COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT
No. SJ-2014-00005

KEVIN BRIDGEMAN ET AL.,

Petitioners,

v.

DISTRICT ATTORNEY FOR THE SUFFOLK DISTRICT ET AL.,

Respondents.

PETITIONERS' AND INTERVENER'S REQUEST FOR BRIEFING AND HEARING CONCERNING IDENTIFICATION AND NOTIFICATION

Petitioners Kevin Bridgeman, Yasir Creach, and Miguel Cuevas and Intervener the Committee for Public Counsel Services ("CPCS") respectfully request that the Single Justice set a briefing schedule and a hearing date to address the identification and notification of Dookhan defendants.

The Full Court's decision in Commonwealth v. Bridgeman, 471 Mass. 465 (2015), empowers Dookhan defendants to challenge their tainted convictions without fear that doing so will yield harsher punishment. But CPCS lacks the resources to identify, notify and advise these defendants of their rights. Some District Attorneys have, at the Single Justice's urging, assisted with identification. But others have not, and none has sought to ensure adequate notification.

Unfortunately, despite the considerable investment of time by the Single Justice, the Full Court, Petitioners, CPCS, and certain District Attorneys' offices, serious identification and notification problems persist more than four years after managers at the William J. Hinton Laboratory Institute ("Hinton drug lab") uncovered misconduct by Annie Dookhan. As shown below, such a quagmire has not resulted -- more accurately, it has not been permitted to occur -- in other states where lab scandals have happened.

Judicial guidance is, thus, warranted concerning (i) who bears the legal and ethical responsibility to identify and notify Dookhan defendants and (ii) how those tasks will be funded and implemented. Without this guidance, thousands of wrongfully convicted individuals will be denied meaningful access to the relief that the Full Court provided in Bridgeman as well as in Commonwealth v. Scott, 467 Mass. 336 (2014), and Commonwealth v. Charles, 466 Mass. 63 (2013).

I. ALL DOOKHAN DEFENDANTS MUST BE IDENTIFIED AND THEN NOTIFIED ABOUT THEIR RIGHTS TO CHALLENGE THEIR TAINTED CONVICTIONS.

In Charles, Scott, and Bridgeman, the Court established how Dookhan defendants can obtain post-conviction relief. This process, which includes a "conclusive presumption" of "egregious government misconduct," Scott, 467 Mass. at 354, and a cap on charge and sentence exposure, Bridgeman, 471 Mass. at 478, re-

flects the Court's judgment that the burden of remedying government misconduct cannot, in fairness, be borne by the defendants victimized by such misconduct. See id. at 476, quoting Lavallee v. Justices in the Hampden Super. Ct., 442 Mass. 228, 246 (2004). But for defendants to challenge their tainted convictions and vindicate their rights, they must first know that they are, in fact, "Dookhan defendants." That is why identification and notification are critical.

A. Dookhan Defendants Can Obtain Meaningful Relief Only If They Know Who They Are.

Dookhan defendants who have not been identified and notified of their rights have no meaningful opportunity to obtain post-conviction relief and will, as a result, continue to bear the burden of the government's misconduct, including the harsh collateral consequences of their wrongful convictions (e.g., potential deportation, loss of employment opportunities, and enhanced repeat-offender penalties).

Consider a Dookhan defendant who was convicted 10 years ago. That defendant's rights will not be vindicated, as the Full Court contemplated in Charles, Scott, and Bridgeman, unless the defendant actually knows that he or she:

- was convicted based on tainted evidence (i.e., Dookhan signed the relevant drug certificate);
- can withdraw his or her guilty plea and obtain a new, fair trial;

- will not face more serious charges or, if convicted again, be sentenced to more prison time;
- has the right, if indigent, to a post-conviction attorney; and
- has the right to advice from that attorney about whether and how to pursue post-conviction relief.

Thus, prompt identification and actual notice are necessary to "ensur[e] that defendants may challenge convictions of drug crimes based on tainted evidence" and to restore the integrity of the criminal justice system. Bridgeman, 471 Mass. at 478.

B. Despite Progress, Thousands of Dookhan Defendants Have Not Yet Been Identified.

More than four years after Dookhan's misconduct was discovered in June 2011, there exists only a partial list of the cases that she compromised. As the Single Justice knows, this partial list represents substantial progress. But it is not nearly enough.

The Single Justice has convened the parties on six occasions between July 2014 and March 2015, and although the District Attorneys initially refused to cooperate with CPCS, subsequent conferences have focused on the practicalities of reconciling "Meier list" entries with docket numbers, collecting identifying information, and obtaining dispositional data.

These efforts have proven productive. The Essex and Suffolk County District Attorney's Offices have now provided docket numbers for many entries on the Meier list. See Affidavit of

Nancy J. Caplan ("Caplan Aff.") ¶ 11. Moreover, after the Single Justice invited other District Attorney's Offices to participate, in March 2015, the District Attorney's Offices for Norfolk, Bristol, and the Cape and Islands also provided some docket numbers. See id. ¶ 19.

Yet as of November 2015, significant identification problems remain:

- The Meier list contains incomplete data on an unknown number of co-defendants because it was based on drug receipts, which did not consistently name all co-defendants. See id. ¶ 8.
- The Suffolk and Essex County District Attorneys have been unable to provide docket numbers for over 8,000 samples on the Meier list. See id. ¶ 12.
- When docket numbers are found, most of them cannot be matched with case information. The Trial Court's information system has yielded dispositions or birth dates for only 20 percent of Suffolk County's docket numbers and only 46 percent of Essex County's numbers. See id. ¶¶ 12-14.
- Docket numbers from the Norfolk, Bristol, and Cape and Islands District Attorneys are still being processed. See id. ¶ 19.
- As of this filing, the Middlesex and Plymouth County District Attorneys have not provided docket numbers for any tainted cases. See id. ¶ 20. Nor have they offered any legal basis for their delay.

Because this process is incomplete, thousands of wrongfully convicted defendants have not been identified. The Full Court has issued major decisions in Charles (2013), Scott (2014), and

Bridgeman (2015), and yet many Dookhan defendants remain in the dark and entirely unaware of their post-conviction rights.

C. Most of the Dookhan Defendants Who Have Been Identified Have Not Been Notified.

The vast majority of Dookhan defendants -- even those whom the District Attorneys have identified -- have received no notification whatsoever. They have not been advised, following the Court's decision in Scott, that they were the victims of egregious government misconduct, or following Bridgeman, that they will not face more serious charges or serve longer sentences if they seek post-conviction relief.

Notification has not occurred because CPCS lacks the resources to locate and contact Dookhan defendants, and because no one else has taken on this critical responsibility.

The Full Court has recognized that CPCS cannot "ascertain which cases may have been tainted by Dookhan's misconduct." Bridgeman, 471 Mass. at 480. It has also acknowledged that, given CPCS's role representing indigent defendants in challenging their tainted convictions, "[i]t cannot be overstated that CPCS has been and will be asked to expend significant resources to handle countless numbers of these cases." Id. at 485-486.

Whether one focuses on identifying, notifying, or eventually representing Dookhan defendants, CPCS will be expected to expend significant resources that it simply does not have. When

Bridgeman was decided, CPCS had one paralegal to locate and contact 20,000 people. Now, it has none. See Caplan Aff. ¶ 24. The drug lab scandal has not gone away, but the funding for CPCS to assist the victims of the crisis has all but disappeared.

Still, with adequate resources, CPCS would be willing to notify and advise Dookhan defendants. See infra at Arg. III. Contrary to the arguments made by the District Attorneys before the Full Court -- suggesting, incorrectly, that CPCS has chosen not to notify Dookhan defendants or that Dookhan defendants have opted not to seek post-conviction relief, see Jan. 8, 2015 Arg. available at http://www2.suffolk.edu/sjc/archive/2015/SJC_11764.html -- CPCS would voluntarily undertake to ensure that Dookhan defendants have adequate notice and a meaningful opportunity to challenge their wrongful convictions.

II. PROSECUTORS HAVE LEGAL AND ETHICAL OBLIGATIONS TO IDENTIFY AND ENSURE ADEQUATE NOTICE FOR DOOKHAN DEFENDANTS.

The burden of correcting this "lapse of widespread magnitude in the criminal justice system," Bridgeman, 471 Mass. at 474, falls on the Commonwealth. To correct the injustices resulting from government's misconduct, and to satisfy their legal and ethical obligations, the District Attorneys must identify all Dookhan defendants and ensure that they receive adequate notice that their rights were violated.

This response is not only dictated by precedent from the U.S. Supreme Court, see Brady v. Maryland, 373 U.S. 83 (1963), the Supreme Judicial Court, see Commonwealth v. Ware, 471 Mass. 85 (2015), and Rule 3.8 of the Massachusetts Rules of Professional Responsibility. It is also how other jurisdictions around the country have responded to lab scandals.

A. Prosecutors Must Identify and Notify All Defendants Whose Rights Were Violated By Government Misconduct.

This Court has held that the outrageous misconduct by Dookhan, a member of the prosecution team, is "entirely attributable to the government." Bridgeman, 471 Mass. at 476. And because the benefit of a remedy for "government conduct" must "inure to defendants," the Court has established a conclusive presumption of "egregious government misconduct" in every case in which Dookhan signed the defendant's drug certificate. Scott, 467 Mass. at 352. The Court in Bridgeman, as in Scott and Lavallee, put the burden of correcting injustice due to government conduct squarely on the Commonwealth. The same principle must apply here: the District Attorneys must identify and notify all defendants whose rights were violated.

Prosecutors have a "well established" obligation to "learn of and disclose to a defendant any exculpatory evidence that is held by agents of the prosecution team." Ware, 471 Mass. at 95, citing Commonwealth v. Martin, 427 Mass. 816, 823-824 (1998).

Thus, the Court recently affirmed that the Commonwealth must "determine the nature and extent" of the misconduct by another state chemist, Sonja Farak, in the State Laboratory Institute in Amherst ("Amherst drug lab"). Ware, 471 Mass. at 94; see also Commonwealth v. Cotto, 471 Mass. 97, 112 (2015). Here, too, prosecutors must identify all of the affected defendants. Otherwise, the failure to determine which convictions have been tainted will effectively block any meaningful post-conviction relief. See Bridgeman, 471 Mass. at 480.

Although the Suffolk and Essex County District Attorneys have made efforts to identify cases affected by Dookhan's misconduct -- as required by the Massachusetts Rules of Professional Conduct, id. (citing Mass. R. Prof. C. 3.8(d)) -- District Attorneys in other affected counties have not done so, risking "inordinate delay" and further violations of due process. Id. at 478-480, n.20.

To be clear, it would not suffice for prosecutors to identify the victims of misconduct but keep that information to themselves. Beyond "learn[ing] of" exculpatory evidence, prosecutors must "disclose" it. Ware, 471 Mass. at 95. Rule 3.8(d) dictates this disclosure must be made "to the defense":

> The prosecutor in a criminal case shall . . . make timely disclosure to the defense of all evidence or information known to the prosecutor that tends to negate the guilt of the accused or mitigates the offense.

The obligation to identify Dookhan defendants cannot be separated from the need to notify them.

It is a universally understood and oft-repeated principle that prosecutors do not represent "an ordinary party to a controversy," but instead "a sovereignty . . . whose interest . . . in a criminal prosecution is . . . that justice shall be done." Berger v. United States, 295 U.S. 78, 88 (1935). In Massachusetts, these words should be translated into actions. If there is to be any prospect of restoring the integrity of the Commonwealth's criminal justice system, the District Attorneys must discharge their twin obligations to identify and notify the defendants who were wrongfully convicted.

B. In Other Jurisdictions Facing Forensic Lab Scandals, Prosecutors Have Voluntarily Worked to Vindicate the Rights of Wrongfully Convicted Defendants.

Unless the problems of identification and notification are addressed, Massachusetts will distinguish itself as an anomaly among the (unfortunately) many jurisdictions that have recently grappled with lab scandals. Elsewhere, prosecutors have almost uniformly responded by voluntarily fulfilling their legal and ethical obligations to identify and notify all potentially affected defendants. For example:

- In Houston, Texas, a technician in a state drug lab was found to have engaged in "dry labbing" on one drug sample, and a preliminary audit revealed two unrelated testing errors. See Affidavit of

Caroline S. Donovan ("Donovan Aff."), ex. 1 at 6-7, 9. District attorneys then collaborated with the Texas Forensic Science Commission and the Innocence Project to notify defendants or defense counsel in all 4,944 cases on which the technician had worked. Id. at 9-12, 18-25.

- In Nassau County, New York, an accreditation inspection followed by an internal review discovered the county forensic lab had committed testing errors in three drug cases and paperwork errors in five blood alcohol tests. Id., ex. 2 at 8, 137-39. The district attorney responded by shutting down the lab, hiring a private lab to retest the past four years' felony drug cases, and notifying all defendants incarcerated on drunk driving or drug convictions based on testing at the lab. Id. at 140; see also id., exs. 3-4.

- In Columbia, South Carolina, a circuit solicitor discovered that a drug sample analysis lacked peer review. Id., ex. 5 at 2. The chief of police ordered a review of pending cases (which uncovered additional problems), closed the lab and alerted the solicitor. Id. at 2-3. The next day, the solicitor sent a memorandum disclosing the lab's errors to all members of the South Carolina bar, citing his obligations under Brady, state criminal procedure, and the rules of professional responsibility. Id., ex. 6.

- In Santa Clara County, California, a lab discovered it had used the wrong chemical in blood tests for methamphetamines for a period of three months. Id., ex. 7. The lab retested all samples that had been tested during that period (approximately 2,500), and found six false positives. Id. The district attorney's office notified all defendants whose samples had been retested, even if the retesting confirmed that the original test result was accurate. Id.

- In Delaware, systemic misconduct and incompetence in the state's drug lab led to missing or compromised evidence. See State v. Irwin, 2014 Del. Super. LEXIS 598, at *21-24 (Del. Super. Ct. Nov.

> 17, 2014). The state police and the state justice department launched an investigation and audit of the drug evidence held at the lab, at which point the state prosecutor's office notified the courts and defense attorneys. Donovan Aff., ex. 8. As the audit progressed, defendants were notified if there was any discrepancy between the drugs held by the lab and the description given by the arresting officer. Id., ex. 9.

In the only instance in which prosecutors did not take voluntary action to remediate the situation, the state supreme court ordered that all affected defendants be notified. See In re Investigation of the W. Va. State Police Crime Lab., Serology Div., 190 W. Va. 321, 336 (1993). West Virginia forensic analyst Fred Zain systematically misreported blood test results, but poor record-keeping made it impossible to determine every case on which Zain had worked. Accordingly, the Supreme Court of Appeals of West Virginia ordered that (1) the Division of Corrections notify all prisoners and parolees of their right to seek post-conviction relief if Zain was involved in their prosecution, (2) the entire investigative file regarding Zain's misconduct be made public, and (3) copies of the file be made available in every prison where a prisoner seeking relief was in custody. See id. at 327-328, 340.

For the Commonwealth and its District Attorneys to do less in response to the Hinton drug lab scandal, which dwarfs other lab scandals in its magnitude, would be inconsistent with the legal and ethical obligations of prosecutors. It would also

render Massachusetts the only jurisdiction in which "egregious government misconduct" in forensic testing is allowed to go uncorrected, leaving thousands of wrongfully convicted defendants to suffer the collateral consequences of their unjust convictions.

III. WITH ADEQUATE RESOURCES, CPCS IS WILLING AND ABLE TO ASSIST WITH NOTIFYING DOOKHAN DEFENDANTS.

Although the District Attorneys must ensure that all Dookhan Defendants receive timely and appropriate notice, CPCS is prepared to assist with and expedite this important effort. But, as demonstrated by the accompanying affidavits, see Caplan Aff. and Affidavit of Anthony J. Benedetti ("Benedetti Aff."), CPCS lacks the resources to provide that assistance, and it cannot take responsibility for that task "in the absence of an additional appropriation that is adequate and targeted for that purpose." Benedetti Aff. ¶ 18.

Adequate resources would include, primarily, the funding to hire much needed staff. As noted above, CPCS had one paralegal assigned to drug lab matters, but that position was eliminated due to a lack of funding. CPCS estimates it would need, among other resources, 16 paralegals to identify and notify approximately 20,000 Dookhan defendants within one year. Caplan Aff. ¶ 41.

A framework for addressing this crippling lack of resources already exists and offers a way forward here. In Lavallee, while recognizing the Legislature's power to appropriate funds to CPCS, the Court nevertheless fashioned a remedy to address "continuing constitutional violation[s]" in the absence of legislative action. Lavallee, 442 Mass. at 241-248. Thus, the Legislature had the option of supplying necessary resources, and "[i]n the meantime," the Court used its superintendence powers "to fashion an appropriate remedy to the continuing constitutional violation suffered by indigent criminal defendants in the courts of Hampden County." Id. at 244.

Here, this Court could similarly fashion a two-pronged approach that implements a remedy while simultaneously allowing for the Legislature to provide necessary resources to CPCS (and perhaps the District Attorneys). If the Legislature decides not to allocate resources, the Full Court could vacate the tainted convictions and order that the underlying criminal cases be dismissed. See Bridgeman, 471 Mass. at 494 (declining to implement a more comprehensive remedy "at [that] time").

Inaction will perpetuate the unacceptable status quo: CPCS cannot identify and notify all of the Dookhan defendants, and the District Attorneys appear committed to their erroneous view that they have no legal or ethical obligations to do so. Thus, defendants are unable to realize the relief that the Full Court

contemplated in Bridgeman, Scott, and Charles. To say that these circumstances risk unconstitutional, undue delay would be an understatement. More than four years into this crisis, which has resulted in thousands of wrongful convictions and widespread violations of the constitutionally guaranteed right to counsel, there is no end in sight.

CONCLUSION

Petitioners and Intervener CPCS respectfully request that the Single Justice set a briefing schedule, and a prompt hearing date, for the Parties (as well as any amici curiae), to address the following issues:

1. Do the District Attorneys have legal and/or ethical obligations to (a) identify and (b) ensure adequate notice for all of the Dookhan defendants?

2. How should Dookhan defendants be notified of their wrongful convictions and post-conviction rights?

Respectfully submitted,

COMMITTEE FOR PUBLIC COUNSEL SERVICES

by its Attorney

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Dated: November 10, 2015

AFFIDAVIT OF SERVICE

I, Caroline S. Donovan, counsel for petitioners-appellants Kevin Bridgeman, Yasir Creach, and Miguel Cuevas, do hereby certify under the penalties of perjury that on this 10th day of November, 2015, I caused a true copy of the foregoing document to be served by Federal Express and electronic mail on the following counsel for the other parties:

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Dated: November 10, 2015

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPREME JUDICIAL COURT
SJ-2014-0005

KEVIN BRIDGEMAN,
& others

v.

DISTRICT ATTORNEY FOR THE SUFFOLK DISTRICT,
and another

AFFIDAVIT OF ANTHONY J. BENEDETTI IN SUPPORT OF JOINT REQUEST OF PETITIONERS AND INTERVENOR THE COMMITTEE FOR PUBLIC COUNSEL SERVICES CONCERNING THE IDENTIFICATION AND NOTIFICATION OF DOOKHAN DEFENDANTS

I, Anthony J. Benedetti, state as follows.

1. I am the Chief Counsel of the Committee for Public Counsel Services (CPCS).

2. Nancy J. Caplan, the attorney-in-charge of CPCS's Drug Lab Crisis Litigation Unit, and I are submitting affidavits in support of the instant motion to provide the Court with information as to what CPCS would require in the way of additional resources to complete the task of providing actual notice to an estimated 20,000 previously-identified Dookhan defendants of their rights under *Commonwealth v. Scott*, 467 Mass. 336 (2014), and *Bridgeman v. District Attorney for the Suffolk Dist.*, 471 Mass. 465 (2015).

3. Some background is needed to put this information in context.

4. Nearly four and one-half years have elapsed since "allegations of misconduct at the [Hinton drug lab] . . . surfaced regarding work performed by Annie Dookhan," *Commonwealth v. Charles*, 466 Mass. 63, 64 (2013), leading to a crisis of "systemic magnitude in [our] criminal justice system." *Scott*, 467 Mass. at 352.

5. In the years since the extent of Dookhan's misconduct was made known, CPCS has maintained – and reiterates here – that this systemic problem will only be resolved through a comprehensive remedy which calls for the automatic dismissal of all Dookhan-tainted convictions unless the Commonwealth makes an adequate showing, by a time certain, as to why dismissal with respect to a particular conviction is not warranted.

6. Indeed, because Dookhan's "egregious governmental misconduct," *Scott*, 467 Mass. at 352, tainted so many convictions, the inherent delay and prohibitive cost of the case-by-case approach has itself become a chief reason why, years later, the Hinton drug lab failure continues to "stain our judicial system and mock the ideal of justice under law." *State v. Gookins*, 135 N.J. 42, 50 (1994).[1/] See Dahlia Lithwick, Crime Lab Scandals Just Keep Getting Worse, Slate

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[1/]In *Gookins*, breathalyser evidence was falsified by an agent of the prosecution. The Supreme Court of New Jersey ordered that the tainted cases be dismissed and required on remand that "[t]he prosecution shall certify to the [trial] court all the evidence that it considers to be untainted that would sustain the prosecution of these cases." *Gookins*, 135 N.J. at 51.

Magazine (Oct. 29, 2015) (available at http://www.slate.com/articles/news_and_politics/crime/2015/10/massachusetts_crime_lab_scandal_worsens_dookhan_and_farak.html). Given the countless number of Dookhan defendants convicted with fraudulent evidence, the usual case-by-case approach simply takes too long and costs too much.

7. The full Court granted CPCS's request to intervene in these proceedings based on its recognition that the agency "has a substantial and immediate interest in these proceedings given its current and future responsibility for providing representation to thousands of indigent Dookhan defendants who want to pursue postconviction relief from their drug convictions." *Bridgeman*, 471 Mass. at 481.

8. As a practical matter, however, CPCS cannot discharge its current and future responsibility for providing post-conviction counsel to those indigent Dookhan defendants who wish to seek to vacate their tainted convictions unless those defendants have first received actual notice that their convictions are in fact tainted, and have then made an informed decision to seek relief.

9. "The prosecutor in a criminal case shall . . . make timely disclosure to the defense of all evidence or information known to the prosecutor that tends to negate the guilt of the accused or mitigates the offense." *Bridgeman*, 471 Mass. at 480, quoting Mass. R. Prof. C. 3.8 (d), 426 Mass. 1397 (1998).

10. Prosecutors' special *Brady* obligations arise from the

recognition that "our system of the administration of justice suffers when any accused is treated unfairly," which occurs when any prosecutor does not give the defendant "favorable" information that is in the prosecutor's possession, custody, or control. *Brady v. Maryland*, 373 U.S. 83, 87 (1963). For this reason, the duties of prosecutors "to administer justice fairly . . . go beyond winning convictions." *Commonwealth v. Ware*, 471 Mass. 85, 95 (2015), quoting *Commonwealth v. Tucceri*, 412 Mass. 401, 402-403 (1992).

11. In the context of the Amherst drug lab fiasco, the Court made clear that the Commonwealth's *Brady* obligations extend to "cases in which defendants already had been convicted of crimes involving controlled substances that [Sonja] Farak had analyzed." *Commonwealth v. Cotto*, 471 Mass. 97, 112 (2015), quoting *Ware*, 471 Mass. at 95.

12. The fact that a defendant's drug conviction is tainted because it was obtained with fraudulent evidence is "obviously exculpatory." *Ware*, 471 Mass. at 95, quoting *Commonwealth v. Tucceri*, 412 Mass. 401, 402-403 (1992).

13. For these reasons, it is my view that the ethical and constitutional obligation of identifying each and every Dookhan defendant and providing those individuals with actual notice of the "favorable" fact that their drug convictions are tainted and subject to a motion to vacate falls squarely on the Commonwealth, in particular

the District Attorneys who used Dookhan's fraudulent evidence (albeit unwittingly) to obtain convictions.

14. The District Attorneys do not share my view, as most recently made clear at the oral argument before the full Court in this case.[2/] The position that the respondents have taken – that they have "*voluntarily* expended time and resources . . . to identify potentially affected defendants," DAs' brief in *Bridgeman* at 58 (emphasis supplied), but that they have no legal or ethical obligation to do so – is regrettable, because that position, in my view, is a significant factor in how unacceptably slow and piecemeal the response of the criminal justice system to the Hinton drug lab failure has been.

