



## **REPORT OF THE BOSTON BAR ASSOCIATION DRUG LAB CRISIS TASK FORCE**

Michael Ricciuti, Chair

Kathleen Joyce

Scott Lopez

Liza Lunt

Christina Miller

Martin Murphy

Mark Smith

### **INTRODUCTION**

The Boston Bar Association created the Drug Lab Task Force (hereinafter, “the Task Force”) in 2012 in the wake of the allegations that Annie Dookhan, a former chemist at the Massachusetts Department of Public Health’s Hinton Drug Testing Laboratory in Jamaica Plain, engaged in criminal misconduct regarding drug evidence seized in connection with thousands of Massachusetts state and federal criminal cases (hereinafter, “the Lab Crisis”). The mission of the Task Force was to review the facts regarding the Lab Crisis and any matters related to it, identify any lessons to be learned from these events, and propose any appropriate recommendations for change. This Report reflects the conclusions and recommendations of the Task Force.

### **OVERVIEW AND EXECUTIVE SUMMARY**

As detailed below, the Lab Crisis has been extraordinarily costly, not just in terms of dollars spent (and to be spent) to address the fallout from Dookhan’s misconduct, but, more importantly, in terms of the damage done to the public’s confidence in the Massachusetts criminal justice system. These are costs that an already overburdened state criminal justice system could not easily afford.

Despite laudable improvements in lab oversight that have taken place in the wake of the Lab Crisis, the Task Force believes that the risk of another such crisis in forensic services in Massachusetts is unacceptably high. The Task Force has thus concluded that additional steps should be taken to guard against intentional or unintentional misconduct in forensic services, a recommendation which is consistent with those made by the Boston Bar Association in the past. Specifically, the Task Force recommends the following:

First, that prosecutors, defense counsel, judges, and policy makers continue the extraordinary joint efforts that were mounted in the aftermath of the Dookhan misconduct to promptly resolve open criminal cases related to Dookhan’s misconduct;

Second, that the Commonwealth further enhance the auditing and oversight of drug labs and consider similar steps regarding all forensic services; and

Third, that the Governor and Legislature review funding levels for forensic services to ensure these services are adequately funded and staffed and that effective auditing and oversight is maintained.

## FACTS

### **A. Dookhan Facts**

Prior to the Lab Crisis, the Massachusetts Department of Public Health (DPH) conducted scientific analyses of suspected narcotics, controlled substances and certain alcoholic beverages for law enforcement and other official uses.<sup>1</sup> These services were provided from two laboratories, the Hinton Laboratory in Jamaica Plain, which served eastern Massachusetts, and the Amherst Laboratory, which served Western Massachusetts.<sup>2</sup> The results of the analyses conducted at these labs were often used as evidence in the prosecution of criminal cases.<sup>3</sup>

In November, 2003, Annie Dookhan was hired as a drug chemist by DPH. She worked in the Hinton Lab testing suspected drug samples for use in criminal cases.<sup>4</sup>

Dookhan became an extremely productive chemist in terms of output. Her colleagues, however, came to question her productivity and to believe that her output exceeded the number of drug samples that could be properly tested in a given amount of time.<sup>5</sup> Indeed, one supervisor was “staggered” by the number of samples Dookhan claimed to have processed, as it was three to ten times what an average chemist could complete.<sup>6</sup> Another supervisor came to a similar conclusion.<sup>7</sup> Further, Dookhan’s fellow lab employees noticed that, in many instances, re-tests of samples Dookhan had identified as cocaine turned out to be heroin, which the employees reported to their supervisors.<sup>8</sup>

Despite these concerns, prior to June 2011, lab management took little action regarding Dookhan<sup>9</sup> beyond performing an audit of her paperwork. For instance, lab management failed to re-test drug samples processed by Dookhan,<sup>10</sup> and because routine monthly re-testing of samples was replaced with technical reviews of chemists’ work, there were no re-tests conducted of Dookhan’s samples.<sup>11</sup>

In the spring of 2011, one of Dookhan’s colleagues complained to a lab supervisor that Dookhan’s sample numbers were, again, suspiciously high. Instead of investigating Dookhan’s conduct, lab leadership gave Dookhan a special project in an attempt to slow her down.<sup>12</sup> Following this complaint,

---

<sup>1</sup> See M.G.L. ch. 112, § 11 and 12.

<sup>2</sup> Commonwealth of Massachusetts Department of Public Health State Laboratory Institute, Policies and Procedures, Drug Analysis Laboratories, September 29, 2004 (“2004 Procedures”), at 3.

<sup>3</sup> 2004 Procedures, at 3.

<sup>4</sup> Massachusetts State Police witness interview.

<sup>5</sup> Massachusetts State Police witness interview.

