SAN DIEGO POLICE DEPARTMENT

FORENSIC SCIENCE SECTION

Quality Assurance Manual

Issuing Authority: Jennifer Shen

1.1 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 form is 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.

1.2 SUBPOENA POLICY

Refer to Department Procedure I.II for the Department policies regarding subpoena issues.

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 operates only on an on-call basis for court.

SUBPOENAS

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

An ill examiner is responsible for notifying the appropriate person or agency of his/her condition in a timely fashion.

If the examiner has a time conflict due to training, the examiner should make the appropriate arrangements with the DA's office. The examiner or his/her supervisor may try to reschedule a court appearance or suggest that another examiner testify in his/her place. If these alternatives are not acceptable to the DA Office, the court requirements take precedence over training.

VACATION NOTICES

The examiner will fill out a vacation notice and include the dates of unavailability. These forms can be typed by the Clerical Unit, signed by the unit supervisor, and then distributed to the prosecutorial agencies by the Clerical Unit.

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

SUBPOENA CONFLICT

Simultaneous subpoenas will be worked out between the attorneys.

For subpoena conflicts with training or vacations, every effort will be made to use alternative solutions, such as testimony from records or reanalysis. In the event that absolutely no alternative solution is accepted by either of the attorneys or judge, the analyst may have to come back from vacation. Training will always be secondary; the analyst, therefore, will not attend the training if the subpoena cannot be resolved.

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

(Please also refer to QA 2.3, Information Disclosure, for additional information)

VIEWING EVIDENCE

Laboratory staff will route defense and prosecution requests for viewing of evidence through the case detective. If the viewing is to be in a non-laboratory area, or at the Narcotics Vault window, primary coordination for the viewing will be handled by the detective. If the viewing will extend into any laboratory unit, advance coordination with the unit supervisor is required.

a. Narcotics will normally be viewed at the Narcotics Vault window.

b. For other evidence types, the viewing will normally occur in the Property Room foyer. It will occasionally be necessary to allow access to the laboratory for evidence viewing. The unit supervisor will coordinate such viewing.

c. Fresh paper will be used on the tables when evidence is viewed. Appropriate safety precautions will also be used.

d. If a laboratory staff member is requested to be present for viewing, then that member should stay for the entire viewing. The viewing will be documented in the analyst's case notes. Testing by the analyst will not be done as part of the viewing process.

e. Space or equipment will generally not be provided to attorneys or experts, in any laboratory section. Approval will be granted by the laboratory manager on a case by case basis

RELEASING EVIDENCE

If a laboratory member receives a direct request for release of evidence, that request will be routed through the case detective.

If evidence is to be released, whether it is under control of the Property Room or the laboratory, a property release form must be provided by the detective for submittal to the Property Room. Evidence in the laboratory will be

returned to the Property Room prior to release by the case detective or sergeant. Exceptions to this are:

a. Splits of narcotic substances, blood and urine for reanalysis, which can be obtained by court order.

b. Specific evidence which is released to another laboratory for additional/continued analysis (i.e. DNA evidence to Cellmark).

   Release to the defense community is not included in this exception.

If the case is from an outside agency and there is no Department detective assigned to it, the examiner can fill out the property release form and release the evidence back to the submitting agency.

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.

1.4 PRIVATE USE OF CITY LABOR, EQUIPMENT, MATERIALS, AND SUPPLIES PROHIBITED

PURPOSE

To reaffirm existing city policy prohibiting the private use of city labor, equipment, materials, and supplies.

DEFINITION

The term "city equipment, materials and supplies" shall mean all city property, including hand tools, power tools, automotive equipment, office equipment and supplies and construction materials.

The term "city labor" shall mean the use of the services of any city employee while he/she is being paid by and performing services for, the City of San Diego.

No distinction is to be made as to the condition of the equipment and materials. This regulation applies equally to items classed as salvage, scrap, or junk.

POLICY

City labor, equipment, materials, and supplies shall not be used for personal or private purposes, either on city premises or elsewhere, by city employees or others, unless specifically authorized to do so by Council approval.

All employees who violate this regulation are subject to discipline up to and including termination and criminal prosecution.

1.5 LABORATORY SECURITY

GENERAL

The laboratory occupies the 6th and part of the 5th floors of Police Headquarters. 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 other doors on the first and second floors, and to the parking garage, is regulated by the use of a card key system.

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

The responding officer will check the area where the alarm has been triggered for signs of forced entry. The officer will knock and notice and 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. An annual key inspection is conducted to monitor the keys.

AUTHORIZED ACCESS

Laboratory supervisors have access to all areas except for the Narcotics Vault. Other unit access authorizations may be given based on various needs.

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 card keyed is understood to be a secure area. Evidence may be left overnight only in these secure areas.

1.6 STANDARDS OF CONDUCT

The laboratory adopts the ASCLD-LAB Guiding Principles of Professional Responsibility for Crime Laboratories and Forensic Scientists as adopted by the American Society of Crime Lab Directors Laboratory Accreditation Board.

These guiding principles will be reviewed and discussed lab-wide on an annual basis.

This document can be found in the laboratory quality system documents.

2.1 ANALYTICAL PROCEDURES

GENERAL

Analytical procedures are outlined 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 ALLOWABLE VARIATION POLICY.

Before applying unit technical methods to casework, an examiner must complete a competency test under the following circumstances:

a. The examiner has just completed training in the method.
b. The examiner transferred to the unit and has not applied the method for over two years.
c. The examiner is a new hire.

NEW METHOD VALIDATION

New technical methods for the laboratory must be validated before being applied to casework.

Proper validation of a new technical procedure requires a complete understanding of the theoretical basis for the method. This knowledge allows for the assessment of specificity, limitations of the method, and possible sources of error.

The primary role of validation is to show that the method works accurately in the San Diego Police Forensic Science Section's laboratory environment.

The new method must be tested using 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 the accuracy of the method at concentrations representative of casework samples.

A proposal for the validation process will be reviewed and approved by the quality manager prior to starting the validation process.

The validation process will be documented in a memo, explaining the process and including an effective date of method implementation. The memo and supporting data will be submitted to the quality manager for review and approval. Competency tests (see 7.6 IN-HOUSE TRAINING) must also be completed.

The quality manager will give final approval before a new method is implemented.

VERIFICATION

Verification is to be used, for instance, when instrumentation is being replaced and the method has not been changed. It is enough to show that standards and controls were tested and the expected results were obtained prior to using the new equipment on casework samples.

CONSUMPTION OF EVIDENCE

When possible, sample(s) 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 whenever possible. If there is an objection to the laboratory consuming the evidence, alternative arrangements will be made for the analysis of the sample(s) in question.

In homicide, sex crimes, and child abuse cases, where no suspect is associated with that case, the analyst will consult with the unit supervisor prior to consuming the sample. These consultations/communications will be documented in the case notes.

In all cases, with or without a suspect and/or no DDA assigned to the case, a notification will be sent to the detective informing him or her of the decision to consume the sample(s). 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 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. Unit

manuals may have additional policies for standards and controls beyond the general verification requirement.

OUTSIDE/UNDUE INFLUENCE

See Policy 4.1.5.b

2.2 HANDLING MONEY AS EVIDENCE

POLICY FOR CHECKING OUT MONEY TO BE PROCESSED (OVER $20.00)

When any examiner is asked to examine or process money (for example, for latent prints or biological evidence), the following procedure applies:

a. An authorization form will be prepared.

b. Prior to signing the form, the work request will be verified by the unit supervisor, or in his/her absence, by the laboratory manager or acting laboratory manager.

c. The signed form will be presented at the Property Room service counter as the money is being signed out.

d. The money will be promptly returned to the Property Room as soon as the examination/processing is completed.

e. Refer to Department Policy 3.02 regarding improperly impounded money in narcotics cases.