15. Although the duty of notification, like the duty of identification, lies with the District Attorneys, it would be preferable if that notification were provided by CPCS. I read the *Bridgeman* decision as endorsing this position. See *Bridgeman*, 471 Mass. at 480 ("The ability of CPCS to identify clients and to assign them attorneys who will represent their interests in postconviction proceedings is crucial to the administration of justice in the Hinton drug lab cases").

16. For a description of what the task of locating identified

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[2/]When pressed by Chief Justice Gants as to whether there exists any "duty of a prosecutor to provide exculpatory information after conviction," the District Attorney for Essex County answered, "That is the *Brady* law, your Honor, which is not on point with these circumstances." As noted in ¶¶9 and 11, *supra*, the Court rejected this view implicitly in *Bridgeman* and explicitly in *Ware* and *Cotto*.

Dookhan defendants and notifying them of their rights looks like, see the affidavit of Attorney Nancy J. Caplan being submitted in support of the instant motion. Based on this experience, we have estimated that it would cost approximately $1.4 million to lease, open, staff, and equip an office tasked with tracking down and providing actual notice to 20,000 identified Dookhan defendants of their rights under *Scott* and *Bridgeman*, with a goal of completing that task within one year from the time that the office was up and running.

17. I must emphasize that our existing appropriation is not sufficient to permit us to take on this task. On November 2, 2015, the Governor signed a supplemental budget that authorized the expenditure of up to $1.235 million by all state agencies incurring costs related to the Hinton drug lab breach. St. 2015, c.119, §2C.I, line item 1599-0054. See also St. 2013, c.3, §2A, line item 1599-0054. We do not know how much of these funds will be made available to CPCS. However, there are more than twenty qualifying state entities other than CPCS that have incurred Hinton lab-related costs. In light of the number of agencies involved, the portion of this recent appropriation ultimately made available to CPCS is certain to be far less than the cost of the location-notification task described in Attorney Caplan's affidavit.

18. Moreover, this agency has a plethora of existing responsibilities and obligations regarding matters unrelated to the

Hinton drug lab fiasco that cannot be deferred. Re-allocating existing agency resources in order to take on the task of tracking down 20,000 Dookhan defendants and providing notice to them of their post-conviction rights could not be accomplished without ignoring those responsibilities and obligations and undercutting other clients' right to the assistance of counsel. In short, robbing Peter to pay Paul is not a reasonable, responsible, or constitutionally permissible approach. Therefore, I would not recommend to CPCS's governing Committee that the agency "voluntarily" take on the location-notification task in the absence of an additional appropriation that is adequate and targeted for that purpose.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 4th DAY OF NOVEMBER, 2015.

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COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPREME JUDICIAL COURT
SJ-2014-0005

KEVIN BRIDGEMAN,
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DISTRICT ATTORNEY FOR THE SUFFOLK DISTRICT,
and another

AFFIDAVIT OF NANCY J. CAPLAN IN SUPPORT OF JOINT REQUEST OF PETITIONERS AND INTERVENER THE COMMITTEE FOR PUBLIC COUNSEL SERVICES CONCERNING THE IDENTIFICATION AND NOTIFICATION OF DOOKHAN DEFENDANTS

I, Nancy J. Caplan, state as follows.

1. I am the Attorney-in-Charge of the Committee for Public Counsel Services' Drug Lab Crisis Litigation Unit (DLCLU), which was created in April of 2013 to handle indigent defense matters arising out of the failure of the Hinton drug lab and associated disclosures of wrongdoing by chemist Annie Dookhan. At present, the Unit consists of me, one staff attorney, and an administrative assistant. This affidavit is submitted to (a) provide the Court with information regarding the deficiencies in the Dookhan defendant data provided to date – data essential to the accurate identification and notification of Dookhan defendants – and the quantum of such data that is still

outstanding; (b) describe, based on DLCLU's experience, what is entailed in locating an already-identified Dookhan defendant and providing the defendant with actual notice of his or her rights to post-conviction relief under the cases pertaining to the Hinton Lab failure, see *Commonwealth v. Scott*, 467 Mass. 336 (2014), and *Bridgeman v. District Attorney for the Suffolk Dist.*, 471 Mass. 465 (2015); and (c) to provide the Court with our best estimate of what additional resources would be required if CPCS were to have sole responsibility for providing notice to an estimated 20,000 Dookhan defendants who have not already received such notice.

2. With respect to the issue described in ¶1(c), *supra*, at the oral argument before the full Court in the case held on January 8, 2015, ADA Weld indicated that the respondents have estimated that there exist approximately 20,000 Dookhan defendants who have not been provided with notice of or the advice of counsel relative to their post-conviction rights. I do not know how the respondents arrived at this estimate. For purposes of this affidavit, however, I have used the figure provided by the respondents to estimate what additional resources would be required in order for CPCS to locate and notify Dookhan defendants who have not yet been counseled of their post-conviction rights.

3. Please note that this estimate *presumes* that CPCS has been provided with adequate information (including accurate names, dates

of birth, case docket numbers, and, where feasible, social security numbers) to permit us to make reasonable location efforts with respect to 20,000 verified Dookhan defendants.

4. Please note as well that I have *not* attempted to calculate the additional resources that would be required to enable CPCS to actually provide counsel to those indigent Dookhan defendants who, having received notice of their rights, elect to seek to vacate their tainted conviction(s).

Deficiencies in the Dookhan defendant data.

5. The task of identifying all defendants convicted of Dookhan-involved drug offenses is, shockingly, far from complete. Today, more than three years after Dookhan's misconduct was revealed and the Hinton drug lab was closed, we still do not have a complete and accurate list of Dookhan defendants and their Dookhan-involved cases.

6. In September, 2012, then Governor Deval Patrick appointed Attorney David Meier to lead a team to "identify all of the individuals who potentially could have been affected by the [then alleged] conduct of Annie Dookhan at the Hinton Drug Laboratory." The Identification of Individuals Potentially Affected by the Alleged Conduct of Chemist Annie Dookhan at the Hinton Drug Laboratory, Final Report to Governor Deval Patrick, David E. Meier, Special Counsel to the Governor's Office, August 2013, at 2. At a press conference with

Attorney Meier announcing this initiative, Governor Patrick stated, "[t]he job of the office is to make sure no one falls through the cracks." Boston Globe, September 21, 2012.

7. As has been highlighted in the course of this litigation, the list compiled by Meier's team, issued in August of 2013, along with the above-cited report, lacks the data necessary for accurate defendant and case identification and is incomplete in many cases involving co-defendants. Thus, Dookhan defendants have undoubtedly fallen thorough the cracks.

8. The Meier list was based entirely on data maintained by the Hinton drug lab. The universe of defendants' names in the list is limited to those listed by police officers on the "drug receipts" that they submitted to the lab with suspected drug evidence. Thus, where police officers failed to list all defendants in a multi-defendant case, or where they used the abbreviation "et al." after the name of only one defendant, co-defendant names are absent from the Hinton drug lab data and, therefore, are absent from the Meier list.

9. Our experience in the DLCLU responding to inquiries from individuals asking whether Annie Dookhan was involved in their drug convictions proves that the Meier list is incomplete with respect to co-defendants.

10. Our experience with the co-defendant problem motivated us to ask, via two sets of letters from Chief Counsel Benedetti, dated

February 11, 2014 and April 11, 2014, that the District Attorneys of each affected county provide us with the police reports associated with their Meier list Dookhan sample entries. It was our view that a comparison of defendants' names in police reports to names on the Meier list and the incorporation of previously omitted names of co-defendants into that list was the only reliable way to remedy the problem. No District Attorney has provided us with police reports in response to our requests.

11. The Meier list does not include defendants' birth dates or case docket numbers (again, for the reason that such data did not exist in the Hinton drug lab data on which the Meier list is based). CPCS sought the docket numbers associated with the Meier list samples and the police reports which would have reflected defendants' birth dates in its 2014 letters to the District Attorneys because, without such information, CPCS would be unable to accurately identify the defendants or the cases associated with the Dookhan samples reflected in the Meier list. No District Attorney's office provided docket numbers in response to CPCS's letters. As a result of this litigation, however, the Suffolk County District Attorney's office and the Essex County District Attorney's office made considerable efforts to provide docket numbers. And, at the behest of this Court, the docket numbers provided were run through the Trial Court's information systems to provide dispositional data and defendants' birth dates.

12. Unfortunately, the Suffolk and Essex District Attorneys were unable to provide docket numbers for over 8,000 Dookhan-involved samples pertaining to their counties' Dookhan cases. Equally concerning, less than fifty percent of the docket numbers provided by the Suffolk and Essex County District Attorneys yielded a match with Trial Court data.

13. The match rate for Suffolk County – twenty percent – was particularly low. This low match rate may have been due, at least in part, to the fact that, at the time the analysis was performed, Boston Municipal Court (BMC) docket information had not been entered into the MassCourts system.

14. The match rate for Essex County Dookhan cases – forty six percent – while better than Suffolk County's match rate, is far from satisfactory.

15. The Trial Court information system analysis did not generate any Superior Court Dookhan case number data. This fact accounts for some small percentage of the low match rates in Essex and Suffolk Counties, but it represents a problem in its own right insofar as it impairs our ability to notify any Dookhan defendants convicted in Superior Court.

16. The Suffolk and Essex County District Attorneys' offices have indicated that their procedure for matching Meier list entries with docket numbers accounted for the names of all co-defendants.

Thus, the enhanced lists produced by both offices should include the names of all defendants prosecuted for offenses associated with a given sample.

17. To test this proposition, CPCS performed an analysis of the data provided by the Suffolk County and Essex County District Attorneys with data from police reports that we were able to obtain from a limited number of closed staff attorney cases. We determined that Essex and Suffolk had not remedied the co-defendant problem, i.e., co-defendant names remain missing from the data provided by Suffolk and Essex.

18. Mark Prior, Supervisor of the Trial Court Information Services, has indicated that his systems do not have the capacity to generate names and docket numbers for co-defendants associated with the docket numbers provided by the Suffolk County and Essex County District Attorneys.

19. At the request of this Court, some but not all of the District Attorneys' offices that are not parties to this litigation have produced Dookhan-sample associated docket numbers. The District Attorneys from Norfolk, Bristol, and the Cape and the Islands produced docket numbers in May, July, and August, 2015, respectively. This essential data was provided nearly three years after Dookhan's fraud was publicly revealed and more than one year after Chief Counsel Benedetti twice requested the data. (It is worth noting that Chief

Counsel Benedetti's second request was made after this Court issued its Scott decision. As such, he was able to point out to the District Attorneys that all of the Dookhan defendants whose docket information he was seeking had viable claims for relief.) This Court transmitted the data to the Trial Court Information Services so that defendants' birth dates and case dispositional information could be generated. As of this date, we have not received that data from the Trial Court.

20. To my knowledge, the Middlesex County District Attorney's Office and the Plymouth County District Attorney's Office have not provided this Court with any docket numbers associated with their Meier list entries. (The Meier list includes 10,999 samples associated with Middlesex County and 8,531 samples associated with Plymouth County.)

Locating and providing Dookhan defendants with notice of their post-conviction rights

21. In April of 2015, CPCS was able to hire one paralegal (at a salary of $32,000) to begin working on the process of locating Dookhan defendants, notifying them that they appeared to have a fraud-tainted conviction and that they had the right to pursue relief from that conviction, and ascertaining whether they wished to consult with an attorney. After a period of training, this paralegal worked with a CPCS attorney with IT expertise to develop a tool to manage and track

a process in which the paralegal would conduct multiple Dookhan defendant searches at the same time, each at a different stage of completion.

22. This tool enabled the paralegal to focus on locating and notifying only those defendants who had been convicted in Dookhan-involved cases. The paralegal's work was restricted to Essex and Suffolk County Dookhan defendants (the only counties from which we had any dispositional data).

23. The paralegal worked on locating and notifying Dookhan defendants in those counties for a short time between the completion of the search management tool and July 31, 2015, one month after funding from the Hinton drug lab reserve was discontinued, leaving CPCS without the capacity to fund his position.

24. Since July 31, 2015, DLCLU has not had a paralegal or any other staff person to continue the Dookhan defendant location-notification work, which the one paralegal had barely started.

25. Still, even that limited experience has given us a good sense of what steps are involved in the location-notification process, and of how much time it takes to obtain good contact information and make a solid attempt to contact a Dookhan defendant.

26. The paralegal's search efforts focus on entries in the database that include a defendant's name, birth date, a docket number, and a conviction on one or more of the drug counts associated

with the Dookhan-involved sample. The paralegal must first determine whether the defendant has already received post-conviction, lab case representation. To do this, he checks the name and docket number against information from the CPCS private counsel "E-bill" system and the CPCS public defender case management system.

27. Where it is determined that a Dookhan defendant has not received post-conviction lab case representation through CPCS, the paralegal looks for current contact information for that defendant.

28. The defendant's birth date is a key identifier in virtually all of the subsequent searches conducted by the paralegal. It should be noted that we still do not have dates of birth in many Essex and Suffolk County cases. And we have yet to receive any such essential Dookhan defendant data from any of the other affected counties.

29. CORI checks are performed where appropriate. CORI's can yield evidence that a Dookhan defendant has a pending case. In such instances, the paralegal can contact the appropriate court, learn the name of the defendant's attorney and get defendant contact information from or attempt to contact the defendant through that attorney. CORI's can also indicate that a Dookhan defendant is on probation. When this occurs, the paralegal can contact the probation officer to obtain the defendant's current contact information.

30. RMV checks can sometimes yield current contact information for individuals who maintain driver's licenses, car

registrations, or official Massachusetts identification cards (and who make timely address change updates).

31. Our paralegal found that he obtained the most valuable defendant contact information through the use of Thompson Reuters' "CLEAR" investigative software. CLEAR searches draw from multiple public and proprietary records, yielding addresses and, in many cases, mobile phone numbers for an individual and, in some cases, for that individual's close relatives.

32. With this information, the paralegal begins the process of attempting to contact a Dookhan defendant. Letters are sent out to what appear to be good, current addresses, phone calls are made, and messages are left.

33. It should go without saying that some of these efforts fail to yield results. Letters are returned as undeliverable. Messages left with family members fail to lead to calls from defendants. The paralegal will attempt alternate means of contacting a Dookhan defendant, drawing from the CLEAR search results, once first attempts have failed.

34. The search process is complicated by the fact that the Dookhan defendant population includes a great many low-income individuals who do not own homes or maintain stable addresses.

35. Still, at a certain point, a judgment to cease efforts must be made once the most current contact information has been obtained and

best efforts have been made to make contact.

36. Once the paralegal makes contact with a Dookhan defendant, he informs that individual that he appears to have a Dookhan-involved drug conviction and that he has the right to pursue vacatur of that conviction. The paralegal also explains that, due to the Bridgeman exposure cap, the Dookhan defendant need not fear that pursuing relief might subject him to additional punishment . The paralegal explains to the Dookhan defendant that, if he is determined to be indigent, he will not have to pay the costs of this post-conviction representation. Finally, the paralegal asks the defendant if he wishes to consult with an attorney.

37. If the Dookhan defendant states that he wants to be advised by counsel, the paralegal assists the defendant in obtaining an indigency determination from the appropriate court, by providing him with a pro se motion, and explains how he can be connected with appointed counsel once determined to be indigent.

38. In his brief tenure with the DLCLU, our paralegal was able to conduct roughly five new searches a day, while simultaneously following up on efforts to make contact with Dookhan defendants for whom he had previously obtained some contact information.

Additional resources required to locate and provide notice to 20,000 Dookhan defendants.

39. Assuming approximately 250 workdays in a year, had CPCS

had the funds to continue his employment, our paralegal would likely have been able to conduct roughly 1,250 searches over a twelve-month period.

40. Given how long Dookhan defendants have had to wait to receive actual notice, let alone relief, we think the pace of notification should increase to the degree that we could reasonably expect to provide actual notice to 20,000 Dookhan defendants within one year.

41. It would take sixteen paralegals working for twelve months to attempt to locate and contact 20,000 identified Dookhan defendants and inform those individuals that their drug convictions are tainted and that they have the right to pursue relief from their convictions.

42. I have been exploring ways in which the location-notification process might be streamlined, such that more searches might be accomplished with fewer paralegals. This would involve contracting out, at a price, computer-based elements of the search process that can be accomplished in batches. At this point, however, I do not know whether any of these approaches are likely to be effective nor whether the costs will be prohibitive.

Conclusion

43. I will close by returning to the problems with the data. If the Commonwealth is unable to remedy the problem of missing Dookhan co-defendants and cannot generate actionable data with respect to more than half of those individuals who have been harmed

as a result of the Hinton lab failure, those unidentified Dookhan defendants will not be told that their convictions are tainted and will remain without true notice and uncounselled as to their rights to seek vacatur of their unconstitutional convictions.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY THIS 9th DAY OF NOVEMBER, 2015.

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COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT
No. SJ-2014-00005

KEVIN BRIDGEMAN ET AL.,

Petitioners,

v.

DISTRICT ATTORNEY FOR THE SUFFOLK DISTRICT ET AL.,

Respondents.

AFFIDAVIT OF CAROLINE S. DONOVAN

I, Caroline S. Donovan, hereby depose and swear as follows:

1. I am an attorney with the law firm of Foley Hoag LLP and counsel for Petitioners Kevin Bridgeman, Yasir Creach, and Miguel Cuevas in the above-captioned matter. I submit this affidavit in support of Petitioners' and Intervener's Request for Briefing and Hearing Concerning Identification and Notification.

2. Attached as Exhibit 1 is a true and correct copy of the *Report of the Texas Forensic Science Commission: Texas Department Of Public Safety, Houston Regional Crime Laboratory, Self-Disclosure* (April 5, 2013), without exhibits, available at http://www.fsc. state.tx.us/documents/FINAL-DPSHoustonReport 041713.pdf.

3. Attached as Exhibit 2 is a true and correct copy of excerpts of the New York State Inspector General's *Investigation*

into the Nassau County Police Department Forensic Evidence Bureau (Nov. 2011), available at http://www.ig.state.ny.us/pdfs/Investigation%20into%20the%20Nassau%20County%20Police%20Department%20Forensic%20Evidence%20Bureau.pdf.

4. Attached as Exhibit 3 is a true and correct copy of a screenshot of the news article *Rice, Mangano Announce Closure of Nassau County Crime Lab*, CBS News (Feb. 18, 2011), available at http://newyork.cbslocal.com/2011/02/18/rice-mangano-announce-closure-of-nassau-county-crime-lab/.

5. Attached as Exhibit 4 is a true and correct copy of a screenshot of the news article *DA Rice Notifies Inmates About Nassau County Crime Lab Problems*, CBS News(Mar. 24, 2011), available at http://newyork.cbslocal.com/2011/03/24/da-rice-notifies-inmates-about-nassau-county-crime-lab-problems/.

6. Attached as Exhibit 5 is a true and correct copy of the Columbia Police Department's *Briefing Notes: Columbia Police Department Drug Laboratory*, available at http://www.columbiasc.net/depts/city-council/docs/2014/council_committees/public_safety/cpd_drug_laboratory_report.pdf.

7. Attached as Exhibit 6 is a true and correct copy of a letter from Solicitor D. Johnson to members of the South Carolina Bar (Aug. 22, 2014), available at http://www.thestate.com/incoming/article13802237.ece/BINARY/Dan%20Johnson%20letter%20to%20the%20SC%20Bar%20about%20the%20Columbia%20PD%20drug%20lab.

8. Attached as Exhibit 7 is a true and correct copy of the press release, *Elevated Methamphetamine Crime Lab Test Found, Fixed* (May 6, 2014), available at https://www.sccgov.org/sites/da/newsroom/newsreleases/Pages/NRA2014/Elevated-Methamphetamine-Crime-Lab-Test-Found,-Fixed.aspx.

9. Attached as Exhibit 8 is a true and correct copy of a screenshot of the new article, *Drug Scandal Hits Medical Examiner's Office*, The News Journal (Feb. 22, 2014), available at http://www.delawareonline.com/story/news/2014/02/21/investigation-reveals-missing-drug-evidence/5703025/.

10. Attached as Exhibit 9 is a true and correct copy of the Delaware Department of Justice and Delaware State Police's *Investigation of Missing Drug Evidence: Preliminary Findings* (June 19, 2014), available at http://www.attorneygeneral.delaware.gov/documents/OCME_Controlled_Substances_Unit_investigation_preliminary_findings.pdf.

Sworn to this 10th day of November, 2015, under the pains and penalties of perjury.

Caroline S. Donovan

EXHIBIT 1

REPORT OF THE

TEXAS FORENSIC SCIENCE COMMISSION

TEXAS DEPARTMENT OF PUBLIC SAFETY HOUSTON REGIONAL CRIME LABORATORY SELF-DISCLOSURE

APRIL 5, 2013

EXHIBIT LIST

Exhibit A	OIG Report
Exhibit B	Texas Rangers Report
Exhibit C	DPS Disclosure
Exhibit D	April Email Alert from Keith Gibson to Law Enforcement & Prosecutors
Exhibit E	Harris Co. DA Letter to Defendants
Exhibit F	Harris Co. Pub. Defender Letter
Exhibit G	Commission Memo to Prosecutors and Judges
Exhibit H	ASCLD-LAB Guiding Principles
Exhibit I	J. Salvador Performance Evaluations
Exhibit J	QAPs re: Salvador Re-Testing Cases

I. BACKGROUND AND STATUTORY AUTHORITY

A. History and Mission of the Texas Forensic Science Commission

In May 2005, the Texas Legislature created the Texas Forensic Science Commission ("TFSC" or "Commission") by passing House Bill 1068 (the "Act"). The Act amended the Code of Criminal Procedure to add Article 38.01, which describes the composition and authority of the TFSC. *See* Act of May 30, 2005, 79th Leg., R.S., ch. 1224, § 1, 2005. The Act took effect on September 1, 2005. *Id.* at § 23.

The Act provides that the TFSC "shall investigate, in a timely manner, any allegation of professional negligence or misconduct that would substantially affect the integrity of the results of a forensic analysis conducted by an accredited laboratory, facility or entity." TEX. CODE CRIM. PROC. art. 38.01 § 4(a)(3). The Act also provides that the TFSC shall develop and implement a reporting system through which accredited laboratories, facilities, or entities may report professional negligence or misconduct, *and* require all laboratories, facilities, or entities that conduct forensic analyses to report professional negligence or misconduct to the Commission. *Id.* at § 4(a)(1)-(2).

The term "forensic analysis" is defined as a medical, chemical, toxicological, ballistic, or other examination or test performed on physical evidence, including DNA evidence, for the purpose of determining the connection of the evidence to a criminal action. *Id.* at art. 38.35(4). The statute excludes certain types of analyses from the "forensic analysis" definition, such as latent fingerprint analysis, a breath test specimen, and the portion of an autopsy conducted by a medical examiner or licensed physician.[1]

[1] For complete list of statutory exclusions, *see* TEX. CODE CRIM. PROC. art. 38.35(a)(4)(A)-(F) & (f).

The statute does not define the terms "professional negligence or misconduct," though the Commission has defined those terms in its policies and procedures. (TFSC Policies & Procedures at 1.2.) The Commission also released guidance for accredited crime laboratories regarding the categories of non-conformances that may require mandatory self-reporting; this guidance is provided with the self-disclosure form located on the Commission's website at http://www.fsc.state.tx.us/documents/LABD.pdf.

The TFSC has nine members—four appointed by the Governor, three by the Lieutenant Governor and two by the Attorney General. *Id.* at art. 38.01 § 3. Seven of the commissioners are scientists and two are attorneys (one prosecutor and one defense attorney). *Id.* The TFSC's presiding officer is designated by the Governor. *Id.* at § 3(c).

The TFSC's policies and procedures set forth the process by which it determines whether to accept a complaint, as well as the process used to conduct an investigation once a complaint is accepted. (*See* TFSC Policies & Procedures at § 3.0, 4.0.) The ultimate result of an investigation is the issuance of a final report.

B. Attorney General Opinion No. GA-0866

On January 28, 2011, the Commission asked Texas Attorney General Greg Abbott to respond to three questions regarding the scope of its jurisdiction under its enabling statute (TEX. CODE CRIM. PROC., art. 38.01). On July 29, 2011, the Attorney General issued the following legal guidance:

1. The TFSC lacks authority to take any action with respect to evidence tested or offered into evidence before September 1, 2005. Though the TFSC has general authority to investigate allegations arising from incidents that occurred prior to September 1, 2005, it is prohibited, in the course of any such investigation, from considering or evaluating evidence that was tested or offered into evidence before that date.

