SAN DIEGO POLICE DEPARTMENT

FORENSIC SCIENCE SECTION

Quality Assurance Manual

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1.1 QUALITY MANUAL AND OBJECTIVES

The laboratory quality manual is a compilation of administrative, managerial, and technical policies that are unique to our laboratory. In addition, the laboratory quality manual incorporates ISO 17025:2005 and ASCLD/LAB *International* supplemental requirements.

Numbered sections 4 through 6 in this manual correspond to ISO 17025 and ASCLD/LAB/*International*-Supplemental Requirements for the Accreditation of Forensic Science Laboratories.

Mission Statement

The mission of the San Diego Police Department Crime Laboratory is to provide the Department and the citizens of San Diego with comprehensive, impartial, reliable, accurate and timely scientific analysis of evidence by experts skilled in the latest forensic technologies.

Vision

Our crime laboratory will consistently strive for excellence in meeting the forensic needs of the local criminal justice community. We will be of sufficient size with sufficient budget, staff, and training to be able to meet all reasonable requests for forensic services submitted by detectives of the San Diego Police Department.

Goals

We will maintain a high level of professional competence through training, proficiency testing, and review of casework.

We will advocate professional development through on-going training and participation in professional organizations.

We will maintain our status as an ANAB accredited crime laboratory.

Objectives

The objectives of the quality system will be articulated and reviewed through the crime lab manager's quarterly management reports and the annual quality system report.

1.2 CONTROL OF LAB SUPPLIES

GENERAL LAB SUPPLIES

Orders can be placed by completing the appropriate forms. Some of the orders may involve the use of open purchase orders while other orders may involve the use of the form PD478. All orders, except for Supply Room orders, are to be routed through the Clerical Unit supervisor. Supply Room orders must be approved by the Crime Laboratory Manager.

The invoices are initialed by unit personnel, and are to be placed in the invoice box in the reception area. The invoices are processed by Clerical Unit staff and are sent to Fiscal Management.

The administrative aide keeps a file of all open purchase orders. Each unit is responsible for determining its supply needs.

Some general items are available through the Central Supply Room. The appropriate supply forms to be used for obtaining items from Supply. Other specialty items may be available through specific contract vendors.

Purchases may be made with petty cash reimbursement with prior approval from Fiscal Management.

OFFICE SUPPLIES

General office supplies are ordered on a weekly basis directly through the laboratory's Clerical Unit. These orders are subject to the approval of the Laboratory Manager and ultimately the Fiscal Management Section of the Department.

If the orders are not specific to an individual, the supplies are placed inside the supply cabinet in the laboratory's reception area.

USE OF CITY/LAB SUPPLIES

All staff members shall use city and laboratory supplies in an economic manner. Laboratory supplies are for official use only and are not intended for personal use.

1.3 SUBPOENA POLICY

Refer to Department Procedure 1.11 for the Department's court and subpoena policies.

COURT STAND-BY

Upon receiving a subpoena, the examiner should contact the DA's office to either make arrangements to be on standby or to arrange a specific time for testimony. The examiner should make an effort to discuss the case with the DA prior to testimony.

The Forensic Chemistry Unit staff also operates on an on-call basis for alcohol related testimony.

SUBPOENAS

Subpoenas are generally processed by the Clerical Unit staff. The analyst will initial or sign the subpoena and return a copy to the Clerical Unit. Unit manuals for Forensic Chemistry will have additional requirements.

If an examiner is unable to testify due to illness or other unavoidable emergency, it is the analyst's responsibility to notify the appropriate person or agency of their condition in a timely fashion.

If the examiner has a time conflict due to training or vacation, the examiner should make the appropriate arrangements with the sender of the subpoena. The examiner or their supervisor may try to reschedule a court appearance, or suggest that another examiner testify in their place. If these alternatives are not acceptable to the attorneys handling the case, the court requirements will take precedence over training. If an analyst receives subpoenas for simultaneous court appearances, they will contact the attorneys involved to coordinate court appearance times.

VACATION NOTICES

Prosecuting agencies commonly served by the crime laboratory will be notified of an analysts' pre-arranged unavailability for court due to vacation or training. The analyst will notify a member of the Clerical Unit of dates of unavailability. The Clerical Unit staff member will prepare a memo stating the dates of unavailability, which will be signed by the analyst's supervisor.

The memo will be distributed to the prosecutorial agencies by the Clerical Unit.

See the unit manuals for any additional specifics on court and/or subpoena policies.

1.4 REQUESTS FOR VIEWING OR RELEASE OF EVIDENCE, SPACE OR EQUIPMENT

(Please also refer to QA 4.13, Control of Records, for additional information)

VIEWING EVIDENCE

Laboratory staff will route defense and prosecution requests for viewing of evidence through the case detective. Evidence viewing will typically occur in the Property Room or the Narcotics Vault. In most instances, the detective will be present. If the viewing will extend into any laboratory unit, advance coordination with the unit supervisor is required.

The following conditions will also apply:

a. Fresh paper will be used on tables on which evidence is viewed. The exception to this requirement is narcotics and toxicology evidence. Appropriate safety precautions will also be used. If a laboratory staff member is requested to be present for viewing, then that member should stay for the entire viewing. Laboratory analysis will not be done as part of the viewing process.

b. Equipment will not be provided to attorneys or outside experts.

c. Viewing of evidence will be documented in FileOnQ or on the property tag if the case has not been entered into FileOnQ.

RELEASING EVIDENCE

Evidence will generally be released by the Property Room or the Narcotics Vault. If a laboratory member receives a direct request for release of evidence, that request will be forwarded to the case detective.

Evidence in the laboratory will be returned to the Property Room prior to release by the case detective.

If the case is from an outside agency, a laboratory analyst working on the case, or a supervisor, can facilitate the process of releasing the evidence. The Property Room can be contacted to guide the individual releasing the evidence through this process.

If the evidence is in the laboratory and has not yet been impounded in the property room, the evidence can be released directly to the detective. The laboratory internal chain of custody form will be used to document the transfer of evidence.

MEDIA REQUESTS

Any request from the media must be routed through the Crime Laboratory Manager for approval.

2.1 CONSUMPTION OF EVIDENCE

CONSUMPTION OF EVIDENCE

When possible, samples will not be consumed in testing so that a sufficient quantity is retained for reanalysis. If the entire sample must be consumed during analysis, the assigned DDA will be consulted before the sample is consumed whenever possible. If there is an objection to the laboratory consuming the evidence, alternative arrangements will be made for the analysis of the sample in question.

In all cases, with or without a suspect and no DDA assigned to the case, a notification will be sent to the detective informing them of the decision to consume the sample. Three business days will be given to the detective to provide an opportunity to respond. The analyst will proceed with evidence consumption in the absence of a response.

STANDARD VERIFICATION

Any reference standard or reference material that does not have an accompanying certificate of traceability or analysis must be internally verified prior to its application to casework. The unit will maintain all verification data. All reference items will be uniquely identified. Unit manuals may have additional policies for standards and controls beyond the general verification requirement.

2.2 HANDLING MONEY AS EVIDENCE

Crime Laboratory personnel must provide an interoffice memorandum to the Property Room, signed by their supervisor, to obtain impounded money amounts over $20.00 for examination. Refer to Department Policy 3.02.

2.3 PHOTOGRAPHY POLICY

PRIMARY CRIME SCENE DOCUMENTATION

Digital photographs taken as the primary documentation of the crime scene will be governed by the Crime Scene Unit manual policy on digital photography. Digital media, such as DVD and Blu-ray discs, created for storage of the primary crime scene images will be treated as evidence and impounded in the Property Room.

CASEWORK DOCUMENTATION

Individual units will be responsible for saving casework digital images in the Lab Images folder on the Department LAN. Photographs taken in the process of evidence examination in the Forensic Biology unit will be saved in the case folder on the Forensic Biology network.

DIGITAL IMAGE DOCUMENTATION

If a digital image is enhanced beyond the normal photographic adjustments (i.e., color, enlargement, brightness, contrast, burning and dodging) in order to reach a conclusion, then the enhanced image will either be saved or printed, and the enhancements will be documented.

LATENT PRINT PHOTOGRAPHS

Latent print digital images generated either at the crime scene or during evidence processing will be saved to one master and one working disc, and assigned a barcode number. These discs will be listed in the Crime Scene Unit report and released to the Property Room. Chain of custody will be tracked through FileOnQ.

ADDITIONAL UNIT POLICY

Individual unit manuals may contain more specific policies on digital photography and image handling.

2.4 POLICY FOR COLLECTING DNA SAMPLES FROM LABORATORY EMPLOYEES AND INTERNS

ELIMINATION DNA DATABASE

For the purposes of this policy, "staff" and "employee" are inclusive of employees, contracted employees (such as janitorial personnel), sales representatives, volunteers, and interns.

The San Diego Police Department Crime Laboratory will maintain a DNA database for elimination purposes. An elimination DNA database is a quality control tool that enables the laboratory to recognize when employee DNA is introduced onto evidence or into the DNA testing process. The purpose of the elimination DNA database; therefore, is to ensure that the information provided to investigators regarding DNA on the items of evidence submitted for analysis is not compromised by the presence of staff DNA. It is only by checking DNA profiles obtained from evidence against elimination DNA profiles that we can assure the integrity of both the evidence and the testing process.

ELIMINATION DNA SAMPLE POLICIES

The elimination DNA database will contain samples contributed voluntarily by Laboratory, Narcotics Vault, and Property Room employees. Forensic Biology and Crime Scene Unit volunteers and interns will be *required* to provide their DNA samples. Intern/volunteer sample profiles will be retained in the database after the service to the laboratory has been completed.

Reference DNA samples for the database will be collected by the Quality Manager with the consent of the employee. Signed consent forms will be kept on file with the Quality Manager. DNA samples will be uniquely identified, and provided to the Forensic Biology Unit as anonymous samples for DNA profiling.

The elimination DNA database, containing the numeric code and DNA profile of each sample will be maintained by the Forensic Biology Unit. Only the Quality Manager will possess the key that correlates each unique code with the employee's name.

With permission of the employee, samples may be kept indefinitely for validation purposes. Samples authorized for validation by the sample donor will be identified with a "v" following the sample identifier. Samples for which no consent has been obtained for use in validations will be destroyed

after the Quality Manager has been informed of the successful DNA profiling and uploading to the staff database. The Quality Manager will mark the sample as destroyed on the key containing the unique code and employee name.

An employee's DNA profile will be removed from the staff database upon *written request* of the employee.

DNA samples provided by former employees not with the laboratory at the time this policy was created have been retained for use in the elimination database and validation purposes. These samples have been assigned a unique numerical identifier to maintain anonymity.

MATCHES TO THE ELIMINATION DATABASE

Staff Match Summary Reports

Should a DNA profile from an employee appear in casework, the DNA case analyst will write a Quality Assurance Summary. The Quality Assurance Summary will identify the employee sample by its code number, the evidence item on which the employee's DNA profile was detected, whether the interpretation of the sample was affected, and any other pertinent details. The Quality Assurance Summary will be submitted to the DNA Technical Manager for review to determine if any further action or information is required. The Quality Assurance Summary will then be forwarded to the Quality Manager. The Quality Manager will review the information, and appropriate actions will be taken to ensure a root cause analysis of the incident. If the association source is internal to the Forensic Biology Unit, the root cause analysis will be conducted jointly by the DNA Technical Manager and Laboratory Quality Manager. The name of the associated donor will be shared with the DNA Technical Manager to ensure that, in addition to the root cause analysis, appropriate corrective actions internal to the Forensic Biology Unit are taken, if necessary.

Quality Assurance Summaries will be maintained in the case record and by the Forensic Biology Unit Technical Manager.

QUALITY INCIDENT REPORTS (QIR)

The associated profile will be identified only by its code number in any Quality Incident Report.

All associations to the elimination database incidents will be logged for tracking purposes by the Quality Manager into the DNA Staff Association spreadsheet. A Quality Incident Report will be written by the Laboratory Quality Manager and the incident tracked, for any association to the elimination database if the likelihood ratio is greater than 1,000. Any association to the elimination database with a likelihood ratio less than 1000 will be tracked for quality assurance purposes by the Quality Manager, but no QIR will be written.

If the root cause analysis reveals no obvious reason for the presence of the staff profile, the input of the Crime Laboratory Manager and/or the DNA Technical Manager may be required. An investigation of the incident will be conducted, and the Crime Laboratory Manager along with the Quality Manager will make a decision regarding any additional course of action.

Quality Incident Reports are maintained by the Quality Manager while a copy of the report is placed in any relevant case files.

ANNUAL CONTAMINATION SUMMARY REPORT

Staff associations will be reported in the annual Quality System Report. The data will be assessed for any trends that might indicate training needs or other remedial action. If necessary, the Forensic Biology Unit will conduct training at the direction of the Quality Manager or Crime Laboratory Manager.

RELEASE OF NAMES OUTSIDE OF THE LABORATORY

Names associated with any staff contamination will not appear in the Quality Incident Report, but may appear in the background documentation prepared by the Quality Manager. The release of donor names outside the laboratory will be at the discretion of the Crime Laboratory Manager or by court order, including court testimony.

RECODING THE SAMPLE

The release of a name does not mandate the recoding of the sample. Each circumstance surrounding the release of a name will be evaluated to determine if recoding is necessary to preserve anonymity.

3.1 POLICY AND PERSONNEL DOCUMENTATION

ELECTRONIC POLICY FILES ARE CONTROLLED DOCUMENTS

Laboratory and unit policy is documented in electronic files that are considered to be controlled documents in their electronic form. These policy files are located in the document management system POWERDMS (DMS), and are the official versions of our management system documents. Printed copies outside of DMS are not controlled.

GENERAL MANAGEMENT

When a unit manual or controlled form is revised, the unit supervisor or DNA Technical Manager will submit the new version with the changes identified to the Quality Manager for final approval. The approved changes will be posted to DMS as soon as practical. The revised file will be posted with the changes identified. The Crime Laboratory Manager will give final approval to the Quality System and Safety Policy changes.

The electronic files in DMS are the files used for audit purposes and are the only official version of the policies/procedures. Working copies may be made by employees as needed. Management is not responsible for maintaining the working copies.

The Quality Manager maintains the electronic files of the quality system and unit policy documents. The Quality Manager will make the appropriate electronic archives of the files as the updates occur. These archives will be made available upon formal request. Quality System documents will be kept for at least the current accreditation cycle or five years, whichever is longer.