2.3 INFORMATION DISCLOSURE

(Please refer to QA 1.3, Requests for Viewing Evidence, Space, or Equipment, for additional information)

CONFERENCING

Prosecutors, defense attorneys, defense investigators and experts will be granted access, by appointment, to examiners for case discussion and interviews. Interviews will be scheduled for normal work hours and for a pre-agreed upon time, adequate for conveying the information requested, keeping in mind the other work responsibilities of the examiner. All interviews are to be documented in the relevant case file, including date, time, participants, and a brief synopsis of the information relayed.

The District Attorney's Office 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

Telephonic or verbal results of a completed identifying analysis can be released to the law enforcement community after technical confirmation of the data by a qualified analyst or with supervisory review. 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 laboratory representative 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 verbal release 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 notes and initialed by the person doing the review/confirmation.

Forensic chemistry results are not an identifying analysis and their verbal release does not require case packet notations.

WRITTEN REPORTS

Final reports will have the analyst's signature in place and all the reviews completed. The original report will be maintained in the laboratory case file: the requested number of report copies will be sent to the requestor.

Alcohol results are recorded in report format and in the Narcotics and Alcohol Database. These reports are routed to various distribution points within the Department and also to the City Attorney's Office. 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, then that case must have a final, formal written report in the final case packet. Distribution of the report will occur as needed.

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

CASE PACKET INFORMATION

Case packet information will be released upon either a court-issued order from the Defense Attorney or from verbal or written directions from the District Attorney's Office or City Attorney's Office.

The alcohol case packets are routinely copied in their entirety and forwarded to the City Attorney's Office.

Defense attorneys will be referred to the DA's or CA's Offices for the copies.

When a request for case packet information is received from an attorney involved in a civil case the laboratory will request that the attorney submit a subpoena. See Civil Subpoena Policy below.

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. The QM must coordinate all civil requests for any documentation with the Records subpoena clerk unless otherwise directed.

PERSONNEL, POLICY, AND TECHNICAL INFORMATION

Refer to the Discovery Responsibilities Policy on the following page.

Bulk discovery requests for archive information (proficiency tests, validations, etc.) will normally be held for review by appointment with the quality manager. Copies of the manuals associated with the specific casework time period will be released as part of the discovery process.

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, defense experts will not be allowed to observe our analyses in progress in the laboratory. If the supervisor determines the outside expert can conduct the exam in the laboratory with minimal disruption, the crime laboratory manager may give approval for an exception to this policy. When samples are insufficient for more than one test, third-party accredited laboratories will be suggested to the prosecutor's office to conduct the analysis.

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 packet and/or QA system documentation must be accompanied by a subpoena. The laboratory package will be compiled and then submitted with the subpoena to the Department's legal advisors for final review and approval prior to release of the documents. 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.

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 deputy QM will coordinate all other discovery requests. Clerical and unit personnel will assist in providing the requested documents to the QM. In the event that the QM is not available to handle a particular request, the unit supervisor will comply with the request, keep a record of what was released, and inform the QM of the release of information.

The quality manager will make every effort to redact names as needed in case files so names not associated with the actual case are not released.

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.

2.4 ISSUING CORRECTIONS

This policy applies to cases that have not been adjudicated.

When a correction needs to be made in a previously issued report, a new report will be issued titled REPORT CORRECTION. If the correction is for a simple typo (a barcode number, an item description, date, etc.), then the correction will stand as an additional report. If the correction is significant, a determination made by the analyst and management, then the report will still be titled REPORT CORRECTION but in this case will supersede the original report.

If the change is only administrative (typically any kind of typo), only an administrative review is required. If any change occurs in technical information (data or conclusion), a technical review is required.

The new report and case packet will be submitted for review and approval by the quality manager prior to its distribution. The quality manager will ensure that any required relabeling of evidence and/or note pages will be completed.

The QM will email the report to the detective with a special notice of the correction in the email subject. If it is a corrected report, the detective will be informed that it supersedes the previous emailed report.

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

If the case has been adjudicated, notification to the quality manager and a note to the case file is sufficient.

Alcohol report corrections will be reviewed by the QM and then released to the Clerical Unit for normal distribution since these reports are not emailed.

Some narcotics reports will go through the process as described above. For other reports, the sequence and type of correction will be guided by the issuance of a final report that by necessity supersedes the preliminary report. These reports will not have to go through QA or have a report correction label. Should factual errors be found in the preliminary report that will be corrected with the issuance of the final report, the analyst will make appropriate notations in the case notes. The original preliminary report will always be a part of the admin docs section.

A quality incident report will only be written if the root cause of the error forcing a superseded report is due to a clear policy or procedure nonconformance.

2.5 NOTE TAKING

GENERAL

Any examination of the evidence must include appropriate documentation. Case notes are the written basis for the report and should reflect results and observations, which would include: evidence contents examined conditions, techniques and methodology used, and relevant dates. Documentation generated during the note taking and analysis steps will be maintained in the case packet. Such documentation would include photos, handwritten notes, worksheets, instrument printouts, and correspondence.

Notes will be taken concurrent with the examination. At a minimum, the notes will indicate start and end date of technical examination. It is occasionally desirable for the examiner to rewrite notes (e.g., from a crime scene) to make them more legible and understandable when they are reviewed. If an examiner rewrites notes, the original notes will also be maintained in the case file. The examiner will indicate "REDONE" or "REWRITTEN" at the top of each page of re-copied notes.

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.

NOTE FORMAT

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

Once the electronic notes are reduced to hard copy (printed or typed from dictation), the hard copy of the notes becomes the final format. Any changes, page headers, etc., will be made according to standard policy requirements.

NOTE PAGE HEADERS

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.

BATCHED SAMPLES

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

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 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.

USING THE BACKS OF NOTE SHEETS

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

IRREGULAR SIZE PAPER

Irregular size paper less 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.

Fingerprint exemplars, which are irregular size sheets of paper in the Latent Print Unit case packets, are exempted from the requirement of being taped to a standard size sheet of paper.

MAKING CORRECTIONS OR CHANGES

If a mistake is made in the notes, 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.

Overwrites and/or obliterations must be lined out, the correct information written adjacent, and initialed as above.

FileONQ CORRECTIONS

If an analyst sees an error that is clerical or administrative in nature, he/she 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 him/her of the errors.

ABBREVIATIONS

Abbreviations will either be included in the case packet or kept on file with the quality manager to be made available for audit or review purposes.

MAKING NOTES ON EVIDENCE SCREENING

Describe the actual item and packaging. Document pertinent observations made concerning each item (e.g., location of stains, location of latent prints, etc.).

List the types of tests performed on each item; document the results of all tests (including tests on standards and/or controls).

Include initials and notes of the person providing verifications.

CHAIN OF CUSTODY

Document in the notes the date and location the evidence was received. Include notes as to disposition of the evidence. Upon completion of analysis, evidence items will be returned to the appropriate locations.

2.6 PHOTOGRAPHY POLICY

DIGITAL PHOTOGRAPHY

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.

CD-R's created for storage of the primary crime scene images will be treated as evidence and stored in the Clerical Unit's photo CD/negative files.

Casework Documentation

Individual units will be responsible for archiving their casework digital images. At a minimum, this will include both a primary and a backup.

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.

Additional Unit Policy

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

Should conditions force the use of 35mm photography, the following photograph and negative policy will be followed:

PHOTOGRAPHY POLICY

Photographs

One master and one working disc with digital images will be created and assigned a barcode number. This number will be in the Crime Scene Unit report and the discs will be impounded to the Laboratory files. The chain of custody will be tracked through FileOnQ. Two copies of the working disc will be provided to the detective.

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 Property. Chain of custody will be tracked through FileOnQ.