<sup>6</sup> Massachusetts State Police witness interview.

<sup>7</sup> Massachusetts State Police witness interview.

<sup>8</sup> Massachusetts State Police witness interview.

<sup>9</sup> In addition, Dookhan’s resume reflected a Master’s Degree that she did not earn. She removed it from her resume when confronted. Massachusetts State Police witness interview. Even though Dookhan took the designation off of her resume, at times the resume was sent out with the master’s degree inappropriately reflected in it. *Id.*

<sup>10</sup> Massachusetts State Police witness interviews.

<sup>11</sup> Massachusetts State Police witness interview.

<sup>12</sup> Massachusetts State Police witness interview.

another lab employee told a lab supervisor that Dookhan had not properly signed out suspected drug samples from the lab evidence room and that it appeared she had forged initials in lab log records.<sup>13</sup> Dookhan was confronted, but denied the allegations. Initially, lab management did nothing about the allegations,<sup>14</sup> and failed to notify the district attorney or police.<sup>15</sup> In June 2011, however, management finally took action. It removed Dookhan from laboratory analysis and began an investigation concerning allegations that Dookhan had falsified records regarding 90 drug samples which were to be used as evidence in criminal cases pending in Norfolk County.<sup>16</sup> Despite initiating this investigation, laboratory managers did not initially report the issue to the DPH commissioner “because they did not appreciate its potential legal significance and because of their opinion that the integrity of the test results had not been affected.”<sup>17</sup> It did not notify the Norfolk County District Attorney about the 90 samples until February 2012, and when it did, it indicated that DPH had “confirmed that there was no evidence to suggest that the integrity of the results was impacted” by Dookhan’s actions, a conclusion that was obviously in error.<sup>18</sup>

In July 2012, the Massachusetts State Police took over the Hinton Lab as part of a budgetary change. In doing so, the State Police conducted an audit of the lab and investigated the multiple allegations against Dookhan. The State Police concluded that the number of samples purportedly analyzed by Dookhan was so high that she could not have performed all of the required tests she claimed to have preformed.<sup>19</sup>

The State Police interviewed Dookhan in an attempt to obtain more information about her suspicious behavior. During the interview, Dookhan confessed to serious misconduct. She admitted that she had mishandled drug samples, she had entirely failed to conduct tests on drug samples that she nonetheless labelled as controlled substances, and that she “contaminated” unknown suspected drugs samples with known drugs before running tests to identify those unknown drugs.<sup>20</sup> In addition, she admitted to falsifying evidence logs and reports regarding drug testing and quality control steps regarding laboratory equipment<sup>21</sup> and bypassing other mandatory office procedures.<sup>22</sup>

---

<sup>13</sup> Massachusetts State Police witness interviews.

<sup>14</sup> Massachusetts State Police witness interview.

<sup>15</sup> Massachusetts State Police witness interview.

<sup>16</sup> Massachusetts State Police witness interview; Letter from Linda Han, DPH Director, to Michael Morrissey dated February 21, 2012 (“Han Letter”), at 2.

<sup>17</sup> Han Letter, at 2.

<sup>18</sup> Han Letter, at 2-3.

<sup>19</sup> Massachusetts State Police witness interview.

<sup>20</sup> Massachusetts State Police witness interview.

<sup>21</sup> Ironically, the US Supreme Court foreshadowed misconduct like Dookhan’s in its June, 2009 opinion in Melendez-Diaz v. Massachusetts, 557 U.S. 305 (2009) when it found that chemists like Dookhan are subject to cross examination at trial. The issue in the case, which emanated from Massachusetts state court, was whether drug certifications -- affidavits completed by drug chemists -- could continue to be introduced into evidence without the testimony of the drug chemist who performed the test reflected on the certification. In practice, drug certifications had served as virtually incontrovertible proof that suspected illegal drugs were, in fact, illegal drugs without any testimony to support these findings. In seeking to preserve that practice, the Commonwealth argued that defendants did not have the Constitutional right to confront the drug chemists because, in part, drug testing

In March 2012, Dookhan resigned from her position as drug chemist at Hinton Lab.<sup>23</sup>

In December, 2012, Dookhan was indicted on 27 criminal counts, including obstruction of justice, tampering with evidence, and perjury.<sup>24</sup> In November 2013, Dookhan pled guilty to all 27 counts, and was sentenced to 3 to 5 years in prison.

## **B. Response to Dookhan Misconduct**

The impact of Dookhan's misconduct was unprecedented, as tens of thousands of open and closed criminal cases were called into question as the result of her alleged wrongdoing. In response, extraordinary measures were taken to address the Lab Crisis.