PERSONNEL INFORMATION

This information is maintained electronically and includes Statements of Qualifications (SOQ) and Court Evaluation Forms. Both forms are controlled documents, and the contents are updated as needed by the Quality Manager or the Clerical Unit personnel. When SOQs are requested by the City or District Attorney's Office, or by the Public Defender's Office, the official laboratory version will be used. The analyst may also send a personal resume in addition to the laboratory's Statement of Qualifications.

4 MANAGEMENT REQUIREMENTS

4.1 ORGANIZATION

4.1.1 The San Diego Police Forensic Science Section is a legal entity with municipal and judicial responsibility.

The laboratory is governed by a formal budget and listed in the San Diego Police Department's official organization chart. See the SDPD organization chart.

The laboratory function and unit descriptions can be found on the city webpage through the following the link: https://www.sandiego.gov/police/services/units. Scroll to Laboratory.

4.1.3 The laboratory facility is divided into multiple areas within the Police Headquarters building which includes: the entire 6th floor; the drying room on the roof; the Narcotics Vault, Polygraph unit, and Questioned Documents unit on the 5th floor; and the shooting room on parking level P2. In addition, field work is conducted in the garage at the Northwestern Command station, and at crime scenes.

In all areas where laboratory work is conducted, including crime scenes, laboratory personnel are governed by casework policies and procedures, and the expectations of the General Quality Policy statement.

4.1.4 The San Diego Police Department Crime Laboratory is part of the San Diego Police Department. The Crime Laboratory Manager reports to an Assistant Chief of Police, who reports to the Executive Assistant Chief of Police, who in turn reports to the Chief of Police. These three levels of management over the Crime Laboratory may influence the priorities of cases worked by the Crime Laboratory, but they do not have any input on the analysis results, conclusions, or reports.

4.1.4.1.1. The Crime Laboratory Manager has responsibility and authority for all positions in the laboratory, and for general laboratory and safety policy.

The official job description document can be found through the following link: Job Description.

4.1.5 a) The Crime Laboratory Manager has an Assistant Manager and a team of technical and administrative supervisors responsible for the technical, clerical, and quality assurance operations. The Quality Manager reports directly to the Crime Laboratory Manager.

The Quality Manager has general authority over unit policies and procedures. The Quality Manager is also responsible for ensuring that the laboratory remains in compliance with accreditation requirements.

Laboratory analysts are responsible for conducting technical analyses within their respective forensic disciplines, as well as implementing the policies of the management system, developing methods, performing validations, and various other duties. All employees are responsible for administering the Laboratory's procedural, technical, and quality policies, and initiating the process for corrective action when departures from policy are discovered.

See Section 4.2.2 General Quality Policy and the department and laboratory organization charts maintained in the quality system documentation.

4.1.5 b) While users may have input as to priorities or technical methods, no individual or entity outside the Laboratory has the authority to dictate choice of method, results, or content of laboratory reports.

The Department has policies and procedures to avoid involvement in any activities that would diminish confidence in its competence, impartiality, judgment or operational integrity.

These policies are the Undue Influence policy and the Department Unbecoming Conduct policy.

In addition, ethics training is required that discusses quality assurance policies, accreditation, professional standards, and the analysis of ethics scenarios.

The San Diego Police Department Policy Manual can be accessed through the following link: Personal Conduct Policies. Section 9.06 of the SDPD Policy

Manual addresses unbecoming conduct, and Section 9.08 of the SDPD Policy Manual addresses gifts and/or gratuities.

4.1.5 c) All staff members are expected to maintain confidentiality on case related information not yet made public, as well as proprietary information obtained from laboratory service vendors and suppliers.

4.1.5 g) SUPERVISION

Each analyst in the Crime Laboratory will report to one and only one supervisor per discipline. The laboratory manager has a written performance plan for each supervisor that includes expectations as to supervisory performance. Each supervisor, in turn, has a written performance plan for each subordinate employee that includes performance evaluation criteria

4.1.5 h.1) TECHNICAL MANAGEMENT

Technical leads are internally identified for each unit except for Forensic Biology. The DNA Technical Manager has been created as an official paid position. For the other laboratory units, where the unit supervisor has previous casework experience in the unit, the supervisor is the technical lead. Where there is no casework experience, a lead will be identified from the unit staff. These designations will be found on the laboratory organization chart.

4.1.5 j) OUT OF CLASS ASSIGNMENT

If the Crime Laboratory Manger is scheduled to be away from the Laboratory, the Assistant Crime Lab Manager or other designee, will serve as the acting Crime Lab Manager. If a first-line supervisor is scheduled to be away from the Laboratory, an individual will be assigned temporarily to fill the vacant position. This individual will possess the knowledge, skills, and abilities required to adequately perform the duties of the position.

The Quality Manager is considered key management, and has a designated deputy Quality Manager. The Deputy Quality Manager is designated on the laboratory organizational chart.

4.1.5 k) COMMUNICATION

Laboratory staff will have opportunities to discuss their activities and ideas in several ways:

Through direct communication with the supervisor

Through discussion at unit meetings

Through discussion at general lab meetings

4.1.6 Top management shall ensure that laboratory communication is carried out through regular unit briefings, a weekly management meeting, and a periodic general laboratory meeting, as scheduling permits.

4.1.7 LABORATORY HEALTH AND SAFETY OFFICER

The laboratory's Safety Program Coordinator is responsible for managing the health and safety program. The Crime Laboratory Manager is responsible for all laboratory health and safety policy issues.

4.1.8 Top management is defined as the Crime Laboratory Manager, the assistant crime lab manager, the Quality Manager, and the Safety Program Manager. Key management is defined as the unit supervisory personnel. These designations are included on the laboratory organization chart. For administrative and technical policies and procedures, top management oversight shall be by the Crime Laboratory Manager and the Quality Manager. For safety and chemical hygiene, top management oversight shall be by the Crime Laboratory Manager and Safety Program Manager.

4.2 MANAGEMENT SYSTEM

4.2.1 MANAGEMENT SYSTEM COMPONENTS

The laboratory management system is comprised of administrative, quality, technical, safety, and management policies in effect lab-wide. The laboratory unit management is further covered by unit level policies and technical procedures.

All Laboratory policies and procedures are made available in DMS. This information is communicated to the staff through safety and QA tailgates. Information is shared through regular briefings held at the unit and management levels, as well as periodic general laboratory meetings.

4.2.2 GENERAL QUALITY POLICY

The Crime Laboratory management and staff are dedicated to meeting, or exceeding, where applicable, the standards of ISO 17025, and the standards defined in the ASCLD/LAB *International* Supplemental Requirements. Management is dedicated to using a variety of quality system tools to find improvements that can be made in our management and technical procedures. See 4.10 Improvements.

Quality assurance is the responsibility of every member of the Crime Laboratory. Through the continuing application of quality assurance standards, the Laboratory ensures it is providing a reliable service to the Department.

All personnel involved in testing activities must be familiar with and apply the policies of this Quality Manual, as well as unit specific policies and technical requirements. All updates to laboratory manuals will be reviewed and signed in Power DMS by staff members and unit supervisors working within those units effected by the changes.

The objectives of the quality assurance program are:

a. To maintain and improve the quality of forensic science services provided to the Department.

b. To identify quality-related concerns in all areas of operation and take corrective steps to prevent their recurrence.

c. To heighten the awareness of all laboratory employees regarding the importance of quality assurance.

The quality system report will provide information annually on the laboratory's efforts to meet these objectives and continually improve upon the effectiveness our management system. See Section 4.15. The quality assurance program consists of the following elements:

a. Training

b. Methods selection, development, validation and documentation

c. Technical and administrative case review

d. Proficiency testing

e. Testimony monitoring

f. Inspections/audits

4.2.2.1 The Laboratory will maintain a quality assurance program administered by a Quality Manager. The laboratory adopts the ASCLD/LAB *International* Guiding Principles of Professional Responsibility for Crime Laboratories and Forensic Scientists.

This document can be found on the ANAB website at the following location. https://anab.qualtraxcloud.com/ShowDocument.aspx?ID=6732

4.2.2.2 The ASCLD/LAB *International* Guiding Principles of Professional Responsibility guiding principles will be reviewed with all analysts and supervisors on an annual basis.

4.2.3 MANAGEMENT COMMITMENT

Top management's commitment to development and implementation of the management system and improvement (Section 4.10) process is documented through the management review process defined in Section 4.15. Management review documentation is maintained in the QA electronic files.

4.2.4 CUSTOMER REQUIREMENTS

The Crime Lab Manager is committed to meeting our customer's needs, as well as meeting statutory and regulatory requirements. It is the expectation of all Laboratory staff members to work with Laboratory management and our customers to consistently achieve this goal. Communication with the

customer and meeting customer requirements is conducted through the work request review process which may involve negotiation as to the scope of the work as defined in Section 4.4. Meeting customer requirements is also achieved through the reporting process as defined in Section 5.10.

4.2.5 DOCUMENTATION STRUCTURE

Each section in the Crime Laboratory operates under a set of procedural and technical methods. Analytical procedures are provided in unit manuals. If a standard procedure cannot be utilized or requires modification in a specific application, the procedure and reason will be recorded in the case notes. Also refer to Section 5.4.1.1 Allowable Variation from Policy/Procedure.

4.2.6 ROLE OF TECHNICAL MANAGER, QUALITY MANAGER, and CRIME LAB MANAGER

In addition to expected casework and case review duties, the Technical Manager is responsible for the following:

a. Technical management of the section.
b. Coordinates with the unit supervisor to create, review, and/or revise technical procedures prior to final approval by the QA Manager.
c. Coordinates training of new employees.
d. Coordinates new method validation, including completion of validation documentation, prior to final approval by QA Manager.
e. Acts as a technical reference for the unit Supervisor and QA Manager.
f. Acts as a mediator when necessary in the technical review of casework in his or her respective forensic discipline.
g. Provides technical consultation as needed to the members of his or her respective unit.
h. Works with the unit supervisor or QA Manager to ensure compliance of the analysts with QA and Unit policies and procedures.

Additional responsibilities may be provided in individual unit manuals.

The role of the Quality Manager is to:

a. Administer the laboratory's proficiency testing program, evaluate results, and recommend corrective steps when warranted.
b. Approve training outlines and monitor training progress.
c. Conduct or coordinate annual audits of each technical laboratory unit except Forensic Biology, including an audit of management team practices and how they affect the quality of laboratory service. The unit audits will include an evaluation of the effectiveness of the technical and administrative case review process. The Crime Laboratory Manager will audit the unit supervisor effectiveness.
d. Maintain and update the laboratory quality system manuals.

e. Evaluate instrument calibration, performance, and maintenance records.
f. Review and approve unit policies and technical procedures.
g. Ensure the validation of new technical procedures.
h. Along with unit supervisors and/or technical managers, investigate technical problems, develop remedial actions, and verify their implementation.
i. Propose corrections and improvements to the laboratory's quality assurance program to the Laboratory Manager.
j. Maintain quality system records related to quality control monitoring which include:
    1. Training records
    2. Records of testimony evaluation
    3. Proficiency/competency tests
    4. Quality incident reports and corrective steps taken where technical problems occur
    5. Statements of Qualifications
    6. Continuing education as required by DNA standards
    7. Audits
k. Ensure compliance with ISO 17025 ASCLD/LAB *International* Supplemental Requirements

The role of the Crime Laboratory Manager is to:

a. Manage the daily operations on the Laboratory.
b. Set general laboratory and quality assurance policies.
c. Resolve any disagreement that arises in the implementation of these quality policies.

The role of the Assistant Crime Laboratory Manager is to:

a. Assist the Crime Lab Manager in managing the operations of the Laboratory.
b. Serve as the acting Crime Lab Manger in their absence.

4.2.7 INTEGRITY OF MANAGEMENT SYSTEM

The Crime Laboratory Manager and Quality Manager ensure the integrity of the management system through a process of policy review and approval of changes.

Changes to any Laboratory policies or procedures require review by the Quality Manager or Crime Lab Manager. Prior to the implementation of any changes, the Quality Manager will evaluate those changes for any conflict

with ISO 17025 or ASCLD/*LAB* International Supplemental Requirements, as well as other internal policies. Once approved, the Quality Manager will post any policy documents to DMS and set the implementation date. For DNA technical and unit policies, the change will be coordinated between the DNA Technical Manager and the Quality Manager. Staff will be required to sign off on changes in PowerDMS.

4.3 CONTROLLED DOCUMENTS

4.3.1 The Crime Laboratory's administrative procedures, technical procedures, training manuals, Statements of Qualifications, and other management system documents are controlled to ensure that they are adequate, approved for use, and that only the current versions of the document are in use. This procedure provides instructions concerning the creation, revision and distribution of these controlled documents.

DEFINITIONS

Document - Information in any medium including, but not limited to, paper copy, electronic file, computer disk, tape, audio or videotape, photograph, or overhead transparency.

Controlled Document - A document used to guide or control a process or required to be used.

Controlled documents include Quality, Policy, Procedure and Training Manuals. Some unit worksheets and forms are controlled if they are required to be used. External documents (such as equipment manuals) and software will be controlled if they meet any of the above criteria. Software will be under the control of individual units.

Document Control - The process for ensuring that controlled documents, including revisions, is reviewed, approved and released by authorized personnel, and distributed to personnel performing the prescribed activities.

Issuing Authority - Personnel that are authorized to approve controlled documents for posting to DMS, the laboratory's document control system.

The issuing authority for laboratory-wide controlled documents is the Laboratory Manager. The issuing authority for unit-specific documents is the Quality Manager or designee.

Document Owner - The individual responsible for creating, reviewing, and maintaining a controlled document, e.g., the Latent Print Supervisor (or designee) is the Owner of the Latent Print Unit Manual.

4.3.2.1 DOCUMENT APPROVAL AND USE

Documents will be prepared by personnel with adequate expertise in the subject matter. The document must include enough detail to ensure that trained personnel can follow the procedure and produce expected results, and that the activity conforms to quality specifications and/or expectations.

The preparer of the document is responsible for:

Preparing the document in the proper format.

Acquiring copies of listed references.

Submitting for review and approval.

The Document Owner or designee is responsible for:

Reviewing the document to ensure that the document is suitable for issue.

Ensuring that, where applicable, documents contain required quality assurance elements (i.e. quality control, measurement of uncertainty, traceability).

Submitting the document to the appropriate issuing authority

Reviewing their unit's controlled documents at least annually and noting the review in DMS.

The Quality Manager or designee is responsible for:

Managing all documents in PowerDMS.

Ensuring that all documents meet QA requirements as outlined in our accreditation standards.