2.7 REPORT STANDARD FORMAT

Revised: November, 2000

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

SUSPECT: SMITH, John
CHARGE: 211 PC
CASE #: 0[illegible]-10000[illegible]
INCIDENT #:
INVESTIGATIVE (Optional) Det. Jackson

[Names of suspect and victim to be in all caps in header only. No other names to be all caps. No all cap names in report body.]

DATE OF INCIDENT:

SCENE LOCATION:

CRIME SCENE SPECIALIST:

Date of incident, scene location, and crime scene specialist headings may be included only if the information is available.

TITLE: (CRIMINALIST, DOCUMENT EXAMINER, etc.)

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 when applicable.

2.8 CASEWORK REVIEW

The role of the supervisor in casework review is to ensure that technical and administrative reviews are completed. All cases 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 his/her 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.

A second opinion, or verification by an independent examiner, is a re-examination of the evidence to determine if the conclusion(s) drawn in the report are appropriate. Second opinions, or verifications, are required on all associative identifications. Second opinions may be required for lesser results, depending on unit policy. Verifications are to be completed preferably by someone who is currently qualified in the discipline, or if necessary, by someone who has past experience in that discipline. If the independent examiner agrees with the primary examiner, he/she will initial the conclusion in the notes and/or include their set of notes in the case record. Associative data in DNA cases is contained in the case record and subject to review and verification through the technical review process.

REVIEW PROCESS

Some elements of technical and administrative review may overlap, such as data transfer checks, particularly if the administrative reviewer is also qualified in the discipline.

Primary Examiner

The primary examiner is responsible for the accuracy of the notes, report, and chain of custody. When the case record is ready for review, the primary examiner is responsible for obtaining the appropriate level of review. The primary examiner will make the required changes and the 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.

Verification

This is an actual assessment of the evidence by a second independent examiner when associative identifications have been made by the primary examiner.

Disagreement in Verification

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 not, a mutually agreed upon third party will be asked to help resolve the disagreement. If no consensus can be reached, the conclusion that gives the most benefit to the suspect will be adopted.

Technical Review

Staff members authorized for casework or who have the discipline as part of their work experience, are authorized to conduct technical reviews in that discipline.

The elements of the technical review include:

a. The notes are complete and legible.

b. Pages are numbered, initialed, and marked with a case identifier.

c. Photos are marked with identifying information.

d. Disposition of evidence is indicated.

e. Appropriate and traceable controls are noted.

f. Where conclusions are appropriate, they have been detailed in the report.

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

h. Conclusions are supported by the data. Conclusions outlined in the report shall be articulated in the notes as well.

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

j. Original condition of the evidence packaging, and date and location it was received, are noted.

k. Instrument operating parameters are included (may not be required for every unit).

l. Chain of custody of the evidence is indicated.

m. Data control (calculation and data transfer checks) is included.

It is the responsibility of the technical reviewer to give substantive feedback to the analyst to assist in correcting deficiencies in the report. In cases where serious technical problems are found, refer to the REPORTING SERIOUS TECHNICAL PROBLEMS policy.

The technical reviewer may be the verifier as well.

Disagreement in Technical Review

If a disagreement between the analyst and technical reviewer cannot be resolved, the issue will be evaluated by the technical lead. If the analyst has conducted the work within policy/procedure, the technical reviewer cannot impose his or her own personal viewpoint onto the primary examiner. The technical reviewer signature indicates that the work was done within the policy/procedural requirements and is acceptable. The technical lead 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.

Administrative Review

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

a. Notes are complete and legible.

b. Pages are numbered, initialed, and marked with a case identifier.

c. Photos are marked with identifying information.

d. Corrections are made in the appropriate format.

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

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.

i. The administrative review is signed off as last step.

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.

The administrative review will not be completed before the technical review (if applicable) is completed.

Units with preprinted report forms may have slightly different review sign off procedures which will be specified in the unit manual.

Some units may have additional review elements listed in their policy manuals.

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.

DRAFT REVIEW REPORT

When a complex typed report is reviewed by the author and changes are necessary, it is permissible for the analyst to mark the report "Draft" and submit it to the technical/administrative reviewer for further changes prior to having it re-typed. With those changes in mind, the analyst can then have the report re-typed into its final form for the technical and administrative reviews. This change in procedure is meant to save typing time when further changes to the report are likely.

It is not necessary that each report go through this "draft" stage. If the analyst feels that the report is in final form and changes are unlikely, then the report should be signed and submitted for technical and administrative reviews.

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. For alcohol cases, the supervisor's signature on the batch report signifies an administrative review of the report.

2.9 POLICY FOR COLLECTING DNA SAMPLES FROM LABORATORY EMPLOYEES AND INTERNS

STAFF DNA PROFILE DATABASE

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

A staff 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 staff 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 staff DNA profiles that we can assure the integrity of both the evidence and the testing process.

STAFF DNA SAMPLE POLICIES

The San Diego Police Department Crime Laboratory will maintain a staff DNA database for elimination purposes. The staff 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. Reference DNA samples will be uniquely coded, and provided to the Forensic Biology Unit as anonymous samples for DNA profiling.

The staff DNA database, containing the numeric code and DNA profile of each staff 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. The use of samples in validations will be tracked.

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.

The samples from employees no longer with the Department will be coded for anonymity and used in the database.

STAFF DNA MATCHES

Staff Match Summary Reports

Should a DNA profile from an employee appear in casework, the DNA case analyst will write a Staff Match Summary report. The Staff Match Summary details 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 Staff Match Summary report will be submitted to the DNA Technical Manager for review to determine if any further action or information is required. The Staff Match Summary report will then be forwarded to the Quality Manager. The Quality Manager will review the report, and appropriate actions will be taken to ensure a root cause analysis of the incident. A Quality Incident Report will be written if the contamination has affected the interpretation of the case.

If the contamination 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 contaminating 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 the source of the contamination is external to the Forensic Biology Unit, then the root cause analysis will be conducted by the Laboratory Quality Manager.

Staff Match Summary reports will be maintained in the Forensic Biology Unit.

Quality Incident Reports (QIR)

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

All contamination incidents will be logged for tracking purposes into the QA Incident Log spread sheet. A Quality Incident Report will be written by the Laboratory Quality Manager if the contamination has affected the interpretation of the DNA test results. 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

Each year a summary report will be prepared detailing the number of staff contamination events that occurred during the year. The data will be assessed for any significant trends suggesting retraining is required. 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. These instances will be restricted to court orders and investigations where the Crime Laboratory Manager decides the proper course of action is to release the name to the investigators.

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 (DMS) and are the official versions of our quality system documents. Field versions of CSU and CSR manuals are made available by the unit supervisor and program coordinator. These electronic and hard copies outside of DMS are not controlled.

GENERAL MANAGEMENT

When a unit manual/policy file needs to be revised, the unit supervisor or DNA technical manager will submit a change request form to the quality manager for final approval. The approved changes will be posted as soon as practical. The revised file will be posted with an indication as to where the change has occurred. 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 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 files. The QM 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 a 10-year period.

PERSONNEL INFORMATION

This information is maintained electronically and includes a Statement of Qualifications and Court Evaluation Forms

The Statement of Qualifications is a controlled document and the contents are updated on a regular basis either by the quality manager or the Clerical Unit personnel. When "CV's" are requested by the City or District Attorney's Office, or by the Public Defender's Office, the official laboratory ASCLD-LAB document will be used. The analyst may choose to send a personal CV in addition to the laboratory's Statement of Qualifications.

Records will be kept for the current, and usually one previous, accreditation cycle.

4.1 ORGANIZATION

LEGAL ENTITY

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 organization charts maintained in the quality system documentation

The laboratory function and unit descriptions can be found on the city webpage following the links: sandiego.gov, Police Department, About SDPD, SDPD Units, scroll to and click on Forensic Science.