2. The TFSC's investigative authority is limited to laboratories, facilities, or entities that were accredited by the Texas Department of Public Safety ("DPS") at the time the analysis took place.

3. The Commission may investigate a field of forensic science that is neither expressly included nor expressly excluded on DPS' list of accredited forensic disciplines, as long as the forensic field meets the statute's definition of "forensic analysis" (*See* Article 38.35 of the Act) and the other statutory requirements are satisfied.

The Commission's investigation of the Texas Department of Public Safety, Houston Regional Crime Laboratory's ("DPS") self-disclosure falls within its statutory jurisdiction for the following reasons: (1) the negligence or misconduct occurred after the effective date of the Act; (2) DPS is accredited by ASCLD-LAB; and (3) controlled substance analysis is an accredited forensic discipline.

C. Limitations of this Report

No finding contained herein constitutes a comment upon the guilt or innocence of any individual. A final report by the TFSC is not prima facie evidence of the information or findings contained in the report. TEX. CODE CRIM. PROC. art. 38.01 § 4 (e); FSC Policies and Procedures § 4.0 (d). The Commission does not currently have enforcement or rulemaking authority under its statute. The information it receives during the course of any investigation is dependent upon the willingness of concerned parties to submit relevant documents and respond to questions posed. The information gathered has not been subjected to the standards for admission of evidence in a courtroom. For example, no individual testified under oath, was limited by either the Texas or Federal Rules of Evidence (*e.g.,* against the admission of hearsay) or was subjected to formal cross-examination under the supervision of a judge. The primary purpose of this report is to encourage the development of forensic science in Texas.

II. SUMMARY OF KEY FACTS AND DISCLOSURE TIMELINE

A. Key Facts

The facts of this self-disclosure are straightforward. On January 26, 2012, DPS examiner Andrew Gardiner was attempting to diagnose a problem with his gas chromatograph-mass spectrometer ("GCMS") as part of the normal course of his work in the laboratory. (*See* OIG Report at **Exhibit A;** Texas Rangers Report at **Exhibit B, 1.7**). To verify the problem he experienced was not with the sample itself but rather with his instrument, Gardiner attempted to run the sample on examiner Jonathan Salvador's GCMS. *Id.* Salvador was out of the office at the time, assisting the drug section supervisor with routine evidence destruction duties. *Id.* In the process of troubleshooting his instrument, Gardiner determined he should run an alprazolam sample on his own instrument to assess how it would perform. *Id.* Gardiner noticed on Salvador's sequence log that the sample directly above the sample he had just run on Salvador's machine was alprazolam, so he decided to use that vial to run on his machine. *Id.* On the sequence log, the sample was labeled L2H-222396 item 1, and it was in location 18. *Id.* Gardiner attempted to retrieve the vial in location 18, but it was labeled L2H-222403. *Id.* Gardiner's first thought was that Salvador had mistyped the label number or inadvertently swapped the vial's location. *Id.* However, no other location in the tray contained vial L2H-222396, so it was apparent to Gardiner the sample's location had not been switched accidentally. *Id.*

Gardiner then pulled the case folder for L2H-222396 and noticed Salvador had experienced difficulty analyzing a pharmaceutical exhibit that appeared to be a slow-release alprazolam tablet. The mass spectral data for L2H-222396 was insufficient to

report a positive finding, while case file L2H-222403 was complete and needed no further analysis. *Id.* Gardiner then sought input from colleague Haley Yaklin regarding her impression of whether Salvador had used the data from L2H-222403 to support the result for L2H-222396. *Id.* Ms. Yaklin agreed it looked suspicious, and both examiners decided to wait to see if Salvador would correct his own mistake during the review process over the next week. *Id.* On January 30, 2012, Gardiner observed that Salvador completed file L2H-222396 and submitted it for technical review (*See* **Exhibit B**). He also observed the data used to support the results in file L2H-222396 was the same data he saw in file L2H-222403. *Id.* Gardiner reported his concerns to section supervisor Severo Lopez on February 3, 2013, while the case was in administrative review. *Id.*

On February 3, 2012, Lopez pulled the case folder and evidence for L2H-222396 and re-tested the sample himself. He confirmed the evidence from L2H-222396 was in fact alprazolam, but that Salvador had used the evidence from L2H-222403 to generate the data supporting his results in L2H-222396. The report Salvador drafted for L2H-222396 was not issued outside the laboratory, and Lopez removed Salvador from casework immediately. On February 6, 2012, DPS management informed the Texas Rangers and the Office of Inspector General. On February 10, 2012, DPS suspended Salvador. (*See* DPS Disclosure Form at **Exhibit C**.) On July 24, 2012, DPS notified Salvador of the agency's intent to terminate his employment (*See* OIG Report at **Exhibit A**). On August 6, 2012, Salvador resigned from DPS.

B. DPS Management Consults Texas Rangers and Office of Inspector General

On February 6, 2012, DPS management reported the situation to the Texas Rangers and the Office of Inspector General. The Rangers assigned investigators on

February 7, 2012, and began interviewing crime lab management and staff on February 8, 2012.

The purpose of the Texas Rangers' investigation was to determine whether there was evidence of criminal activity by Salvador, and to report their conclusions to the Harris County District Attorney's office. The Rangers reviewed relevant case documents and interviewed Salvador, Gardiner, Yaklin, Lopez and Keith Gibson, the director and quality manager of the laboratory. (*See* **Exhibit B**.) The Rangers observed that Salvador was defensive throughout their interview and was "unable to provide a consistent, plausible reason explaining why or how the evidence from file L2H-222403 ended up being used to generate the results report which was submitted for file L2H-222396." (*See* **Exhibit B**.) Though Salvador "conceded he might have made a mistake," he denied that he engaged in any intentional wrongdoing. *Id.*

The Rangers reported their findings to the Harris County District Attorney's office. On May 5, 2012, the Harris County District Attorney's office presented the case to a Harris County grand jury. (*See* **Exhibit B**.) The grand jury returned a no-bill, and the Rangers closed their file on September 12, 2012. *Id.*

The DPS Office of Inspector General ("OIG") interviewed crime lab management and staff in April 2012, after the Rangers completed their investigation. (*See* **Exhibit A**.) The OIG's investigation was internal to DPS and administrative in nature. *Id.* OIG investigators reviewed relevant documents and interviewed Salvador, Gardiner, Yaklin, Lopez and Gibson. *Id.* The investigators concluded the following:

> The evidence supports that on Thursday, 01-26-2012, at approximately 8:55 a.m., while performing his duty as a forensic scientist, Jonathan Salvador improperly acted with total disregard for policy and procedure by testing sample L2H-222403 and recording those results for sample L2H-222396. *Id.*

Both the OIG and Texas Ranger investigations focused narrowly on alleged wrongdoing by Salvador during the alprazolam incident. As discussed below, the Commission's investigation incorporated the work of the Rangers and OIG without duplicating efforts. Because conclusions regarding the specific incident were clear, the Commission focused its investigation on the circumstances and environment in the laboratory leading to the incident; lessons learned from the incident; and recommendations for DPS and other laboratories going forward. The Commission's work is intended to benefit Texas crime laboratories that may face similar circumstances, and also to educate the criminal justice system regarding challenges faced in cases involving high volume disciplines such as controlled substance.

III. COLLABORATIVE EFFORTS TO PROVIDE NOTICE TO AFFECTED DEFENDANTS AND MEMBERS OF CRIMINAL JUSTICE SYSTEM

A. Step One: DPS Notice to TFSC, ASCLD-LAB, Prosecutors and Submitting Law Enforcement Agencies

On February 21, 2012, DPS management alerted the Commission, ASCLD-LAB, prosecuting attorneys and submitting law enforcement agencies about the alprazolam incident (*See* **Exhibit C**). The email communication advised affected parties that all evidence worked by Salvador in the previous 90 days would be re-analyzed. *Id.* On April 26, 2012, DPS management emailed a second notice to the agencies explaining that two additional errors were discovered in Salvador's work during the review of 148 cases constituting 90 days of work. (*See* **Exhibit D**.) DPS also identified 4,944 total drug cases by county (equaling 9,462 pieces of evidence) worked by Salvador during his employment from 2006-2012, and advised law enforcement and prosecutors they could request re-analysis of any case in which the evidence has not yet been destroyed. *Id.* On

June 30, 2012, DPS submitted a follow-up written disclosure to the Commission, including the results of re-testing conducted. (*See* **Exhibit C**.)

The Commission contacted submitting law enforcement agencies in an attempt to estimate the percentage of the 4,944 total cases for which evidence was destroyed as part of the normal course. Evidence submitted by DPS officers constituted a total of 1,978 cases, and only 21 of those cases were destroyed. Though the Commission did not receive answers from all agencies, staff estimate that between 50-75% of the evidence is available for re-testing, including evidence submitted by DPS officers.

On April 27, 2012, immediately after DPS released the re-testing results, the Texas District and County Attorneys' Association ("TDCAA") posted a notice on its website advising affected members of a suggested protocol for alerting stakeholders, including: (1) notifying the courts of the issue; (2) notifying the local criminal defense bar; (3) pulling all of the cases on the list provided by DPS and checking the disposition for convictions; (4) locating the evidence, and if it still exists, submitting it for retesting (DPS or local departments); and (5) for any case where re-testing yielded inconsistent results (or cases with now-destroyed evidence) requesting that the court appoint an attorney to take the case through a writ process if appropriate.

B. Step Two: Notice to Defendants

1. Counties Affected

Salvador performed casework for 36 Texas counties during his employment, including: Angelina; Austin; Brazoria; Brazos; Burleson; Chambers; Colorado; Fort Bend; Galveston; Grimes; Hardin; Harris; Hidalgo; Houston; Jackson; Jasper; Jefferson; Leon; Liberty; Madison; Matagorda; Montgomery; Nacogdoches; Newton; Orange; Polk;

Sabine; San Augustine; San Jacinto; Shelby; Trinity; Tyler; Walker; Waller; Washington; and Wharton.

The following table divides the counties into tiers by volume of cases. Commission staff tabulated the total number of cases using DPS case identification numbers. The vast majority of Salvador casework is concentrated in 23 counties. The numbers represent all cases worked by Salvador, including *both* felonies *and* misdemeanors. The table also includes cases with a wide range of dispositions, including but not limited to dismissals, plea agreements and jury convictions.

TIER	**COUNTIES BY TIER**
ONE: > 250 cases	**5 Counties:** Fort Bend, Galveston, Harris, Liberty, Montgomery
TWO: 101-250 cases	**10 Counties**: Brazoria, Chambers, Grimes, Hardin, Jasper, Matagorda, Polk, Walker, Waller, Wharton
THREE: 10-100 cases	**8 Counties:** Austin, Jefferson, Newton, Orange, San Jacinto, Trinity, Tyler, Washington
FOUR: < 10 cases	**13 Counties:** Angelina, Brazos, Burleson, Colorado, Hidalgo, Houston, Jackson, Leon, Madison, Nacogdoches, Sabine, San Augustine, Shelby

2. Responses of Harris, Galveston and Montgomery

The top three counties affected (by volume of cases) are Montgomery (1,287), Galveston (849), and Harris (327), in that order. In Harris County, the District Attorney sent letters to potentially affected defendants (*See* **Exhibit E**) informing them of the non-conformance and referring them to the Harris County Public Defender's Office, which

will handle requests for re-testing and initiate the writ process where appropriate. The Harris County Public Defender then sent a letter to each defendant (*See* **Exhibit F**) alerting him or her that the office is available to assist with re-testing requests and related court filings.

The Montgomery County District Attorney has taken the position that all cases for which evidence still exists shall be re-tested by DPS. The District Attorney's office also sent notice to the last known address of each potentially affected defendant and/or defense counsel. In addition, the District Attorney suggested the most prudent course would be for the county to appoint specific counsel for the purpose of handling writs for affected cases. Since that time, Montgomery County has been working with DPS to achieve re-testing using a systematic approach that prioritizes cases in which defendants are serving or have served jail time.

In Galveston County, the District Attorney sent letters to potentially affected defendants. The Galveston County courts also appointed specific defense counsel to assist defendants with the writ process. The Galveston County District Attorney has adopted a general policy to dismiss charges in cases where no evidence is left to test or where evidence was ever left in Salvador's custody.

At its October 2012 meeting, the Commission concluded the policies established by the three most affected counties, while not identical, were all reasonable methods of ensuring defendants are: (1) notified of the issue in the crime lab; and (2) given access to designated counsel for assistance with re-testing and/or the writ-filing process. However, Commissioners were concerned the notice process may not be equally robust in the other 33 counties affected. Because courts, prosecutors and defendants in smaller counties may

not have access to the same resources as Montgomery, Galveston and Harris Counties, the Commission instructed its staff to work with TDCAA, the Texas Criminal Defense Lawyers' Association ("TCDLA"), the Texas Commission on Indigent Defense and the Innocence Project of Texas ("IPOT"), to determine whether a notice protocol could be offered to ensure affected defendants in smaller counties have the same notice and access to counsel as defendants in larger counties. Commissioners determined such a protocol could be used as a model in future cases involving high volume forensic analyses, such as in the controlled substance discipline.

On November 14, 2012, Investigative Panel Chair Dr. Sarah Kerrigan and the Commission's General Counsel held a conference call with representatives from the Texas Commission on Indigent Defense, the Harris County Public Defenders' Office, and IPOT. The group agreed to the following approach during the call:

1. Harris, Montgomery and Galveston Counties have notice methods in place already, using the Harris County Public Defender's Office as a contact point for Harris County defendants and court-appointed counsel in Montgomery and Galveston Counties for defendants in those counties. Those three counties should continue to implement their approaches as discussed.

2. For the remaining counties, IPOT will serve as the point of contact for assisting defendants with re-testing requests and the related writ-filing process as necessary. Because IPOT has extensive experience with high volume case screening, they are well positioned to review cases and work with courts and prosecutors in the various counties affected.

3. The Commission will request the list of affected defendants from DPS so that IPOT may send letters similar to the Harris County Public Defender's letter.

4. Using Harris County as a model, the Commission will put together a model notice letter and distribute it to affected prosecutors (*See* **Exhibit G**.)

5. The Commission on Indigent Defense will discuss the model notice with the judge responsible for the affected administrative region and ask for his support in distributing the notice to other affected judges.

6. IPOT will inform the Texas State Bar Committee on Indigent Defense and the Governor's Office regarding the collaborative process envisioned and seek their feedback. The Commission will seek similar input from DPS.

On November 16, 2012, the Commission's General Counsel met with TDCAA's Director of Government Relations, who agreed to assist with review of the model notice and distribution to TDCAA's affected members. The issue was also discussed during TDCAA's December 2012 conference for elected district and county attorneys. TDCAA canvassed its members to determine whether any additional information or assistance would be helpful, and provided updated contact information to the TFSC for counties in which prosecutor turnover occurred as a result of the November 2012 election.

On December 3, 2012, the Commission distributed the model notice to prosecutors and responded to emails and follow-up questions. On December 17, 2012, the Commission on Indigent Defense briefed the regional presiding judges on the non-conformance and the model notice. The regional presiding judges agreed to forward the memo describing the incident and the model notice to the judges in each of the affected counties in their region.

On January 18, 2013, DPS provided the list of defendants to the Commission for distribution to IPOT. IPOT is currently in the process of contacting affected defendants in the 33 counties outside of Harris, Galveston and Montgomery. To facilitate this process, IPOT developed a partnership with TCDLA to request volunteer attorneys who accept court appointments and will represent defendants in smaller counties. Assistance from TCDLA is critical in light of the resource limitations and lack of uniformity among

the 33 counties. In addition, IPOT prepared standardized notice and pleading documents to assist volunteer attorneys. IPOT is also tracking data on the number of defendants in each county who have been contacted by either IPOT or a volunteer attorney. IPOT will submit this data to the Commission at the end of the notification process.

IV. TFSC INVESTIGATION

A. Statutory Requirement for Written Report

An investigation under the TFSC's enabling statute "must include the preparation of a written report that identifies and also describes the methods and procedures used to identify: (A) the alleged negligence or misconduct; (B) whether the negligence or misconduct occurred; and (C) any corrective action required of the laboratory, facility, or entity." *Id.* at 4(a)(3)(b)(1). A TFSC investigation may include one or more: (A) retrospective reexaminations of other forensic analyses conducted by the laboratory, facility, or entity that may involve the same kind of negligence or misconduct; and (B) follow-up evaluations of the laboratory, facility, or entity to review: (i) the implementation of any corrective action required . . . . ; or (ii) the conclusion of any retrospective reexamination under paragraph (A). *Id.* at 4(a)(3)(b)(2).

B. TFSC Review Process

On July 27, 2012, the Commission voted to elect a three-member investigative panel to review the DPS disclosure. Panel members include: Dr. Sarah Kerrigan (Chair), Dr. Nizam Peerwani, and Atty. Bobby Lerma. Commission staff reviewed thousands of pages of documents and audio/video material submitted by DPS over the course of the investigation and made those documents available to Commissioners for review. Panel members also held non-deliberative conference calls on December 20, 2012 and January 17, 2013, to assess whether sufficient documentary evidence had been gathered to allow

Commissioners to conduct substantive deliberations, and instructed staff regarding requests for additional information. Dr. Kerrigan and Commission staff visited the DPS Houston Regional Crime Laboratory on January 8, 2013, at which time they conducted interviews of Gardiner, Yaklin, Lopez, and Gibson. Dr. Kerrigan and staff also met with D. Pat Johnson, DPS Deputy Assistant Director of Law Enforcement Support, Crime Laboratory Service. General Counsel Lynn Garcia contacted Salvador and his attorney, informed them of the Commission's deliberative process and the timing of this report, and provided contact information and an opportunity to speak with the Commission at any time leading to the release of this report. The Commission has not been contacted by either party.

On October 5, 2012, Dr. Kerrigan and the investigative panel provided an update regarding the status of the investigation to the full Commission. On January 25, 2013, the full Commission deliberated regarding the contents of this report, voted to issue a finding of professional misconduct against Salvador, and instructed staff regarding the contents and recommendations to be provided in this report. The Commission's findings are reflected below.

C. Observations

1. Crime Laboratory Transparency and Cooperation

The Commission commends DPS for its transparency in disclosing the issues described to the Commission, ASCLD-LAB, law enforcement and other stakeholders. The panel was particularly impressed by the honest and forthcoming nature of discussions with staff and management during the site visit. It is clear this incident affected the examiners and management at DPS in a profound way. Despite being

chronically understaffed, management worked hard to provide the Commission with follow-up information and additional data when requested.

2. Ethical Standards of Forensic Scientists

The act of using evidence in one case to support the results issued in another case is one of the most serious ethical violations that can occur in a crime laboratory. As set forth in ASCLD-LAB's *Guiding Principles of Professional Responsibility for Crime Laboratories and Forensic Scientists,* forensic scientists are obligated to conduct full and fair examinations. Conclusions must be based on "the evidence and reference material relevant to the evidence, not on extraneous information, political pressure, or other outside influences." (*See* **Exhibit H**.) In addition, forensic scientists must "honestly communicate with all parties (the investigator, prosecutor, defense and other expert witnesses) about all information relating to their analyses, when communications are permitted by law and agency practice." *Id.*

The specific incident involving the alprazolam analysis in case #L2H-222396 was investigated thoroughly by the Rangers and OIG, and nothing in the record provides an alternative explanation for Salvador's actions. Fortunately, DPS performs technical review on 100% of the controlled substance casework prior to administrative review and release to the submitting agency. This review ensures that results meet the reporting criteria and standards set by DPS. However, the misrepresentation of the data would not be identified during the technical review process. During interviews with the Rangers, it was clear Salvador struggled to maintain acceptable performance. It was well-recognized by those performing technical reviews, and his supervisor, that his work was frequently returned for administrative and technical corrections. Therefore, the Commission

decided it was more important to focus on the circumstances and environment in the laboratory leading up to the violation itself. The Commission's inquiry included a review of Salvador's performance over his six years at DPS. The Commission focused on identifying systemic issues that may have allowed the incident to occur so that improvements may be made to protect against future recurrence.

3. Low Case Output

Salvador's performance evaluations show he had difficulty maintaining adequate case output throughout the course of his employment. (*See* **Exhibit I.**) In his evaluations, drug section supervisor Severo Lopez noted a "lower case output than expected" for multiple years. Though DPS does not have a quota requirement, most examiners in the drug section are expected to complete between 85-100 cases per month, absent extraordinary circumstances. Salvador often had difficulty meeting the minimum expectation. He often "scrambled" toward the end of the month and was frequently concerned about whether he would meet expectations.

4. High Correction Rate

In addition to problems analyzing a sufficient number of cases per month, Salvador had problems with too many corrections. His evaluations stated that "more than 1 in 3 of Salvador's case folders were returned for corrections." *Id.* Most of the corrections were administrative in nature, but some technical corrections were noted as well. Salvador's evaluations also indicated that he should "pay careful attention to details especially when encountering difficult or unusual samples." *Id.* The evaluations further stated that he should "carefully explore and determine possible causes for negative results before reaching a conclusion of negative." *Id.* The evaluations instructed Salvador to

"avoid short cuts" and "strive to minimize clerical and technical errors on reports to less than 10% returned for correction." *Id.*

Meetings with examiners further supported the conclusion that Salvador struggled with corrections and an overall understanding of the chemistry, especially in difficult cases. One examiner who performed a large percentage of the technical reviews on Salvador's cases observed that he "just made so many mistakes." While most of the mistakes were administrative, a few were technical. Examiners were consistent in their view that Salvador was very friendly and helpful, just not the right type of person for the job. More than one examiner shared concerns about Salvador's high error rate and lack of understanding of the chemistry with the drug section supervisor.

In retrospect, examiners and management observed that Salvador might have been afraid to ask for help with the alprazolam analysis in case #L2H-222396, because he had been spoken to about two other analysis-related problems in the months before the alprazolam case. One involved the contamination of his instrument by tadalafil and another involved his failure to positively identify hydrocodone. There was a perception that Salvador simply "could not afford" to have another mistake, such as the failure to positively identify the alprazolam in L2H-222396.

Interviews with management further support the conclusion that the quality of Salvador's work was not optimal. Issues with Salvador's work were described as "very systemic." At one point, the laboratory director maintained an error log to monitor the number of cases returned for correction per examiner. The log revealed that Salvador's work was sent back for correction in more than 1 in 3 cases. Management tried to work with Salvador, conducting remedial training and providing coaching and counseling.

Salvador was very accepting of the criticism, and always corrected issues immediately and vowed to do better. When asked whether the quality of Salvador's work was acceptable under DPS standards, management described the quality of Salvador's work as "right on the edge" of acceptability.

Salvador's high error rate caused the drug section supervisor concern, which he shared with the laboratory director. The laboratory relied on the review process—both technical and administrative review—to provide a safety net for Salvador's work product. The drug section supervisor described his attempts at "compassion" toward Salvador because despite his limitations, Salvador's attitude was always positive, he accepted redirection, and was a valuable member of the laboratory—often volunteering for routine tasks and duties that other examiners preferred to avoid. It was clear management made good-faith efforts to help Salvador improve, and were completely shocked that Salvador would ever use evidence from one case to support the results in another.

When asked why Salvador's written evaluations do not appear to fully capture the concerns about Salvador shared by employees and management, management explained they tried to note the concerns in the written section of the evaluation, but conceded the evaluations may have been "too polite." When asked why he received "meets expectations" in the vast majority of the categories, the drug section supervisor explained that Salvador was always "on the line" between "meets expectations" and "needs improvement." The laboratory manager also explained that he and the section supervisor struggled in deciding which of the two categories was appropriate. When asked why Salvador was promoted despite the concerns regarding his lack of attention to detail and understanding of the chemistry, the section supervisor indicated that promotions at DPS

are standard based on years of service, and he did not feel it was appropriate to deny a promotion unless the person was totally inept, which Salvador was not. There was also a perception that forensic scientists at DPS are paid below their peers in the field, and thus they try not to deny people salary increases. The lab manager explained that in running a laboratory, management recognizes that "everyone has their strengths and weaknesses," and the issues raised about Salvador's work were never anything "catastrophic" until the incident with the alprazolam.