Ensuring periodic review of controlled documents by appropriate supervisor or designee to determine if revisions are needed.

Reviewing and approving controlled documents for which they are the issuing authority.

Informing unit supervisors or designees when submitted changes have been made.

The Laboratory Manager is responsible for:

Approving controlled documents for which she is the issuing authority.

4.3.2.2 Documents will be in Adobe Acrobat PDF or MS Word format, and will be made available to relevant Laboratory staff through PowerDMS. The Quality Manager sets the document access level for each employee.

Working documents are maintained on the department LAN, G drive, in the Supervisor folder.

Documents will be reviewed annually and revised, if necessary, to ensure that they reflect current policies, practices and technology. Typically, each document will be reviewed in conjunction with the mandatory annual audit. Review dates will be set by the Quality Manager in PowerDMS. The QA manual will be reviewed at least annually by the Quality Manager and DNA Technical Manager on an agreed upon date.

When a document is replaced in PowerDMS, the previous version of that document is automatically archived. DMS will label this obsolete document with a blue A for "Archive." Archived documents are only viewable by DMS administrators.

4.3.2.3 Each controlled document will be identified with the title of the document. Each document will also have a footer with the page number and total number of pages, the phrase "Printed Copies are Not Controlled," and the name of the document (document name is not required on the first page). The date of the document will be appended to the filename, e.g., "Quality Manual May 2017." The issuing authority will be identified. The footer for single page controlled documents will only require a version number and/or date, and issuing authority.

4.3.3.1 CONTROLLED DOCUMENT CHANGE APPROVAL

Document revisions are subject to the same review, approval, documentation and issuance requirements of the original document as stated above. Changes to controlled documents are made by Top Managers, Technical Managers, Supervisors, or designees.

4.3.3.2 Changes to a controlled document will be made using the 'Track Changes" function of MS Word. Upon revision, unit and technical procedures manuals will be posted in PowerDMS. The version identifying the changes made ("tracked changes"), and the version with the changes accepted ("clean") will be uploaded into PowerDMS. Assigned personnel must sign off

on the tracked changes version through PowerDMS. Only clean versions of Statements of Qualifications will be posted to PowerDMS. This document requires an electronic signature in PowerDMS by the relevant analyst.

4.3.3.4 The amended document will be submitted to the Quality Manager or Crime Lab Manager for review. Notification of the needed review can be sent through email. The Quality Manager or Crime Lab Manager will accept the changes in MS Word. The document will be saved as an Adobe Acrobat PDF document, and then uploaded to DMS by the Quality Manager or designee. Upon approval, the document will be made available to the appropriate personnel through PowerDMS for review and signature.

4.3.3.4.1 Documents will be posted to DMS by the Quality Manager or designee. Posting of a document to DMS indicates approval of that document for use and posting by the Quality Manager or Crime Laboratory Manager.

4.3.3.5 At the discretion of the Issuing Authority, forms or worksheets may be labeled with the disclaimer, "Previous versions of this form may be used."

4.3.3.6 Quality Assurance Tailgates will be distributed through and maintained in PowerDMS. Once the signature process for a tailgate has been completed, it will be archived as the new tailgate comes online.

4.4 WORK REQUESTS (CONTRACTS)

4.4.1 WORK REQUEST REVIEW

All Laboratory work requests are stored in the LabLynx database. Work requests are generally entered into LabLynx by the submitting Detective or Officer. However, laboratory personnel can also enter requests to LabLynx. Work requests submitted by Detectives and Officers are reviewed by the Clerical Unit staff. The request is then printed and distributed to the unit Supervisor.

The unit Supervisor or designee will review the request again and seek clarifications, if necessary, from the person submitting the request. Selection and prioritizing of items to be analyzed will occur. Whoever conducts this review will initial the work request.

The reviewer of the request must ensure the laboratory has the capability and resources to meet the requirements of the request. Test methods selected for analysis are defined in individual unit manuals as stated in Section 5.4.1. The LabLynx work request entry portal includes the statement "ITEMS ANALYZED AND METHODS USED ARE AT THE DISCRETION OF THE LABORATORY MANAGEMENT AND/OR ANALYST."

If a detective attempts to deliver a work request directly to an analyst, the detective will be instructed to enter the request into LabLynx, or redirected to the clerical staff to have the request entered into the lab tracking database, date stamped, and then to have the request delivered to the Supervisor.

The requests that are categorized as "not to be worked" will be sent back to the detective with a note of its disposition, and they will be deleted from the case tracking database. When the request is deleted from the case tracking database, a comment to that effect will be entered on the database, and the case shell will remain in the database.

While analysts are generally not to accept work requests from anyone other than the Supervisor or designee, priority or rush verbal work requests will occasionally be received by an analyst. Additional work under these circumstances requires Supervisor or designee approval prior to commencement of work. Work can be initiated without having to wait for a formal work request. The detective will submit a request as soon as is feasible. Work requests will normally not be assigned longer than a year. Supervisors are expected to monitor case assignments through LabLynx to ensure cases approaching one year are prioritized for completion and help resolve any issues that might be contributing to delaying the completion of work.

4.4.2 Information from any pertinent discussions with the submitter of a request will be documented on the work request or on the communication log maintained in the case record. Any significant change made to a work request will be documented on the request.

4.4.3 Review of work requests involving work that is to be subcontracted for analysis will follow the same procedures for work request review defined in this section. Records of communications with Detectives or Officers submitting work requests involving cases where work is subcontracted, will be maintained in the case record.

4.4.4 Changes to the work request may occur. Typically, only those items most likely to provide probative results will be selected for analysis. The number of items selected for analysis may depend on available resources. This decision is usually made by the unit Supervisor or designee, but can also be made by the analyst assigned to do the work.

The potential for changes is communicated on the work request portal in LabLynx with the following statement: "ITEMS ANALYZED AND METHODS USED ARE AT THE DISCRETION OF THE LABORATORY MANAGEMENT AND/OR ANALYST." Examiner may be used for some disciplines instead of analyst. The unit Supervisor may determine that the request will not be worked due to, for example, the nature of the request, the nature of the evidence, a high probability that the work would not lead to useable results, an extremely low priority, or due to a rush timeline that cannot be met. If the Supervisor determines that the request will not be worked, that decision and the reason for the decision will be shared with the requestor.

4.4.5 Once work has commenced, any changes to the work request will be evaluated as stated in Sections 4.4.1 through 4.4.4. The result of those changes will be communicated to all effected personnel.

4.5 SUBCONTRACTING OF TESTS AND CALIBRATIONS

4.5.1 SUBCONTRACTORS

The San Diego Police Department Crime Laboratory uses BioTox Laboratories for the toxicological analysis of blood and urine. NMS Laboratories is used for specialized toxicology and is included in ANAB list of accredited laboratories. Other laboratories may be selected for subcontracting of work as needed. Competence of subcontracted laboratories will be established by the SDPD Crime Laboratory before any evidence is sent to the subcontracted laboratory for analysis. When available, subcontractors accredited to nationally recognized accrediting bodies will be used. See Section 4.4.4.

4.5.2 The SDPD Laboratory Toxicology Request form has a disclaimer that states the laboratory reserves the right to select the final method to be used for evidence analysis.

4.5.3 The laboratory is responsible to the customer for the work of BioTox or any other subcontractor the laboratory chooses. Should any nonconformance occur or a customer complaint be received, the subcontractor's work will be subject to review and if necessary, the facilities subject to audit/inspection to resolve the nonconformance or complaint.

4.5.4 BioTox, along with any other laboratory that is subcontracted with on any temporary basis, will have on file with the San Diego Police Forensic Science Section proof of competence.

4.6 PURCHASING

4.6.1 SELECTION OF SUPPLIES AND SERVICES

Procedures for purchasing supplies are detailed in Department Procedure 1.21 available at the following link: Purchasing Procedure. Storage requirements are included in the Laboratory Safety Manual, Safety Data Sheets, and unit policy manuals.

4.6.2 VERIFICATION

Supplies, reagents, and consumable materials affecting quality of tests and/or calibrations will not be used until they been inspected and/or verified to be in compliance with required standards or specifications. Quality control testing will be required for critical supplies (see Section 4.6.4).

4.6.3 PURCHASING

The Crime Laboratory Manager and/or designee will review all purchase orders for appropriateness and give final approval with a signature. All purchase records are kept by the Clerical Unit Administrative Assistant.

4.6.4 CRITICAL SUPPLIES

Only Forensic Biology and Forensic Chemistry units have critical reagents. Refer to unit policies and records pertaining to the evaluation of those suppliers. A list of these suppliers will be maintained by each unit.

4.7 CUSTOMER SERVICE

4.7.2 CUSTOMER FEEDBACK

The laboratory will conduct an annual customer satisfaction survey to evaluate its own effectiveness in delivering forensic services.

The customer survey form will be distributed generally by the Crime Lab Manager. Survey questions will be created by the Crime Lab Manager and will be designed to solicit input on timely and relevant topics.

Management will evaluate the surveys received throughout the year and incorporate the survey results in the subsequent quarterly management report. The survey results will be considered in the development of improvements and preventive actions.

4.8 COMPLAINTS

4.8.1 Any complaint regarding any element of laboratory services or the quality system, shall be directed to the attention of the Crime Laboratory Manager. The Laboratory Manager or designee will investigate the complaint, seek a resolution, and contact the complainant when appropriate.

The Crime Laboratory Manager will track these complaints for management review purposes and maintain the associated records for five years or one full accreditation cycle, whichever is longer.

Procedure:

The Crime Laboratory Manager (or designee) will:

a) Determine the nature of the complaint: i.e. administrative or technical.
b) Notify the appropriate Supervisor.
c) Confer with the Quality Manager as appropriate.
d) Conduct a fact-finding to determine the facts of the situation.
e) If necessary, consult with the proper outside authorities (i.e. Internal Affairs, EEO, etc.).
f) Follow any Department Personnel regulations as necessary.
g) Complete a report of findings and, if necessary, any recommendations.
h) Implement corrective actions and/or deal with department policy violations.

Complaints regarding HR issues (leave time, salary, hours, discipline, etc.) are outside the scope of accreditation and will not be tracked. Complaints regarding the quality system will be referenced in the annual system report compiled by the Quality Manager.

4.9 CONTROL OF NONCONFORMING WORK

Nonconforming work (casework or proficiency tests) refers to any aspect of testing or test results that does not comply with policy or procedural requirements.

4.9.1 REVIEW

If nonconforming work is identified, a documented review will be conducted, and a quality incident report will be issued (QIR) by the Quality Manager or designee when all of the following conditions are met:

- A policy or procedural violation has occurred,
- Reanalysis of the sample or extract cannot be performed,
- The evidence or test results have been adversely affected or it is uncertain if there are any adverse effects.
- There is potential for the problem to recur.

If the evidence or test results have been adversely affected, a remediation plan will be developed that addresses the scope of the problem (historical), fixes the immediate problem (present), and establishes a protocol to prevent reoccurrence (future).

Administrative nonconformances would rarely meet the above conditions. Therefore, administrative nonconformances would not require a quality incident report.

When non-conforming work is identified that adversely affects on-going or future casework, it is the responsibility of the Quality Manager, Crime Lab Manager, Assistant Crime Lab Manager, or DNA Technical Manager in issues related to the Forensic Biology Unit, to suspend casework, withhold test reports, and/or recall work as necessary. These same entities will authorize the resumption of work after the non-conformance has been corrected.

The quality incident report and supporting documentation will be maintained in the case record and in the Quality Manager's electronic records. If the investigation results in changing information provided in a report that has been finalized, a corrected report will be issued. See Section 4.11, Corrective Action.

4.9.3 DNA STAFF ASSOCIATION

Should a DNA staff association occur in casework, as discovered through a hit in the elimination database or identification of an analyst's own DNA profile on case evidence or quality control samples, a DNA Unexpected Results summary will be written by the DNA Technical Manager. Additionally, a quality incident report will be issued by the Quality Manager if the likelihood ratio for the inclusion of the staff member lies above the "limited support for inclusion" range (greater than 1000). In instances where the likelihood ratio falls below this threshold, a QIR will not be written, but the Quality Manager will be notified to investigate the source of the possible contamination and track the information to identify potential trends.

4.9.4 DISCREPANCIES

A discrepancy is defined as either 1) errors in evidence descriptions or counts, or 2) an apparent conflict or error in the final conclusions or data of analytical results. A final conclusion is one issued in a report after the appropriate reviews have been completed.

Should an examiner encounter an apparent discrepancy in their casework, the examiner will notify the unit Supervisor and/or the Technical Manager as soon as practical. If evidence appears to be missing, either the unit Supervisor or a unit colleague can witness and verify the discrepancy. Upon discovery of the discrepancy, the examiner will contact the submitting Officer via email to inform them of the discrepancy and seek information that might help in resolving the issue. The e-mail notification to the officer will be maintained in the case record. If the issue is not resolved, the Quality Manager will be notified, and further investigation may commence depending on the nature of the discrepancy. If the discrepancy is not resolved, the situation will be reviewed and documented in a quality incident report.

4.10 IMPROVEMENTS

The laboratory is dedicated to a process of improvement. The following are examples of the tools used in the process:

Quality Policy Statement defining the roles and responsibilities of employees in the quality process.

Audit results that help management identify opportunities for improvement.

Corrective actions and follow-up assessments which create formal tracking of incidents and effectiveness of resolutions.

Suggestion for improvement process which creates opportunities to implement preventive actions.

Technical review which gives an opportunity for peer review of technical work.

Administrative Review of casework.

Management review which is an annual compiling of relevant information acquired through the quality system and identifying improvements that can be made.

Participation in proficiency testing and evaluation test results.

4.11 CORRECTIVE ACTION

Refer to Section 4.9 Nonconforming Work for policy and procedure on the management of nonconforming work.

4.11.1 Should corrective actions be necessary to remediate any nonconforming work, a plan to implement those corrective actions will be developed by the Quality Manager and if necessary, a unit designee.

4.11.2 Corrective actions will start with an investigation to determine the root cause(s) of the problem.

4.11.3 The Quality Manager will:

a) Determine if an issue-specific audit is necessary depending on the nature and scope of the nonconformance.
b) Ensure that policy/procedures have been revised to effectively remediate the situation or
c) Ensure that practices have been appropriately modified to properly reflect policy/procedure
d) Ensure that any affected casework has been redone
e) Ensure that any notices to customers have been sent
f) Compile all necessary documentation for the QA records and disclosure in case files

If the corrective action involves the Forensic Biology Unit, these actions will be taken in conjunction with the DNA Technical Manager.

