorandum on NKO, under the Criminal Law Section. If you have any questions regarding this information, please contact: Maj Tom Merritt, at thomas.merritt@navy.mil or via telephone at (202) 685-7061.

DEPARTMENT OF THE ARMY
OFFICE OF THE JUDGE ADVOCATE GENERAL
CRIMINAL LAW DIVISION
2200 ARMY PENTAGON
WASHINGTON, DC 20310-2200

REPLY TO
ATTENTION OF:

DAJA-CL

2 April 2012

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Brady Notice - Meade Forensic Toxicology Drug Testing Laboratory

1. The December 2011 inspection of the Ft. Meade Forensic Toxicology Drug Testing Laboratory (FTDTL), resulted in the discovery of two issues concerning four laboratory employees:

a. Error by Fort Meade FTDTL technician: Non-Conforming Event (NCE) 11-10-02 details a laboratory technician's failure to place a Blind Quality Control (BQC) tube in an initial screening batch for testing and her attempt to conceal this mistake. On 26 October 2011, personnel in the lab's screening section realized that a BQC tube was missing from position number 100 in the specimen tray. The technician tried to conceal her error by putting the BQC tube on the ground as though the tube fell out of the tray. When questioned by her supervisor, the technician initially denied the mistake and postulated that the missing tube must have fallen out of the tray. The technician then claimed to "find" the missing tube behind a work desk. When further confronted by her supervisor and told that her story was impossible, the technician admitted that she had placed the tube behind the work desk when questioned about the incident.

b. The initial BQC was discarded and the batch was repoured. The technician was decertified for labeling and aliquotting and placed in a retraining status. She was also counseled about following Standard Operating Procedures (SOPs), attention to detail, avoiding distractions, and integrity. The technician error did not affect the actual screening for controlled substances, nor did it undermine the outcome. For more details on this event, please see the attached memorandum which describes Non-Conforming Event 11-10-02.

c. Submission of False Timecards: During the inspection, the Laboratory Administrator reported to an inspector that there were three lab processors who falsified timecards (November 2009, June 2011, and November 2011). These individuals were counseled for their actions and then made corrections to their timecards.

2. This information is being released pursuant to Brady v. Maryland, 373 U.S. 83 (1983) and Rule for Courts-Martial 701. Please ensure this notice is disseminated to all judge advocates in your command as well as judge advocates in subordinate commands.

3. Anyone with technical questions regarding the information contained in the attached memorandum should contact LTC Peter Platteborze, USAMEDCOM, at 210-221-7989. If you

DAJA-CL
SUBJECT: Brady Notice – Ft. Meade Forensic Toxicology Drug Testing Laboratory

have questions particular to this legal notice, please contact CPT Jacqueline J. DeGaine at 571-256-8185 or at jacqueline.j.degaine.mil@mail.mil.

Enclosure

CHARLES N. PEDE
COL, JA
Chief, Criminal Law Division

DISTRIBUTION:
Chief, U.S. Army Trial Defense Service
Chief, U.S. Army Defense Appellate Division
Chief, U.S. Army Government Appellate Division
Chief Judge, U.S. Army Trial Judiciary
Commander, The Judge Advocate General's Legal Center and School
Office of the Judge Advocate General, U.S. Air Force
Office of the Judge Advocate General, Code 20, U.S. Navy
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Staff Judge Advocate, U.S. Army Military District of Washington
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DEPARTMENT OF THE ARMY
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND
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REPLY TO
ATTENTION OF

MCHO-CL-H

7 March 2012

MEMORANDUM FOR Office of the Judge Advocate General, Criminal Law Division, 2200 Army Pentagon, Washington, DC 20310-2200

SUBJECT: Technician Error at Fort Meade Forensic Toxicology Drug Testing Laboratory

1. In October 2011, the Fort Meade Forensic Toxicology Drug Testing Laboratory (FTDTL) discovered an error had occurred during the pouring of service member specimens for a routine urinalysis. The error consisted of the technician failing to place a Blind Quality Control (BQC) specimen into a screening batch and initially concealing her error by placing the missing tube behind the work desk. The error was easily identified through the normal laboratory review process. Prior to analysis, the screening technician verifies all test tubes are present. In this situation, one specimen was missing from the batch and the screening technician notified the supervisor. An investigation was started immediately. The specimen aliquots were never tested. All of the aliquots were destroyed and the specimens were repoured and tested.

2. Background:

a. The Fort Meade FTDTL receives Service Members' samples for testing in a sealed specimen bottle. The first step in a controlled substance test is an immunoassay screening. The technician will pour from the specimen a one or two milliliter (mL) aliquot (sample) into a test tube. The aliquots are grouped into batches containing 98 service member specimens and two Blind Quality Control (BQC) specimens. The BQCs are samples containing known amounts of drug that are inserted into the batch disguised as service member specimens. They are unknown to the instrument operator.

b. After the aliquots are poured, the specimens are placed into secured storage awaiting transfer to the screening department. In this instance, the Screening Technician found only 99 specimens in the batch during tube verification and notified the supervisor. An investigation immediately started. The Processing Technician who poured the aliquots originally denied the mistake and postulated that the missing tube must have fallen out of the batch. The technician then proceeded to find the missing tube behind a work desk. However, shortly after the discussion with the supervisor, the Processing Controller admitted that she had discovered the missing BQC tube in the specimen tray holding the specimens bottles for that testing batch. She had removed the cap from the BQC tube and placed it behind the desk prior to stating to her supervisor she found the tube in that location instead of in the tray.

c. Because of this error, the original 99 sample aliquots were destroyed and never tested. The batch was repoured in its entirety and tested according to laboratory SOP.

MCHO-CL-H
SUBJECT: Technician Error at Fort Meade Forensic Toxicology Drug Testing Laboratory

3. Actions Taken: The Processing Technician was immediately decertified and placed into a training status. The Technician was counseled regarding the importance of following the SOP and attention to detail. In addition, the Technician was reminded about the lack of integrity shown during the initial investigation of the incident and how her actions reflect negatively on the Fort Meade FTDTL and the entire Army Drug Testing Program.

4. Conclusion: The technician error did not affect the testing or undermine the results reported by the laboratory. The initial sample aliquots were destroyed and never tested. The samples were repoured, tested, and reported according to SOP. Though the occurrence of the error is troubling, the error itself did nothing to affect the subsequent outcome of the testing.

5. We regret any inconvenience associated with this matter. Please contact the undersigned at 210-221-7989 or email at peter.platteborze@us.army.mil if you have further questions or concerns.

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LTC, MS
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