5. Salvador's Value in Other Areas of Laboratory Work

As indicated above, there was consensus among management and examiners that Salvador was a major asset in the laboratory when it came to volunteering for difficult jobs that no one wanted to do. He was friendly and easy to work with, accepted criticism and direction well, and assisted during difficult projects such as when the laboratory moved buildings in 2011. Salvador's easygoing and collegial demeanor contributed to management's reluctance to more aggressively discipline or dismiss him before the alprazolam incident. Because he accepted criticism well, management tried very hard to work with him by providing verbal counseling and remedial on-the-job training.

6. Perceptions Regarding Discipline

Until recently, there was a perception in the laboratory (among both examiners and management) that it was extremely difficult to discipline or terminate an employee within the DPS system. During Director McCraw's tenure, greater efforts have been made to re-vamp the evaluation system and roll out new evaluation procedures. Management will begin using a new evaluation form in the next evaluation cycle, beginning at the end of 2013. In addition, DPS top management has reminded all

laboratory managers and section supervisors—both verbally and in writing—of their obligation to accurately report employee performance on evaluations, and to use the various disciplinary tools and forms available.

7. Laboratory Staffing Challenges

During on-site interviews in January, the Commission observed that examiners displayed competence, diligence and great concern for the integrity and reliability of the work performed in the laboratory. While the Commission was impressed with the quality of the current examiners, the DPS Houston regional laboratory is operating under tremendous budgetary strain. Though the laboratory has new examiners in training for drug analysis, the drug chemistry section had only three people actively performing full-time casework during the Commission's on-site visit in January 2013. Two of the section's most experienced examiners were not working controlled substance cases at the time of the visit because they were being cross-trained to perform blood-alcohol analysis to alleviate the tremendous backlog in that area. As of April 5, 2013, the laboratory has an additional two examiners who just completed training and are performing supervised casework, while one additional examiner still in training. The under-resourcing of the crime lab has also impacted management's staffing decisions. Terminating an employee means hiring and training a replacement, which takes many months and is difficult to bear when the laboratory is already understaffed.

D. Negligence/Misconduct Finding

While the terms "professional negligence" and "professional misconduct" are not defined in the Commission's enabling statute, the Commission has defined these terms in its policies and procedures, as follows:

> "Professional Misconduct" means, after considering all of the circumstances from the actor's standpoint, the actor, through a material act or omission, deliberately failed to follow the standard of practice generally accepted at the time of the forensic analysis that an ordinary forensic professional or entity would have exercised, and the deliberate act or omission substantially affected the integrity of the results of a forensic analysis. An act or omission was deliberate if the actor was aware of and consciously disregarded an accepted standard of practice required for a forensic analysis." (TFSC Policies & Procedures at 1.2.)

> "Professional Negligence" means, after considering all of the circumstances from the actor's standpoint, the actor, through a material act or omission, negligently failed to follow the standard of practice generally accepted at the time of the forensic analysis that an ordinary forensic professional or entity would have exercised, and the negligent act or omission substantially affected the integrity of the results of a forensic analysis. An act or omission was negligent if the actor should have been but was not aware of an accepted standard of practice required for a forensic analysis." (TFSC Policies & Procedures at 1.2.)

At its January 25, 2013 meeting, the Commission voted unanimously that Salvador's actions in this case constituted "professional misconduct" as defined in the Commission's policies and procedures. This conclusion was based on the following analysis: (1) by using the evidence in case #L2H-222403 to support the results issued in case #L2H-222396, Salvador failed to follow the standard of practice generally accepted at the time, both as expressed in DPS policies and procedures and in the ASCLD-LAB Guiding Principles of Professional Responsibility (*See* **Exhibit A**, **Exhibit H**); (2) the report generated by Salvador for case #L2H-222396 substantially affected the integrity of the results of the forensic analysis because it was based on evidence from case #L2H-

222403, thereby requiring the laboratory to re-analyze the evidence and re-issue a report. Though the re-analysis confirmed the initial scientific findings reported by Salvador, the results were based upon accurate supporting data from the case in question.

Salvador fraudulently misrepresented data after attempting analysis on a pharmaceutical drug exhibit. However, during the course of the Commission's investigation, there was no evidence to suggest that there were property control issues of a systemic nature that might preclude future re-testing of evidence.

E. Results of DPS Re-Testing to Date

Re-analysis of Salvador's casework during the 90-day period surrounding the incident resulted in four additional corrective actions, referred to by DPS as "Quality Action Plans" (QAPs). Following is a description of each QAP:

1. One exhibit containing two packets of powder, visibly different in color. Salvador reported that both contained Cocaine-HCl. Upon retesting, one contained Cocaine-HCl, and one contained Cocaine base (crack). Salvador had conducted the FTIR confirmation test on only the Cocaine-HCl item.

2. Smoking pipe exhibit. Salvador reported contained Tetrahydrocannabinol. Upon retest, 0.46 gram of Marihuana was scraped from the pipe bowl.

3. One completed item of evidence discovered unsealed in Salvador's work station.

4. Plant material identified as Marihuana despite only a faint color test; re-analysis indicated it was not Marihuana.

In addition, examiners who reviewed the cases during the 90-day period described "poor documentation, poor technique and poor decision-making" by Salvador. In the months since the initial 90-day re-analysis was performed, examiners have re-analyzed 440 additional cases. The laboratory also has 155 requests for re-testing pending as of April 5, 2013. The re-analysis of the 440 cases resulted in the following QAPs:

1. Weight of Cocaine exhibit reported by Salvador as 8.06 kg. Upon retest, the weight was corrected to 6.95 kg. The incorrectly reported weight was attributable to a math error, not a weighing error or a loss of weight.

2. Failure to properly identify mushrooms which contained psilocin, likely due to incorrect extraction method or insufficient sample.

3. Weight on a Cocaine exhibit incorrectly reported by Salvador as 33 gm. Upon retest, it was reported as 0.33 gm. This was not a weighing error, but a data entry error on the lab report.

The attached QAPs correspond to the cases cited above. (*See* **Exhibit J**.) The Commission will release an addendum to this report reflecting any additional QAPs when all re-analysis is completed.

V. APPELLATE COURT DECISIONS IN SALVADOR CASES

The Texas Court of Criminal Appeals has begun hearing applications for writs of habeas corpus in cases where Salvador analyzed the evidence. The Court releases its decisions on a weekly basis. Decisions may be accessed by clicking on the "Hand Down List" tab on the Court's website at http://www.cca.courts.state.tx.us. As of this writing, all published decisions have involved cases from Galveston County, though the Commission anticipates cases from other counties will follow in the near future. To date, the Court has overturned convictions *both* in cases where the evidence was destroyed *and* in cases where there is still evidence remaining to re-test. The Court reasoned that because the evidence was in Salvador's custody, ". . . custody was compromised, resulting in a due process violation." (*See e.g.*, *Ex Parte Sereal*, No. 76,972 (Tex. Crim. App. 2013), *Ex Parte Hobbs*, No. AP-76,980 (Tex. Crim. App. 2013).)

The potential impact of these decisions on convictions obtained in Salvador cases is difficult to overstate. Though it is too early to tell whether every conviction for which a writ application is filed will be overturned, these decisions emphasize the absolutely

critical role played by forensic scientists in the criminal justice system. It is imperative that Texas crime laboratories use this experience as a tool for improving quality standards, especially with respect to identifying red flags in employee performance. As this case so powerfully demonstrates, the safety and security of our communities often depend upon the integrity and reliability of the work performed in our state's crime laboratories.

VI. LESSONS LEARNED AND RECOMMENDATIONS

The Commission makes the following recommendations:

1. Texas crime laboratories should develop methods to reduce the likelihood of ethical violations. For example, laboratories should re-examine evidence at random (where possible) to ensure reported results are consistent, and to discourage examiners from taking short-cuts, even when there are severe backlogs.

2. Texas crime laboratories should ensure their evaluation systems effectively reflect staff performance. Evaluations containing consistent questions about an examiner's understanding of analytical processes, attention to detail, or tendency to take "short cuts" demand special attention.

3. Texas crime laboratories should review their hiring systems to flag issues early during the probation period. If current recruiting and probation programs are ineffective, management should initiate appropriate changes to strengthen them.

4. Laboratory management should be cautious not to allow an examiner's positive and collegial demeanor to mask inadequate or marginal performance. Though "compassion" is an admirable quality in many circumstances, the potential impact of a major non-conformance is simply too great to justify or minimize signs of underperformance in a crime laboratory.

5. Consequences of examiner underperformance should be clear and consistent. Government bureaucracy should not impede laboratory management's ability to make key hiring and termination decisions. Moreover, laboratory supervisors and managers, who are ultimately responsible for the performance of their employees, should have effective means to recommend changes in employment scope or status where necessary.

6. DPS should continue to provide re-analysis results for Salvador cases to the Commission. The Commission will publish final results in an addendum to this report.

7. Limited resources and the lack of centralization of legal representation pose a number of challenges regarding notification practices. In high volume cases where notice to defendants is particularly challenging, stakeholders in the criminal justice community should use the example set in this case, and work together to provide a common sense approach to notice. Such an approach should ensure actual notice is given to defendants to the extent possible, and that defendants are given a resource to consult regarding applicable legal remedies.

8. As the Commission gains more experience with crime laboratory self-disclosures and complaints, issues may emerge that were not anticipated, and for which no other agency appears to be in a position to coordinate a response. A glaring example in this case is the need to facilitate a uniform approach to communication with prosecutors and notice to defendants, especially considering: (a) numerous counties with disparate resources have been affected; (b) large volumes of evidence have been brought into question; and (c) many defendants are indigent with limited access to legal representation. Statewide policymakers and members of the Legislature should consider these issues when crafting future policies affecting the criminal justice system.

9. All laboratories should follow DPS's example by taking a proactive approach to disclosure, including but not limited to reporting facts that may rise to the level of negligence or misconduct.

10. The Texas Forensic Science Commission should sponsor a crime laboratory management training program for all publicly funded Texas laboratories addressing such issues as interviewing and selecting quality examiners, succession planning, leadership development, and performance management.

11. The Texas Legislature should adequately fund crime laboratories to support high quality examiners and reduce the impact of financial pressures on management decisions related to the hiring and termination of staff.

EXHIBIT 2

State of New York
Office of the Inspector General

Investigation into the Nassau County Police Department Forensic Evidence Bureau

November 2011

Ellen N. Biben
State Inspector General

State of New York
Office of the Inspector General

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I. SUMMARY OF INVESTIGATION

On February 18, 2011, the Nassau County Police Department Forensic Evidence Bureau (FEB), a forensic laboratory, was closed due to grave concerns about the integrity of testing being performed at the lab. This closure followed a series of public reports about problems at the laboratory, including the fact that the American Society of Crime Laboratory Directors/Laboratory Accreditation Board (ASCLD/LAB) had placed the lab on probation on December 3, 2010, on the heels of a scathing inspection report. This was the FEB's second ASCLD/LAB probation in four years – a dubious distinction making it the only forensic laboratory in the state to have been subject to such a sanction once, let alone twice.

Weeks before the FEB's closure, information surfaced that the lab had engaged in flawed analyses in testing for MDMA, the illegal substance commonly known as "Ecstasy," and that this information affected criminal cases prosecuted by the Nassau County District Attorney's Office. Questions immediately arose as to the extent of the problems at the lab and whether these problems impacted the integrity of other lab results.

In response to these questions and to protect the public's confidence in the criminal justice system, on February 25, 2011, Governor Andrew M. Cuomo issued Executive Order No. 9, which directed the Inspector General to investigate "the oversight and operation of the Forensic Evidence Bureau." Pursuant to this Executive Order, the Inspector General conducted an investigation, which included a comprehensive examination of the FEB's history and operation, as well as the regulatory requirements

and systems to which it was subject. The following report documents the findings and recommendations of the Inspector General's investigation.[1]

Forensic laboratories test different types of evidence and the findings are often used in the investigation, prosecution and defense of criminal cases. Forensic testing is an essential and reliable tool in the criminal justice system, facilitating the just and fair resolution of cases: as has been demonstrated repeatedly, forensic evidence can be as valuable to incriminate as it can be to exonerate a criminal defendant. Given these significant implications, the public deserves to have unshakable confidence in the integrity of forensic testing, an objective which demands the careful monitoring of forensic laboratories to ensure the reliability of their results.

To that end, New York was at the forefront of monitoring forensic testing, when, in 1994, it became the first state to create a commission to oversee all forensic laboratories within the state, the New York State Commission on Forensic Science (Forensic Commission). Executive Law § 995-a created the Forensic Commission, a 14-member board empowered with, among other things, "develop[ing] minimum standards and a program of accreditation for all forensic laboratories in New York State." Pursuant to this legislative mandate, the Forensic Commission requires that all forensic laboratories in New York State be accredited by a private accrediting agency, ASCLD/LAB.[2] Currently, the Forensic Commission oversees 22 forensic laboratories in New York State.

[1] Attached to this report as appendices are a timeline of relevant events in the history of the FEB accreditation process, and the text of Executive Law §995.

[2] The Forensic Commission permits a laboratory that is performing only toxicology analysis to be accredited by either ASCLD/LAB or the American Board of Forensic Toxicology, Inc. (ABFT).

The FEB, prior to its closure was one of the laboratories subject to Forensic Commission oversight. Since its formation in 2003, the FEB was housed within and operated by the Nassau County Police Department and provided forensic evidence for prosecutorial agencies within Nassau County. From the beginning, however, the FEB struggled to maintain the requirements necessary for its accreditation. In every one of its mandatory inspections, ASCLD/LAB cited the FEB for an exceedingly high number of problems ranging from smaller technical issues to more significant ones, such as the absence of an effective quality assurance system. As a result, from 2006-2010, the FEB was twice placed on probation by ASCLD/LAB.

The FEB was purportedly subject to multiple layers of oversight including laboratory management, the Nassau County Police Department, the County Executive's Office, and the Forensic Commission. The investigation revealed, however, that the FEB was plagued with significant and pervasive problems that were allowed to persist due to failures at each level of this oversight.

The failure at the laboratory level was profound. Over its eight-year history, the FEB suffered from weak leadership, a dysfunctional quality management system, analysts with inconsistent training and qualifications, and outdated and incomplete testing procedures. As a result, the laboratory operated absent the rigors and precision necessary in scientific testing, which created an environment where mistakes were more likely to occur and less likely to be detected. Not surprisingly, testing mistakes did in fact occur. Specifically, recent retesting of certain drug chemistry analyses by FEB has not yet been completed, but preliminary results indicate that more than 10 percent of the laboratory's drug chemistry results had some inconsistencies in testing that should have been detected

by lab personnel. Notably, some of the issues identified thus far affect charges in criminal cases, a pattern that is, unfortunately, likely to continue. Overall, the Inspector General found problems at the lab that not only affected the drug chemistry section but also had the potential to affect every other discipline in the laboratory. Consequently and in the exercise of caution, the Inspector General has recommended a broader review of testing results to include every discipline at the lab to ensure the reliability of the FEB's conclusions. Any testing issues that affect individual criminal cases have been and continue to be handled by the Nassau County District Attorney's Office within the criminal justice system.

The FEB's problems were exacerbated by failures on the part of the Nassau County Police Department, within which the FEB operated. The Police Department should have been, but was not, appropriately attentive to the FEB. While the Inspector General determined that important information about the FEB was minimized as it was reported up the chain of the Police Department hierarchy, when Police Department leadership did learn of the numerous unfavorable accreditation reports, they took little if any action with respect to the issues raised in the reports. Furthermore, the Police Department did not communicate the results of the unfavorable inspections or the probationary status to either the Nassau County District Attorney's Office or the County Executive, as it should have.

These failures continued up through the County level. The County Executive's Office had supervisory authority over the Police Department as well as the three Nassau County labs, of which FEB was one. However, Thomas Suozzi, the County Executive for the relevant period, deferred the oversight of and responsibility for the FEB to the

Police Department because the County Executive viewed the FEB as merely a small part of the larger police organization. In this way, the County Executive rendered his office entirely dependent on the Police Department for information about the County's forensic crime laboratory. This dependence proved to be unreliable and, as a result, the County Executive was not appropriately informed about significant lab issues, including the unfavorable inspection reports or the FEB's probation in 2006.

While not charged with the oversight of the FEB, the Nassau County District Attorney – who often predicated criminal charges on FEB's testing – was similarly uninformed about the lab's problems. In January 2006, District Attorney Kathleen Rice succeeded Denis Dillon as District Attorney, and she was reelected to that office in November 2009. During her tenure, the FEB continued to have problems, including being placed on probation by ASCLD/LAB in August 2006. However, District Attorney Rice did not learn of any of these problems until December 2010, after she received an unofficial call from a Forensic Commission member informing her of a scathing ASCLD/LAB inspection report and the resulting probation of her County forensic laboratory. Until December 2010, according to her own testimony, District Attorney Rice was unaware of problems at the lab, the accreditation process, or the existence of the Forensic Commission. Up to that point, she and her office took for granted the reliability of the evidence provided by the FEB – a confidence that, in this instance, was misplaced.

The Inspector General notes, however, that when current County Executive Edward Mangano, who assumed office in January 2010, and District Attorney Rice were made aware of the problems at the laboratory, they responded appropriately and closed the FEB. In addition, the County Executive, the District Attorney's office and the Police

Department have been properly attentive to the ongoing retesting effort; and, plans for a new civilian state-of-the-art forensic laboratory proposed by County Executive Mangano and endorsed by District Attorney Rice and the Police Department are in development.

Finally, oversight at the state level failed to identify and effectively address the magnitude of the FEB's problems, as it should have. The Forensic Commission, and by extension its administrative arm – the Office of Forensic Services – within the Division of Criminal Justice Services, has broad authority and discretion in the oversight of forensic laboratories. However, the Forensic Commission disregarded its mandate by failing to provide the FEB the assistance and monitoring it desperately needed. In particular, the Forensic Commission failed to impose its own sanctions once it learned that the FEB was placed on probation in 2006 by ASCLD/LAB; it neglected to conduct its own inquiry into the reasons for the probation, or even take the minimal step of notifying County Officials of the lab's continued precarious status. Moreover, although the Forensic Commission possesses the authority to set forth requirements specifically tailored to promote uniformity, quality and excellence among forensic laboratories in New York State, it failed to do so. Instead, the Forensic Commission abdicated most, if not all, of its responsibility for oversight of the FEB and other forensic laboratories across the state to a private accrediting agency, ASCLD/LAB.

The confluence of these failures in oversight enabled the FEB to operate as a substandard laboratory for far too long. In so doing, these failures deprived Nassau County, the criminal justice system, and the public of their right to have complete and unfettered confidence in forensic testing. These failures have also now required the County to commit to a retesting effort, which has been and will continue to be a financial

burden on an already fiscally strained County. Accordingly, this report and the accompanying recommendations seek to prevent repetition of these failures and to reinvigorate the existing system of forensic laboratory oversight in order to restore public confidence and maintain New York State's preeminence in forensic testing.

II. INTRODUCTION

A. The Closure of the FEB and the Resulting Investigation

On November 7-11, 2010, the Nassau County Police Department laboratory, referred to within the Police Department as the Forensic Evidence Bureau (FEB), was inspected by an international accrediting body, the American Society of Crime Laboratory Directors/Laboratory Accreditation Board (ASCLD/LAB), as required by the New York State Commission on Forensic Science. Following the inspection, ASCLD/LAB sent a formal report dated December 3, 2010, to FEB Commanding Officer Det./Lt. James Granelle informing him that the laboratory had been placed on probation for failing to meet ASCLD/LAB criteria in 26 areas. When the probation was imposed, the FEB was the only forensic laboratory in the country under this ASCLD/LAB sanction. Even more noteworthy, this was the second time in four years that this extraordinary measure was instituted against the FEB.

On December 10, 2010, the Nassau County Police Department removed Granelle as commanding officer of the laboratory, and on December 13, 2010, Nassau County Executive Edward Mangano placed Pasquale Buffolino, Ph.D., director of forensic genetics at the Nassau County Medical Examiner's Office, as acting director of the FEB. Peter Pizzola, Ph.D., a consultant and former director of the New York City Police Department Crime Laboratory, was also recruited to assist in correcting deficiencies at the laboratory. Among their first actions, Buffolino and Pizzola met periodically with FEB analysts and supervisors.

During one of these meetings in December, the drug chemistry section supervisor, Det./Sgt. Charles Conti, and Deputy Commanding Officer Det./Sgt. Michael Cole

informed Buffolino that the lab had encountered unusual results from a purity determination of MDMA[3] (Ecstasy) for a pending prosecution, and had ceased MDMA quantitation, or purity, testing until additional MDMA standard (laboratory-produced pure MDMA used for comparison purposes) could be obtained. The pure MDMA standard would assist the drug chemists in determining the source of the problem. Conti related to Buffolino his suspicions that another compound might be co-eluting, or not separating, from the MDMA thereby skewing the determination of the MDMA's purity – a required measurement for certain charges under the New York State Penal Law. Upon learning this information, Buffolino instructed Conti and Cole to review past MDMA quantitation cases to determine whether any needed to be sent to another lab for re-analysis.

Conti and Cole reviewed approximately 35 MDMA purity cases from 2003 through 2010 and determined, based on the reported test results contained in each file, that nine cases should be re-analyzed. On or about December 17, 2010, these nine cases were sent to the Suffolk County Crime Laboratory for re-analysis which revealed significantly different results; in one case, Suffolk's test results produced a 70 percent lower purity determination than the FEB's. The different results affected the criminal charges in three of the nine cases.[4] On January 26, 2011, Buffolino presented the nine re-analyzed cases to the Nassau County District Attorney's Office. Upon receipt of these results, Nassau County District Attorney Kathleen Rice called for the closure of the drug chemistry section of the laboratory, and, on February 10, 2011, county officials

[3]MDMA is an acronym for methylenedioxymethamphetamine.
[4] These individual cases have been handled by the District Attorney's Office within the criminal justice system.

announced the drug chemistry section's indefinite closure due to errors in MDMA testing.

On February 16, 2011, after the drug chemistry section had already been closed, Buffolino spoke to FEB's former Quality Assurance Manager, Melanie McMillin, regarding the calibration of the instrument and the aforementioned MDMA quantitation findings. McMillin then forwarded Buffolino a September 22, 2010 e-mail from Conti to her and Granelle regarding the cessation of MDMA purity testing. As this e-mail pre-dated by several months Conti's and Cole's discussion with Buffolino regarding problems in MDMA purity testing, it caused Buffolino to question what was known in the lab regarding MDMA testing and when it was known. He brought this e-mail to the attention of the District Attorney's Office. Based on the aforementioned disclosure, on February 18, 2011, District Attorney Rice and County Executive Mangano announced that, due to the above revelations that police supervisors were aware of problems with Ecstasy testing as far back as September, the entire FEB was being closed.

Upon learning about the closure of the drug chemistry section and the entire FEB from the media, the Inspector General immediately commenced an investigation to determine if misconduct or malfeasance contributed to the closure of the FEB as alleged, pursuant to Executive Law Article 4-A and Coverdell jurisdiction.[5]

[5] The federal Paul Coverdell Forensic Science Improvement Program, of which New York State is a grantee, requires grant recipients to designate an independent entity with authority to investigate allegations of serious negligence or misconduct by laboratory personnel substantially affecting the integrity of the forensic results. The New York State Commission on Forensic Science, which oversees public forensic laboratories in New York, has designated the State Inspector General as the independent entity to investigate such allegations in laboratories under its jurisdiction. Furthermore, because the FEB receives funding from New York State, the Inspector General also possesses jurisdiction under Executive Law Article 4-A to investigate allegations of fraud, criminal activity, conflicts of interest and abuse in the laboratory and to review laboratory procedures in regard to prevention and detection of such.

In addition, on February 25, 2011, Governor Andrew M. Cuomo issued Executive Order No. 9, which directed the Inspector General to investigate the operations of the FEB. Executive Order No. 9 acknowledged the Inspector General's aforementioned dual bases for jurisdiction over laboratories in New York State. Governor Cuomo then specifically expanded the Inspector General's powers to "allow for a more comprehensive and independent investigation of the oversight and operation of the Forensic Evidence Bureau" as follows:

> Pursuant to section six of the Executive Law, I hereby appoint Ellen Biben, the New York State Inspector General, to study, examine, investigate, review and make recommendations with respect to forensic testing practices and procedures of the Nassau County Police Department Forensic Evidence Bureau including, but not limited to, compliance with relevant law, standards, and protocols.

Accordingly, the Inspector General's office broadened the investigation.