Corrective actions will generally be completed with a QIR issued, if required, within 30 days of discovery of the non-conforming work. Any extensions to this reporting timeframe will be documented in the QIR, with the reason for the extension included.

4.11.4 The Quality Manager will monitor the corrective actions to ensure they have been effective.

4.11.5 An internal audit will be conducted when identification of nonconformities casts doubts on the laboratory's compliance with its own

policies and procedures, or on its compliance with ISO 17025 and ASCLD/LAB-*International* Supplemental Requirements for Accreditation. See Section 4.14.

4.12 PREVENTIVE ACTION

4.12.1 PREVENTIVE ACTION

Top management conducts a review of suggestions for improvement that arise out of the internal audit process. Suggestions for improvement can be made at any time. Actions taken as a result of the suggestions are documented and tracked.

The Quality Manager creates an annual Quality System Report that evaluates quality system information to identify where preventive actions can be taken. This report is reviewed by the crime lab manager.

Preventive actions can arise out of the general improvement process discussed in Section 4.10.

4.12.2 The following procedure is used for implementing preventive and corrective action:

a) If a suggestion for improvement is received by management, it will be evaluated by the applicable unit Supervisor and Quality Manager for its overall effect on existing policy/procedure.
b) If warranted, an implementation plan will be developed.
c) The Quality Manager will log the suggestion and its final outcome in spreadsheet format to track actions for inclusion in the Quality System Report.

Actions taken will be evaluated for effectiveness, if applicable, according to a timeframe set during the process of addressing the action or as part of the annual Quality System Report.

4.13 CONTROL OF RECORDS

4.13.1 GENERAL

Case records and casework documentation will be tracked by either a department case number, incident number, or an external agency case number.

Records associated with the Quality System or Management System are stored on the Department LAN and/or Power DMS by the Quality Manager. These records are stored for 5 years or 1 full accreditation cycle, whichever is longer.

On occasion, the laboratory will perform work related to an Internal Affairs (I.A.) investigation. A department case number will be assigned, and documentation will be maintained in a case record. These records will be filed in a locked cabinet in the Laboratory Manager's office. A card will be placed in the main laboratory file indicating the location of the I.A. case packet.

4.13.1.1 The Clerical Unit receives case records for filing. The case records are color coded for the year and filed numerically, and scanned in their entirety to a folder on the department LAN. Toxicology and Blood Alcohol reports are filed separately.

The Clerical Unit will maintain the hard copies of the current year plus the two previous years. At the end of that time, homicide and sex crime hard copy case files will be sent to the Department's Records Section, and all other hard copy case files will be purged. Alcohol files will not be sent to Records. Electronic records will be retained indefinitely.

If a case folder is identified as ONGOING, the case file will be kept in an ACTIVE drawer in the laboratory.

4.13.1.2 All laboratory staff members have access to hard copy and electronic case records with the exception of Internal Affairs cases. Laboratory staff can retrieve a case record from the clerical files as needed, completing an out-card and putting it in place of the removed file if the case record is to be removed from the file room. The lab member will return the case file to clerical staff who will re-file it. Electronic file security is limited so that only the clerical staff and lab management can create and delete case folders from the Department LAN.

4.13.1.3 Laboratory records are maintained in secure areas of the lab, and on the department LAN.

4.13.1.4 The Department's network is backed up on a regular basis per information technology policy

4.13.2 TECHNICAL RECORDS

4.13.2.1 Any examination of evidence must include appropriate documentation. Case records include handwritten or typed notes, forms, instrument data, and information obtained from external sources. Case records are the basis for the report and must reflect the person responsible for the sampling or testing, observations, to include: evidence contents examined, evidence conditions, methods of analysis, relevant dates, and results.

4.13.2.2 Notes will be taken concurrent with the examination.

4.13.2.2.1 At a minimum, the notes will indicate a start and end date of technical examination.

4.13.2.3 If a mistake is made in the record, the incorrect information is to be crossed out without erasing, making illegible, or deleting the original information. The correct information will be entered alongside. All such alterations, or interlineations, will be initialed by the person making the correction or addition. If the corrections or interlineations are done on a date other than that listed at the top of the notes page, the date will also be noted with the initials. Otherwise, it is understood that the change was made on the date of the notes page.

Any irregularity, such as lost original pages, etc., should be documented before the submission for supervisory review.

Laboratory employees will not use any correction fluids or correction tape in laboratory records.

When changes made to hard copy case records that have been previously scanned and saved on the department LAN, the electronic version must also reflect that change. Obliterations should not be made to the original notes page after the report has been scanned. Typically, the change will include added information, such as adding documentation to reflect review of the record upon testimony for another analyst. The amended note page will scanned behind the original note page, retaining the originally scanned page.

It is occasionally desirable for the examiner to rewrite or type notes (e.g., from a crime scene) to make them more legible and understandable. If an examiner rewrites notes, the original notes will also be maintained in the case record. The examiner will indicate "REDONE" or "REWRITTEN" (or similar verbiage) at the top of each page.

4.13.2.3.1 FileOnQ CORRECTIONS

If an analyst sees an error that is administrative in nature, they will fix the error. If the error is complicated, encompasses many entries, or significantly changes what might be in the officer's report, the analyst is to contact the Detective/Officer and inform them of the errors.

4.13.2.3.2 Examination records are considered complete once they are submitted for technical review. Any material changes made to case records after submission for technical review will be documented in the notes as having been changed as a result of the review process. Material changes are considered those related to the technical information contained in the analytical record which may or may not have an effect on a conclusion. Administrative or grammatical changes do not need to be tracked.

4.13.2.4 Documentation generated that reflects all testing performed will be maintained in the case record. Such documentation can include photos, handwritten notes, worksheets, instrument printouts, and correspondence. Administrative documentation will also be retained. See Section 4.13.2.8.

Unit policy documents contain additional requirements specifying the contents of the final case records that are submitted to the Clerical Unit for filing.

4.13.2.5 Records to support conclusions shall be such that in the absence of the analyst, another competent reviewer could evaluate what was done and interpret the data.

4.13.2.5.2 Instrument parameters are documented in individual unit technical procedures manuals.

4.13.2.6 Individual note pages will have the following heading information:

a. Case number or incident number

b. Date (or date of analysis)

c. Examiner's handwritten or electronically generated initials (the unit must be able to demonstrate that the electronic signatures are secure)

d. Page numbers so that the total number of pages is reflected on the first page

4.13.2.6.1 Samples for alcohol analysis are analyzed in batches. Analytical batches will be identified by a batch sequence number, which will be associated with the date the samples were set up for analysis, or the date on which analysis was performed, (e.g. 042118). If more than one analytical batch is analyzed in a single day, the second batch will be followed by a letter, with batch "A" indicating the second analytical run of that day.

4.13.2.7 When examination records are prepared by an individual other than the analyst who interprets the findings and prepares the report, the handwritten initials of that individual shall be on the page(s) of examination record(s) representing their work.

4.13.2.8 ADMINISTRATIVE DOCUMENTATION

Records created as a result of evidence examination will be added to the case file as notes. Any document that is used to form an opinion or conclusion, or a form such as phone log or chain of custody document that is generated during the course of the Analyst's casework examination, must be

incorporated into the notes. The administrative documentation will be binder or paper clipped together with both the case number and "Administrative Documentation" or "ADMIN DOCS" being marked on the first page.

Case management information may be added to the administrative documents, such as item numbers, property tags, etc. Administrative documents are not used to record observations or results by the examiner.

4.13.2.9 When samples from different cases are batched for processing, the printouts from the analysis includes the unique case or sample identifier for each case sample.

4.13.2.10 Backs of note pages and backs of preprinted forms will not be used for note taking.

4.13.2.10.1 Irregular size paper smaller than the standard size of 8 ½ x 11 will be taped to a standard size sheet of paper. Only the attached note sheet needs to be appropriately marked if the large sheet has no note-taking information. If both sheets have notes on them, both sheets need to be appropriately marked.

4.13.10.2 Self-adhesive labels may be affixed to notes pages without the need for the analyst to initial or date the label if it was added prior to technical review. If the label is added after submission for technical review, it must be initialed and dated by the analyst.

4.13.2.11 Notes will either be taken in ink or entered directly into a computer. Pencil is acceptable for drawings, sketches, or tracings.

Electronic notes can be printed and maintained in the case record, or can be stored electronically under the case number. (See the Forensic Biology Unit Policy Manual for electronic data storage requirements.) Once the electronic case records are reduced to hard copy, the hard copy of the record becomes the final format. Any changes, page headers, etc., will be made according to standard policy requirements.

4.13.2.12 VERIFICATION/SECOND OPINION

A verification, also referred to as a second opinion, is an independent re-examination of the evidence by a second analyst to determine if the conclusions drawn in the report are appropriate. Requirements as to what types of analyses require verifications are detailed in the Questioned Documents, Latent Print, Trace Evidence, and Firearms unit manuals.

Verifications shall be conducted by an individual who has been competency tested in the specific task(s) that the review is encompassing. If the independent examiner agrees with the primary examiner, they will initial and date the conclusion in the notes and/or include their set of notes in the case record.

In the event of a disagreement between analysts during the verification stage, the case will not be withdrawn from the verifier to seek an alternative, agreeable conclusion. The analyst and verifier will discuss the evidence and findings to see if they can reach agreement. If no agreement can be reached, a mutually agreed upon third party will be asked to help resolve the disagreement. If no consensus can be reached between the analyst and the verifier, the result reported will reflect the more conservative conclusion discussed between the two parties. In some cases, this will result in reporting the conclusion as inconclusive or no identification. Changes made to the case records as a result of verification are documented and identified as such. The resolution of this discrepancy will be recorded in the case record.

Consultation

An examiner may consult another examiner from a different unit for advice on case approach. When that advice affects whether or how an item of evidence is collected or analyzed, the consultation shall be noted, initialed and dated by the consultant.

4.13.2.13 Abbreviations will either be included in the case record or defined in the unit manual.

4.14 AUDITS

ANAB INSPECTIONS

The laboratory is subject to annual surveillance activities and a full on-site assessment every four years by ANAB.

4.14.1 INTERNAL AUDITS

Internal audits are conducted annually for all accredited units to ensure compliance with ISO 17025 and ASCLD/LAB-*International* Supplemental Requirements for Accreditation, as well as laboratory policies. The breath alcohol program is also audited to ensure compliance with our own policies and Title 21 regulations. Internal audits are coordinated by the Quality Manager.

Volunteers from the bench level or the management team may be used as auditors. When possible, auditors independent of the activity being audited will be used. External auditors may also be used.

All auditors, internal and external, will receive auditor training from the QA Manager prior to beginning the audit process. Training is required for auditors only once during each 4 year accreditation cycle. Training will include instructions on how to evaluate and verify compliance to ISO 17025 and ASCLD/LAB-*International* standards, laboratory procedures, and management system requirements.

DNA audits will be conducted, and auditors will be selected and trained, according to QAS requirements.

Auditors will be provided a checklist of audit items which includes accreditation standards and laboratory requirements. Auditors will evaluate laboratory activities to determine conformance to these requirements, and note any non-conformances or areas of concern. Sampling and testing processes will be witnessed as part of the audit. Any issues of concern that arise during the audit, which are not included on the provided checklist, will be noted in the relevant Comments section.

In the year that the laboratory has an on-site assessment for re-accreditation, the ANAB assessment will satisfy our annual report requirement. The internal audits still need to be conducted.

Every other year, the Forensic Biology Unit will be required to undergo an external QAS audit. In the alternate year, the DNA audit will be an internal audit conducted to ensure compliance with the QAS.

For audit purposes, the laboratory will be divided into the following sections:

Crime Scene

Crime Scene Reconstruction

Firearms

Forensic Biology

Forensic Chemistry

Forensic Technology

Latent Prints

Management

Quality Assurance

Questioned Documents

Trace Evidence

Internal Audit Report Process

For all audits conducted, a report containing any findings and recommendations for improvements will be issued by the Quality Manager. The unit supervisor will evaluate the findings and recommendations and respond appropriately. The Crime Laboratory Manager will address any unresolved issues. The DNA Technical Manager will take the lead in audit issue evaluation and response for QAS audits.

ANNUAL QUALITY SYSTEM AUDIT

On an annual basis, the quality system will be audited. This will include an audit of the Quality Manager's records and management of the proficiency testing system, personnel information, unit audits, policy and technical manuals, and incident documentation.

MANAGEMENT OPERATIONS

Management operations are assessed annually through confidential interviews by the Laboratory Manager assessing the supervisory team effectiveness. The Crime Lab Manager's effectiveness will be evaluated by the Assistant Crime Lab Manager through confidential interviews with supervisory staff, and if necessary, other laboratory staff members. These interviews will be documented and the results shared with the Crime Lab Manager.

4.14.1.2 QUALITY SYSTEM DOCUMENT RETENTION

All quality system documents are electronic and are retained electronically for at least five years or 1 full accreditation cycle, whichever is longer. Quality system documents include proficiency and competency test records, quality incident reports, audit documents, training records, case files, and court testimony evaluations.

4.14.2 AUDIT EFFECTIVENESS

The audit process includes tracking of all corrective actions taken to ensure that they have been effectively implemented. This will be done by the Quality Manager and may be done in conjunction with the unit Supervisor and/or Crime Laboratory Manager.

The implementation of corrective action(s) will be followed with an evaluation of the effectiveness of the action(s) taken to resolve the finding. If the validity of test results is revealed through the audit process, the assigned detective and the prosecuting attorney will be notified in writing.

4.15 MANAGEMENT REVIEW

On an annual basis, the Laboratory Manager and Quality Manager will conduct a review of the previous year's management system and testing activities to ensure their continuing suitability and effectiveness, and to introduce necessary changes and/or improvements.

The Review shall take account of:

The suitability of policies and procedures,

The outcome of recent internal audits,

Corrective and preventive actions,

Effectiveness of corrective and preventive actions

Assessments by external bodies,

The results of proficiency tests,

Customer feedback.

Complaints,

Changes in the volume and type of the work,

Recommendations for improvement,

Reports from managerial and supervisory personnel,

Other relevant factors, such as quality assurance activities, resources and staff training.

This information will be compiled in an annual quality system report prepared by the QA Manager, or in the Quarterly Management Report (QMR), prepared by the Crime Laboratory Manager.

The Crime Laboratory Manager will review the quality system report. The quality system report along with the Manager's QMR to the Chief of Police will serve as the basis for a discussion on any changes necessary to increase the Laboratory's effectiveness and to make improvements. Laboratory goals will be established and discussed in the QMRs. Any actions deemed to be necessary by the Laboratory Manager will be implemented in an appropriate time frame (depending on City processes) and monitored to make sure the changes have been implemented.