COVERAGE OF MANAGEMENT SYSTEM

The laboratory facility is divided into multiple areas which include the drying room on the headquarters roof, the 6th floor laboratory, Polygraph and QA on the 5th floor, Room 138 on the first floor, the shooting room on parking level P2. In addition, field work is conducted at the vehicle impound area at the Eastern Area Command station, and crime scenes.

In all areas where laboratory work is conducted, laboratory personnel are governed by casework policy and procedure and the expectations of the General Quality Policy statement.

Policy/procedures are provided electronically by LAN access in the laboratory and by access to laptop hard drive electronic files.

4.1.4 DEPARTMENT CHAIN OF COMMAND

The San Diego Police Department Crime Laboratory is part of the larger 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

The crime laboratory manager has responsibility and authority for all positions in the laboratory, and for general laboratory and safety policy.

Refer to the official job description at the end of this document.

4.1.5.b Undue Pressures/Influence

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 personnel policies also address gifts and/or gratuities:

> DEAPRTMENT POLICY: 9.08 GIFTS OR GRATUITIES POLICY
>
> Definition: "Gift" or "Gratuity" as used herein, includes, but is not limited to, meals, beverages, money, property, loan, promise, service, or entertainment.
>
> Members shall not solicit nor accept any gift or gratuity from any police-regulated business or person employed by, or having an interest in, a police-regulated business.
>
> Members shall not solicit nor accept from any person, business or organization, any gift or gratuity for the benefit of the member or others if it may be reasonably inferred that the person, business or organization:
>
> 1. Seeks to influence action of an official nature or seeks to affect the performance or nonperformance of an official duty; or
>
> 2. Has an interest which may be affected directly or indirectly by the performance of an official duty.
>
> While on duty, members shall pay full price for any goods, products or services obtained.

4.1.5.d Maintaining Integrity

The laboratory 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, department personnel policies, accreditation, professional standards, and the analysis of ethics scenarios.

DEPARTMENT POLICY:9.06 UNBECOMING CONDUCT POLICY (Revised 01/26/04)

Officers shall conduct themselves, both on and off duty, in such a manner as to reflect favorably on the Department. Officers shall not conduct themselves in any manner that could bring the Department into dispute or reflects discredit upon the officer as a member of the Department, or impairs the operation and efficiency of the Department or officer.

Members shall not engage in any conduct that is unbecoming an employee of the Department, nor which impairs the operation of the Department.

4.1.5.e Define the Organization

The San Diego Police Department is managed by a police chief with the assistance of several assistant chiefs of police. The Crime Laboratory is located within Police Headquarters and is managed by a crime laboratory manager who answers directly to one of the assistant chiefs of police.

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 crime laboratory manager has final authority over general laboratory policies including safety, and personnel issues. The quality manager has general authority over unit policy and procedure. The quality manager is also responsible for ensuring that the laboratory remains in compliance with accreditation guidelines.

See quality statement.

See the department and laboratory organization charts maintained in the quality system documentation.

4.1.5.g Sufficient 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 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 will be 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 laboratory manger or a first-line supervisor is required 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.

Key Management: 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

Hugh Curfman is the laboratory's health and safety officer and is responsible for managing an effective 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, quality, safety, and assistantmanagers. 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 and Quality managers. For safety and chemical hygiene, top management oversight shall be by the Crime Laboratory and Safety managers.

July 1, 1996
(Revised)

CLASS SPECIFICATION

SAN DIEGO CITY CIVIL SERVICE COMMISSION

CRIME LABORATORY MANAGER

DEFINITION:

Under direction, to supervise through subordinate supervisors, the evidence collection and analysis, criminalistics and related functions of the Crime Laboratory; and to perform related work.

***EXAMPLES OF DUTIES:**

- Supervises, through subordinate supervision, the Police Crime Laboratory;
- Reviews the analytical reports and criminalistic evaluations for technical accuracy before they are presented in court in the more serious cases, such as homicides and burglaries;
- Directly supervises the physical and chemical examinations of evidence in major cases of critical importance;
- Provides technical information and assistance to private organizations and other governmental agencies;
- Makes decisions relative to research on new scientific crime detection methods;
- Instructs Police Officers in criminalistics;
- Develops, defines and creates criminalistic procedures and techniques;
- Coordinates the activities of the various functions on the major cases to ensure efficient processing and evaluation of evidence;
- Evaluates new scientific equipment for feasibility of purchase;
- Prepares budget estimates for the Crime Laboratory;
- Evaluates the performance of subordinates;
- Performs related work.

MINIMUM QUALIFICATIONS:

Equal to college graduation with a Bachelor's degree in Criminalistics, Forensic Science or a physical or biological science, and five years of professional experience in criminalistics including two years of experience supervising professional criminalists. Qualifying professional criminalistics experience must include one or more of the following areas: 1)forensic serology or D.N.A.; 2)firearms identification; 3)narcotic analysis; 4)trace evidence analysis. A Master's degree in Criminalistics or Forensic Science may substitute for one year criminalistics experience.

NOTE: Additional qualifying experience may substitute for education lacked on a year for year basis.

***EXAMPLES OF DUTIES** performed by employees in this class. These may not include all required duties, nor are all listed tasks necessarily performed by everyone in this class.

****MINIMUM QUALIFICATIONS** for determining the education, training, experience, special skills, and/or licenses which may be required for employment in the class. These are reevaluated each time an examination is opened.

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.

These policies are made available in the document management system (DMS). This information is communicated to the staff through monthly (approximately) safety and QA tailgates, and at times of policy change. Information is shared through weekly briefings held at the unit and management levels as well as periodic general laboratory meetings.

4.2.2. POLICY STRUCTURE

The laboratory quality manual is a compilation of administrative, managerial, and technical policies that are, in part, unique to our laboratory while other policies follow ISO 17025:2005 and ASCLD-LAB 2010 supplemental requirements.

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 be recognized for excellence in meeting the forensic needs of the local criminal justice community. The laboratory 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 advocate professional development through active participation in professional organizations.

We will maintain our status as an ISO 17025-accredited crime laboratory.

Objectives

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

General Quality Policy

The Crime Laboratory management and staff are dedicated to meeting, or exceeding, where applicable, the standards of ISO 17025 and the ASCLD-LAB 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/quality control is a prime function and responsibility of every member of the Forensic Science Section. It is through rigorous quality assurance and quality control that the laboratory can ensure it is providing a reliable service to the Department.

The laboratory will maintain a quality assurance program administered by a quality manager. The laboratory adopts the ASCLD-LAB standards of professional responsibility as outlined in our policy 1.6 STANDARDS OF CONDUCT as a model of professional conduct.

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 system report will provide information annually on the laboratory's efforts to meet these objectives. Summary information on audit findings, policy changes, customer survey responses, and tailgate reviews will be included. This report will be reviewed by top management.

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.

The role of the quality manager is to:

a. Administer the laboratory's proficiency testing program and (along with the unit supervisor) evaluate results and recommend corrective steps when warranted.

b. Approve training outlines and track training progress.

c. Conduct annual audits of each technical laboratory unit except for Forensic Biology, including an audit of management team practices and how they affect the quality of laboratory service. The crime laboratory manager will audit the unit supervisor effectiveness. The unit audits will include an evaluation of the effectiveness of the technical and administrative case review process.

d. Maintain and update the laboratory quality system manuals.

e. Evaluate instrument calibration, performance, and maintenance records.

f. Review and approve unit SOP and technical procedures.

g. Ensure the validation of new technical procedures.

h. Along with unit supervisors or technical leads, 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 and the ASCLD-LAB supplemental

The role of the crime laboratory manager is to:

a. Set general laboratory and quality assurance policies.

b. Resolve any disagreement that arises in the implementation of these quality policies.