This investigation examined the many factors ultimately resulting in the closure of the FEB. Following the imposition of probation, the District Attorney's Office and Buffolino formulated a plan to reanalyze or review cases in disciplines which received the most criticism from ASCLD/LAB. Following the closure of the laboratory, however, the number of cases to be reanalyzed and reviewed was increased to thousands of FEB cases; as such, retesting of cases is still ongoing. Although the Inspector General was involved in monitoring the reanalysis, this investigation did not focus on the individual retested cases. Rather, the Nassau County District Attorney's office was notified (and continues to be notified) regarding retesting results, and any issues with respect to individual cases are being handled by that office and the criminal justice system. Instead, the Inspector General conducted an investigation, which included a comprehensive examination of the FEB's history and operation, as well as the regulatory requirements

and systems to which it was subject both within Nassau County and New York State. Set forth below are the findings of this investigation.

B. Investigative Methodology

Pursuant to Executive Law Article 4-A, "covered agencies" within the Inspector General's jurisdiction including "all executive branch agencies, departments, divisions, officers, boards and commissions, public authorities (other than multi-state or multinational authorities) and public benefit corporations, the heads of which are appointed by the governor and which do not have their own inspector general by statute," are required to provide documents and witnesses to the Inspector General without resort to a subpoena. The Inspector General also possesses the authority to issue subpoenas in furtherance of an investigation. Indeed, this authority is explicitly enumerated in Executive Law § 54, which provides the Inspector General with the power to "subpoena and enforce the attendance of witnesses" and "require the production of any books and papers deemed relevant or material to any investigation, examination or review."

In addition, Executive Order No. 9 issued by Governor Cuomo on February 25, 2011, directing the Inspector General to investigate the operations of the FEB, empowered the Inspector General to subpoena and enforce the attendance and examination of witnesses under oath, and require the production of any related materials. Accordingly, the Inspector General issued 140 letter requests and subpoenas to both governmental and private entities.

The Inspector General employed an array of investigative techniques in the inquiry that resulted in this report. The Inspector General requested and reviewed all relevant

documents and materials: FEB staff computer hard drives, and tens of thousands of document pages and e-mails spanning 2003 to the present. The Inspector General also conducted more than 100 interviews. Further, staff members from the Inspector General's office toured the Nassau County FEB laboratory numerous times and, with the assistance of the Nassau County Police Department, secured all of its contents. Additional site visits included other New York State forensic laboratories for comparison and educational purposes.

III. BACKGROUND

Forensic laboratories test different types of evidence and the findings are often used in the investigation, prosecution and defense of criminal cases. Forensic laboratories are divided by discipline relating to the type of evidence analyzed: for example, typically, the drug chemistry discipline identifies and analyzes illegal or illicit substances; toxicology, a subdiscipline of drug chemistry, analyzes the concentration of alcohol, drugs or other chemicals in blood and urine; the firearms and tool marks discipline determines the operability of a weapon and conducts microscopic analysis of bullets; the latent prints discipline identifies finger, palm and foot prints; the trace evidence discipline examines and identifies small quantities of evidence, such as hair, fire debris, footwear impressions, etc.; and the questioned documents discipline identifies the source of handwritten or printed text and uncovers alterations, additions, or deletions to documents.

In order to explain fully the circumstances which resulted in the closure of the FEB and the Inspector General's findings and recommendations, an overview of the

all necessary steps to identify the root causes contributing to the areas of non-compliance and systematically address each to ensure that, henceforth, the [FEB] adheres to all accreditation standards imposed by ASCLD/LAB and the Commission on Forensic Science."

In response to the absence of any representative of the FEB at the December 7, 2010 meeting of the Forensic Commission, Byrne concluded his letter by mandating the appearance of a representative at the next Forensic Commission meeting scheduled for March 29, 2011.

M. Problems Discovered in Nine MDMA Cases Result in the Closure of the Drug Chemistry Section and Ultimately the Entire Lab

On December 13, 2010, Nassau County Executive Edward Mangano placed Pasquale Buffolino, Ph.D., director of forensic genetics at the Nassau County Medical Examiner's Office, as acting director of the FEB. Peter Pizzola, Ph.D., a consultant and former director of the New York City Police Department Crime Laboratory, was recruited to assist in correcting deficiencies at the laboratory. As part of the remediation, Buffolino, joined at times by Pizzola, met with FEB members to assess what had occurred to warrant so many citations for noncompliance, and to prepare a remediation plan within the 30-day timeframe mandated by ASCLD/LAB and subsequently the Forensic Commission. Nassau County District Attorney Chief of Staff Meg Reiss reported that after Buffolino and Pizzola became involved in the review, she and her colleagues received a far different presentation as to the seriousness of the report. Specifically, although upon initial review of the report, Buffolino had not found anything

that would affect the integrity of the actual outcomes of the testing, he considered it "very sloppy science."

At one of these meetings between Buffolino and the FEB staff on or about December 19, 2010, Conti, after conferring with Cole, decided to inform Buffolino of the circumstances surrounding the cessation of MDMA quantitation testing in September 2010. When they did so, Buffolino appeared angry and asked why the standard had not arrived as yet. They explained to him that the order had mistakenly been canceled. Buffolino then ordered Conti and Cole to review past felony cases to see if similar problems existed. Conti and Cole consulted the lab's computer system and determined that approximately 35 felony MDMA cases had been tested since 2003. They proceeded to examine those 35 cases and determined that in nine of the cases, the quality of the graphical peaks indicated that co-elution, or lack of separation of other compounds, appeared to be occurring requiring retesting. It must be noted that their review was consistent with a standard technical review – reviews that were supposed to have been practiced in the laboratory but clearly were not based on their ability to easily cull out these nine cases.

Those nine cases were sent to the Suffolk County Crime Laboratory for retesting, which revealed differences in the FEB's purity analyses affecting criminal charges in favor of three defendants. Notably, the nine cases spanned every chemist in the drug chemistry section and the most recent three drug chemistry section supervisors, an indication of the pervasiveness of the MDMA quantitation analytical deficiencies. In January 2011, Buffolino met with Jack Mario, the examiner from the Suffolk County Crime Laboratory who had conducted the reanalysis. Mario informed him that issues

existed as to "the interpretive and analysis processes within those cases and that three of them had changes in the drug charge." He then contacted Nassau County Assistant District Attorney Teri Corrigan, the Narcotics bureau chief, and Pizzola, to discuss the results. Buffolino then participated in a telephone conversation with Reiss and Deputy County Executive Robert Walker during which it was decided to cease any drug chemistry testing. On February 10, 2011, County officials announced the drug chemistry section's indefinite closure due to errors in MDMA testing.

In the wake of the December 3, 2010 ASCLD/LAB report placing the FEB on probation, further facts emerged regarding the cessation of MDMA quantitation analysis which resulted in the closure of the drug chemistry section of the FEB. Buffolino contacted McMillin, who had resigned from the FEB for employment with the ATF, regarding the aforementioned MDMA quantitation findings. In response, McMillin forwarded Buffolino the September 22, 2010 e-mail from Conti to her and Granelle regarding the cessation of MDMA purity testing which pre-dated by several months Conti's and Cole's discussion with Buffolino regarding problems in MDMA purity testing. Conflicting accounts of what occurred in September 2010 caused Buffolino concern as to what was known in the lab regarding MDMA testing and when it was known. This new revelation caused him to question the integrity of the drug chemistry section and whether it should continue to function. He immediately brought this information to the attention of the County Executive and the District Attorney's Office.

Mangano related that he received a call from District Attorney Rice expressing her concerns about the FEB continuing testing at all. Mangano then concluded to close the entire lab, "as a belt-and-suspenders approach, as a precaution." On February 18,

2011, District Attorney Rice and County Executive Mangano announced that, due to the above revelations that police supervisors were aware of problems with Ecstasy testing as far back as September, the entire FEB was being closed.

N. Plan Developed to Review FEB's Drug Chemistry, Blood Alcohol and Latent Prints testing

1. Scope of the Retesting Plan

Following the imposition of probation, Nassau County officials, and specifically District Attorney Rice, recognized that a system of review would be necessary to establish the reliability of evidence previously analyzed by the FEB. Therefore, as early as December 2010, a plan was formulated to review or reanalyze cases in the disciplines that received the most nonconformances by ASCLD/LAB – blood alcohol, latent prints, and drug chemistry. As to blood alcohol, because ASCLD/LAB determined that technical reviews in that discipline had been conducted by supervisors not deemed competent to do so, County officials decided to have 100 percent of blood alcohol cases since 2005 technically reviewed by a competent examiner. The County retained outside toxicology experts to perform the technical review, which revealed no errors.[73]

The audit of latent prints has only recently commenced, but includes a random sampling of a percentage of casework from each latent print examiner (approximately 150 cases in total) from 2007 to the present. Of note, during the pendency of this

[73] During the review process Margaret Fisher, the FEB's sole blood alcohol analyst, discovered nine cases in which she mismatched test results to the wrong defendants. When she discovered her mistake, she immediately notified a supervisor and the information was ultimately provided to the District Attorney's Office and the Inspector General. The mismatches affected the charge in five of the nine cases, and these cases are being handled by the District Attorney within the criminal justice system.

investigation, the Police Department resumed latent print analysis. The Police Department is able to engage in this unmonitored testing because Executive Law § 995 specifically excludes latent print analysis from forensic oversight and accreditation: "For purposes of general forensic analysis the term 'forensic laboratory' shall mean any laboratory operated by the state or unit of local government that performs forensic testing on evidence in a criminal investigation or proceeding or for purposes of identification provided, however, that the examination of latent fingerprints by a police agency shall not be subject to the provisions of this article." Currently, this latent print unit cannot, under the Executive Law, be monitored by the Forensic Commission. However, any positive identification by this unaccredited latent print unit is being confirmed by an outside accredited laboratory. Within Nassau County, the plan for the future forensic laboratory includes a latent print section. As a result, latent print analysis in Nassau County will and should be subject to ASCLD/LAB *International* accreditation and policies and Forensic Commission oversight.

With regard to the drug chemistry section, the initial plan included technical review of cases from 2007 to the present and retesting of 10 percent of the cases of each drug chemist performed in that same period. However, after the retesting of nine MDMA cases revealed significant differences from the FEB's results and affected the criminal charges in favor of the defendant in three of the nine cases, the plan was expanded to include retesting of all felony cases since 2007 – approximately 3500 in total.[74] To accomplish this reexamination, Nassau County engaged the services of a private forensic laboratory, the National Medical Services Labs (NMS), to perform reanalysis and to conduct forensic testing for pending cases until the new forensic laboratory becomes

operational. In response to this outsourcing of testing, the Police Department has created the "Evidence Management Unit" to administer the processing of evidence to the appropriate laboratory.[75]

Additionally, the Nassau County Executive authorized the hiring of staff for the newly formed civilian forensic laboratory, under the leadership of Pasquale Buffolino, Ph.D., to replace the FEB. Buffolino and those staff already hired are not only working towards achieving ASCLD/LAB *International* accreditation in the disciplines once handled by the FEB, but are conducting comparative analyses to reconcile the NMS test results with those of the FEB. The results of the comparisons are immediately reported to the Inspector General, the Nassau County District Attorney, County Executive and Police Department.[76]

2. Initial Results

Reanalysis of 814 felony drug cases has been completed, approximately 20 percent of the total number of cases scheduled to be retested. Preliminary results indicate that the majority of FEB test results are largely consistent with NMS's reexamination results. Nonetheless, approximately 13 percent of this preliminary reanalysis – an unacceptably high percentage – indicate some inconsistencies in testing. These errors reflect the lack of an adequate quality system and other problems which plagued the FEB, as discussed in this report. Specifically, the reanalysis thus far has revealed patterns of

[74] Additional analyses earlier than 2007 are being conducted at the specific request of the District Attorney.
[75] In late June 2011, marijuana evidence was sent to NMS by a common carrier and was determined to have been stolen. The investigation into the stolen marijuana is still ongoing, however as a result of this incident the Inspector General insisted that the Police Department cease using any common carriers for this purpose.
[76] Reexamined cases in which conclusions differ from determinations made by the FEB have been and will continue to be immediately addressed by the criminal justice system.

EXHIBIT 3

Rice, Mangano Announce Closure Of Nassau County Crime Lab

February 18, 2011 7:42 PM By Sophia Hall

Filed Under: ed mangano, Erin Marino, Kathleen Rice, Nassau County Crime Lab

County Exec Ed Mangano and DA Kathleen Rice announce lab closure (Photo: Mona Rivera)

NEW YORK (CBSNewYork) — Nassau County District Attorney Kathleen Rice and County Executive Edward Mangano announced Friday that the entire Nassau County crime lab has been shut down during an investigation into a series of errors.

00:00 00:00

WCBS 880's Sophia Hall reports

00:00 00:00

1010 WINS' Mona Rivera reports

Rice dropped the bombshell on Friday, reports CBS 2's Jennifer McLogan.

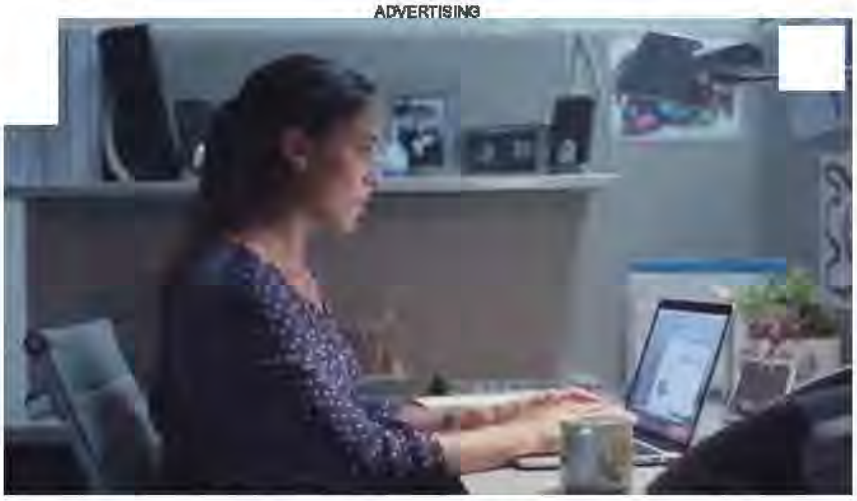
"Upon my request, the county executive has ordered the immediate closure of the remaining sections of the crime lab," Rice said.

The total shuttering of the lab came just after its former director testified that his supervisors knew months — if not years — ago about inaccuracies with the lab's testing of drugs and apparently

failed to act.

"I think it's too early to use words such as a cover-up," Rice said.

"You have to investigate who knew, when they knew, whether testing continued," Mangano added.



They said police officials apparently knew examiners were producing inaccurate measurements in drug cases before December, when a national accreditation agency placed the lab on probation for a second time, citing shoddy work and cutting corners. Violations in the testing of drugs Ketamine and ecstasy may have meant some defendants faced stiffer charges than they should have.

"You look at the faces of the county executive and district attorney and that tells you it's a complete and total nightmare for them," said Marc Gann, president of the Nassau County Bar Association.

The lab's lapses are calling into question evidence used to prosecute defendants in past and current criminal cases. At least 16 motions have been filed seeking to dismiss or overturn convictions.

The first of as many as 9,000 potential defendants is seeking to have her guilty verdict overturned because of problems with the lab. Erin Marino, 30, a teacher from Hicksville, is the first defendant demanding a guilty verdict be set aside — due to violations uncovered within the lab.

She was convicted in August 2010 of aggravated vehicular assault.

"They've admitted that they've messed up the way they took the test and the law is clear when you don't calibrate. When you don't maintain, the evidence doesn't come in," defense attorney Brian Griffin said.

MORE NEWS

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Taxpayers also wonder if jail doors will be thrown open.

"Get the right people who are covering this up in jail, and the people who are in jail for no reason, out," said Sal Alvarado of Mineola.

"Let's get to the root of what these problems were and what can be done to correct them," added Pat Novak of Garden City.

Rice said drug testing was compromised, but that there was no evidence of wrongdoing in blood, fingerprints and ballistics.

Until confidence and credibility are restored the crime lab testing will be outsourced. The county said it plans to build a new, state-of-the-art crime lab facility in New Cassel at Nassau's Public Safety Center — and hire experts from the private sector to help run it.

On Thursday, it was revealed calibrating machines to test blood-alcohol levels hadn't been checked in three years. The former head of the lab was subpoenaed, along with the current lab director and its forensic scientist.

Should those convicted following tests done at the lab have their convictions overturned? Comment Below

Sophia Hall

This is a real dream for a girl from a small Ohio city -- to work for the greatest news station in the country, WCBS -- but it was a little journey for me to get here. After graduating from Ashland University in Ashland, Ohio, and Columbia College...

More from Sophia Hall

EXHIBIT 4

DA Rice Notifies Inmates About Nassau County Crime Lab Problems

March 24, 2011 6:48 PM By Mona Rivera

Filed Under: blood-alcohol tests, Kathleen Rice, Mona Rivera, Nassau Bar Association, Nassau County Crime Lab, Sophia Hall

Nassau County Crime Lab (credit: File Photo)

MINEOLA, N.Y. (CBSNewYork/AP) — Nearly 300 inmates have been notified that there have been questions regarding the accuracy of the Nassau County crime lab.

District Attorney Kathleen Rice's office has sent letters to local and state inmates jailed in Nassau County for drug or drunken-driving convictions.

Kathleen Rice addressed reporters Thursday about the letters. 1010 WINS' Mona Rivera reports.

00:00 00:00

The letter includes contact information for legal aid or Nassau Bar Association attorneys, who inmates would be able to call collect to find out if their case had been impacted, 1010 WINS' Mona Rivera reported.

In February, officials acknowledged that the lab mismatched reports on blood-alcohol tests in drunken driving cases last fall. Rice also said that six cases involving drug arrests for ecstasy and Ketamine

may have been compromised.

WCBS 880's Sophia Hall has more on the crime lab problems

Rice cautioned that it was "not necessarily true" that the letters would serve as a 'get out of jail free' card. She plans to have evidence in as many as 3,000 cases retested, going back several years.

Earlier this month, a judge ordered a retrial in a drunken driving case because of questions about the crime lab, which was shut down in February.

Mona Rivera

Follow @WINSmona

Mona Rivera has covered everything from politics, crime, and business, to human interest stories. She was proud to fly with the Navy Blue Angels and not throw up or pass out during the aerobatic maneuvers! Follow @WINSmona You first heard Mona...

More from Mona Rivera

Comments

EXHIBIT 5

CITY OF COLUMBIA

Columbia Police Department
Memorandum
Office of the Chief

BRIEFING NOTES

Columbia Police Department Drug Laboratory

Purpose:

The purpose of this briefing note is to explain the circumstances surrounding the decision to close the Columbia Police Department's Drug Analysis Laboratory.

Background:

On April 11, 2014, Chief Holbrook was sworn in as the City of Columbia's Police Chief. Upon being sworn in, Chief Holbrook introduced a 90 Day Action Plan to be implemented by CPD staff. The first phase of the action plan involved overall department assessment. During the assessment phase Chief Holbrook personally met with personnel, first line supervisors, and area commanders to assess and understand current practices, procedures, and areas of concern.

On May 8, 2014, Chief Holbrook met with Captain D. Oree to discuss the Criminal Investigative Division and tour facilities under his command. At that time, Chief Holbrook learned the drug analysis lab was budgeted for two Chemists, but staffed with one drug chemist, Brenda Frazier. As a result, a case backlog existed. Further assessment indicated a variety of issues of concern.

A synopsis of events which occurred during Ms. Frazier's employment is as follows: Ms. Frazier was hired on December 27, 2011, to work alongside Senior CPD Chemist Melissa Hendricks. Personal differences between the two chemists quickly surfaced, proved unresolvable and Ms. Hendricks resigned her position on June 22, 2012.

Beginning on June 11, 2012, Ms. Frazier was provided training by Retired SLED Major Carlotta Stackhouse. Major Stackhouse was previously in charge of SLED's forensic

lab and at the time an Adjunct Professor at Morris College. Ms. Frazier completed her forensic training on August 3, 2012. At the conclusion of her forensic training, Ms. Frazier entered a regional peer review system with other forensic chemists from Orangeburg Department of Public Safety, Aiken County Sheriff's Office and Lexington County Sheriff's Office. Note: Peer review is a required lab process where other forensic chemists review your work to ensure accepted forensic protocols are followed.

On October 22, 2012 through November 1, 2012, Ms. Frazier attended the S.C. State Law Enforcement Academy, earning her Class III Law Enforcement Certification.

Ms. Frazier continued drug lab testing during this time period. On February 28, 2014, the regional peer review group refused to allow Ms. Frazier to continue as a participant in the review group, due to her inability to accept criticism and resistance in conforming to the group's methodologies.

Ms. Frazier continued to test CPD drug cases while superiors attempted to resolve the peer review issues, and a second CPD chemist could be hired.

On May 8, 2014 a second chemist position was posted in hopes of hiring another chemist, thus allowing in-house peer review to be achieved. This position remains unfilled. The posted salary for this position is $45,233 – $59,790.

On June 16, 2014 the Fifth Circuit Solicitor's office requested lab results for a pending drug case; however no peer review had been conducted, resulting in an incomplete analysis. It was determined that a significant number of cases were pending court and in need of review. At that time, Chief Holbrook contacted the RCSD and requested Lab Director, Dr. Demetra Garvin to conduct an assessment or GAP – Analysis of the CPD Drug Lab. This request was made in order to ID areas of concern, determine the necessary steps to address case backlogs and/or re-establish peer review.

On July 11, 2014, Dr. Garvin completed her GAP Analysis and she submitted her findings to CPD for review. Immediate corrective action began to address identified deficiencies. (*Examples: repair eye wash station, install fire extinguisher, open fume hood, replace dated chemicals, complete key audit).*

On July 21, 2014, the Fifth Circuit Solicitor's office notified the Chief of a CPD trafficking case where an independent lab conducted a weight analysis on a case which was previously tested by Ms. Frazier. The test found weight discrepancies. The Solicitor reported the mistake to Chief Holbrook, who immediately ordered all further testing by

CPD Chemist Brenda Frazier suspended, pending further review. All pending and immediate future CPD drug evidence was ordered to be submitted to SLED drug lab for analysis.

On August 5, 2014, Chief Holbrook again requested assistance from RCSD Lab Director, Dr. Demetra Garvin. Dr. Garvin was requested to conduct a peer review of all outstanding cases lacking review and pending court (190 cases). The review process is ongoing for identified cases which fell in that category.

As a result of the mounting lab related issues and deficiencies, Chief Holbrook ordered the lab closed on August 21, 2014. On that same day, Chief Holbrook sent a letter to Solicitor Dan Johnson informing him of the lab closure.

On Friday, August 22, 2014, Ms. Frazier was relieved of her operational duties. On August 22, 2014, Chief Holbrook received a correspondence from Solicitor Dan Johnson (dated 8/18/14) asking CPD to consider ceasing lab operations and utilizing an independent lab agency that follows accepted forensic protocols for any future testing. On Friday afternoon, Chief Holbrook met with Teresa Wilson, Columbia City Manager, and informed her of the circumstances surrounding the decision to close the lab. On the evening of August 22, 2014, Solicitor Dan Johnson sent a letter to the S.C. Bar Association informing them of the current situation involving the City of Columbia's Police drug chemistry lab and Chemist Brenda Frazier.

Current Situation:

Ms. Frazier submitted her letter of resignation on Monday, August 25, 2014. The Columbia Police Department has determined Ms. Frazier has been involved with the testing of 746 drug cases; of those 746 cases, 190 cases are being retested and reviewed by Dr. Garvin, RCSD Lab Director and/or her designee. This process is estimated to take approximately 30 days with a projected cost of $10,000 to $15,000 dollars. The Fifth Circuit Solicitor's Office is conducting a case by case review/ audit of all cases involving Ms. Frazier to determine the best course of action to ensure fair and ethical prosecution and case dispositions, based on sound evidence and grounded in accepted scientific methodology.

At this time, all drug evidence needing analysis is being submitted to the SLED drug chemistry lab for testing.

Recommendations:

In response to the aforementioned, the following options are listed for consideration:

- CPD Drug Chemistry Lab should remain closed until long term action plan can be developed.
- Continue to submit evidence to SLED for analysis.
- Complete immediate improvement of evidence storage facility, to include space, air quality, and refrigeration capacity, evidence drying area, bulk evidence storage, and evidence processing.
- Immediately hire two budgeted drug lab chemists.
- Assign CPD chemists and property evidence technician to the Richland County Drug Laboratory for training and an analysis partnership.