The system report will be written in the first quarter of each year. Since the QMR's are written throughout the year, the management review is considered an ongoing process.

5.1.3 The laboratory will routinely check the reliability of its reagents. The frequencies are established by unit policy and may range, for example, from quarterly checks to a per use basis.

5.1.3.1 Reagents will be labeled at a minimum with the identity of the reagent and the date of preparation and/or lot number and, as applicable, storage requirements. Records will be maintained in the individual units as to who made the reagent and the components used in preparation.

5.1.4 All reagents, whether prepared in the laboratory or purchased, will be tested for reliability before use or, if appropriate, at the time of testing. See specific unit policies for testing requirements for reagents.

5.2 PERSONNEL

5.2.1 TRAINING

GENERAL

Prior to commencing casework, every employee new to a unit will be assessed by the supervisor, DNA Technical Manager, or designated experienced examiner to ascertain their knowledge of the job they shall be conducting. This assessment may consist of informal discussions, exercises, and/or practical assessments.

A customized training plan will be developed for new employees, taking into account the results of the new employee's assessment. Training outlines are available in individual unit manuals or under separate cover.

The unit Supervisor or DNA Technical Manager will forward completed program training documentation to the Quality Manager for review and approval.

Prior to the start of unsupervised casework, two things must be on file with the Quality Manager:

- documentation by the Quality Manager of the final review and approval of training materials and competency test(s) taken by the trainee, and
- authorization for casework and use of instrumentation.

When a new technology or analytical method is introduced into any laboratory section, the affected employees will be trained in the theory behind, and application of, the new method before they apply the method to casework analysis, or technically reviewing work in which the method was applied. Competency testing may be required depending on the nature of the change as defined in Section 5.2.6.2.2.

5.2.1.1 TRAINING PROGRAM DESIGN

The supervisor, DNA Technical Manager, or designated trainer will implement an organized training program which will ultimately be documented in a completed checklist or memo, depending on the nature or extent of the training. The training program will consist of determining the body of knowledge that the trainee needs, an outline of material to be covered, a reading list, practical exercises, and test(s) to assess competency.

Every examiner new to a given area of analysis will successfully complete a competency test prior to commencing casework in that area.

The trainee's ability to assess the significance of evidence and develop conclusions will be evaluated using either of the following methods:

Co-signed or supervised casework with experienced examiners.

Conducting verification examinations (2nd opinions on casework)

Having the Technical Manager, Supervisor (if case qualified), or trainer conduct the preliminary technical reviews on the first several completed cases (amount to be determined by supervisor/technical manager).

The trainee may also be subjected to a moot court exercise at the completion of the above items depending on the trainee's background and discretion of the person implementing the training program.

RETRAINING

In the event that an analyst or examiner is required to undergo retraining due to identified casework deficiencies, the Quality Manager and the unit Supervisor or DNA Technical Manager will develop a training plan based on the unit's training manual and the nature of the casework deficiencies. The Laboratory Manager will give final approval of the training plan.

VOLUNTEER/INTERN LABORATORY WORK

Volunteers and interns may be trained for independent casework in some units, such as the Crime Scene Unit.

TRAINEE NOTES

Trainees may be involved in actual casework situations where they will take notes as part of their background participation, such as notes taken while at a crime scene observing the laboratory's personnel processing and/or reconstructing the scene. These notes will remain with the trainee, but they will not be scanned for electronic archiving, as they do not contain any analytical or material information. The trainer will make a notation in their own notes as to the presence of the trainee, and that trainee notes were taken.

These notes will not be provided as part of regular discovery unless they are specifically asked for by the DDA.

CAREER DEVELOPMENT

Laboratory management supports and encourages participation in professional training or continuing education opportunities by providing available resources that may include budgeted and/or grant funding, and/or city time. All DNA analysts are required to have annually a minimum of eight hours of continuing education in subject areas relevant to the developments in DNA technology.

5.2.1.2 Training programs shall also include training in the presentation of evidence in court, ethical practices in forensic science, and a general knowledge of forensic science, and applicable criminal and civil law procedures.

5.2.2 TRAINING EVALUATION

Employees who attend technical training classes will evaluate the training using the Training Evaluation Form. The employee will evaluate the effectiveness and relevance of the training and complete the form within two weeks of completing the training.

The supervisor will use the form to evaluate the suitability of the class for future training needs.

5.2.3 ADDITIONAL COMPETENT LABORATORY PERSONNEL

The laboratory makes use of support personnel who are neither full-time employees nor are they under formal contract. These personnel may be either volunteers or interns. All volunteer/intern personnel will be trained to the level of their assigned duties. For those personnel conducting actual casework, their training (technical procedures, health and safety, QA/ethics) and successful completion of a competency test will be documented.

5.2.4 JOB DESCRIPTIONS

Job descriptions, including official city job information sheets, can be found by accessing the following link: Job Descriptions. These sheets are subject to the rules of City Personnel Policies and are beyond the control of the laboratory. Some additional job description information can be found in the individual unit policy files.

5.2.5 The laboratory shall authorize analysts to perform particular sampling, testing, and test reporting upon completion of training and competency testing. Upon authorization, the employees may perform analyses and examinations in the areas specified, issue official reports, render opinions and interpretations, conduct technical reviews in the scope of his or her casework, use applicable forensic databases and software, operate all instrumentation associated with the categories of examinations specified, and if appropriate, perform specific tasks that create items that could be used for testing.

These authorizations, along with records of educational and professional qualifications, training and experience, shall be readily available.

TRAINING EVALUATION FORM

Name of Attendee: Class Title:

Dates of Attendance: Sponsor: Length of Class:

Funding:

On a scale of 1 (poor) to 5 (excellent), please evaluate the class attended:

Was the class/instructor well organized?

1 2 3 4 5

Was the class relevant to the needs of the attendee?

1 2 3 4 5

Was the information presented immediately applicable to the work process?

1 2 3 4 5

Was the class material at the right level of the attendee?

1 2 3 4 5

Should this class be recommended for future training?

1 2 3 4 5

Comments:

5.2.6.2.1 COMPETENCY TESTING

All laboratory personnel whose job responsibility includes test report writing shall complete a competency test and achieve the intended result before performing testing on a test item or performing specific tasks that create items that could be used for testing.

5.2.6.2.2 The competency test shall, at a minimum, include the following: A practical examination that covers the spectrum of anticipated work to be performed;

- A written test report to demonstrate the individual's ability to properly convey results and/or conclusions and the significance of those results/conclusions; and
- A written or oral examination to assess the individual's knowledge of the discipline, category of testing, or task being performed;
- Testimony evaluation through the use of a mock trial.

The competency test will be completed by the analyst and submitted to the trainer without second opinions, or technical or administrative reviews.

For the introduction of new technology to those already involved in casework, targeted testing will be used. The associated competency test will only need to be in the form of practical samples.

5.2.7 The laboratory has a library of reference materials that are available for use by the staff. Forensic reference materials are also purchased as needed and as budgeting allows. In addition, individual units will have discipline specific reference materials. Supervisors will allow a reasonable amount of work time to be taken by employees to review pertinent professional literature.

5.3 ACCOMMODATIONS AND ENVIRONMENTAL CONDITIONS

5.3.1 The laboratory environmental conditions are under control of the Department's Facilities Management staff.

5.3.2 The laboratory has areas that have separate environmental conditions to optimize instrument efficiency.

The Trace SEM room and Forensic Biology Amplification areas are kept cooler than other rooms for efficiency of instrument operation. These room temperatures are not critical and do not require temperature monitoring. If it is noted that room temperature change has affected the efficiency of the instrumentation in these areas, Facilities Management will be notified.

5.3.3 There is strategic separation in the ventilation of the SEM and the general laboratory so that the Firearms environment does not introduce contaminants into SEM room. This is to prevent any possible contamination through room air mixing of GSR particulate debris. Measures to detect environmental contamination are in place and specified in Trace Evidence policy.

Per Forensic Biology policy, separate areas are designated within the Unit for sampling, DNA extraction, PCR setup, and for the analysis of amplified DNA. Several measures to prevent contamination are detailed in Forensic Biology policy manual.

5.3.4 The laboratory occupies the 6th and part of the 5th floors of Police Headquarters, as well as the Firearms shooting room on P2.

Public access to this building is limited and regulated by armed officers in the front and rear lobbies on levels 1 and 2. Access through all building entry doors and the parking garage is regulated by the use of a card key system. Visitors do not have unrestricted access to the operational areas of the laboratory.

Doors for laboratory areas are routinely locked. All laboratory areas are accessed by electronic card keys. Should a door be opened without a card key, such as with a regular hard key, an alarm event registers in the computer system. If the occurrence is after hours, the watch commander's office is notified. An officer will be dispatched to the laboratory to check the status.

The responding officer may use the emergency master laboratory card key for access to the laboratory unit. The emergency card key is kept in a sealed envelope in the Watch Commander's Office. Laboratory management will be notified.

KEY LOG AND AUDIT

The Quality Manager maintains a key log listing the key numbers assigned to the laboratory staff members. Electronic access is managed by the building's Facilities unit. Facilities maintains a list of employee electronic key card access levels.

AUTHORIZED ACCESS

All analysts have access to the specific laboratory areas in which they work, or in which there is an established need for access. All laboratory employees have access to the clerical area, conference room, and the file room. Laboratory supervisors have access to all areas except for the Narcotics Vault.

EMERGENCY KEY ACCESS

The Watch Commander's Office will maintain a master card key for emergency purposes only. This key will be kept in a sealed envelope and checked for seal integrity during the safety officer's monthly safety inspection. If the emergency key is used, a notation will made by the user on the envelope containing the key, and the key and envelope will be returned to the Quality Manager for resealing and placement back into the Watch Commander's Office.

SECURE AREAS

Any room that is accessible using a card key is understood to be a secure area. Evidence may be left overnight only in these secure areas.

5.3.5 The Department has environmental maintenance contract personnel who clean the laboratory on a regular basis. Special cleaning arrangements (carpets, floor waxing, etc.) can be made by appointment. All laboratory employees are expected to maintain clean working areas to ensure

a safe working environment and minimize the potential for contamination. Specific housekeeping procedures are included in individual unit manuals where appropriate.

5.3.6 The laboratory has a health and safety program that is administered by the Laboratory Safety Officer, and is under the ultimate direction of the Safety Program Coordinator.

5.4 TEST METHODS, VALIDATIONS, VERIFICATIONS

5.4.1 METHODS

The laboratory will use technical procedures that are documented in the unit policy/procedure manuals. These procedures are subject to review and final approval by the Quality Manager.

5.4.1.1 ALLOWABLE VARIATION FROM PROCEDURE

While the laboratory operates under many documented policies, procedures, and technical methods, there may be circumstances or situations that require a variation from policy/procedure to adequately resolve them.

For technical procedures, the sample examined may dictate that some minor modification of the standard laboratory procedure be employed. This is at the discretion of the analyst. Any variation from analytical procedures must be documented in the case record.

If a standard laboratory procedure cannot be utilized or requires modification for a specific application, the procedure selected must be fit for its intended use and validated prior to use in analysis of evidence. Modified and new test methods require approval by the unit Technical Manager and Quality Manager prior to implementation.

Any intended variation from analytical policies/procedures requires approval from the unit Technical Manager, as well and the Quality Manager. A summary detailing the need for the modification, as well as the procedure to be used will be submitted and approved prior to applying the method to test items.

Administrative and non-technical procedures conducted at variance with policy without prior approval may be subject to a quality assurance review and report detailing corrective actions if necessary.

Laboratory request forms state that the method used is at the discretion of the laboratory. The method used is included in laboratory reports.

5.4.2.1 PERFORMANCE VERIFICATION

The laboratory can adopt previously validated procedures by using in-house verification. Performance verification can be demonstrated through the use of appropriate controls and standards. Performance verification records will be maintained for future reference.

Equipment replacement will be followed with performance verification prior to use on casework.

5.4.3 LABORATORY-DEVELOPED METHODS

Prior to the introduction of nonstandard procedures, a validation plan shall be submitted to QA for review and approval. The plan will be updated as development proceeds.

5.4.4 NON-STANDARD METHODS

Non-standard methods will be validated prior to implementation for use on casework.

5.4.5 VALIDATION OF METHODS

Validation is the confirmation by examination and the provision of objective evidence that the particular requirements for a specific intended use are fulfilled.

The laboratory will validate non-standard methods, laboratory designed/developed methods used outside their intended scope, and amplifications and modifications of standard methods to confirm that the methods are fit for the intended use. Validation will be completed and analysts applying the method will be trained in the new method prior to the application of the method.

Validation will include testing of known samples designed to resemble actual evidence materials. Factors such as matrix, sample age, environment, and

sample uniformity may need to be taken into account. For methods providing quantitative information, validation will include detection limit determinations and an estimation of uncertainty of measurement of the method at concentrations representative of casework samples. DNA quantitation processes are excluded from this requirement. The scope of the validation shall be as broad as is necessary, based on the elements listed in ISO 17025 5.4.4 and 5.4.5.

The validation process and results will be documented in a validation summary, explaining the process and will include an effective date of method implementation. The validation summary and supporting data will be submitted to the Quality Manager for review and approval. Competency tests may be required depending on the method implemented at the completion of the validation. See section 5.2.6.2 Competency Testing.

Participation in the validation of a new method can serve as proof of competency. Therefore a competency test may not be required.

The Quality Manager will give final approval before a new method is implemented.

5.4.6 UNCERTAINTY OF MEASUREMENT

Uncertainty of measurement applies only to the Forensic Chemistry and Firearms Units. Procedures for measuring and reporting uncertainty are provided in Forensic Chemistry and Firearms Unit technical manuals.

5.4.7 CONTROL OF DATA

5.4.7.1 Calculation and data transfer checks occur as part of the review process as specified in Section 5.9.4 of this policy.

5.4.7.2a Commercially purchased software used for data acquisition may be considered sufficiently validated. Laboratory developed software or modifications made to purchased software used in acquisition/processing of data shall be validated depending on the nature of the modification to ensure suitability of use.

5.4.7.2b All department computers used for data entry or collection, data storage, data transmission, and data storage connected to the Department LAN are subject to the city's network security policies which can be found at

https://citynet.sandiego.gov/it/services/policies. In addition, the Police Department is required to comply with DOJ security policies administered by the Department's Data Systems group.