4.2.3 MANAGEMENT COMMITMENT

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

4.2.4 CUSTOMER REQUIREMENTS

Communication with the customer and meeting customer requirements is conducted through the work request review process (see policy 4.4) which may involve negotiation as to the scope of the work. Meeting customer requirements is also achieved through the reporting process as defined in policy 2.7.

4.2.5 DOCUMENTATION STRUCTURE

The policy structure is defined in 4.2.1 of this policy.

4.2.6 ROLE OF QUALITY MANAGER

The responsibilities of the laboratory quality manager are defined on pages 46-47 of this document.

4.2.7 INTEGRITY OF MANAGEMENT SYSTEM

The crime laboratory manager ensures the integrity of the management system through a process of proper review and approval of changes.

General laboratory policy procedure proposals for policy changes will be presented in writing to the management team either at the weekly management meeting or through email distribution. . The management team will discuss the proposals. After any changes are made to the policy as a result of this discussion, the crime lab manager will evaluate those changes for any conflict with ISO/ASCLD-LAB requirements and other internal policies and set the implementation date. The General Lab Change Proposal form will be used to document the management system policy changes.

Unit policy/procedure change proposals will be coordinated between the unit supervisor and the quality manager. For DNA technical policy, the change will be coordinated between the DNA technical and quality managers. The request for change form will be completed. Staff will be required to sign off on changes in PowerDMS. The Unit Change Proposal form will be used for unit policy/procedure changes.

4.3 CONTROLLED DOCUMENTS

The Crime Laboratory's administrative procedures, technical procedures, training manuals 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, computer disk or 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 and maintaining a controlled document, e.g., the Latent Print Supervisor (or designee) is the Owner of the Latent Print Unit Manual.

PROCEDURE

Controlled Document Preparation - Documents will be prepared by personnel with adequate expertise in the subject. The document must include enough detail and specificity to ensure that the activity conforms to quality specifications and/or expectations.

Format – Document uploaded to DMS will be in Adobe Acrobat PDF or word format.

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. The date of the document will be appended to the filename, e.g., "Quality Assurance Manual - 04-30-2008.doc." 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.

Location - Controlled documents will be uploaded to DMS.

The Crime Scene Unit Supervisor or designee will ensure that a current controlled copies of the following documents are available on the PDAs or laptops of Crime Scene Unit Personnel:

Crime Scene Unit Manual;

Forensic Biology Unit Manual;

Firearms Unit Manual;

Trace Evidence Unit Manual;

Criminalist Crime Scene Manual;

Quality Assurance Manual.

Controlled Document Change Approval – A supervisor or designee wishing to make a change to a controlled document will revise the document using the 'Track Changes' function of MS Word. The document will be saved as an

Adobe Acrobat PDF document, and then uploaded to DMS. A Change Request Form will be sent to the Issuing Authority. Upon approval, the document will be made available to the appropriate personnel through DMS. The change form and changed pages, if possible, will be saved in the unit folder in the QA electronic files.

Revised Controlled Documents – Upon revision, the controlled document will be uploaded into DMS. Assigned personnel must sign off on the revised controlled documents through the DMS program.

When a revision has been approved, the quality manager or designee will make the change in the following manner:

Scan the Change Request pages to the unit folder and place into the current year. Link the change pages in the current QA system worksheet.

Verify that the changes in the document match the Change Request.

Save the "Track Changes" version of the document to the appropriate supervisor folder at the root level of G drive.

Hide the deletions in the document.

Ensure that formatting is correct.

Change the date of the filename in the footer to the effective date of the document.

Accept changes in the MS Word file

Save the MS Word file to the appropriate Supervisor Files folder.

Delete the previous version of the MS Word file in the Supervisor Files folder.

Upload the tracked and untracked version PDF files into DMS

Once a manual file has been made obsolete with a new revision, the old working file will be deleted since the archived file will reside in DMS. DMS will label this obsolete document with a blue A for "Archive." Archived documents are only viewable by DMS administrators.

Controlled Document Availability - All Laboratory personnel will have "read access" to the documents for which they are responsible. "Write access" will be restricted to the laboratory manager, assistant manager, supervisors, quality manager, and laboratory safety officer to prevent unauthorized changes.

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

Review of Controlled Documents - Documents should be reviewed regularly and revised to ensure that they reflect current policies, practices and technology. The revised document is subject to the same review, approval, documentation and issuance requirements of the original document as stated above. At a minimum, each document will be reviewed annually in conjunction with the mandatory annual audit. Review dates will be tracked by the quality manager in DMS. The QA manual will be reviewed at least annually by the quality manager and DNA technical manager on an agreed upon date.

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

DMS will identify the issuing authorities for each document by listing the document approver.

RESPONSIBILITIES:

The preparer of the document is responsible for:

Preparing the document in the proper format.

Acquiring copies of listed references.

Submitting for review and approvals using the Request for Change Form.

The Document Owner or designee is responsible for:

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

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

Preparing a Request Form and submitting the document and Request Form 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:

Maintaining the controlled documents in DMS.

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

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

Reviewing for approval controlled documents for which they are the issuing authority.

Informing [illegible] supervisors or designees when submitted changes have been made.

The laboratory manager is responsible for:

Approving controlled documents for which they are the issuing authority.

4.4.2 WORK REQUEST REVIEW

In general, work requests are initially reviewed by the Clerical Unit staff for logging purposes. This includes date stamping the request with date of receipt into the laboratory, review of services requested, assignment to the appropriate unit, and logging the request into the case tracking database. The request is then distributed to the unit.

The unit (either the supervisor, analyst, or both) will review the request again and seek clarifications, if necessary, from the requesting detective. Selection and prioritizing of items to be analyzed will occur. Whoever conducts this review will initial the work request.

Once the work is assigned, changes may occur with additional information or shifting priorities. The potential for changes is communicated on the work request with the following caveat: "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, for example, to 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.

The requests that are categorized as "not to be worked" will be sent back to the detective with a note of its disposition. They will also be deleted from the case tracking database so they are not counted in the unit backlog. 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.

The work requests clearly indicate that the items to be tested and choice of method are at the discretion of the laboratory.

Work requests received directly by the unit should be directed through the Clerical Unit for logging purposes. If a detective attempts to deliver a work request directly to an analyst, the detective will be redirected to the front office to have the request officially entered into our lab tracking database, date stamped, and then to have the request delivered to the supervisor.

While analysts are not to accept work requests from anyone other than the supervisor or designee, priority or rush verbal work requests will occasionally be received. Work can be initiated without having to wait for a formal work request or the completion of an evidence list. The analyst, unit supervisor, or detective will complete a written request for case tracking purposes, and this can occur after the work commences. The unit supervisor and detective need to be kept informed of the rush work being done.

Work requests will normally not be assigned longer than a year. Supervisory approval must be given and documented in the case record for a case to extend beyond the 1-year mark.

4.4.5 REVIEW OF SUPPLEMENTAL WORK REQUESTS

Supplemental or amended work requests will be subject to the same review process as the original request.

4.5 SUBCONTRACTING OF TESTS AND CALIBRATIONS

4.5.1 SUBCONTRACTORS

The San Diego Police Forensic Science Section uses BioTox, a subcontractor for the toxicological analysis of blood and urine.

4.5.2 The BioTox form has a disclaimer that states clearly to the customer that 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 to use. Should any nonconformance occur or a customer complaint be received, the subcontractor work will be subject to full review and if necessary, the facilities subject to audit/inspection to resolve the nonconformance or complaint.

4.5.4 This subcontractor, 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. NMS is used for specialized toxicology and is included in ASCLD-LAB's list of accredited laboratories.

4.6 PURCHASING

4.6.1 SELECTION OF SUPPLIES AND SERVICES

In general, the selection of vendors for supplies and services is driven by a low bid process by the City of San Diego. In some cases a vendor may be identified as a sole source provider. The City will ultimately identify a vendor that we are obligated to use.