Attachments:

#1 GAP – Analysis report by Dr. Garvin

#2 CPD memo dated August 21, 2014, ceasing CPD lab operations

#3 CPD letter to Solicitor Dan Johnson dated August 21, 2014

#4 Letter from Solicitor Dan Johnson to Chief Holbrook dated August 18, 2014

#5 Letter to S.C. Bar Association from Solicitor Dan Johnson dated August 22, 2014

#6 Media release from CPD dated August 23, 2014

#1

TO: Dana Oree, Captain, Columbia Policy Department
FROM: Demi Garvin, BS, Pharm. D. R. Ph., D-FTCB
RE: GAP-Analysis, Drug Analysis Laboratory
Date: July 11, 2014

On July 11, 2014, at the request of Captain Dana Oree, I conducted a "gap analysis" of the Columbia Police Department (CPD) Drug Analysis Laboratory, located at 1 Justice Square. This evaluation began at 8:30AM and was concluded at 2:30PM. During that time, I was escorted and assisted by Ms. Brenda Frazier, CPD Drug Chemist. At no time was I left unattended. Ms. Frazier was extremely professional. She greatly facilitated the evaluation-it would have been impossible to perform it effectively without her assistance.

Please note that at the conclusion of the evaluation, Ms. Frazier was provided with a verbal summary of my observations, recommendations and critical findings (detailed below). Such communication is not only a matter of professional courtesy, it is also a routine practice during laboratory assessments.

I have detailed below: a) general observations or recommendations (i.e. actions that should be strongly considered for process improvement, but do not directly impact quality of test results or safety) and b) critical findings (i.e. actions that should be taken as soon as possible because quality of test results and/or safety is being/will be impacted). For your convenience, I have divided these topics by subject matter, although please be aware that there is overlap. For this evaluation, I chose not to use a proscribed, pre-published inspection checklist as the nature of my evaluation was "less formal" and not associated with preparations for any official accreditation process (i.e. ASCLD/LAB or FQS assessment).

I) Safety/Security

- The Drug Analysis Laboratory was extremely clean and well organized. Ms. Frazier has made very good use of the space that she has been given to conduct testing. She was able to locate everything that I asked for during the evaluation.
- Critical Finding-the eyewash stations/showers must be checked quarterly for functionality with documentation of the process. Per Ms. Frazier, at least one of these stations is currently non-functioning.
- Critical Finding-the fire extinguisher must be inspected as soon as possible (annual inspection required). There should be a fire extinguisher in the drug lab, not just the marijuana lab area.
- Critical Finding-the chemical fume hood in the Marijuana/Crime Scene Laboratory must remain in the "on" position at all times. There is no other ventilation in the lab areas and the existence of toxic organic solvents presents a serious health hazard to personnel.
- Critical Finding-the organic solvents storage cabinet is not acceptable. It is not rated for such storage and is not grounded. The doors appear to be broken. A spark or other ignition source could cause a catastrophic fire or explosion.
- Critical Finding-there is an excessive accumulation of both organic solvents and other chemicals (e.g. acids and bases). Example, I counted four, 3.78 L containers of formaldehyde (used in the preparation of chemical tests). This is an excessive amount of this solvent-it is toxic to the liver. At least one container of an acid was observed to have changed color (sign of deterioration). An inventory of all solvents, chemicals, reference materials, etc. should be conducted and an outside vendor should remove excessive quantities of waste. Minimal quantities of these materials should be ordered.
- Critical Finding-an air quality test should be performed by an outside vendor to ensure that there is sufficient ventilation to address and minimize the potential accumulation of toxic vapors.

- Critical Finding-the use of "dormitory" style refrigerators/freezers is unacceptable. One of the chemicals, acetaldehyde (used in the chemical analysis of marijuana), is a potential explosive. An explosion-proof refrigerator should be purchased to accommodate this compound (as well as other materials used by the chemist). This unit would substitute for both of the currently used dorm-style refrigerators.
- Critical Finding-a key audit should be conducted to identify all individuals who have keys to the laboratory and access to the large bank vault (storage vault). This vault serves as a short term evidence storage unit for case work and also houses the pure crystalline/powder controlled substances (e.g. cocaine, amphetamine, etc). There is currently no inventory being performed on these drugs, so there is no way to ascertain when/if inappropriate amounts are being removed/diverted. These compounds would be evaluated by DEA and DHEC during an audit and so they must be inventoried on at least an annual basis. DEA/DHEC permits reflect the former and current chiefs' names, respectively, but should reflect the chemist's name. It is this individual who must answer to DEA/DHEC during an audit and should be responsible for developing/explaining the controlled substance inventory procedures. Drug Laboratory permits must be separate from any K-9 unit activities.

II)Procurement

- Recommendation-Ms Frazier indicated that many weeks/months may pass before consumables, chemicals, reference materials, etc are obtained, once ordered. This timeline is too long and if possible, should be reevaluated for enhanced efficiency.

III) Equipment/Supplies

- Critical Finding-distilled water should be traceable and purchased from a scientific source (i.e. VWR, Fisher). It should not be purchased from the grocery store, etc. The Barnstead distilled water system is obsolete and should be discarded. The laboratory does not use sufficient volumes of distilled water to warrant the purchase of a new (and very expensive) distilled water system. Bottled, traceable, distilled water is sufficient.
- Critical Finding-a complete inventory of drug reference materials, reagents, solvents, and chemicals should be conducted on a semi-annual basis. I observed the presence of expired and/or possibly deteriorated materials that should have been discarded, but that have been used in testing.
- The current FTIR (Nexus 470, Thermo Fisher) should be replaced as it is essentially not supported by the manufacturer.
- The current GC/MS (6890/5973, Agilent Technologies) should be replaced as it is nearing the end of its useful life and is no longer supported by the manufacturer.
- Critical Finding-the laboratory is not on UPS; battery back-up units of sufficient capacity should be placed on each instrument in order to protect sensitive electronics during power surges and failures.

IV)Quality Control/Best Practices

- Critical Finding-all refrigerator/freezer temperatures should be monitored with NIST-traceable thermometers on a daily basis. (Note that one explosion-proof unit is needed as described above.)

- Critical Finding-the temperature of the "bank vault" may be unacceptable for storage of drug reference materials and physical evidence. I am concerned that the lack of ventilation may be degrading the evidence. Example, one submitted case supposedly contained "a rock like substance" (as described by the officer), but at the time of analysis, was described as a liquid by the drug chemist. An experiment should be conducted as soon as possible to determine whether alternate storage is needed.
- Critical Finding-the Duquenois Levine Reagent (chemical test for marijuana) was being stored in the chemical fume hood. This reagent must be refrigerated at all times when not in use.
- Critical Finding-laboratory weights are calibrated each year by the SC Department of Agriculture. This process and the resulting certificate of calibration are not sufficiently robust for forensic applications. The laboratory should contract with another more appropriate vendor for this function (e.g. Troemner).
- Critical Finding-there appear to be two laboratory balances in use by Ms. Frazier. If the laboratory is engaged in the analysis of PWID and trafficking case work, the current balances are insufficient for these large cases (Ex. a 10 kilo drug case could not be accurately weighed with the current balances). In addition, the annual calibration certificates issued by Mettler Toledo should be traceable. I strongly recommend semi-annual (versus annual) balance calibration by this outside vendor.
- Critical Finding-I noted several mathematical/other errors on the laboratory worksheet. The worksheet also reflects the use of four balances. That does not appear to be consistent with laboratory practice. Errors and inconsistencies should be corrected as soon as possible.

V)Administrative/Technical Review

- Twelve laboratory case files were randomly selected for administrative and technical ("peer review"). Several corrections were made by Ms. Frazier during my time in the laboratory. It is a certainty that all forensic chemists will make errors, whether administrative or technical in nature. Laboratory processes should be such that systematic administrative and technical errors are prevented and random errors are identified and corrected quickly and effectively. The laboratory must have procedures in place to identify such nonconformities and correct them prior to issuing laboratory reports. In the event that errors are detected after a laboratory report is issued, the laboratory must also have a procedure to address this situation.
- Critical Finding-**100% peer review** should be conducted prior to the issuance of any CPD issued-laboratory report-regardless of whether the analysis was for marijuana or other drugs. Peer review should be conducted on-site, by a competent, proficiency tested analyst. Travel to a remote location for peer review is: inefficient, does not allow for rapid correction of nonconformities and subsequent case turn around, nor does it allow for potential on-site assessment of quality records, the physical evidence, BEST bag, etc. by the individual conducting the peer review.
- Critical Finding-of the 12 cases reviewed, 58% had instances of broken chain of custody-i.e. COC documentation was improperly completed). While this was not due to drug chemist procedures, I note it here because a broken chain of custody would/should prevent the drug results from being accepted by the courts and review of the chain of custody documentation should be a component of the laboratory's peer review process.

- I encourage the agency to conduct in-house training of Evidence and Property Room staff and submitting officers on this issue and to require a proper COC prior to marijuana and other drug testing.

VI) Proficiency Testing

- Ms. Frazier participates in an external proficiency program (Collaborative Testing Services (CTS), Drug Analysis) on a semi-annual basis. I reviewed her latest proficiency test documentation which was thorough, complete, and accurate. She is to be commended for her participation and test results, given that participation in external proficiency testing is voluntary for unaccredited laboratories.

VII) Training/Professional Development

- I reviewed Ms. Frazier's training and professional development history while at CPD. She is to be commended for her participation in the DEA Special Training Seminar for Drug Chemists and the two Agilent-sponsored GC/MS Training Courses. She has also attended local forensic drug chemistry meetings.
- Critical Finding-I feel that Ms. Frazier should have additional focused intensive training in certain aspects of forensic drug chemistry. This would not only lead to overall process improvement, but would give her the confidence that she needs to handle casework, troubleshoot instrumentation, understand theory and forensic terminology, etc. (Refer to Staffing comments below.)
- Forensic drug chemists are required to receive twenty hours of documented continuing education each year (Refer to the *Scientific Working Group for the Analysis of Seized Drug Guidelines (SWGDRG)*). Continuing education can be achieved in a variety of ways (web-based, conferences, training courses). On-going continuing education is critical to cutting edge analysis, enhanced technical expertise and effective operations.

VIII) Records/Laboratory Documents/Procedures

- Critical Finding-long term storage of laboratory records should be in a secure, climate controlled environment (e.g. Iron Mountain, in house location).
- Ms. Frazier has a laboratory standard operating procedures (SOP) manual and is currently developing a chemical hygiene plan. She is to be commended. A review/assessment of these documents was beyond the scope of this gap analysis. The SOP should be reviewed by a qualified drug chemist for consistency with current lab practices and should be revised to include best practice recommendations (e.g. SWGDRG). Review and revision should be conducted on at least an annual basis.

IX) Staffing

- Critical Finding-the daily operations (case load) and quality and safety practices required in this laboratory extend beyond the capabilities of one analyst. A search for another qualified, experienced forensic drug chemist should be initiated as soon as possible. It is strongly recommended that this individual have:

- Bachelor of Science (BS) degree from an accredited institution with 10 years experience in GC/MS, IR instrumentation, from a high volume laboratory, preferably ABC-certified or,
- Master of Science (MS) degree from an accredited institution with at least 5-7 years experience in GC/MS, IR instrumentation, from a high volume laboratory, preferably ABC-certified and,
- Refer to SWGDRG for additional, specific personnel prerequisites

- Critical Finding-the above-described employee would supervise the laboratory's daily operations in all of its facets; Ms. Frazier would report to this individual on the organizational chart; her employee evaluation would also be conducted by this individual. Additional training, mentoring and peer review would also be facilitated with this arrangement.

I appreciate the opportunity to assist the agency in its path toward process improvement. I would like to extend my sincere appreciation to Ms. Frazier for her invaluable assistance and her professionalism during my evaluation. She has accomplished much during her time at the agency. With additional structure and support, I am confident that she and her colleague(s) will be able to meet and exemplify best practice forensic chemistry guidelines.

Respectfully submitted,

Demi Garvin

#2

CITY OF COLUMBIA

Columbia Police Department
Memorandum
Office of the Chief

To:	All Personnel	Date:	08-21-14
From:	William H. Holbrook, Chief of Police		
Subject:	CPD Drug Laboratory	Initials:	WHH

Effective immediately, the Columbia Police Department drug laboratory shall cease all operations. All drug testing will be conducted by the SLED drug laboratory.

As stated in Captain Oree's email dated July 21, 2014, the Columbia Police Department property room will facilitate the delivery of seized drugs to SLED for analysis.

If you have any questions related to this matter, contact your commander for assistance.

Thank you in advance for your assistance.

3

City of Columbia
Police Department
"The Positive Difference"
William "Skip" Holbrook
Chief of Police

August 21, 2014

Solicitor Dan Johnson
Fifth Judicial Circuit Solicitor's Office
1701 Main Street
Columbia, SC 29201

Dear Solicitor Johnson:

On August 21, 2014, I directed all Columbia Police Department drug laboratory operations to cease in entirety. All chemical drug analysis had already been discontinued effective July 21, 2014.

All Columbia Police Department personnel have been directed to follow normal drug seizure and submission procedures for submitting drugs for analysis. All drug analysis will be conducted by the SLED drug laboratory.

I am at your disposal in order to address any questions or concerns you may have regarding Columbia Police Department's lab operations. Thank you in advance for your counsel and assistance with this important matter.

Sincerely,

William H. Holbrook
Chief of Police

C: Deputy Chief Melron J. Kelly
Captain Dana Oree

1 Justice Square | Columbia, South Carolina 29201
Phone: 803-545-3500 Fax: 803-733-8326
www.columbiapd.net

#4

The State of South Carolina

Dan Johnson
Solicitor

Paulette Edwards
Deputy Solicitor

Daniel R. Goldberg
Deputy Solicitor

Brett Perry
Deputy Solicitor

SOLICITOR'S OFFICE
Fifth Judicial Circuit

August 18, 2014

Chief William Holbrook
Columbia Police Department
1 Justice Square
Columbia, South Carolina 29201

Dear Chief Holbrook:

On June 16, 2014, I informed you that my office had concerns with the quality of forensic drug chemistry cases prepared by Ms. Brenda Frazier at the City of Columbia Police Department Drug Analysis Laboratory. At your request, a GAP-Analysis of the City of Columbia Police Department Drug Laboratory was performed by Dr. Demetra Garvin with the Richland County Sheriff's Department.

Representatives of the Fifth Circuit Solicitor's Office met at length with Dr. Garvin who explained in detail the critical findings of the GAP-Analysis. As a result of Dr. Garvin's findings, the Fifth Circuit Solicitor's Office will not prosecute any future cases which are dependent on a drug analysis performed by Ms. Frazier. We are currently in the process of conducting a case-by-case audit of all pending City of Columbia drug cases in order to determine the best course of action to ensure fair and ethical prosecution, which is based on sound evidence and grounded in accepted scientific methodology. In addition, in compliance with our obligations under Rule 5 of the South Carolina Rules of Criminal Procedure, *Brady v. Maryland*, 373 U.S. 83 (1963), *Giglio v. United States*, 405 U.S. 150 (1972) and their progeny as well as our ethical obligations set forth in Rule 3.8 of South Carolina Rules of Professional Conduct we will be informing the defense bar of the same.

I implore you to cease operation of chemical drug analysis at the City of Columbia Drug Laboratory and to have all future drug analyses performed by an independent agency that is in compliance with and utilizes accepted forensic protocols. Further, it is my legal opinion that the City of Columbia should not operate a Drug Laboratory until qualified personnel can be hired and adherence to the industry accepted best practices can be ensured.

Please do not hesitate to contact me with any questions pertaining to this matter.

RECEIVED
AUG 22 2014
Chief of Police

Sincerely,

Dan Johnson
Solicitor
Fifth Judicial Circuit

5

The State of South Carolina

Dan Johnson
Solicitor

Paulette Edwards
Deputy Solicitor

Daniel R. Goldberg
Deputy Solicitor

Brett Perry
Deputy Solicitor

SOLICITOR'S OFFICE
Fifth Judicial Circuit

MEMORANDUM

TO: Members of the South Carolina Bar
FROM: Solicitor Dan Johnson, Fifth Judicial Circuit
DATE: August 22, 2014
RE: ***Columbia Police Department Drug Laboratory***

On June 16, 2014, the Fifth Circuit Solicitor's Office learned that there may be issues with the quality of forensic drug chemistry cases prepared by Brenda Frazier at the City of Columbia Police Department Drug Analysis Laboratory. Our office promptly notified Chief William Holbrook and at his request, a GAP-Analysis of the City of Columbia Police Department Drug Laboratory was performed by Dr. Demetra Garvin with the Richland County Sheriff's Department on July 11, 2014, and August 5, 2014.

As a result of Dr. Garvin's findings and at the recommendation of the Fifth Circuit Solicitor's Office, on August 21, 2014, Chief William Holbrook issued a directive to cease operation of the Columbia Police Department drug laboratory. Pursuant to Chief Holbrook's directive, the Columbia Police Department will submit drug evidence to SLED for analysis. Chief Holbrook has been diligently working with the Fifth Circuit Solicitor's Office to identify and address areas of concern and has taken prompt and decisive action to ensure future analysis is done in accordance with best practices.

In compliance with our obligations under Rule 5 of the South Carolina Rules of Criminal Procedure, *Brady v. Maryland*, 373 U.S. 83 (1963), *Giglio v. United States*, 405 U.S. 150 (1972) and their progeny as well as our ethical obligations set forth in Rule 3.8 of South Carolina Rules of Professional Conduct, Dr. Garvin's relevant critical findings are as follows:

- The laboratory's standard operating procedure was issued subsequent to the date analysis was performed. In addition, many of the described procedures did not appear to be consistent with actual laboratory practices.

- The laboratory's balance program is not grounded in sound quality assurance measures to allow for confidence in reported weight values for items of physical evidence.
- The choice of proper sampling and/or sample selection methods may not be familiar to or well understood by Brenda Frazier. Sampling of physical evidence may not have been done in accordance with best practice.
- Storage temperature in the drug laboratory may be unacceptable for storage of drug reference materials and physical evidence. Temperature and lack of ventilation may result in degradation of the physical evidence.
- Brenda Frazier has significant gaps in her previous training and experience and may not currently possess the knowledge necessary to competently perform drug analysis.

The Fifth Circuit Solicitor's Office is currently in the process of conducting a case-by-case audit of all City of Columbia drug cases analyzed by Brenda Frazier in order to determine the best course of action to ensure fair and ethical prosecution and dispositions, which are based on sound evidence and grounded in accepted scientific methodology. The audit includes not only a review of pending cases but of closed cases in which Brenda Frazier preformed the drug analysis. Should any discoverable information arise in an individual case, counsel of record will be promptly notified.

Please do not hesitate to contact me with any questions pertaining to this matter.

Sincerely,

Dan Johnson
Solicitor
Fifth Judicial Circuit

#16

Holbrook, William H

From:	Timmons, Jennifer A
Sent:	Saturday, August 23, 2014 12:29 AM
To:	allwisproducers@wistv.com; news@wach.com; news19@wltx.com; eyewitnessnews@abccolumbia.com; safety@thestate.com; online@thestate.com; Allen Wallace ColaDaily
Subject:	STATEMENT REGARDING CPD DRUG LAB

On August 21, 2014, Chief William Skip Holbrook made the voluntary decision to cease operations of CPD's Drug Analysis Laboratory. Shortly after accepting the Chief of Police position, Holbrook conducted an overall assessment of CPD operations, including the drug laboratory.

As a result of that assessment and concerns of the Fifth Circuit Solicitor's Office, in early July, Chief Holbrook requested that the Richland County Sheriff's Department (RCSD) conduct an audit and assessment, or 'GAP-analysis' of the CPD drug laboratory. As a result of the GAP-analysis findings, Chief Holbrook ordered all chemical drug analysis halted at CPD.

Further peer review and assessment by RCSD confirmed Holbrook's initial concerns.

On August 21, 2014, Holbrook ordered the CPD drug lab closed until further notice.

The Columbia Police Department is committed to the continued collaboration with SLED, RCSD, and the Fifth Circuit Solicitor's Office on this matter, and in the interest of justice.

Officer Jennifer Timmons
Public Information / Media Relations
The Columbia Police Department
#1 Justice Square
Columbia, S.C. 29201
Office (803) 545-4251
Main (803) 545-3500

Sent from my iPad

EXHIBIT 6

The State of South Carolina

Dan Johnson
Solicitor

Paulette Edwards
Deputy Solicitor

Daniel R. Goldberg
Deputy Solicitor

Brett Perry
Deputy Solicitor

SOLICITOR'S OFFICE
Fifth Judicial Circuit

MEMORANDUM

TO:	Members of the South Carolina Bar
FROM:	Solicitor Dan Johnson, Fifth Judicial Circuit
DATE:	August 22, 2014
RE:	***Columbia Police Department Drug Laboratory***

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As a result of Dr. Garvin's findings and at the recommendation of the Fifth Circuit Solicitor's Office, on August 21, 2014, Chief William Holbrook issued a directive to cease operation of the Columbia Police Department drug laboratory. Pursuant to Chief Holbrook's directive, the Columbia Police Department will submit drug evidence to SLED for analysis. Chief Holbrook has been diligently working with the Fifth Circuit Solicitor's Office to identify and address areas of concern and has taken prompt and decisive action to ensure future analysis is done in accordance with best practices.

In compliance with our obligations under Rule 5 of the South Carolina Rules of Criminal Procedure, *Brady v. Maryland*, 373 U.S. 83 (1963), *Giglio v. United States*, 405 U.S. 150 (1972) and their progeny as well as our ethical obligations set forth in Rule 3.8 of South Carolina Rules of Professional Conduct, Dr. Garvin's relevant critical findings are as follows:

- The laboratory's standard operating procedure was issued subsequent to the date analysis was performed. In addition, many of the described procedures did not appear to be consistent with actual laboratory practices.

- The laboratory's balance program is not grounded in sound quality assurance measures to allow for confidence in reported weight values for items of physical evidence.
- The choice of proper sampling and/or sample selection methods may not be familiar to or well understood by Brenda Frazier. Sampling of physical evidence may not have been done in accordance with best practice.
- Storage temperature in the drug laboratory may be unacceptable for storage of drug reference materials and physical evidence. Temperature and lack of ventilation may result in degradation of the physical evidence.
- Brenda Frazier has significant gaps in her previous training and experience and may not currently possess the knowledge necessary to competently perform drug analysis.

The Fifth Circuit Solicitor's Office is currently in the process of conducting a case-by-case audit of all City of Columbia drug cases analyzed by Brenda Frazier in order to determine the best course of action to ensure fair and ethical prosecution and dispositions, which are based on sound evidence and grounded in accepted scientific methodology. The audit includes not only a review of pending cases but of closed cases in which Brenda Frazier preformed the drug analysis. Should any discoverable information arise in an individual case, counsel of record will be promptly notified.

Please do not hesitate to contact me with any questions pertaining to this matter.

Sincerely,

Dan Johnson
Solicitor
Fifth Judicial Circuit

EXHIBIT 7

Elevated Methamphetamine Crime Lab Test Found, Fixed

For release on May 5, 2014

CONTACT:
David Angel, Assistant District Attorney
(408) 792-2857

ELEVATED METHAMPHETAMINE CRIME LAB TEST FOUND, FIXED

The Santa Clara County District Attorney's Office has found and fixed a two-month error in crime lab testing for the presumptive presence of methamphetamine. The Office is disclosing the issue to defendants, and taking steps to ensure future tests are accurately generated.

The one-time error caused six methamphetamine test results taken from January through March to show a presumptive "positive" test, which were later determined by a confirmatory test to be "negative." None of these six individuals are in-custody based upon the potentially erroneous presumptive result. One case is civil and not criminal, and in one case charges were never filed. In another case, a defendant pleaded "No Contest" and was sentenced to jail after the presumptive test result erroneously gave a "positive" for methamphetamine. However, further testing confirmed he was "negative" for methamphetamine, but he was "positive" for PCP. The PCP test was not available at the time of the defendant's plea. The attorneys for all the potentially affected defendants have been notified. The D.A.'s Office is also notifying about 2,500 defendants and their lawyers that their test results were processed during the period in question, even though these tests have already been re-evaluated and determined to be accurate.

Said District Attorney Jeff Rosen: "Human error will always exist within the criminal justice system. However, it is vital that we quickly find any possible mistakes and quickly fix them. We did that in this case."