Computers associated with individual characteristic databases (IBIS,ALPS,CODIS), are subject to policies set by the entities that operate those databases.

5.4.7.2c Computer systems that operate instrumentation are not connected to the Department LAN. These computers are supported by the Department's Data Systems group and, in some instances, through service contracts. Automated equipment used in the laboratory is maintained through vendor service contracts.

5.4.7.2.1 The laboratory is a secure area with restricted access to equipment and instrumentation.

5.5 EQUIPMENT

5.5.1 The laboratory has available equipment that is appropriate for the levels of testing that are conducted by the Laboratory units. Should any lab person make use of equipment not owned/covered by the laboratory, compliance with the requirements of the international standard shall be ensured.

5.5.2 Where appropriate, calibration/performance checks are specified in the unit methods. These checks/calibrations are documented by unit personnel.

Microscopes, stereoscopes, and electronic balances will be given a preventative maintenance service once per year, to be arranged by the Quality Manager. The Quality Manager will keep records documenting the annual external servicing of the microscopes. Balance check sheets will be kept in each balance book. Preventative maintenance will be performed on instruments and equipment on a schedule according to specific service contracts.

Servicing of a non-routine nature (i.e. any repairs, calibrations, etc.) will be recorded in the maintenance calibration log book maintained within the unit, except for the records involving balances and microscopes.

BALANCE CHECK POLICY

In addition to the annual service provided by an outside vendor, balances will be checked on a quarterly basis using NIST traceable weights for each of the remaining three quarters by Lab Technicians or Criminalists. The annual external check will serve as the fourth quarter check. Documentation for service and calibration checks will be maintained in the Forensic Chemistry unit.

5.5.3 The Crime Laboratory Manager will authorize designated personnel for use of appropriate equipment. Instructions for instrument operation will be maintained so that they are readily available to unit personnel needing them.

5.5.4 Equipment is uniquely identified in the form of serial number, city property tag, or other means as designated by the unit policy.

5.5.5 Records (calibrations, performance checks, and maintenance) for the equipment will be maintained in each of the Laboratory units. These records will include elements as defined in ISO 17025:2005, 5.5.5.

5.5.6 Critical measuring equipment, if defined as such and if transported, will be transported in such a way to ensure proper functioning, and prevent contamination, or deterioration.

All measuring equipment is stored in the individual laboratory units in which it is used. Unless identified as being out of service, all measuring equipment is available and considered suitable for use in measuring and analysis. See Section 5.5.12.

Measuring equipment used for crime scene processing or reconstruction is stored in the crime scene response vehicles.

5.5.7 If a piece of equipment is known to be defective in its performance or gives suspect results, performance diagnostics must be done. If it becomes necessary to take the equipment out of service for a significant repair (such as having to call in a service rep), it will be isolated or marked with OUT OF SERVICE. This does not include routine servicing, preventive maintenance, or general trouble shooting. An evaluation of any effect on casework will be made and documented. A corrective action procedure will be initiated if necessary. Once the equipment has been repaired, a performance verification will be conducted and documented prior to any casework analysis. This documentation will be reviewed and subject to final approval by the Quality Manager prior to issuing any new casework reports.

5.5.8 Where appropriate and practical, equipment will be labeled with status of the calibration, such as the calibration contractor label on the laboratory balances indicating the due date of the next external calibration check.

5.5.9 If the equipment goes outside the control of the laboratory, the calibration/performance of the instrument will be verified by the laboratory prior to use on any casework.

5.5.10 Where appropriate, equipment performance checks are detailed in the unit policy/procedure manuals.

5.5.11 Should any of the performance expectations be redefined, appropriate updates will be made in the documented policies, procedures, or software.

5.5.12 Equipment within laboratory units is considered to be within secure areas as access to each area is restricted to authorized personnel. The equipment is thus safeguarded against unauthorized adjustments.

5.6 MEASUREMENT TRACEABILITY

5.6.1 GENERAL

All calibrations in the laboratory comply with the *ASCLD/LAB Policy on Measurement Traceability*. Refer to the unit manuals for specific calibration information.

Laboratory equipment used in testing is subject to calibrations and/or periodic performance checks. These checks may be done either annually, quarterly or on per run basis as specified in general laboratory or unit policy.

The general laboratory equipment policy, Section 5.5, describes the requirements to have microscopes and balances checked and serviced by an outside contractor on an annual basis. Balances are additionally required to be checked internally on a quarterly basis.

5.6.2 SPECIFIC REQUIREMENTS

5.6.2.1. CALIBRATION

5.6.2.1.1. For those contractors providing calibration services for the laboratory, proof of competence will be maintained in the laboratory files.

5.6.3 REFERENCE STANDARDS

Reference materials and standards used by the laboratory are specified in the unit manuals.

5.6.3.1 The Quality Manager maintains a NIST certified ruler. This ruler will be checked on a quarterly basis to determine if any visible damage has occurred. If damage has occurred, the ruler will be recertified if possible. If recertification is not possible, the ruler will be replaced. The Quality Manager will maintain a log of these checks.

5.6.3.2.1 Reference collections shall be fully documented, labeled, and kept in secure areas of the laboratory.

5.6.3.3 Reference materials have defined performance expectations and are evaluated each time they are used for comparison in analysis. Once the results of the reference materials have been evaluated and determined to be within performance expectations, the related analysis will have been determined to be a success if all other performance parameters are met. Successful performance expectations are also a confirmation that the reference materials are valid. This is a continuous check process.

5.6.3.4 Reference materials will be handled, transported, and stored in a safe manner as required by the Laboratory Safety Manual, Chemical Hygiene Plan, Safety Data Sheet, or unit procedures. Weights and measures reference standards are stored under normal room conditions.

The NIST certified ruler referenced in Section 5.6.3.1 is stored in the Quality Managers office in a location intended to isolate the ruler to prevent damage. Caution must be used when transporting and using the ruler to prevent damage.

Weights used by the Forensic Chemistry and Forensic Biology units are stored in a box that has been manufactured to prevent damage during storage and transport. Weights are transported between units in this box to prevent damage during transport. Caution must be used when transporting and using these weights to protect against damage to the weights.

5.7 SAMPLING

5.7.1 The laboratory does not sample a part of a substance, material, or product and perform testing to report on the whole. The laboratory only reports results as they relate specifically to the items being tested. The items specifically tested are identified in the test report.

5.8 HANDLING OF TEST AND CALIBRATION ITEMS

5.8.1. HANDLING OF TEST ITEMS

Evidence is received directly by the analyst assigned to perform the work from the Property Room, the Narcotics Vault, or directly from the Officer or Detective requesting walk-in analysis. After evidence is received from the Property Room or Narcotics Vault, it is transported to the laboratory by the analysts receiving the item(s). See Sections 5.8.4 through 5.8.4.6 for procedures regarding handling, protection and storage of evidence items within the Laboratory.

Procedures for handling evidence items collected at crime scenes are provided in the Crime Scene Unit manual.

CHAIN OF CUSTODY

All evidence transfers occurring through the Property Room or Narcotics Vault are processed and documented in FileOnQ. All evidence items are given a unique barcode number. The chain of custody for each uniquely barcoded evidence item transferred must be tracked. FileOnQ securely tracks the individuals transferring and receiving the items(s), the location, the item(s) being transferred, and the date and time of transfer. Requirements for chain of custody documentation in the case record, if any, are provided in the unit manuals. See Section 5.8.2 for instructions of creating sub-items.

Upon completion of analysis, evidence items will be returned to the appropriate locations, either the Property Room, Narcotics Vault, or the Officer requesting walk-in analysis.

The San Diego Police Department Property Room is not a laboratory function. The Property Room maintains its own chain of custody on property tags for evidence prior to June 2011 and a separate electronic property management system, FileOnQ, for evidence newer than June 2011. Check-ins and check-outs of test items from the Property Room are documented on these property tags or in the electronic record.

Blood and Urine Samples impounded prior to June 2011 were tracked using sequential “B” or “U” numbers obtained from a laboratory generated log book.

Controlled Substance evidence impounded prior to June 2011 were tracked using impound tag numbers.

Evidence items are returned to the Property Room after the completion of analysis. Storage, retention, and disposal of evidence is the responsibility of the San Diego Police Department Property Room; therefore, these process are controlled by their procedures.

INTERNAL TRANSFERS

Transfers of test items internal to the laboratory are documented on laboratory chain of custody forms (PD-482 form) or electronically in FileOnQ. Exceptions to the required use of this form include:

- field transfers
- internal transfers of blood and narcotics evidence in the Narcotics Vault
- walk-ins when the officer or detective maintains custody of the evidence
- the use of a specific unit form that suits the unit's specific needs

5.8.1.1.1 ADDITIONAL ITEMS

Generated Evidence – items created through the examination process (i.e. tapelifts, swabs taken).

Found Evidence - items that were discovered during the examination process (cigarettes in a shirt pocket, socks inside a shoe, loose debris from clothing)

Subdivided Items - hairs or fibers from a tape lift that are taken off the lift for examination.

If an analyst receives an item containing numerous sub-items to be processed for prints (for example—tools in a toolbox), and only three of the sub-items yield usable prints, the three sub-items can be separately packaged for identifying purposes and placed back in with the original barcoded evidence item (the tools are put back in the toolbox). They can be given an A, B, C (for instance) designator in the note packet. The generated fingerprint cards, or ESDA lifts, etc., will be separately barcoded.

5.8.1.1.2 No unsealed evidence will be accepted into the laboratory system for analysis. Exceptions to this are:

The Narcotics Vault: the unsealed evidence is held until properly sealed by the officer.

Crime Scene Unit: items are initially brought in unsealed from the crime scene for inventory and processing and later sealed before release to the Property Room.

Large items (doors, car fenders) will be received unsealed as long as they are properly marked with case number and item number. If possible, the area of interest will be covered or otherwise protected from loss or damage.

Firearms: firearms retrieved from the watch commander's office may not be sealed at the time of retrieval by the laboratory examiner.

5.8.2 ITEM NUMBERING

The unique identifier for all evidence items is defined by the barcode number. In the case where the evidence has not yet been barcoded, the property tag and item number will serve as the unique identifier.

For discs bearing latent print images, the disc will be marked with some case identifying information and image range on the disc, and then placed into an envelope that will be barcoded.

Unique identifiers for evidence which is maintained under the property tag system will use the property tag, case number, and designated item number. Blood and urine evidence will use the old master log numbers. Narcotics evidence will use the narcotics impound tag number and designated item number. Should the evidence ultimately be barcoded, the barcode will become the unique identifier.

SUBITEMS

Items do not have to be sub itemized if they are being noted for inventory purposes. Once an inventory item is separated for analysis, it must be given a unique identifier. It may either be given a separate barcode number using FileOnQ and packaged separately, or, if placed back into the original container with the other items, it must be given a separate barcode number or sub item designation such as barcode #A or barcode #1. This information must be added to the Comments field in FileOnQ as well as to the outside container. In addition, the laboratory will apply a sticker to the outside container indicating the package contains multiple items of evidence. The Forensic Chemistry Unit is exempted from this requirement.

The unique identifier for latent prints is the barcode number For morgue and elimination prints, the unique identifier, if not the barcode number, is a case or incident number and name of the subject.

5.8.3 EVIDENCE IRREGULARITIES/DISCREPANCIES

The condition of the test item must be documented, indicating in the case record if there are any abnormalities or discrepancies. When there are apparent discrepancies between the barcode information, request information, and/or packaging information, the examiner will communicate with the submitter to resolve any discrepancy.

If the condition of the test item or the discrepancy affects the test method, appropriate notations will be made in the case record and notice sent to the customer. Sealing irregularities must be recorded in the case record.

5.8.4 Test items in the laboratory will be maintained/packaged so as to avoid deterioration, loss, deterioration change, or contamination. Specific handling requirements, such as refrigeration and/or freezer storage, are specified in the unit manuals.

5.8.4.1 Evidence that is not considered to be in process of examination must be sealed. Exceptions will be made for evidence items that are not conducive to traditional sealing. This will be determined at the discretion of the analyst.

5.8.4.2 Evidence containers must be sealed in a manner to preserve the integrity of the evidence. The seal should ensure that tampering would be detected. Container openings will be sealed with evidence tape or evidence seals across the longest direction of the opening. Staples and/or removable tape do not constitute a proper seal. The initials and date will flow from the seal to the package.

Narcotics and toxicology evidence not in the process of examination is kept secured in the Vault. Access to the Vault is restricted to Vault Unit staff and the Crime Laboratory Manager and Assistant Manager.

Evidence in the process of examination will remain secured in the laboratory section in which the examination is occurring. All Laboratory sections, with

the exception of the clerical area during normal business hours only, are locked at all times, with limited access as described in Section 5.3.4. All Laboratory areas are monitored by the Laboratory security system.

5.8.4.2.1 The longest retention for evidence in the process of examination is one year. Allowance for variation must be granted by supervisory review of the case situation. This relates to the maximum time a case can be assigned.

5.8.4.3. MARKING THE EVIDENCE

Each individual item of evidence examined must be marked so that it is traceable to the case or incident number. The evidence must also be marked with the analyst's initials. This means the barcode will generally be used for traceability. Firearms evidence is normally already uniquely identified with a serial number that is used in the FileOnQ system. If the item does not lend itself to marking, its proximal container or identifying tag must be marked. Verifiers will also mark the item or container with their initials. Initialing of the container will suffice when the examination is preliminary.

Evidence will be divided into four categories: 1) evidence that is unmarked, 2) evidence that is already marked, 3) evidence that cannot be marked due to its physical limitations (cartridge case, bullet, swab, etc.), and 4) evidence that should not be marked due to contamination/alteration issues.

1) If the evidence is unmarked, it will be marked with the barcode.

2) Evidence that is already marked with unique information such as the serial number on a firearm or the case identifying information on a latent print card, does not need to be marked with the barcode unless the information is absent or incomplete.

3) The proximal container of evidence that cannot be marked due to the physical limitations of its size will be marked with the barcode.

4) Evidence will not be directly marked if it can be handled in its entirety such as cell phones, lighters, etc, when DNA contamination is an issue. The evidence will not be marked if marking the evidence might affect the evidence analysis, such as arson evidence sealed in KAPAK or paint cans. Marking the proximal containers with the barcode will suffice.

5.8.4.4 PHOTOGRAPHS AS PRIMARY EVIDENCE

When an item can only be recorded through photography (crime scenes, latent print impressions), the original photographic images will be treated as evidence. Primary evidence photographs will be burned to a master copy CD/DVD, sealed, entered into FileOnQ, barcoded, and submitted to the Property Room. Chain of custody will be tracked in FileOnQ. Working copies of the CD/DVD will be made. The working copies do not have to be sealed.