Procedures for purchasing supplies are detailed in a City of San Diego Purchasing Guidelines document that is available from our Clerical Unit.

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 4.6.4).

4.6.3 PURCHASING

The crime laboratory manager and/or designee will review all purchase orders for appropriateness and gives final approval with a signature. All purchase records are kept by the Clerical Unit administrative assistant.

4.6.4 CRITICAL SUPPLIES

Only Forensic Biology has critical reagents and therefore the need to evaluate those particular suppliers. Refer to Forensic Biology for unit policy and records pertaining to the evaluation of those suppliers.

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.

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

San Diego Police Department

[Company Address]
[City, ST ZIP Code]

San Diego Police Department requests your help. Please complete the following Customer Satisfaction Survey based upon the service provided to you over the last year.

HOW WOULD YOU RATE YOUR PERSONAL INTERACTIONS WITH LABORATORY EMPLOYEES OVERALL?

☐ Poor ☐ Adequate ☐ More than Adequate ☐ Excellent

HOW WOULD YOU RATE YOUR INTERACTION WITH THE ANALYSTS?

☐ Poor ☐ Adequate ☐ More than Adequate ☐ Excellent

HOW WOULD YOU RATE YOUR INTERACTIONS WITH THE SUPERVISORY STAFF?

☐ Poor ☐ Adequate ☐ More than Adequate ☐ Excellent

HOW WOULD YOU RATE YOUR INTERACTIONS WITH THE CLERICAL STAFF?

☐ Poor ☐ Adequate ☐ More than Adequate ☐ Excellent

DID THE SERVICE PROVIDED BY THE LABORATORY MEET YOUR NEEDS?

☐ No ☐ Somewhat ☐ Yes ☐ Exceeded Expectations

WAS THE WRITTEN REPORT PRESENTED IN A CLEAR FASHION?

☐ No ☐ Somewhat ☐ Yes ☐ Exceeded Expectations

WAS THE ANALYST OR THE SUPERVISOR AVAILABLE TO ANSWER ANY FOLLOW-UP QUESTIONS?

☐ No ☐ Sometimes ☐ Yes ☐ N/A

WERE THE RESULTS PROVIDED IN A PROFESSIONAL AND CLEAR FASHION IN COURT VIA TESTIMONY?

☐ No ☐ Somewhat ☐ Yes ☐ N/A

DID YOU FEEL THAT THE NEGOTIATION OF THE WORK REQUEST (IF IT OCCURRED) WAS A REASONABLE PROCESS?

☐ No ☐ Somewhat ☐ Yes ☐ N/A

DO YOU FEEL THAT IN GENERAL, RESULTS WERE PROVIDED TO YOU IN A TIMELY MANNER?

☐ No ☐ Sometimes ☐ Most of the Time ☐ Always

COMMENTS

4.8 COMPLAINTS

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

The laboratory manager will track these complaints for management review purposes.

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

DEFINITION

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

REVIEW

If nonconforming work is identified, a documented review will be conducted when 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 affects.

The review will be documented in a quality incident report (QIR). 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).

The report must also establish, if possible, a root cause.

Administrative nonconformances would rarely meet the above conditions and therefore would not require a quality incident report.

DNA CONTAMINATION

Should DNA contamination be found in the casework and it affects the interpretation of the case results, a quality incident report will be issued.

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 lead/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. As soon as practical, the examiner will contact the submitting officer via email to provide a discrepancy notification. The e-mail notification to the officer will be copied to the quality manager. If the discrepancy is not resolved, the situation will be reviewed and documented in a quality incident report.

FINAL REPORT

The quality incident report and supporting documentation will be maintained in the case record and in the quality manager efiles. Should the circumstances be deemed of a high priority, the final report may be released proactively with the case 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 to 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 preventative actions.

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

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

4.11 CORRECTIVE ACTION PROTOCOL

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

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.

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
g) Monitor the corrective actions to ensure they have taken effect.

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

4.12 PREVENTIVE ACTION

Management does 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 crime laboratory manager creates the annual management report that evaluates quality system information to identify where preventive actions can be taken.

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

The same procedure is used for implementing preventive and corrective actions. See below.

Procedure:

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 manager's report.

4.13 CONTROL OF RECORDS

CASE IDENTIFYING INFORMATION

Case packets and casework documentation will be tracked by either a department case number or a laboratory sequence/case i.d. number if a department case number is not available. The laboratory case i.d. number will be obtained from the Clerical Unit staff as they either enter the case into the case-tracking database or close out a request with a report form.

FILING

The Clerical Unit receives the packets for filing. The case packets are color coded for the year and filed numerically. All short reports and walk-in reports from Firearms, all lab # cases and Crime Scene Unit reports, are filed in the main clerical files. Toxicology reports are filed separately in the Clerical Unit.

ACCESS

Case records will be filed by Clerical staff. Once filed, Laboratory staff can retrieve a case record as needed, completing the case file check-out log and an out-card if the case record is to be removed from the Clerical Unit. The lab member will return the case file to clerical staff who will re-file it.

INTERNAL AFFAIRS FILES

On occasion, the laboratory will perform work related to an Internal Affairs (I.A.) investigation. A department case number or laboratory sequence number will be assigned, and documentation will be maintained in a case packet. These packets 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.

CASE FILE RETENTION AND PURGING

Clerical 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 purged to the Department's Records Section and all other hard copy case files will be purged. Alcohol files will not be sent to Records.

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

ELECTRONIC STORAGE

All current case files will be scanned for electronic storage and placed on the Department's network. This network is backed up on a regular basis per Information Technology Policy.

CASE PACKET CONTENTS

Unit policy documents contain policy details specifying the contents of the final case packets that are submitted to the Clerical Unit for filing.

TECHNICAL RECORDS

Note taking policies are detailed under policy 8.5 NOTE TAKING.

4.14 AUDITS

ASCLD-LAB INSPECTIONS

The laboratory is subject to an annual surveillance visit by ASCLD-LAB followed by a full assessment every four years also by ASCLD-LAB.

4.14.1 INTERNAL AUDITS

Accredited units, and units having documented methods, are reviewed by an internal audit team on an annual basis. This audit examines unit compliance with ASCLD-LAB accreditation guidelines and laboratory policy. The audit will be conducted by the QA Unit. Volunteers from the bench level or the management team may be used.. An external auditor or auditors may be used.

In the year that the laboratory is officially assessed for re-accreditation, the ASCLD-LAB 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 DNA Advisory Board audit. In the off year, the DNA audit will be an internal audit conducted using QAS standards.

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

Crime Scene	Latent Prints
Crime Scene Reconstruction	Management
Firearms	Quality Assurance
Forensic Biology	Questioned Documents
Forensic Chemistry	Trace Evidence
Forensic Technology	

Internal Audit Report Process

For all audits conducted, a report containing any findings and recommendations for improvements will be issued. 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, by confidential interviews by the quality manager interviewing the supervisory team about the manager's effectiveness, and through the evaluation of the full ASCLD-LAB criteria checklist for inclusion in the annual report.

4.14.1.2 QUALITY SYSTEM DOCUMENT RETENTION

All quality system documents are electronic and are retained electronically essentially indefinitely. 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 insure that they have been effectively implemented. This will be done by the QA unit 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.

4.15 MANAGEMENT REVIEW

On an annual basis the laboratory manager will conduct a review of the previous year's quality system report to ensure system effectiveness and to introduce necessary changes and/or improvements.

A comprehensive report of quality assurance activities will be compiled by the quality manager and include findings from review of the following if available:

The suitability of policies and procedures,

The outcome of recent internal audits,

Corrective and preventive actions,

Assessments by external bodies,

The results of proficiency tests,

Customer feedback,

Complaints.