In late August and early September, Chief Justice of the Superior Court Barbara Rouse, Chief Justice of the District Courts Lynda Connolly, and Chief Justice Charles Johnson held meetings with members of the Committee for Public Council Services, bar advocates, numerous District Attorneys' Offices, and the judiciary to implement policies and procedures for addressing the thousands of cases affected. Through this collaboration, the parties worked diligently to quickly identify cases where Dookhan had tested the drugs and prioritized cases where the defendant was incarcerated upon conviction or awaiting trial.

In September 2012, Governor Patrick appointed a task force led by a highly-experienced criminal lawyer, David Meier, to undertake an investigation designed to identify those individuals potentially affected by Ms. Dookhan's misconduct and "to ensure that prosecutors, defense attorneys, and judges were provided with as much information as possible ... to enable them to respond appropriately to the alleged misconduct from their respective positions within the criminal justice system."<sup>25</sup> One of the innovations initiated by Meier was to convene regular meetings involving all of the stakeholders in cases arising from Dookhan's misconduct, including prosecutors, defense lawyers and police officers. "At the joint criminal justice meetings, in addition to the review and distribution of [lists of priority cases impacted by the alleged wrongdoing], prosecutors, defense counsel, and representatives of the various other agencies discussed certain Dookhan-related legal, practical, and ethical issues that were then arising within the

---

was neutral and scientific and thus not prone to distortion or manipulation. The Supreme Court disagreed, concluding that a criminal defendant has a Sixth Amendment right to confront laboratory chemists just as he does regarding other witnesses against him. In so holding, the Court noted that forensic evidence was subject to manipulation in terms that were prophetic: "According to a recent study conducted under the auspices of the National Academy of Sciences, . . . "[b]ecause forensic scientists often are driven in their work by a need to answer a particular question related to the issues of a particular case, they sometimes face pressure to sacrifice appropriate methodology for the sake of expediency ." ... A forensic analyst responding to a request from a law enforcement official may feel pressure-or have an incentive-to alter the evidence in a manner favorable to the prosecution. ... While it is true, as the dissent notes, that an honest analyst will not alter his testimony when forced to confront the defendant, ... the same cannot be said of the fraudulent analyst . See Brief for National Innocence Network as Amicus Curiae 15-17 (discussing cases of documented "drylabbing" where forensic analysts report results of tests that were never performed)." 509 U.S. at 318-19.

<sup>22</sup> Massachusetts State Police witness interview.

<sup>23</sup> Massachusetts State Police witness interviews.

<sup>24</sup> <http://www.boston.com/metrodesk/2012/12/17/annie-dookhan-indicted-counts-obstruction-justice-due-court-dec/Qtgf5ZXp5mim7BqYID4I/story.html>

<sup>25</sup> Meier Report, at 2.

court system on a frequent basis ... [including] real life, practical considerations related to the ongoing response by the criminal justice system.”<sup>26</sup> Through these meetings and collaboration amongst the stakeholders, an admirable level of transparency and cooperation was established, as all those involved in this matter worked towards ensuring that justice was done.

In August 2013, Meier concluded the investigation and reported that 40,323 cases were impacted by Dookhan’s wrongdoing.<sup>27</sup> Despite this staggering number, defense lawyers believe that many more cases are potentially affected by Dookhan’s misconduct.

As a result of Dookhan’s actions, state agencies and the courts have been forced to spend millions of dollars and countless hours on issues associated with the Lab Crisis. The already overburdened criminal justice system has been forced to address thousands of motions filed in open and closed criminal cases seeking relief because of Dookhan’s misconduct. Since the fall of 2012, almost 1,000 defendants have been given nearly 3,000 special Superior Court hearings in eight counties arising from Dookhan’s misconduct, and the Department of Correction has released more than 300 people convicted in drug cases involving evidence handled by Dookhan. Court records showed that more than 600 people have had convictions against them vacated or set aside or have been released on bail pending new trials because of Dookhan.<sup>28</sup>

### **C. Alleged Misconduct by Other Chemists**

While Dookhan’s misconduct is the most serious instance of wrongdoing by a forensic scientist working for the Commonwealth in recent memory, it is not the only such instance. In fact, after the Dookhan allegations came to light, two other forensic scientists were charged with similar misconduct.

The first set of allegations concerned a drug chemist at the DPH drug lab in Amherst (“the Amherst Lab”). In January, 2013, Sonja Farak, one of only three chemists at the Amherst Lab, was arrested and charged with tampering with drug evidence. Farak allegedly removed a drug sample that had tested positive for cocaine and replaced it with one that did not. District attorneys undertook internal case reviews of their prosecutions to determine which, if any, of them involved Farak as a testing chemist, and concluded that Farak’s misconduct undermined the integrity of drug evidence in multiple criminal cases. Further, a superior court judge found that Farak may have tampered with drug evidence beginning in the summer of 2012. As a result of Farak’s misconduct, new trials have been ordered in multiple state cases and hundreds of pending drug cases have been dismissed because Farak is no longer available to testify about her analysis of suspected illegal drugs.