See the Crime Scene and Latent Print Unit manuals for additional details.

5.8.4.5 Evidence collected from crime scenes by laboratory personnel will be protected against loss, cross transfer, contamination, and deleterious change during transport to the laboratory facility. Evidence items will be packaged and closed (without necessarily sealing) for preservation and protection. Evidence sealing will occur once proper documentation of the evidence has occurred, and the items are ready for impounding.

5.8.4.6 Procedures for the operation of individual characteristic databases (IBIS, ALPS, and CODIS) are detailed in the unit manuals for Firearms, Latent Prints, and Forensic Biology.

5.8.4.6.1 All samples used for searches in the individual characteristic databases (ICD) are considered evidence and are handled according to laboratory evidence handling policies.

5.8.4.6.1a Samples used in an ICD search will meet all requirements of evidence handling.

5.8.4.6.1b Any ICD sample not treated as evidence shall meet 5.8.4.6.2 - 5.8.4.6.4.

5.8.4.6.2 Non-evidence ICD samples will be uniquely identified.

5.8.4.6.3 ICD samples under control of the laboratory will be protected against loss, cross transfer, contamination, and deleterious change.

5.8.4.6.4 Access to ICD samples are restricted to those persons authorized by the Crime Laboratory Manager.

5.9 ASSURING THE QUALITY OF TEST RESULTS

5.9.1 The laboratory undertakes several measures to assure the quality of the test results. These measures include both external and internal processes.

The measures are:

Documentation of training and completion of competency tests prior to starting casework.

Annual completion of proficiency test in each discipline practiced by the individual.

Use of appropriate standards and controls where specified in the method.

Application of documented, currently accepted scientific methods.

Stringent technical review of casework and results by qualified personnel.

Verifications for identification and positive associations.

Periodic performance checks on instruments involved in casework, as defined in unit and laboratory policy.

Court performance evaluation.

Annual audit of casework, evidence handling and documented policy and procedure in all disciplines.

Nonconformance and corrective action procedures.

5.9.2 Quality control data obtained through performance measurements of the instruments or of the chemical methods being used are continuously evaluated during the operation of the instrument, application of the method, and technical review of the casework documentation.

Should this evaluation of the quality control data at any time show that the performance expectations are not being met, corrective actions will be taken before any case results can be reported.

5.9.3 The laboratory's Quality Manager will administer the proficiency testing program and maintain the program's records. A plan for

proficiency testing covering the current 4 year accreditation cycle will be maintained.

5.9.3.1 When conducting proficiency tests analysis, the laboratory's own approved test methods shall be used. Laboratory analysts will individually analyze proficiency test samples, and then follow the unit protocol for obtaining a second if necessary, a technical review, and an administrative review of their analytical report.

5.9.3.2 The laboratory's proficiency test program will comply with the ANAB *Proficiency Testing and Review Program*.

5.9.3.3 Each Supervisor and analyst engaged in testing activities shall successfully complete at least one external or internal proficiency test per calendar year in their forensic science discipline(s).

In the following laboratory sections, one external proficiency test in each calendar year must be successfully completed:

Firearms Trace Evidence Crime Scene Reconstruction

Documents Latent Prints Forensic Technology

Crime Scene Unit – Latent Print Processing

If the analyst practices more than one discipline (i.e. trace evidence analysis and crime scenes), then additional proficiency tests will be required.

The Forensic Chemistry Unit must complete an annual external test in both alcohol analysis and controlled substances. Each Forensic Chemistry Unit analyst must complete at least one annual proficiency test in alcohol analysis and one in controlled substances if they have completed training in both disciplines.

In Trace Evidence, each analyst must be tested in each of their qualified sub disciplines once every four years.

Criminalists participating in crime scene reconstruction will have to complete an annual proficiency test in this area. Proficiency tests will vary each year to encompass bloodstain pattern analysis, which is an externally provided test, and shooting incident reconstruction, which will created internally if an acceptable external test is not available.

CRIME SCENE UNIT PROFICIENCY TESTING

Crime Scene Specialists participating in crime scene functions are required to complete an annual proficiency test specific to the crime scene functions. This proficiency will be in the form of a mock crime scene designed and administered by the Crime Scene Unit supervisor. See the Crime Scene Unit manual for the proficiency test plan and requirements.

5.9.3.3.1 Every DNA examiner must complete at least two proficiency tests in each calendar year. Both proficiency tests must be external in that each test is returned and published in the provider's national data. The requirement is as follows: one test must be completed in the first six months and the second test must be completed in the second six months, with the interval between the tests to be no less than four months and no greater than eight months.

5.9.3.4 Proficiency test samples will be obtained from ANAB approved providers, when available.

5.9.3.5 The Quality Manager will maintain records of proficiency testing. Documentation maintained will be conformance with ASCLD/LAB-*International Supplemental Requirements.*

5.9.3.6 Proficiency test records will be maintained for one full ANAB accreditation cycle or five years, whichever is longer.

PREDISTRIBUTION TESTING

The laboratory may occasionally be asked to participate in predistribution testing by our proficiency test provider. If we do participate, the test results need to be resubmitted to the provider by the official test deadline.

PROFICIENCY TEST RESULTS

Proficiency test results will be graded with the following designations:

PASS = all inclusions, exclusions, and technical data are correct.

PASS* (pass with asterisk) = a discussion/review of the technical data and/or responses is necessary.

INVALID = a problem with the test materials exists, disqualifying the test.

NO PASS = due to an error, the laboratory results do not match the test target values. A review will be conducted and any determined error will be classified as a Class I, Class II, or Class III error as defined in the ANAB Proficiency Test Program Overview document. A NO PASS, Class I error, will be reported to the City and District Attorney's Office as mandated by the BRADY legal decision.

5.9.4 TECHNICAL and ADMINISTRATIVE REVIEW

All case reports will be technically and administratively reviewed.

This policy defines a minimum standard for both technical and administrative reviews. Individual units may have additional review elements defined in their unit manuals. The examiner is responsible for their observations, approach, methodology, examinations, results, and conclusions. The reviewer is responsible for making sure these elements, and any other additional elements appropriate for the case, are evaluated when completing the technical review.

The examiner is responsible for the accuracy of the notes, report, and chain of custody. When the case record is ready for review, the examiner is responsible for obtaining the appropriate level of review. The examiner will make the required changes, and the technical review process will be considered complete when the reviewer initials and dates the report. The case record is then forwarded to the unit Supervisor, or designee, for administrative review.

Technical Review

5.9.4.1 The elements of the technical review include:

a. The notes are complete and legible.

b. Chain of custody of the evidence is indicated in the case notes.

c. Disposition of evidence is stated in the report.

d. Discs and images are marked with identifying information.

e. Results, opinions, interpretations, and conclusions are accurate, properly qualified, and supported by the technical record.

f. Test methods are in conformance with applicable policies and procedures.

g. Data for relevant traceable controls is present.

h. Verification of identification are completed, if required, and the verification is documented.

i. Where conclusions are made, they have been detailed in the report and stated in the notes.

j. Where no conclusions can be reached, the reasons for the inability to reach conclusions are stated in the report.

k. Methods or general techniques are listed or described in the report.

l. Notes state the evidence was sealed when obtained from the Property Room or action taken if the evidence was not sealed when received.

m. Manual calculations performed are correct.

n. Data transfers are correct.

o. All changes made to the case notes as a result of verification or technical review are documented and identified as such.

p. Associations are properly qualified in the test report,

q. The test report contains all required information.

The technical reviewer signature indicates that the work was done within the policy/procedural requirements and is acceptable.

It is the responsibility of the technical reviewer to give feedback to the analyst to assist in correcting deficiencies in the report. In cases where serious technical problems are found, refer to Section 7.2 Reporting Serious Technical Problems.

The technical reviewer may be the verifier as well.

5.9.4.2 Staff members who have been competency tested in the specific task(s) that the review is encompassing are authorized to conduct technical reviews in that discipline.

5.9.4.3 The author or co-author of the report may not perform the technical review.

5.9.4.4 If a disagreement between the analyst and technical reviewer cannot be resolved, the issue will be evaluated by the unit Technical Manager/Lead, or another analyst mutually agreed upon by both parties if the disagreement involves the Technical Manager/Lead. If the analyst has conducted the work within policy/procedure, the technical reviewer cannot impose their own personal viewpoint onto the primary examiner. The Technical Manager/Lead or designee will assess whether the case analyst's work falls within written policy when called upon to settle a disagreement. If no consensus can be reached in the technical review stage, and the analyst has done the work within specified policy/procedure, the case must be resolved in favor of the casework analyst. Changes made to the case record as a result of verification or technical review are documented and identified as such.

Administrative Review

5.9.5 The administrative review will not be completed before the technical review (if applicable) is completed. Administrative reviews can be completed by any technical or management staff member other than the author of the report.

No report will be considered final until the analyst's signature is in place and the technical and administrative reviews are documented.

Requirements for reporting and review of walk-in requests in the Firearms unit are provided in the Firearms unit manual.

5.9.5.1 Elements of the administrative review (some elements may overlap with technical review) include:

a. Notes are complete and legible.

b. Notes pages include the case or incident number, analyst's initials, date, and page number. The first page of notes must include the total number of pages.

c. Corrections are made in the appropriate format.

d. The report is in the proper format; correct grammar and spelling are used.

e. The report includes all key information.

f. Documentation of external case conversations (detectives, attorneys, outside experts) leading to substantive casework decisions and/or interpretations are included in the record.

g. The analyst's signature is in place.

h. The technical review has been completed.

5.9.5.2 DOCUMENTATION OF THE REVIEWS

The completion of the technical and administrative reviews will be indicated on the report and, at a minimum, the technical reviewer's initials will be on the first page of notes as well. For alcohol cases, the Supervisor's signature on the batch report signifies an administrative review of the record.

5.9.5.3 SUBSTITUTE REPORT SIGNATURES

The technical reviewer or Supervisor, if currently qualified, may sign a report in lieu of an analyst who is unavailable to sign. The technical reviewer or Supervisor who signs a report for another analyst will initial each page of the notes to signify that the work has been reviewed.

5.9.6 Each examiner who has testified during the calendar year must have at least one court review completed for the year. This court review may be done in person by the supervisor or peer, or by a telephonic survey with the prosecuting attorney on the case. A Court Testimony Evaluation form will be completed and forwarded to the Quality Manager.

Feedback on court performance will be given to the examiner by the Supervisor and the presentation of the feedback will be documented on the review form.

For a less than satisfactory court review, retraining may include coaching and/or mock trials. The subsequent testimony of the analyst must be reviewed directly by management.

5.9.7 Testimony evaluation records will be kept in the electronic records maintained by the Quality Manager for at least one full accreditation cycle or five years, whichever is longer.

5.10 REPORTING THE RESULTS

5.10.1 GENERAL

The results of each test or series of tests carried out by the laboratory shall be reported accurately, clearly, unambiguously and objectively, and in accordance with any specific instructions in the test methods.

All report requirements as specified in sections 5.10.2 and 5.10.3 will be found in the case record (either the report and/or notes).

Reports created for the use of internal customers may be reported in a simplified way. Internal customers are identified as anyone within the San Diego Police Department.

5.10.2 TEST REPORTS

Each test report shall include at least the following information, unless the laboratory has valid reasons for not doing so:

a) A title

b) The name of the laboratory. Because the laboratory operated from a single location, normally serving a single agency, no address is required.

c) The Case and/or Incident number, and on each page, an identification in order to ensure that the page is recognized as a part of the test report and a clear identification of the end of the test report or calibration certificate.

d) The name and address of the customer. We define address in our case as being either the requesting unit or the requesting area command since the laboratory normally serves a single agency. If the report is for an outside agency, the name of the agency will be included with the requesting officer.

e) Identification of the method(s) used.

f) A description of, the condition of, and unambiguous identification of the item(s) tested.

g) The date of receipt of the test item(s) where this is critical to the validity and application of the results, and the date of performance of the test (included in the test record).

h) Since the laboratory does not sample to report on the whole, there is no reference to sampling in the test report.

i) The test results with, where appropriate, the units of measurement.

j) The name(s), function(s) and signature(s) or equivalent identification of person(s) authorizing the test report.

k) Where relevant, a statement to the effect that the results relate only to the items tested.

The following general format will be used for all test reports. Additional requirements may be found in individual unit manuals.

SAN DIEGO POLICE DEPARTMENT
FORENSIC SCIENCE SECTION
___UNIT LABORATORY REPORT

(The report title will reflect the unit doing the work, or a special type of report, such as

CRIME SCENE REPORT, VEHICLE EXAMINATION REPORT
CORRECTION, etc.)

VICTIM:	DOE, Jane	Last name of suspect and victim to be in all caps in header only.
SUSPECT:	SMITH, John	
CHARGE:	211 P.C.	
CASE #:	00-100000	
INCIDENT #:		
INV. UNIT:	Det. Jackson	

(Optional)

DATE OF INCIDENT:

SCENE LOCATION:

CRIME SCENE SPECIALIST:

TITLE: (CRIMINALIST, DOCUMENT EXAMINER, etc.)

Date of incident, scene location, and Crime Scene Specialist headings may be included if the information is available.

In the body of the report:

EVIDENCE EXAMINED (Headings will be in bold caps)

Items will be listed including barcode and a brief description.

METHODS USED

RESULTS

CONCLUSIONS

Report body headings may be different for different types of reports. For example, a Criminalist's report from a crime scene may have the headings:

BRIEFING

SCENE

DESCRIPTION

OBSERVATIONS

CONCLUSIONS

There is flexibility in what report body headings are used. For some reports, for example, it may make the report more readable to combine **"RESULTS and CONCLUSIONS."** For another example, an examiner may list **"ITEMS SUBMITTED"** rather than **"EVIDENCE EXAMINED."**

Times New Roman 12 pt. font will be used.

Additional page headers will be formatted as follows:

UNIT NAME

Case # (and supplemental report #, if applicable)

Page ___ of ___

Signature block will be in **Bold Initial Caps,** and will show name, title and date. Below the signature block will be spaces for initials and date of administrative review and technical review.

5.10.3 Reports will have the analyst's signature in place and all the reviews completed. Reports are considered to be in their final state after the review process is complete, and the report bears all signatures. Prior to this, reports are considered to be drafts. The original report will be maintained in the laboratory case file, and the report will be emailed to the requestor.