The laboratory manager will also consider:

Changes in the volume and type of the work,

Any other reports from managerial and supervisory personnel,

To what extent laboratory objectives are being met,

Anything else deemed to be appropriate for the review.

An analysis of the data in the comprehensive quality system report will be conducted by the laboratory manager. The quality system report along with the manager's quarterly management reports (QMR) to the chief will serve as the basis for a discussion on any changes necessary to increase the laboratory's effectiveness and to make improvements in policy, procedure, and/or process. Laboratory objectives 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 process) and monitored to make sure the changes have been implemented.

The system report will be written in the first quarter of each year, and reflect the quality system for the full previous 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. Records will be maintained as to who made the reagent and that its reliability was tested and worked as expected. This documentation may either be in a reagent log or, if required on a per use basis, may be in the case record.

5.2.2 TRAINING EVALUATION

Employees who attend technical training classes will evaluate the training using the QA 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 (see 7.6 IN-HOUSE TRAINING) will be documented.

5.2.4 JOB DESCRIPTIONS

Job descriptions is a file containing the official city job information sheets. 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. The authorization will specify giving opinions and operation of equipment. 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 Competency Testing

5.2.6.2.2 For any laboratory personnel whose job responsibility includes test report writing, a competency test shall include, at a minimum:

- Examination of sufficient unknown samples to cover the anticipated spectrum of assigned duties and evaluate the individual's ability to perform proper testing methods;
- 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

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 examples.

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.

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 mix and mingle with the 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 DNA extraction, PCR setup and for the analysis of amplified DNA. Several measures to prevent contamination are detailed in Forensic Biology policy.

5.3.4. Access and laboratory security are defined in the laboratory's security policy 1.5.

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.

5.3.6 The laboratory has a health and safety program that is administered by the laboratory safety officer, and under the ultimate direction of the crime laboratory manager.

5.4.2 METHODS

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

Laboratory request forms state that the method used is at the discretion of the laboratory.

General techniques used are listed in laboratory reports or worksheets released with the report.

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 PLANNING

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

5.4.4 VALIDATION

Nonstandard procedures will be validated prior to implementation for use on casework.

5.4.5 VALIDATION PROCESS

Validation shall occur for any nonstandard methods or for methods used outside their intended use.

The laboratory will document the procedure used for validation. The results will include an assessment to determine if the method is fit for its intended use.

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.

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 QA policy 2.8 Casework Review.

5.4.7.2a Commercially purchased software used for data acquisition may be considered sufficiently validated. Laboratory modification of software used in acquisition/processing of data shall be validated/verified depending on the nature of the modification.

5.4.7.2b Units will have procedures to ensure protection of data where appropriate.

5.4.7.2c Computer equipment, unless specifically associated with instrumentation, is under the care of the Department's Data Systems division. Instrument computers are normally handled by outside 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 QM. The quality manager will keep records documenting the annual external servicing of the microscopes. Balance check sheets will be kept in each balance book. Other instruments and equipment, where appropriate, will be given a preventative maintenance as per service contract if any exist.

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

The balances are checked on an annual basis by an outside vendor.

Additionally, the balances will be checked on a quarterly basis for three quarters by the lab technicians. The increments measured for the calibration checks of the pan balance will be 1, 5, 10, 50, 100 and 200 grams. The annual external check will serve as the fourth quarter check.

For analytical balances, the range measured will be from .01 to 100 grams, with increments at .01, .05, .10, .50, 1.00, 5.00, 10.00, 50.00, and 100.00.

The acceptable range will be within five percent of the true value for the weights. The weights will be NBS certified. The log sheets will be maintained under unit control.

5.5.3 The 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. 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, prevent contamination, and/or deterioration.

5.5.7 If a piece of equipment is shown 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, then the proper calibration/performance 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, and/or software..

5.5.12 The unit equipment is considered to be within secure areas as each area has controlled/restricted access to only authorized personnel. The equipment is thus safeguarded against unauthorized adjustments.

5.6 MEASUREMENT TRACEABILITY

5.6.1 GENERAL

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 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

All calibrations in the laboratory are traceable. Refer to the unit manuals for specific calibration information.

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.

5.6.3.1-3 Reference materials have defined performance expectations and are evaluated each time they are used in a run. Once the run results of the reference materials have been evaluated and determined to be within performance expectations, the run will have been determined to be a success. Successful performance expectations are also a confirmation that the reference materials are valid. This is a continuous check process.

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

5.6.3.3. All standards and controls are evaluated for performance at each use and documented in the case record.

5.6.3.4 Weights and measures reference materials are stored under normal room condition. Each unit will address the appropriate storage needs of the reference materials used for casework.

5.7 SAMPLING

5.7.1 The laboratory does not sample and test to report on the whole. The laboratory only reports results as they relate specifically to the items being tested.

5.8 HANDLING OF TEST AND CALIBRATION ITEMS

5.8.1.1 Chain of Custody

The San Diego Police Department Property Room is not a laboratory function. The Property Room maintains its own chain of custody on a property tags for evidence prior to June 2011 and a separate barcode system 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

New blood and urine samples will be barcoded for tracking purposes. Older samples will be tracked through a barcode number.

Controlled Substances

Newer narcotics evidence samples are tracked by the barcode system. The older narcotics evidence will continue to be tracked by the impound tag number.

Internal Transfers

Transfers of test items internal to the laboratory are documented on laboratory chain of custody forms (PD-482 form). 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 = 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.

5.8.2 ITEM NUMBERING

The unique identifier for general criminalistics 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.

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.

For CDs or DVDs 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 old 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 separately barcoded and packaged or, if placed back into the original container with the other items, it must be given a separate barcode 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, if not the barcode, is a case/sequence number, envelope number, and card number. For morgue and elimination prints, the unique identifier is a case or sequence number and name of the subject.

EVIDENCE IRREGULARITIES/DISCREPANCIES

5.8.3 The condition of the test item must be documented, indicating in the case record if there are any abnormalities or discrepancies. If discrepancies are noted, follow the nonconformance and corrective action protocol (QA policy 4.9), 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, or receiving an item unsealed, must be recorded in the case notes.

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.

INTERNAL EVIDENCE SECURITY

5.8.4 Test items in the laboratory will be maintained/packaged so as to avoid deterioration, loss, or deleterious change, and 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 progress 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 not be left unattended overnight in rooms not covered by the laboratory alarm system, nor will the evidence be left unattended in an unlocked room if no one is present.

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 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, and DNA 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, and stored in the Clerical Unit records. They will be available through a documented check-in/check-out process. 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/or 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 are considered evidence and are handled according to laboratory evidence handling policies. Occasionally, a ten print card may be used in an ALPS search and these ten print cards are not considered evidence. Samples maintained in the AFIX tracker database are considered reference samples.

5.8.4.6.1a Evidence samples used in an individual characteristic database search will meet all requirements of evidence handling.

5.8.4.6.1b Any individual characteristic database 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/or deleterious change.

5.8.4.6.4 Access to ICD samples are restricted to those persons authorized by the laboratory director.

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 identifications 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 program.

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 has a documented proficiency test program, as specified in policy Laboratory QA policy 7.3. This policy addresses ASCLD-LAB supplemental policies 5.9.3.1 – 5.9.3.6.

5.9.4 The laboratory's case records and report review policy is documented in laboratory QA policy 2.8.

5.9.5 The laboratory addresses case work review prior to the release of reports in laboratory QA policy 2.8.

5.9.6 The court testimony review policy is documented in laboratory QA policy 7.2

5.9.7 All QA records will be retained for at least a 10-year period.

5.10 REPORTING THE RESULTS

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).

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.

Reports created for the use of internal customers may contain abbreviated results.

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 is included in the test report but since the laboratory is a single laboratory normally serving a single agency, no address is required.

c) Unique identification of the test report 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.