When testing blood or urine for the presence of drugs, the Crime Lab performs a presumptive screening test. Each sample is tested twice, and the results are either "positive," "negative," or "inconclusive." All "inconclusive" tests are tested further. "Positives" and "negatives" are reported as such. An "inconclusive" or "negative" result does not necessarily indicate the absence of methamphetamine in the blood. Rather, because the Crime Lab adheres to the highest accreditation standards, it will report as "negative" or "inconclusive" those cases where the presence of methamphetamine is present in the person's system, but below a certain threshold.

A criminalist in April discovered the error, caused when another criminalist created control standards for the test using an incorrect compound that

increased the test's sensitivity. Pending a review, the analyst who made the initial mistake has been re-assigned from drug testing duties. As part of the review, four years of methamphetamine test control results were back-checked and ratified as accurate. Freshlycreated drug control samples will be documented and double-checked by a second criminalist prior to use and test control standard reagents will be labeled more clearly.

# # #

EXHIBIT 8

Drug scandal hits Medical Examiner's Office

Sean O'Sullivan, The News Journal *9:04 a.m. EST February 22, 2014*

(Photo: Getty Images/iStockphoto)

In a growing scandal, investigators have discovered drugs sent to the Delaware Medical Examiner's Office for testing between 2010 and 2012 have gone missing – sometimes replaced with fakes – imperiling more than a dozen drug prosecutions and possibly many more.

"I don't think this is going to end soon. This is the tip of the iceberg," said Delaware Public Defender Brendan O'Neill.

The problem was discovered by prosecutors earlier this month at trial during a Kent County drug prosecution, according to State Prosecutor Kathleen Jennings. Since then she said the office has been moving quickly to investigate and notify the courts and defense attorneys.

The full scope of the problem is not yet known and investigators have not yet identified a suspect. But at least 15 cases have been flagged by investigators as having tainted or missing evidence.

Almost all the cases where drugs have gone missing involve Oxycontin tablets. In at least one case, the one that set off the investigation, a prosecutor at trial immediately recognized that pills in evidence that were supposed to be Oxycontin were in fact blood pressure medication. In other cases it appears the drugs were simply taken from evidence storage.

At least one marijuana case is also involved.

Delaware State Police are leading the investigation and Sgt. Paul Shavack said the Office of the Chief Medical Examiner is cooperating fully.

"Based on the nature of the ongoing investigation, the Controlled Substances Lab has discontinued drug analysis; however, all other functions of the Office of the Chief Medical Examiner remain uninterrupted and fully functional," Shavack said.

Hal Brown, deputy director at the Medical Examiner's office, confirmed there is an investigation and said his office welcomes the review by prosecutors and state police.

"We do not know if the source of these discrepancies occurred here or elsewhere," Brown said. "We hope they will get to the bottom of it and hopefully it will get resolved soon."

The medical examiner's evidence locker has been secured by the Delaware State Police. An outside company will be doing an audit of all the evidence in the locker related to pending cases to make sure it has not been tampered with or replaced with fakes.

In addition, police agencies across the state have been asked by the Delaware Attorney General's Office to do an audit of drug evidence they have sent into the medical examiner for testing to see if it matches up with medical examiner's records.

"This is considered an active and ongoing investigation being led by Delaware State Police Criminal Investigative Detectives," Shavack said, adding that no further information would be released at this time so as not to jeopardize the ongoing investigation.

In the case where blood pressure pills had been substituted for Oxycontin, Jennings said all charges related to Oxycontin were dropped.

Jennings said the state then immediately launched an investigation to determine the scope of the problem and took "additional measures to ensure the integrity of evidence in criminal drug prosecutions ... [and] notified defense counsel and the courts of this matter in order to ensure that the due process rights of the accused are protected."

O'Neill said the scandal "raises serious questions about the integrity of the state's drug testing laboratory."

"The theft of drugs by lab personnel undermines the reliability of the lab's work, casts doubt on the lab's test results and the credibility of the lab's employees," O'Neill said, calling for the state to quickly identify the employee or employees responsible.

"Any convictions achieved by the state's use of false, fraudulent or fabricated evidence blatantly and egregiously violates defendants' constitutional rights to due process and fair trial," O'Neill said.

"We need to address the issues raised by this scandal promptly and thoroughly," he said.

The case has similarities to a scandal from 2012 in Boston where a former chemist with the state's Department of Public Health admitted to faking test results in at least 1,100 criminal cases. Prosecutors charged chemist Annie Dookhan only tested a fraction of the samples she was sent in order to "improve her productivity and burnish her reputation."

So far in Delaware, however, it appears most of the problems are related to theft not falsification.

Dookhan's fraud left the Massachusetts criminal justice system scrambling to try to repair the damage. So far the episode has cost Massachusetts more than $8.5 million to deal with the situation. The state has also set aside another $8.6 million for this fiscal year. A number of drug defendants have also been set free.

In November, Dookhan was sentenced to three to five years in prison.

Information from the Associated Press was used in this story.

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EXHIBIT 9

INVESTIGATION OF MISSING DRUG EVIDENCE:

PRELIMINARY FINDINGS

INTRODUCTION

On February 20, 2014, the Delaware State Police ("DSP") and the Delaware Department of Justice ("DDOJ") initiated an investigation of the Office of the Chief Medical Examiner ("OCME") Controlled Substances Unit ("OCME-CSU" or "CSU") and ordered the cessation of all day-to-day operations. This order was issued to allow for a thorough investigation of OCME-CSU operations based upon irregularities identified in evidence that had been submitted to that laboratory. The DDOJ and DSP, together with the assistance of law enforcement agencies statewide, have inspected thousands of pieces of drug evidence, interviewed current and former OCME employees and other witnesses identified in the investigation, and reviewed thousands of documents. It must be emphasized that this investigation is ongoing. However, to date, the investigation, has revealed that:

1. Systemic operational failings of the OCME resulted in an environment in which drug evidence could be lost, stolen or altered, thereby negatively impacting the integrity of many prosecutions. These systemic failings include:
   a. Lack of management;
   b. Lack of oversight;

c. Lack of security;

d. Lack of effective policies and procedures.

2. As a result of the systemic failures, evidence in several cases has been lost or stolen.

3. The loss of this evidence is not always traceable to any one individual.

This preliminary report sets forth the investigative findings that directly impact the integrity of forensic services offered by the OCME-CSU. The purpose of this report is to inform Delawareans on matters of public concern, to update the Delaware Judiciary on matters that directly impact its day-to-day operations, and to advise defendants of matters pertaining to the prosecution of their offenses. The General Assembly has moved quickly to address many of the identified issues and seeks to improve the provision of forensic science services to Delaware citizens.[1] The DDOJ and DSP respectfully submit this investigative summary.[2]

[1] SB 241, 147th GA.

[2] The Delaware Department of Justice maintains the "powers, duties and authority to investigate matters involving the public peace, safety and justice." 29 *Del. C.* § 2504(4). In issuing this report, the DDOJ emphasizes its unique and special obligation to inform the public while, at the same time, refrain from making comments which may heighten public condemnation of any individuals. *See* DRPC 3.6, 3.8 and comments thereto. Based upon these obligations and in recognition of the pending prosecution of individuals affiliated with the OCME-CSU, the DDOJ and DSP are necessarily constrained in their ability to publicize every aspect of this investigation.

I. Initial Discovery

On January 14, 2014, the trial of Tyrone Walker began in the Superior Court of the State of Delaware, in and for Kent County. Walker had been arrested for drug dealing charges stemming from an undercover investigation. Walker and his co-defendant Jonah Pratt were arrested for drug offenses and sixty-seven 30mg oxycodone pills were seized. This evidence was secured in a DSP evidence envelope, and the quantity and type of evidence was documented on the exterior of that package; thereafter, the evidence was submitted to the OCME-CSU for testing. An OCME forensic chemist concluded that the pills contained oxycodone. Upon the completion of testing, the evidence was returned to DSP Troop 3 for storage.

During trial, the evidence envelope was presented to the investigating officer who observed that the original seal on the envelope was intact, that the left side of the envelope had a seal indicating that a chemist from the OCME-CSU had opened the package, and that there were no overt signs of tampering to the exterior packaging. The envelope was opened and found to contain ten pink, round pills with the inscription of "M 32" – a blood pressure medication known as metoprolol. All of the seized oxycodone was missing. Following this revelation, trial was recessed, and Walker was afforded the opportunity to, and did, enter a guilty plea to a lesser charge.

The evidence envelope and pills were returned to Delaware State Police Troop 3. Upon closer inspection, a small cut was discovered concealed beneath a

folded flap of OCME evidence tape. The discrepancy was noted, and the envelope was resealed and placed back into secure storage.

II. OCME Response

On January 15, 2014, OCME Deputy Director Hal Brown ("Brown") was alerted to this occurrence. Brown advised investigators that, to eliminate the potential for inadvertent evidence exchange, OCME-CSU procedures require that a chemist have only one case open at a time. Brown reviewed all cases handled by the chemist on the same day that the evidence in Walker's case was analyzed to determine whether any other case analyzed that day contained ten pink metoprolol pills that may have been inadvertently exchanged. The discrepancy was believed to be an OCME recordkeeping error and OCME lab managers reviewed the case paperwork. OCME was unable to locate the missing oxycodone pills, and was unable to determine the origin of the pink pills.

Thereafter, all "pill"[3] cases secured within Delaware State Police Troop 3 were identified and examined. Each of the envelopes was visually examined, opened, and the contents were compared to the evidence listed on the exterior of the packaging. Some cases had not been sent to the OCME, while others had been sent but returned prior to testing. During this internal audit, one case was identified in which 212 oxycodone pills were missing. Investigators confirmed that OCME had received 240 pills of which three were sampled by an OCME chemist and tested positive for oxycodone.

[3] Cases including pain pills and other prescription medication.

III. The Problem Expands

On January 27, 2014, a Forensic Evidence Specialist ("FES") advised a Delaware State Police Evidence Detective of the issues that arose during the Walker trial. This FES also shared that a problem had been discovered with a case submitted by Delaware State Police Troop 2 in New Castle County. Seven evidence envelopes were submitted in that case, and the first envelope was labeled as containing 170 oxycodone pills. When the first envelope was opened, however, a chemist discovered that the 170 oxycodone pills were missing and had been replaced with 71 assorted pills. The chemist explained that 74 assorted pills were in the envelope when he opened it and that he tested three; his testing revealed that these three pills contained clonazepam – a muscle relaxant. This chemist acknowledged using the entirety of the three pills for testing, leaving 71 pills. Another OCME chemist was present for this discussion; both chemists suggested that, to avoid a similar mix-up from happening in a future case, investigators should not attempt to identify submitted evidence.[4] All of the evidence associated with that case was then collected by DSP Investigators and returned to Troop 2.

On January 29, 2014, the investigator who seized the seven pieces of evidence in this case reopened the evidence envelope that was marked as containing 170 oxycodone pills. He immediately recognized that the envelope did not contain the evidence (pills) he had seized. The remaining six items were opened and reviewed

[4] It is important to note that, while law enforcement investigators are not equipped to scientifically determine the composition of seized evidence, prescription drug makers employ a system of colors and pill labeling to allow consumers to differentiate medications. Investigators refer to databases, such as rx.com to identify seized evidence. Moreover, investigators must quantify, either by number or weight, their submissions.

and, in addition to the a large number of missing pills, four bags of marijuana were completely missing. An audit of all evidence held at Delaware State Police Troop 2 commenced.

Based on the expanding scope of compromised evidence, during the first week of February, Delaware State Police Executive Staff directed the suspension of any drug evidence submissions to OCME. A further review of drug evidence at all Delaware State Police Troops statewide was initiated.

IV. The OCME-CSU Investigation Begins.

On February 19, 2014, the formal investigation of OCME-CSU was launched. The investigation was divided into two parts: (1) the criminal investigation into the theft of drugs; and (2) the audit of all evidence submitted to, or held by, OCME. On February 20, 2014, members of the DDOJ and DSP responded to the OCME facility, located at 200 S. Adams St., Wilmington, Delaware, and informed OCME management of the criminal investigation and suspended OCME's internal audit as well as all operations within the OCME-CSU. All OCME employee access to the drug vault was revoked, and employees were directed to cease testing of any submitted evidence. As an added security measure, a separate key lock was placed on the drug vault door, which limited access to designated DSP personnel.

OFFICE OF THE CHIEF MEDICAL EXAMINER

I. Overview of the OCME

The OCME is one of twelve divisions that constitute the Department of Health and Social Services ("DHSS") for the State of Delaware. The OCME was established in 1970, following the abolishment of the earlier coroner system. The Forensic Sciences Laboratory is, by statute, established within the OCME.[5] In its present form, the OCME houses the following units: Death Investigation, Histology, Toxicology, Controlled Substances, DNA, and Arson. The OCME is overseen by a Chief Medical Examiner; presently, and at all times pertinent to this investigation, Dr. Richard Callery ("Callery") has served as the Chief Medical Examiner.[6] The OCME employs a senior management team comprised of the Chief Medical Examiner (also referred to as the Director), a Deputy Director, a Deputy Chief Medical Examiner, a DNA Technical Leader, a Chief Toxicologist, and a Controlled Substances Laboratory Manager.

The OCME-CSU receives and analyzes substances suspected of containing illegal or dangerous substances, collected and submitted by Delaware law enforcement agencies. To perform qualitative drug analyses, the OCME-CSU employs instrumentation capable of identifying a wide range of illegal substances. The most common drugs submitted for analysis are marijuana, cocaine, methamphetamine, amphetamine, heroin, prescription drugs and designer drugs.[7]

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[5] 29 *Del. C.* § 4708.
[6] Callery reports to DHSS Deputy Secretary Henry Smith who, in turn, reports to DHSS Secretary Rita Landgraff.
[7] http://dhss.delaware.gov/dhss/ocme/controlled.html.

There are three types of personnel positions in the OCME-CSU based upon the functions they perform: Analytical Chemist, Laboratory Technician, and Forensic Evidence Specialist; all are supervised by the Controlled Substances Unit Manager. Analytical Chemists are responsible for the analysis and identification of substances using established forensic scientific testing methodology; the results of these analyses are documented in reports maintained in the OCME's internal case management system, Forensic Laboratory Information Management System ("FLIMS"). Laboratory Technicians are responsible for maintaining the instrumentation within the CSU. Forensic Evidence Specialists ("FES") are responsible for receiving drug, toxicology, and DNA evidence from law enforcement agencies, either by appointment or through regular courier runs, logging evidence into FLIMS, storing evidence in the drug vault, transferring cases to chemists for analysis, and returning drug evidence to law enforcement agencies. FES seize, store and then destroy medications collected during death investigations. Finally, FES provide a statewide courier service to transport evidence from locations throughout the State to the OCME laboratory in Wilmington.

II. Evidence Submission to OCME-CSU

Controlled substance evidence, commonly referred to as "drug evidence," is submitted to OCME by law enforcement agencies in two ways: (1) through scheduled direct submission by law enforcement; or (2) through an OCME courier (in most instances, an FES). New Castle County law enforcement agencies, based on their close proximity to the OCME building, typically schedule an appointment

with a FES to submit drug evidence directly to OCME, while larger law enforcement agencies in New Castle County, such as the Wilmington Police Department, the New Castle County Police Department, and the Delaware State Police arrange appointments due to the regularity and volume of submissions. When a representative from the submitting agency arrives at OCME, the FES will cross check the submission sheet with the exterior packaging of the evidence being submitted. Thereafter, the FES brings the submitted evidence to the FES office and secures it in the drug vault.

Agencies in Kent and Sussex Counties use the OCME courier system to transport evidence to OCME in Wilmington. Law enforcement agencies notify the OCME FES of pending drug evidence submissions; the agencies then are instructed to have a representative meet at a predetermined collection location at a scheduled time. The FES will cross check the submission sheet with the evidence being submitted and cross check the return sheet for any evidence being returned from OCME to the law enforcement agency. The newly submitted evidence is then secured and transported back to OCME where it is ultimately documented in the OCME case management system and secured in the drug vault.

At the conclusion of both processes, the FES has possession of the drug evidence. The FES then logs the evidence into FLIMS, affixes the evidence container with an OCME evidence sticker and places it into the drug vault in sequential order. If the evidence submitted is an oversized package, it is placed in a designated area of the drug vault.

III. OCME Physical Layout

The CSU and FES office are located on the second floor of the main building at 200 South Adams Street in Wilmington, Delaware. Primary access to the building, including public access, is through an exterior door facing South Adams Street. Entry through this door is granted by the front desk receptionist, who is positioned to see visitors through glass doors, and communicates with visitors using an intercom system. Visitors to the lab are required to sign in on a log located at the front desk. There is an employee entrance on the north side of the building that is controlled by a programmed key fob supplied to OCME employees. The entrance to the morgue is located on the east side (rear) of the building behind a chain link fence and electronic gate; the morgue door contains a keyed lock. The electronic gates are frequently left open during business hours. The building is also equipped with a security alarm which may be activated and deactivated by employees granted this privilege.

The first floor houses administrative offices; the Chief Medical Examiner's office and the Deputy Director's office are located on this floor. The morgue, autopsy rooms, and the DNA lab are located on the basement level, and the Toxicology Lab, the Controlled Substances Lab, the Forensic Evidence Specialists Office, and the drug vault are located on the second floor. The basement and second floor may be accessed through stairwells or elevators; elevator access is controlled by a programmed key fob. Thus, while some employees may be limited in their

ability to use the elevator, all individuals within the building may access the various floors through the unsecured stairwell.

The FES office, Controlled Substances Unit and Toxicology Unit are located on the second floor. The Toxicology Unit is located at the southern end of the floor, and the offices and laboratory contain large banks of windows that allow full view into and from the hallway. The Controlled Substance Unit is located on the north side of the second floor. The FES office is centrally located on the second floor, and the drug vault is located through a doorway off of the FES office. The doors to access the Toxicology Laboratory, Controlled Substance Laboratory, and FES office are controlled by a numeric keypad. Each OCME employee is assigned a unique code that limits access to certain areas based on job responsibilities and as authorized by the Director or Deputy Director Director. A list of each employee's access to areas within the OCME building is maintained by the Quality Assurance Manager, when provided notification of changes.

Only personnel with access to the FES office may access the drug vault. In addition to the numeric keypad access required to access the FES office, the drug vault is secured with an alarm that may only be disarmed with the entry of a code. The alarm is generally armed at the close of normal business hours and disarmed at the start of the day. Additionally, a programmed key fob is required to open the drug vault door. In addition to these three layers of security, there is a camera located outside the drug vault which records activity at the vault door; there are no cameras inside the drug vault. The camera records to digital media in an unsecured

cabinet in an unsecured room on the first floor of OCME. Recorded video is overwritten each week.

OCME employs a system of pass through lockers to allow for the secure return of tested evidence. Drug evidence is distributed to chemists by FES personnel who place assigned cases in an individual chemist's secured locker. Once testing is complete, the chemist may return the evidence to FES in person or deposit the evidence in a pass through safe located on the wall of the second floor hallway. To use the evidence pass through, the employee opens the metal door, places the evidence inside the box, closes the door, and presses a metal button next to the door which locks that specific door. The drug vault is located on the other side of the pass through boxes, and there is one large metal panel that controls access to all the boxes from within the drug vault. The panel is secured by a keyed lock.

IV. OCME Security

OCME employs a combination of alarms, key fobs, electronic locks, and cameras. The OCME building alarm is activated at the end of normal business hours and is deactivated upon the commencement of the business day. A private alarm company maintains a list of OCME employees charged with responding to the facility in the event the alarm is triggered. The alarm code is provided to select employees with the approval of OCME senior staff; approval is generally cleared by the Deputy Director. Nonetheless, there are no consistent, established criteria for the distribution of the alarm code to OCME personnel. For example, one casual

seasonal employee was provided the building alarm code because she worked early hours, while another casual seasonal employee assigned to work similar hours was denied the code because she was "part time."

Most OCME employees do not work during nighttime hours or on weekends. Of course, pathologists, forensic morgue assistants, and forensic investigators are required to work irregular hours as their duties require them to respond to and investigate suspicious deaths and homicides. One such employee advised that there were times when he would report to the building on a weekend and find that the alarm was turned off. Forensic investigators were known to come in early on the weekend, turn off the building alarm, then return later in the evening to reset the alarm. Moreover, some Forensic investigators occasionally slept in the OCME annex during their "on call" shifts. This provided them free access to the OCME buildings.

In addition to the alarm for the OCME building, there is another alarm for the drug vault. This alarm may be deactivated with a four digit alarm code. Much like the building alarm, the vault alarm is deactivated during normal business hours while forensic evidence specialists are working.

OCME uses a combination of electronic keypad locks and a Locknetics Touch Key I-Button system to control employee access to various areas within the buliding. The Locknetics Touch Key I-Button system uses a programmable key fob programmed by an OCME employee using proprietary software. OCME key fobs are programmed using the software on a laptop computer with employee access

being defined by the Deputy Director. Each employee who has a key fob is assigned a unique system identifier and assigned access rights accordingly. The Locknetic system tracks entries through each door. The system is capable of storing the most recent entries for each door; specifically, the system captures the user identifier, as well as the date and time of entry.

The laptop used to program the key fobs and store the entry data was originally kept on a cart in the maintenance shop; more recently, the cart was stored in the air handler room. Neither room affords appropriate security for the information maintained on this computer. The laptop employs the Windows 95 operating system. Investigators learned that sometime after the year 2000, the value of the entry data was compromised. Employees attribute this glitch to "Y2K" issues – computer programming issues prompted by the date change from 1999 to 2000. Regardless of the origin or explanation, all door entries now show an entry date of January 1, 1970, and do not provide an accurate date and time of access. This problem was known to OCME staff and management, yet no corrective action was taken. Thus, the stored entry key fob data is of no value to investigators.

The OCME has an external and internal camera system. Video captured by the camera system may be viewed on a monitor located in an unsecured storage closet on the first floor of the building. The camera located in the FES office faces the drug vault door. The camera records to digital media within an unsecured cabinet in the unsecured storage closet. The digital media is "rewritten," that is, overwritten by newer video footage, at approximately 7-day intervals. There was no

system in place to review stored footage, and no efforts were made to record captured footage before the overwrite. The capabilities and limitations of the video surveillance equipment was common knowledge to OCME employees. Recently, OCME has contracted with a security firm to install additional cameras within the building.

Access to the building alarm code was distributed to several employees. Furthermore, key and key fob access permissions were not adjusted when employees moved to different assignments within OCME and were not withdrawn when employees left OCME employment. For example, one employee retained key fob access to the drug vault until February 2014, despite being reassigned to another unit in September 2013. Additionally, investigators learned that an employee who retired in 2008 was still in possession of an OCME key and key fob as recently as February 2014. When contacted, the retired employee was able to locate and return the key and key fob to OCME.

While not capable of identifying a precise date, employees recall having observed the door to the drug vault propped open numerous times over the years. When the DSP secured the drug vault on February 20, 2014, a well-worn, wooden chock was observed in the area adjacent to the door. Based on witness interviews, investigators believe this was used to hold the door open. It should be noted that while the door to the vault was left open to allow employees access while working in the FES office, one would need the code for the electronic key pad to enter the closed

FES office door. Thus, a level of physical security was retained while the vault remained open.

The practice of propping open doors was not limited to FES and the drug vault. During a June 2013 external audit, the back door with access to the laboratory through the morgue intake room was found propped open on two occasions. OCME management was notified of this finding and corrective action was taken to ensure the proper closing and locking of the door.

V. Hiring and Staffing at OCME-CSU

OCME employs a combination of full time and part time (casual/seasonal) personnel to fulfill its various responsibilities. OCME employs individuals with a wide range of education and experience, and some positions, such as laboratory technicians, experience frequent turnover. The human resources section of DHSS provides guidance and direction to OCME on issues pertaining to hiring and promotion. Vacancies are announced in job postings that outline the job duties and any unique requirements of the particular post. Prospective applicants are required to complete an employment application and supplemental questionnaire and are asked to provide a resume. Applicants are screened, and positions are filled pursuant to the State of Delaware hiring process. Upon hiring, OCME employees are required to submit to a fingerprint based criminal history check; this record check identifies offenses resulting in an arrest. Employees are not screened for drug use upon hiring, and are not subject to random or on demand drug screening while employed in any position within OCME. No additional formal background

assessment is completed; however, OCME management have employed publicly available internet tools to research prospective candidates.