5.10.3.1 In addition to the requirements listed in 5.10.2, test reports shall, where necessary for the interpretation of the test results, include the following:

a) Deviations from, additions to, or exclusions from the test method, and information on specific test conditions, such as environmental conditions.

b) Where relevant, a statement of compliance/non-compliance with requirements and/or specifications.

c) Where applicable, a statement on the estimated uncertainty of measurement; information on uncertainty is needed in test reports when it is relevant to the validity or application of the test results, when a customer's instruction so requires or when the uncertainty affects compliance to a specification limit.

d) Where appropriate and needed, opinions and interpretations (see 5.10.5).

e) Additional information which may be required by specific methods, customers or groups of customers.

5.10.3.2 RESULTS INVOLVING SAMPLING

This section is not applicable to our procedures. The laboratory does not sample to report on the whole.

5.10.3.3 INFORMATION DISCLOSURE

WRITTEN REPORTS

Reports are the most common method for disclosing information.

Alcohol results are recorded using a summary report format, and entered into the Narcotics and Alcohol Database. These reports are routed to various distribution points among the local prosecuting agencies. Please refer to the Forensic Chemistry Unit manual for specific information.

If a case is disposed of prior to the completion of casework, and the disposition has no relation to any laboratory results of the case in progress, then a report does not have to be written.

If the case is disposed of based on any release of laboratory results from a case in progress, a report must be issued for that case. Distribution of the report will occur as per laboratory policy.

Defense attorneys will be referred to the District Attorney's (DA) or City Attorney's (CA) Office for report copies unless special directions have been received from the DA's or CA's Office.

CONFERENCING

Prosecutors, defense attorneys, defense investigators and experts will be granted access, by appointment, to examiners for case discussion. The case prosecutor and/or the investigator on the particular case will be notified of any defense conference so they have an option of being present.

VERBAL RESULTS

Results of completed individualizing analysis can be released to the law enforcement community after technical confirmation of the data by a qualified analyst, prior to the final report being issued. Information from preliminary review of the evidence resulting in general class characteristic information can be released by the analyst without technical confirmation or supervisory review. The individual releasing the verbal results must notify the customer at the time of release that the results may not have been formally technically reviewed, and that the results are preliminary.

Any pre-report release of results will be documented in the notes as to what information was released and to whom. The review/confirmation must also

be indicated in the case record and initialed by the person doing the review/confirmation.

CASE RECORDS

Case records, including analytical data and notes, will be released upon either a court-issued order received from the Defense Attorney, or from verbal or written directions from the District Attorney's Office or City Attorney's Office.

Alcohol case records are routinely provided in their entirety to the District Attorney's Office. Alcohol reports without notes are sent to the City Attorney's Office.

Defense attorneys without a court order will be referred to the DA's or CA's Office for case records.

If a request for only a report is received from a detective or the DA/CA's office, the report can be sent without going through the Quality Manager. If a request for any laboratory document; however, comes from a civil attorney litigating a department case, the request must be routed through the Quality Manager.

OUTSIDE EXPERTS IN THE LAB

For examination of evidence items, defense experts are expected to use their own facilities and equipment. Due to the potential for disruption of casework processes, the crime laboratory does not allow observation of analyses in progress.

UNREASONABLE REQUESTS

Any request for information or records that the analyst and unit Supervisor deem to be unreasonable and/or burdensome should be referred to the department's legal advisors for review and direction.

CIVIL SUBPOENAS

Civil requests for case record and/or QA system documentation must be accompanied by a subpoena. The requested materials will be compiled and then submitted Records Division Subpoena Clerk. If the

City is a defendant in the matter, the litigation unit of the City Attorney's Office will be contacted and the subpoena will be discussed with the assigned litigator. The Quality Manager must coordinate all civil requests for any documentation with the Records Division Subpoena Clerk unless otherwise directed.

DISCOVERY RESPONSIBILITIES

Alcohol discovery will be handled by the Forensic Chemistry Unit directly (refer to the Forensic Chemistry Unit manual on alcohol policies).

The Quality Manager or designee will coordinate all other discovery requests. In the event that the Quality Manager is not available to handle a particular request, the unit supervisor or other designee will comply with the request, keep a record of what was released, and inform the Quality Manager of the release of information.

The Quality Manager will make every effort to redact confidential information, such as the names of victims not related to the case being requested, as needed in case files.

PERSONNEL, POLICY, AND TECHNICAL INFORMATION

Discovery requests, proficiency tests, validations, etc., will normally be held for review by appointment with the Quality Manager. Laboratory manuals are available for download on the City of San Diego public website at the following location: https://www.sandiego.gov/police/services/crime-laboratory-documents

REQUESTS BY ANOTHER LAB FOR GENERAL INFORMATION

To assist other laboratories making new policy or changing procedures, the laboratory may share general policy/procedure information that is published in the unit or laboratory manuals. Any request for background data that may have been collected, for instance, as part of a validation, will be subject to approval by the Crime Laboratory Manager.

5.10.3.4 TESTIMONY TO THE RECORD

The laboratory analyst who conducted the work is normally required to provide the testimony to that work unless the courts agree to a variation in the process. If testimony is based upon casework record generated by

another analyst, the review of all pages in the case record will be documented.

Cosigners of reports written by trainees will indicate on the first page of the notes that they have reviewed all note pages.

5.10.3.5 SIGNIFICANCE OF ASSOCIATION

The significance of any association shall be communicated clearly and qualified properly in the report.

5.10.3.6 ELIMINATIONS

When comparative examinations result in the elimination of an individual or object, the test reports shall clearly communicate the elimination.

5.10.3.7 INCONCLUSIVES

When no definitive conclusions can be reached, the test report shall clearly communicate the reason.

5.10.5 OPINIONS AND INTERPRETATIONS

Conclusions as used in the SDPD crime laboratory reports include opinions and interpretations. The basis for conclusions shall be documented in the case record. Drug chemistry and Toxicology (blood alcohol) reports do not contain opinions and interpretations.

5.10.6 RESULTS BY SUBCONTRACTORS

The results issued by our BioTox subcontractor are issued in BioTox reports (on their letterhead) and are distributed by our laboratory.

Certificates of calibration are issued by our calibrating subcontractors such as San Diego Scale and CMI for Intoxilyzers, and by other vendors as needed.

5.10.7 ELECTRONIC TRANSMISSION OF RESULTS

The laboratory shall issue electronic results to only verified destinations. This may occur through fax, email attachments, download from a secure file cloud account, through the LabLynx portal, or through release of a CD with document files.

5.10.8 REPORT FORMAT

The format of the general laboratory report is defined in Section 5.10.2, Report Format. Latent Prints, Firearms, and Forensic Chemistry, also have defined templates to use in addition to the general laboratory format.

5.10.9 REPORT AMENDMENTS

Analyses completed after the completion of a report will be provided in a Supplemental Report. The report will contain the title "Supplemental Report," along with the numerical version of the supplement, such as "Supplemental Report I."

5.10.9.1 ISSUING CORRECTIONS

All corrected reports will be titled "REPORT CORRECTION." If the correction is related to a technical issue, the new report will replace the original report. The background section of the report will provide details as to the correction made, and reference the original report it replaces or supersedes. The new report will be technically and administratively reviewed.

If the correction is related to a non-technical issue, such as a name or barcode number correction, a simple report stating the correction made will be issued. This report will not contain the analytical information provided in the original report; therefore, it will not replace the original report. This report requires an administrative review, but a technical review is not required.

All report corrections, along with the related case record, will be submitted for review and approval by the Quality Manager prior to their distribution. The Quality Manager will ensure that any required re-labeling of evidence and/or note pages has been completed.

The report will be emailed to the requestor with a notice of the correction in the email subject.

The report (and case packet, if applicable) will be turned into the Clerical Unit for filing.

If the report error is discovered in the process of writing a Final-Narcotics Analysis report or a Supplemental Forensic Biology report, of the correction can be identified in the Final or Supplemental report. These reports will be routed through the Quality Manager, but can be emailed to the requestor without identifying it as a corrected report in the email sent. A quality incident report will only be written if the root cause of the error initiating the report correction is due to a policy or procedure nonconformance.

6.1 ON-CALL POLICY AND PROCEDURES

POLICY

The Crime Laboratory services are often required during irregular hours. Personnel working within strategic disciplines will be assigned on-call duty to provide support and services to the Department. Employees placed in an on-call status shall be compensated for such time in accordance to provisions of their respective MOUs.

On-call personnel will be available by Department telephone. Every effort will be made by the responder to arrive at the scene within 60 minutes of the notification. It is the responsibility of the on-call personnel to notify the duty supervisor of any problems or conflicts that occur. A memo will be provided to Payroll which will include the on-call dates, personnel names, positions, and ID numbers.

ON-CALL PERSONNEL ROLES

The on-call rotation will include the following personnel:

DUTY SUPERVISOR: A laboratory duty supervisor will be available to provide appropriate numbers for contact or directly handle a problem if necessary. The duty supervisor will maintain a current on-call roster and a list of call-back telephone numbers of all laboratory personnel.

CRIME SCENE RECONSTRUCTION CRIMINALISTS: Two Criminalists each week are available for crime scene reconstruction to include, bloodstain pattern interpretation, shooting incident reconstruction, or biological evidence search at crime scenes.

INTERVIEW AND INTERROGATION SPECIALIST: The interview and interrogation specialists are available for after-hours polygraph examinations.

CRIME SCENE SPECIALIST: There will be 3 on-call Crime Scene Specialists to handle any crime scene callout. The first call assignment has the responsibility to notify the 2nd or 3rd callout assignment for any additional callouts. The Crime Scene Specialist is responsible for the collection, preservation, and documentation of the evidence.

VAULT: Vault staff members have special access to the narcotics impound storage area. They will be on-call for emergencies that involve the vault or to receive large impound seizures.

SCHEDULING OF ON-CALL PERSONNEL

On-call rotations will be on a Tuesday to Tuesday basis starting and ending at 0730 hours. On-call rotation schedules will be prepared by December for the following year. The yearly schedules will be prepared by the Crime Scene Reconstruction Program Coordinator and Crime Scene Specialist Supervisor. The schedules will be distributed to the named personnel and the clerical staff.

A weekly on-call roster will be prepared and distributed by the Clerical Unit staff from the master on-call calendar. Copies of this roster will be distributed to the named personnel, Laboratory Manager, Clerical Unit staff, Homicide Division, and the Watch Commander.

LABORATORY VEHICLES

Department vehicles will be assigned to on-call personnel. This may include the duty supervisor. These vehicles are not assigned to any individual. They are rotated for use by whoever is currently on call. Use of personal vehicles for crime scenes is discouraged. If circumstances force personal vehicles to be used, c-mileage will be made available.

In addition to using the vehicle to travel to and from the workplace or crime scene, the vehicle can be legitimately used for personal business within San Diego County by the person on call, as long as the individual can respond directly to the crime scene from his or her location.

6.2 CRIME SCENE MANAGEMENT

Crime Scene Specialists and Criminalists on call are frequently called upon to leave one scene to process another related scene. This could be for search warrant purposes, processing a suspect or vehicle, or processing a secondary or primary crime scene related to the current investigation.

Proper management of multiple crime scenes involves taking numerous administrative and technical precautions.

ADMINISTRATIVE PRECAUTIONS

If the additional scene processing (suspect, morgue, vehicle, etc.) is necessary before the processing is completed at the current crime scene, it may be advisable to call out another Crime Scene Specialist to process the new scene.

If another Crime Scene Specialist is not called out, then it will be up to the primary Crime Scene Specialist, and a Criminalist, if present, to make sure to:

Request that the scene be secured until they have completed all immediately necessary work at the first scene;

Request a rest and/or preparation period as needed;

Follow appropriate technical precautions to avoid scene cross contamination.

TECHNICAL PRECAUTIONS

The Crime Scene Specialist and Criminalist must evaluate the circumstances of the crime and determine if any or all of the following technical precautions need to be followed:

Detectives must be cautioned against entering multiple scenes (including vehicles) without changing clothes and shoes; Crime Scene Specialists will document the admonishment and detective's actions in their notes;

Crime Scene Specialists and Criminalists must change clothes and shoes before entering any additional scene (including vehicles) if victim/suspect contact is a critical issue;

Suspect processing precautions will extend to wearing sufficient protective clothing such as gloves, lab coat, etc.

The Crime Scene Specialist and Criminalist must recognize when they are facing extreme circumstances and take additional technical precautions appropriate for the circumstances that may not be specifically included in this policy.

PROCESS CONTROL

Laboratory personnel at crime scenes have an obligation to admonish other personnel at the scene if the normal order of processing is being disrupted or if the handling of evidence occurs prior to proper documentation. Notations of the situation must be made in the notes.

If evidence or scene cannot be processed in original condition, this must also be reported in the evidence and/or photo list. The supervisor and/or Quality Manager will be notified.

7.1 REPORTING SERIOUS TECHNICAL PROBLEMS

If the technical or administrative reviewer finds a serious technical problem in casework or on a proficiency test, it is incumbent upon the reviewer to bring the problem to the attention of the unit supervisor or Quality Manager. Serious technical problems observed in DNA casework will be reported to the DNA Technical Manager by either the analyst who discovers the issue, or the unit supervisor. Examples of serious technical problems would include conclusions not supported by, or in conflict with, the data or serious flaws in the analysis or case approach. Please refer to the Proficiency Test Result and Casework Discrepancy Review procedure for review procedures.

Technical problems generated from outside the laboratory process affecting casework will be documented in the case report and notes.

Technical problems generated from laboratory process affecting casework must be reported to The Quality Manager so that an improvement process, if possible, can be conducted.

ANAB REPORTING

Significant or substantive occurrences of nonconformance will be disclosed to ANAB within thirty calendar days of determining the nonconformance has occurred, and will be reported to ANAB in the Crime Laboratory Manager's Annual Report.

QA reports will be placed into case packets, and with the approval of the Crime Laboratory Manager, may be forwarded ahead of discovery to the DA/City Attorney's offices, or any other appropriate office in the following situations:

> if the technical problem or policy violation results in the reporting of incorrect results;
>
> if the QA report documents an evidence discrepancy or mishandling of evidence such that casework processing has been detrimentally affected;
>
> as determined appropriate by the Crime Laboratory and Quality Manager.

Any reports that are forwarded ahead of discovery will be forwarded directly to the attorney handling that particular case.

RELEASE OF BRADY MATERIALS

During the course of a personnel investigation, or a casework or proficiency test review by management, the Crime Laboratory Manager may determine that the situation falls under the Brady reporting requirements and make a one-time release of the pertinent information to the assigned deputy district attorney assigned to the case.