5.10.3 TEST REPORTS ADDITIONAL

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 The laboratory has procedures for release of case work information. These procedures are documented in 2.3 Information Disclosure.

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 report 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.

5.10.4 CALIBRATION CERTIFICATES

5.10.4.1 Traceable standards of known value are used and specified in policy and procedure.

5.10.4.2 Only the standards that are specified are used, tested, and documented in the calibration records. When the calibration results are reported, the uncertainty of measurement is taken into account.

5.10.4.3 Maintenance and calibration records before and after repairs and maintenance of instruments are all contained in the unit calibration documentation. These records are released on a regular basis to the primary customer of the laboratory and to other customers as requested in the discovery process.

510.4.4 The calibration records will contain only specified intervals.

5.10.4.5 The release of the calibration records is per procedure described in the clerical assistant manual and unit policy.

5.10.4.6 The author of the calibration records is documented in the record.

5.10.4.6.1 Once the calibration results are documented, the calibration records are marked for identification as to who conducted the test. Release of these records to the customers does not constitute a re-issue of a certificate and the records do not have to go through full review.

5.10.5 OPINIONS AND INTERPRETATIONS

Opinions and interpretations shall be clearly identified in the test report and their basis shall be documented in the case record. Conclusions as used in the SDPD crime laboratory reports include opinions and interpretations. 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, or release of CD with document files.

5.10.8 REPORT FORMAT

The format of the general laboratory report is defined in Lab QA policy 2.7 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

Report amendments shall be handled according to laboratory QA policy 2.4.

6.1 ON-CALL POLICY AND PROCEDURES

POLICY

The Forensic Science Section services are often required during irregular hours. Personnel in strategic areas 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 following personnel will be rotated on call:

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.

TRAJECTORY and BLOOD SPATTER CRIMINALISTS: Two criminalists each week are available for trajectory or blood spatter reconstruction 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

General 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 will be posted on the laboratory administration bulletin board.

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, laboratory administration bulletin board, Homicide Division and the Watch Commander.

MISCELLANEOUS

Department vehicles will be assigned to on-call personnel performing crime scene duties. This may include the duty supervisor. Use of personal vehicles for crime scenes is discouraged. If circumstances force personal vehicles to be used, c-mileage will be made available. Please review 5.2 LABORATORY VEHICLE POLICY.

6.2 LABORATORY VEHICLES

Laboratory vehicles are available for use by on-call crime scene specialists, criminalists, and interview and interrogation specialists. These vehicles are not assigned to any individual. They are rotated for use by whoever is currently on call.

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.

6.3 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 ALLOWABLE VARIATION FROM POLICY/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 analysis protocol be employed. This is at the discretion of the analyst.

Variations from policies/procedures are allowable in those circumstances requiring alternative actions. A QA report for significant variations will be issued that explains what the variation was and why the variation was allowed.

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.

7.2 COURT REVIEW

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, by a telephonic survey with the prosecuting attorney on the case, or by peer review. A court sheet will be completed and kept in the electronic records maintained by 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, remediation may include coaching and/or mock trials. The subsequent testimony of the employee must be reviewed directly by management.

7.3 PROFICIENCY TEST POLICY

Proficiency testing is an essential process required of an accredited crime lab. Proficiency test samples will be obtained from ASCLD-LAB-approved providers, when available.

The laboratory's quality manager will administer the proficiency testing program and maintain the program's records.

Laboratory members 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.

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

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.

Every DNA examiner must complete at least two proficiency tests in each calendar year. Both of these 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.

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

All laboratory supervisors who personally analyze evidence in the areas of firearms, trace evidence, forensic biology, narcotics, documents, or latent

prints, or who participate in crime scene processing or reconstruction, will participate in proficiency testing under the above provisions.

Criminalists participating in crime scene reconstruction will have to complete an annual proficiency test in this area.

CRIME SCENE PROFICIENCY TESTING

Those individuals participating in crime scene functions are required to complete an annual proficiency test specific to the crime scene functions.

Crime Scene specialists will be subject to a check-list type of review to be done during actual crime scene processing. A satisfactory rating of a minimum number of skills will be required for completion of the annual proficiency test. If this number is not obtained during the crime scene chosen for review, then an additional short written test will be administered at a later time. The subject matter for the test will be photography, evidence preservation, and fingerprint processing, whichever subjects were not covered at the proficiency scene.

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 ASCLDLAB's 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.

7.4 REFERENCES FOR ADDITIONAL QUALITY SYSTEM DOCUMENTS

EDUCATION AND TRAINING

This is tracked through the statement of qualifications.

EXAMINATIONS CONDUCTED

The types of examinations conducted by the laboratory are contained in the policy documents for each unit.

SAFETY

The laboratory has a fully documented safety program that is coordinated through the combined efforts of the laboratory safety officer and crime laboratory manager.

7.5 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. 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 PROTOCOL 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 QA so that an improvement process, if possible, can be conducted.

ASCLD-LAB REPORTING

Significant or substantive occurrences of nonconformance will be disclosed to ASCLD-LAB within thirty calendar days of determining the nonconformance has occurred, and will be reported to ASCLD-LAB 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 Officers, 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; and

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.

7.6 IN-HOUSE TRAINING

GENERAL

Prior to commencing casework, every new employee will be assessed by the supervisor or designated experienced examiner to ascertain his or her knowledge of the job they shall be conducting. This assessment may consist of informal discussions, exercises, and/or practical assessments. At a minimum, the assessment will be comprised of a practical and a written or oral test.

A customized training plan will be developed for new employees, taking into account the results of the new employee's assessment. Training outlines may be found in the individual units, either in the unit manual or under separate cover.

If a person transfers from one laboratory unit to another, a similar assessment will be conducted.

The unit supervisor 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
- the authorization for casework and use of instrumentation.

TRAINING PROGRAM DESIGN

The supervisor or designated trainer will conduct 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 organized training program will consist of determining the body of knowledge that the student needs to master, preparing an outline of material to be covered, preparing a reading list, administering practical exercises, and testing to assess assimilation. .

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

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

Co-signing casework with either the instructor or other experienced examiner.

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).

Where applicable, training programs shall also include training in the presentation of evidence in court.

The student may also be subjected to a moot court exercise at the completion of the above items depending on the student's background and supervisory discretion. The laboratory and/or quality manager will observe unless the moot court is conducted in a formal courtroom setting.

Individuals in training may use equipment/methods on training samples or while under the direct supervision of an authorized user.

REQUIRED REVIEW AND APPROVAL OF COMPETENCY TESTING

Prior to a competency test being administered, the unit supervisor/technical manager or designee will forward a notice of intent to administer a competency test to the quality manager for review and approval. This notice should include the following:

a. Who is taking the test
b. What training elements or category it covers
c. The source of the standards/samples.
d. Expected results, or answer key.

COMPLETION OF THE COMPETENCY TEST

A competency test will be completed by the analyst and submitted to the supervisor/technical manager without second opinions or technical and administrative reviews. The purpose of the competency test is to assess the individual examiner rather than the system.

VOLUNTEER/INTERN LABORATORY WORK

Volunteers and interns may be trained for independent casework in some units, such as the Crime Scene Unit. Other units may allow volunteers/interns to do only supervised casework, as in Latent Prints.

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 be scanned for electronic archiving. The trainer will make a notation in their own notes 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 court.

REMEDIAL TRAINING

In the event that an analyst or examiner is required to undergo remedial training due to identified casework deficiencies, the quality manager and the unit supervisor will develop a retraining plan based on the unit's training manual and the nature of the casework deficiencies. The laboratory manager will give final approval of the remedial training plan.

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.

7.7 REVIEW OF PROFESSIONAL LITERATURE

Supervisors will allow, and encourage, a reasonable amount of work time to be taken by employees to review pertinent professional literature.