The compromised cases discovered in Delaware in early February, coupled with the exposure of drug lab issues in other jurisdictions, prompted OCME senior management to revisit the feasibility of conducting background checks, polygraph exams, random drug testing, and pre-employment drug testing in selecting and monitoring OCME employees. To date, none of these procedures have been implemented.

The limited employee screening process has prompted numerous "red flags" to go unnoticed. For example, a casual seasonal administrative specialist, suspected of theft from a former employer, was hired and quickly granted security access. While the information concerning the prior conduct was, at the time of hiring, merely conjecture, no efforts were made to contact prior employers or coworkers to better understand the circumstances of the matter. The candidate was hired in 2008 and, within days, moved to a position within the Forensic Evidence Specialist Unit. Another employee, hired in 2010, left a previous post under suspicion of theft. In that instance, the prior employer was contacted and expressed concerns. Again, in the face of questionable prior conduct, the decision was made to hire this applicant as a forensic evidence specialist.

VI. Management

The Deputy Director of OCME is responsible for the day-to-day management of all OCME operations, except for the medical aspect of death investigations performed by the team of pathologists. A frequent practice at OCME was to hire an individual for a vacant position and thereafter move the employee to a position of greater immediate need. As a result of this practice, FES positions were frequently staffed by individuals neither qualified for, nor interested in, performing detailed, forensic evidence management.

The hiring of the previously described casual seasonal administrative specialist is illustrative of these assignment practices. While initially hired to serve as the front desk receptionist in 2008, within a week of joining OCME, the employee was tasked with completing work on controlled substances. Despite a lack of qualifications, this employee continued to work in the Controlled Substances Unit through 2013. Throughout this timeframe, this employee's assignments expanded to include tasks traditionally associated with forensic evidence specialists and lab managers. For example, the employee accepted and returned evidence, transferred evidence from the drug vault to chemists, assigned cases to chemists, and served as liaison with the DDOJ on drug testing issues. This employee was reassigned to the receptionst post and stripped of all controlled substances duties when the Controlled Substances Unit leadership changed in late 2013.

There were other instances of OCME employees performing tasks well beyond their designated assignments. In March 2010, a FES provided two weeks

notice of departure. Before leaving, the employee was asked to show other OCME employees how to perform the tasks of a FES. As a result of this hasty training, from March through June 2010, existing OCME employees were assigned to work as FES. Internal coverage of this job function continued until the vacancy was filled in July 2010. Similarly, in 2009, another FES was injured and reassigned to the front desk to answer phones for a period of three years; during this extended recovery period, this employee continued to perform some forensic evidence duties and assisted the Toxicology Unit while other OCME staff performed FES duties.

In 2013, a more senior management position was added to oversee CSU and FES operations. The position was filled from within the existing ranks of OCME by a manager with demonstrated management deficiencies. A 2009 internal audit found that FES, under the leadership of this individual, lacked operational policies or procedures. An evidence manual with a 2008 revision date was located during this investigation; the manual contains policies and procedures that are outdated, and witnesses have advised that the manual was never formally approved and distributed. A new manager now oversees CSU and FES operations and the 2014 internal audit of the unit was postponed to afford the new management the opportunity to assess operations. An expressed goal of OCME is to review and revise the entire CS Quality Manual to meet all ISO 17025 requirements.

VII. Accreditation

OCME is accredited by Forensic Quality Services ("FQS") using standards developed by the International Organization for Standardization ("ISO"). FQS is a member of the American National Standards Institute – American Society for Quality ("ANSI-ASQ") National Accreditation Board family of brands. FQS provides accreditation for forensic laboratories. An accreditation cycle includes the initial, on-site assessment for accreditation and follow-up surveillance assessments until the end of the cycle, when a re-accreditation starts a new cycle. Accreditation cycles cover two to five years, allowing the lab to determine what is best for its operations. OCME was issued its current Certificate of Accreditation on June 15, 2012. The certificate is valid until June 15, 2016.

In some instances, OCME has written policies and procedures in place that govern the actions of employees in the Controlled Substances Unit and FES. Investigators have concluded that established policies were not always followed, and changes in policy and procedures were not always properly updated or communicated. As a result of this investigation, DHSS has contracted with Andrews International to review and assess OCME policies and procedures, and any other areas of concern. It is expected that Andrews International will offer "best practices" to be implemented by OCME.

VIII. Evidence Receipt & Handling

Each piece of drug evidence submitted to OCME is assigned an internal tracking number. OCME employees manually enter the police complaint number, the defendant's name, the type of evidence, the submitting agency, and the submitting officer into the internal evidence tracking system; this information is garnered from the exterior packaging of the submitted evidence. This information, once entered, is associated with the submitted evidence by the internal tracking number. The internal tracking number is handwritten on a sticker and affixed to the exterior of the evidence package.

This unique identifier is used to track evidence within the evidence management system. The current system, FLIMS, has been used since 2012; prior to FLIMS, a Lotus Notes system was used to track evidence. Lotus Notes cases have a "CS" prefix, while FLIMS cases have a "FE" prefix. FLIMS allows law enforcement agencies to "pre-log" evidence scheduled for submission to OCME. Through a web-based system, referred to as "FA Web," agencies may enter basic data pertaining to evidence scheduled for submission. When evidence is pre-logged, OCME cross checks the submitted evidence with the law enforcement agency "pre-log" before evidence is accepted. This capability has greatly reduced the amount of data entry being conducted by FES personnel.

A paper receipt is generated for evidence received from law enforcement agencies. The receipt and submitted evidence are cross checked by the submitting officer and the receiving employee. The evidence is then logged into the tracking

system. Investigators have found that some evidence was not immediately logged into the tracking system upon receipt. Often, submitted evidence was placed in the drug vault to be logged into Lotus Notes or FLIMS at a later time. As a result of the delay between receipt and logging, many cases showed a discrepancy between the date the evidence was received by OCME and the date the law enforcement agency submitted the evidence. In most cases, the difference was a few days; however, cases have been identified with a difference of several weeks.

In addition to these logging delays, investigators discovered several data entry errors. Often, the errors involved documentation of the wrong officer or the wrong agency as submitting a particular piece of evidence. Based upon a review of available records, coupled with witness interviews, investigators have concluded that many of the data entry mistakes were made by employees assigned to perform tasks beyond the scope of their employment.

Seized drug evidence is packaged by law enforcement agencies in a variety of containers. During the investigative audit, investigators observed drug evidence stored in paper envelopes, plastic envelopes, paper bags, cardboard boxes, plastic bins, and metal cans. Most drug evidence submitted to OCME fit on the rolling evidence shelf system in the drug vault; oversized evidence was stored in another area within the drug vault. When DSP secured the drug testing laboratory on February 20, 2014, OCME records indicated that approximately 8,568 pieces of evidence were stored within the vault. The DSP audit revealed the actual number to be 9,273 pieces of evidence.

Investigators identified issues with respect to the storage of evidence within the OCME drug vault. Witnesses revealed that, at times, smaller evidence envelopes fell between shelves, fell to the floor, or shifted behind larger envelopes. When found, these smaller envelopes were placed inside larger envelopes by OCME employees. Witnesses also advised that small amounts of loose drugs were occasionally found on the floor of the drug vault. As these loose drugs could not be associated with a specific submission, they would be placed in a manila envelope inside the drug vault on a shelf by the door. One former employee opined that the loose drugs fell to the floor because the dehumidifier in the vault dried the evidence adhesive seal.

OCME-CSU failed to recognize the import of maintaining the integrity of submitted evidence. Witnesses advised that lab managers would remove evidence from the drug vault without properly logging it out. Another former OCME employee recalled seeing drug evidence in the lab manager's personal office. This same manager was known to maintain a separate box of "old" evidence in the drug vault.

Evidence was, at times, lost and there were instances of evidence being stored improperly. A former OCME employee described an instance where a marijuana plant was submitted for analysis, but was not sufficiently dry to test. Rather than returning the evidence, the plant was placed in a dryer in a back stairwell at OCME; all OCME employees have access to the stairwell. Another chemist advised that marijuana and heroin packets had fallen into the pockets of

their lab coat and bench drawer; as the origin of these drugs could not be determined, the evidence was disposed of without completing a report or notifying a supervisor.

Mishandling of evidence was not limited to drugs submitted for analysis by police agencies. OCME forensic investigators secure prescription drugs from death scenes, and the drugs accompany the body to the OCME building where the medication is transferred to FES for storage in the drug vault. The medications are sealed in clear evidence bags and are stored on an evidence shelf awaiting destruction after 90 days; after 90 days, the evidence bags are boxed and incinerated. Despite this protocol, during the removal of evidence from the drug vault, DSP investigators found a box containing medications from death cases dating back to 2012. One of the bags appeared to have been ripped open. While these cases should have been destroyed by, at latest, March 2013, an OCME employee explained that there was no method to log and track evidence secured in death cases and, thus, no system to determine when evidence should be destroyed. There was some documentation of destroyed evidence, and investigators were provided three lists of cases that had been destroyed in 2013.

IX. Evidence Analysis

Different procedures for transferring evidence to and from the drug vault to assigned chemists have been employed. Prior to the implementation of the FLIMS system in 2012, drug evidence was pulled from the drug vault by FES personnel and placed into the assigned chemist's locker for analysis. Once the evidence was

tested, it would be picked up by FES personnel and returned to the drug vault. Following the switch to FLIMS in 2012, chemists would hand deliver analyzed evidence to FES personnel or would place the evidence in the pass through locker system. At the end of 2012, the Lab Manager instructed chemists to check the FLIMS database frequently for case assignments and directed them to make arrangements with FES to receive cases for testing and then return the evidence through the pass through system.

FLIMS allowed for a more detailed accounting of evidence transfers than the Lotus Notes system it replaced. The value of the Lotus Notes and FLIMS data, however, is contingent upon the accuracy of the data input. As previously discussed, a lab manager was observed removing evidence from the drug vault without logging it out, and in February 2012, dozens of cases had been given to chemists without the assignment being documented in the system. Data entry issues continued into 2013 and, in February 2013, controlled substance chemists were reminded to properly document the return of evidence to FES.

A large portion of drug evidence submitted to OCME is never tested. Rather, it is held in the drug vault until testing is requested by the applicable law enforcement agency. In many instances, evidence is returned to the submitting agency without analysis because a resolution is reached in the associated criminal case. Prior to 2012, OCME attempted to analyze every piece of drug evidence submitted. However, chemists were unable to meet the demand and a backlog of cases developed. Thus, in 2012, OCME modified its policy to only analyze drug

evidence when requested. Tested drug evidence is generally returned to the submitting law enforcement agency shortly after the report is completed and approved, and untested drug evidence is generally returned after OCME learns of the resolution of the associated case.

One employee was advised by a laboratory manager that all drug evidence needed to be retained for three years. As the drug vault filled, the three year retention requirement was adjusted to two years then one year. "Old" evidence was to be returned to the submitting law enforcement agency; nevertheless, during the DSP investigative audit, evidence from as far back as 1989 was found in the drug vault. On an earlier occasion, a former employee had discovered drug evidence from the 1970's.

Compounding these retention issues is the fact that some members of the controlled substances staff unnecessarily retained drug evidence for internal training and testing. Each chemist has drugs, provided by Collaborative Testing Services ("CTS"), in their locked drawers to use for proficiency testing; thus, there is no reason for holding seized evidence. Yet, during the investigative audit, two boxes containing various pieces of unrelated drug evidence were located inside the drug vault; the boxes were collected and inventoried. The former Lab Manager claimed that these boxes contained evidence from closed cases and that the drugs were retained for chemist training and proficiency testing. Another laboratory manager explained that he retained as much as 40 grams of marijuana from a case for use in future testing. Prior to the scheduled destruction of drug evidence in

2012, the former Lab Manager requested that the disposal be delayed to allow an assessment of whether any of the evidence could be used for future research or testing. One chemist was found to have had a marijuana case in their possession for approximately 6 days according to the OCME chain of custody; the case was opened and resealed, but was never tested, yet a quantity of marijuana was found to be missing.

Investigators also learned that chemists employed varying testing methodologies. When testing the chemical composition of submitted pills, most chemists would remove a portion of a pill for analysis and mark the tested pill with a number or, if the pill was too small, secure it in tape or wax paper. Investigators found that one chemist would "consume" all of the tested pills in the analysis; thus, when audited, several cases analyzed by this chemist contained one to three fewer pills than originally submitted. The issue was addressed internally through OCME training.

It was also discovered that one chemist was assigned to perform evidence analysis despite their failure of internal proficiency tests. This chemist was retrained, and again failed the tests. Nonetheless, OCME management determined that it was critical to have the chemist performing the essential duties of the position. Thus, despite failing to demonstrate proficiency, this chemist was assigned to analyze marijuana cases and cases within the jurisdiction of the Family Court of the State of Delaware. Investigators concluded that these assignments were made based on the fact that few of those cases proceed to trial.

OVERALL IMPACT/COST

DSP began its investigation into missing drugs on January 15, 2014. The investigation started at Troop 3, and by the end of January expanded to Troop 2. By mid February, a statewide investigation was launched. DSP has committed a team of four veteran investigators to lead this investigation. Additional DSP investigators have assisted, and during periods of this investigation twenty full-time sworn officers have provided full-time support. These investigators were pulled from their regular assignments, thus causing an increased workload on their co-workers.

All drug evidence removed from OCME was transported to and stored at DSP Troop 2. Shelving was purchased and installed to organize the storage of over 9,000 pieces of drug evidence. In addition to the investigative team, three troopers were assigned full time to oversee the process of auditing each piece of evidence secured from the OCME drug vault. The contents of each package was dual confirmed and the results documented. Many Delaware police agencies committed personnel and resources to support this phase of the operation. In addition to the audit of evidence stored at OCME, each DSP Troop, and every Delaware law enforcement agency reviewed drug evidence stored within their headquarters. Moreover, the Troop 2 Evidence Detection Unit has been and will continue to transport drug evidence to NMS Labs in Pennsylvania for testing.

DDOJ joined the investigation in February 2014. To date, thirteen DDOJ employees have been assigned to the investigation and have committed hundreds of

hours beyond their regular, full-time employment responsibilities to this investigation.

The impact of the issues identified in this report on Delaware's criminal justice system is profound. Criminal cases have been dismissed, charges have been reduced, and thousands of offenders are seeking to overturn their convictions. There are motions and appeals pending in Delaware Courts which raise claims based upon the facts uncovered in this investigation. As of this writing, over 500 pleadings have been filed state-wide and more are expected. As a direct results of the OCME failures, over 200 drug charges have been dismissed and over 60 cases have been reduced. An outside laboratory has been retained to test Drugs seized by Delaware law enforcement agencies; to date, over 400 pieces of evidence have been submitted to this lab at a cost of well over $100,000.00.

Cases have been dismissed and reduced based upon compromises to evidence submitted to, or returned from, OCME. The compromised cases include lost or missing oxycontin, marijuana, heroin, and cocaine. Eighty-two defendants have been notified of discrepancies in the drug evidence in their cases. Discrepancies were identified in cases prosecuted by both State and Federal Authorities and the source of discrepancies range from theft to measurement inconsistency.[8] The latter category – measurement inconsistency – have been dubbed "anomaly cases;" while a

[8] Four types of measurement inconsistency were identified. First, some chemists "consumed" three complete pills in their testing process; thus, cases tested by these chemists would have three fewer pills than originally submitted. Second, the weight of some drugs is reduced as they continue to dry after seizure; the greatest weight reduction is observed in marijuana, a plant material. Third, seizing officers weigh drugs together with their packaging while forensic chemists remove submitted samples from their packaging. Fourth, counting errors occur in cases where large quantities of evidence is seized; it is not uncommon for thousands of bags of heroin to be seized at one time and for a slight counting error to be encountered.

more benign category, offenders impacted by measurement inconsistency, too, have been notified.

As a result of the facts and circumstances uncovered in this investigation, three OCME employees have been suspended, two of whom have been indicted in the Superior Court.

First, Callery is currently the subject of an ongoing investigation related to his position as Chief Medical Examiner. Therefore, a full description of his conduct cannot be offered at this time.

Next, CSU Laboratory Manager Farnam Daneshgar is the subject of a criminal prosecution related, in part, to his position as Lab Manager I/Analytical Chemist; while a full description of his conduct cannot be offered, it can be reported that Daneshgar was indicted by a New Castle County grand jury for Possession of Marijuana (Title 16 Section 4764), Possession of Drug Paraphernalia (Title 11 Section 4771), and 2 counts of Falsifying Business Records (Title 11 Section 871). Additionally, according to a witness, Farnam Daneshgar left OCME in 1990 after it was alleged that he was "dry labbing" testing results; the phrase "dry labbing" is used to describe the practice of declaring a result without performing the analytical testing to produce the result. Other witnesses claim that Daneshgar has engaged in other instances of "dry labbing" since his return to OCME in 2006.

Finally, James Woodson was hired as a forensic evidence specialist in 2010 and worked in that capacity until being hired as a forensic investigator in September 2013. Woodson, too, is the subject of a criminal prosecution related to

his position as a forensic evidence specialist; therefore, a full accounting of his role cannot be included at this time. Woodson was indicted by a New Castle County grand jury for Trafficking Cocaine 10-50 grams (Title 16 Section 4753A), Theft of a Controlled Substance (Title 16 Section 4756), Tampering with Physical Evidence (Title 11 Section 1269), Official Misconduct (Title 11 Section 1211), and Unlawful Dissemination of Criminal History Record Information (Title 11 Section 8253).

In total, thus far, the audits have revealed 51 pieces of potentially compromised evidence, stemming from 46 cases. The details of those compromised cases is as follows:

1. In 2010, the Wilmington Police Department ("WPD") submitted a number of seized pills, based on labeling believed to contain Alprazolam and Adderall, to OCME for analysis. The evidence was tested, found to contain Alprazolam and Addreall, and returned to WPD. During an audit, 4 Alprazolam and 4 Adderall pills were found to be missing.

2. In 2010, the Newark Police Department ("NPD") submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to NPD. During an audit, 79 grams of marijuana was found to be missing.

3. In 2010, the DSP submitted a number of seized pills, based on labeling believed to contain oxycodone, to OCME for analysis. This evidence was not analyzed by an OCME chemist and was returned to DSP. During an audit, it was discovered 58 oxycodone pills were missing.

4. In 2010, the DSP submitted a number of seized pills, based on labeling believed to contain oxycodone, to OCME for analysis. This was not analyzed by an OCME chemist and was returned to DSP. During an audit, it was discovered 99 oxycodone pills were missing.

5. In 2010, the Milford Police Department ("MPD") submitted a number of seized pills, based on labeling believed to contain oxycodone, to

OCME for analysis. This was not analyzed by an OCME chemist and was returned to MPD. During an audit, it was discovered 60 oxycodone pills were missing.

6. In 2010, the MPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to MPD. During an audit, 55 grams of marijuana was found to be missing.

7. In 2011, the WPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to WPD. During an audit, 163 grams of marijuana was found to be missing.

8. In 2011, the WPD submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain prescription drugs, and returned to WPD. During an audit, 109 Endocet pills and 72 oxycodone pills were found to be missing.

9. In 2011, the WPD submitted seized plant material, believed to contain marijuana, to OCME for testing. The evidence was tested, found to contain marijuana, and returned to WPD. During an audit, 310 grams of marijuana was found to be missing.

10. In 2011, the DSP submitted a seized substance, believed to contain cocaine, to OCME for testing. The evidence was tested, found to contain cocaine, and returned to DSP. During an audit, 44 grams of cocaine was found to be missing.

11. In 2011, the DSP submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to DSP. During an audit, 107 oxycodone pills were found to be missing.

12. In 2011, the NPD submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to NPD. During an audit, 44 oxycodone pills were missing.

13. In 2011, the WPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to WPD. During an audit, it was discovered 3 pounds of marijuana was missing.

14. In 2011, the WPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to WPD. During an audit, it was discovered 6.25 pounds of marijuana was missing.

15. In 2011, the Bridgeville Police Department ("BPD") submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to BPD. During an audit, it was discovered 27 oxycodone pills were missing.

16. In 2011, the WPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to WPD. During an audit, it was discovered 1 pound of marijuana was missing.

17. In 2011, the New Castle County Police Department ("NCCPD") submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to NCCPD. During an audit, it was discovered 57 oxycodone pills were missing.

18. In 2011, the MPD submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to MPD. During an audit, it was discovered 100 oxycodone pills were missing.

19. In 2011, the NCCPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to NCCPD. During an audit, it was discovered 280 grams of marijuana was missing.

20. In 2013, the DSP submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to DSP. During an audit, it was discovered 150 oxycodone pills were missing.

21. In 2012, the WPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to WPD. During an audit, it was discovered 19.5 pounds of marijuana was missing.

22. In 2012, the DSP submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to DSP. During an audit, it was discovered 67 oxycodone pills were missing.

23. In 2012, the NPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to NPD. During an audit, it was discovered 799 grams of marijuana was missing.

24. In 2012, the DSP submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was not analyzed by an OCME chemist and returned to DSP. During an audit, it was discovered 502 oxycodone pills were missing.

25. In 2012, the NPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to NPD. During an audit, it was discovered 161 grams of marijuana was missing.

26. In 2012, the DSP submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to DSP. During an audit, it was discovered 170 oxycodone pills were missing.

27. In 2012, the DSP submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to DSP. During an audit, it was discovered 37 oxycodone pills were missing.

28. In 2012, the WPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to WPD. During an audit, it was discovered 7 pounds of marijuana was missing.

29. In 2012, the Middletown Police Department submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to Middletown Police Department. During an audit it was discovered 28 oxycodone pills were missing.

30. In 2012, the WPD submitted a seized brick, based on packaging believed to contain cocaine, to OCME for analysis. The evidence was

tested, found to contain cocaine, and returned to WPD. During an audit, it was discovered 2.282 kilograms of cocaine was missing.

31. In 2012, the NCCPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to NCCPD. During an audit, it was discovered 84 grams of marijuana was missing.

32. In 2012, the DSP submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was tested, found to contain oxycodone, and returned to DSP. During an audit, it was discovered 177 oxycodone pills were missing.

33. In 2012, the WPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to WPD. During an audit, it was discovered 1 pound of marijuana was missing.

34. In 2012, the DSP submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was not analyzed by an OCME chemist and returned to DSP. During an audit, it was discovered 165 oxycodone pills were missing.

35. In 2012, the WPD submitted a seized brick, based on packaging believed to contain cocaine, to OCME for analysis. The evidence was tested, found to contain cocaine, and returned to WPD. During an audit, it was discovered 1 kilogram of cocaine was missing.

36. In 2012, the DSP submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was not analyzed by an OCME chemist and returned to DSP. During an audit, it was discovered 212 oxycodone pills were missing.

37. In 2012, the WPD submitted a number of seized bags of material, based on labeling believed to contain heroin, to OCME for analysis. The evidence was tested, found to contain heroin, and returned to WPD. During an audit, it was discovered 1,533 bags of heroin were missing.

38. In 2012, the WPD submitted a number of seized pills, based on labeling believed to contain prescription drugs, to OCME for analysis. The evidence was not analyzed by an OCME chemist and returned to WPD. During an audit, it was discovered 118 oxycodone pills were missing.

39. In 2013, the WPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to WPD. During an audit, it was discovered 4 pounds of marijuana was missing.

40. In 2013, the NCCPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to NCCPD. During an audit, it was discovered 8 pounds of marijuana was missing.

41. In 2013, the DSP submitted a number of seized pills, based on labeling believed to contain oxycodone, to OCME for analysis. This evidence was not analyzed by an OCME chemist and was returned to DSP. During an audit, it was discovered 99 oxycodone pills were missing.

42. In 2013, the DSP submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to the DSP. During an audit, it was discovered 28 grams of marijuana was missing.

43. In 2013, the DSP submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to the DSP. During an audit, it was discovered 140 grams of marijuana was missing.

44. In 2013, the NCCPD submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was tested, found to contain marijuana, and returned to the NCCPD. During an audit, it was discovered approximately 1-3 pounds of marijuana was missing.

45. In 2013, the DSP submitted seized plant material a number of seized pills, believed to contain marijuana and oxycodone, to OCME for analysis. The evidence was not analyzed by an OCME chemist and returned to the DSP. During an audit, it was discovered 170 oxycodone pills and 2.6 pounds of marijuana was missing.

46. In 2013, the DSP submitted seized plant material, believed to contain marijuana, to OCME for analysis. The evidence was not analyzed and returned to the DSP. During an audit, it was discovered 1.8 pounds of marijuana was missing.