---

<sup>26</sup> Meier Report, at 6-7.

<sup>27</sup> Meier Report, at 12.

<sup>28</sup> See “Annie Dookhan, former state chemist who mishandled drug evidence, sentenced to 3 to 5 years in prison,” Boston Globe, November 22, 2013, available at <http://www.boston.com/news/local/massachusetts/2013/11/22/annie-dookhan-former-state-chemist-who-mishandled-drug-evidence-agrees-plead-guilty/lhg1mwd9U3J8eh4tNBS63N/story.htm>.

On January 6, 2014, Farak pleaded guilty in Hampshire Superior Court to stealing drugs from the Amherst Lab, tampering with evidence and drug possession.<sup>29</sup> She was sentenced to 2 1/2 years in prison, with 18 months to serve and the rest suspended during five-year probation.<sup>30</sup>

The second set of allegations concerned Hinton Lab chemist Kate Corbett. On November 22, 2013, Corbett, who was then working as a chemist for the Massachusetts State Police, was fired for misrepresenting her credentials as a chemist. Corbett had worked as a chemist at the Hinton Lab since 2005. She and other analysts were placed on paid leave when the lab was closed as a result of the Dookhan investigation. As part of its take over of the labs, the State Police began conducting background checks on chemists' education. During that review, a discrepancy arose regarding Corbett's education. Corbett had stated on her resume when she applied for the job at Hinton Lab that she earned a Bachelor of Science from Merrimack College in 2003. She had also testified to this fact during criminal cases in which she was called to testify about drug analyses she had performed. The State Police's background check revealed, however, that although Corbett had graduated with several credits in chemistry, she did not complete all the prerequisites for a chemistry degree. She graduated from Merrimack College with only a Bachelor of Arts in Sociology.

Corbett was terminated for allegedly misstating her credentials and allegedly falsely testifying in state and federal court that she held a degree in chemistry when she did not.<sup>31</sup> As with Dookhan and Farak, district attorneys are reviewing each of Corbett's cases to determine the impact of her misconduct, which is expected to lead to challenges to convictions in which Corbett testified.

#### **D. Other Forensic Issues**

Although a comprehensive review of all other forensic services in Massachusetts is beyond the scope of the Task Force's mission, the Task Force did identify a serious issue in the recent past with respect to medical examination services in Massachusetts.

In 2007, a public report about the Massachusetts Office of the Chief Medical Examiner ("OCME") commissioned by the Executive Office of Public Safety found that the OCME was overwhelmed with work, faced a significant backlog of bodies awaiting medical analysis and was near collapse as a result of a lack of funding and ineffective management.<sup>32</sup> The report (the "OCME Report") concluded that "[w]hile the OCME is fulfilling its basic legal responsibilities, it is doing so with great difficulty [and][t]he risk of inaccurate determinations of cause of death will increase if immediate corrective measures are

---

<sup>29</sup> See "Ex-Mass. Lab Chemist Pleads Guilty to Drug Theft," The Associated Press, January 7, 2014, available at: <http://www.wbur.org/2014/01/07/sonja-farak-evidence-tampering>.

<sup>30</sup> See *id.*

<sup>31</sup> Corbett is challenging her firing and maintains that she has proper credentials.

<sup>32</sup> See Joseph M. Desmond, "Repeated problems in State Medical Examiner's Office result in unreliable certification as to cause of death," Massachusetts Bar Association Section Review, 2008, V10 N1, available at: <http://www.massbar.org/publications/section-review/2008/v10-n1/repeated-problems-in-state-medical-examiner%E2%80%99s-office-result-in-unreliable-certification-as-to-cause-of-death>.

not instituted.”<sup>33</sup> In addition, it concluded that the OCME was “chronically underfunded” and “remains below the national average when viewed from a cost per capita standpoint, the generally accepted standard in the industry, as well as below ... recommended funding.” It noted that the “continued advocacy of all stakeholders” was “necessary” to address the underfunding.<sup>34</sup>

As a result of these findings, the OCME Report recommended that OCME’s funding be increased and that the functions of the Commission on Medicolegal Investigations (CMLI), an oversight board established under state law, be enhanced. As to the letter, the OCME Review also found that the CMLI was moribund. The CMLI exists in the Executive Office of Public Safety to (a) provide guidance and oversight to effectively carry out investigations by medical examiners; (b) establish qualifications for appointment of medical examiners, forensic pathologists, and related professionals; (c) advise the chief medical examiner regarding the annual budget; and (d) review and approve the comprehensive system for the delivery of medicolegal services in the Commonwealth.<sup>35</sup> By statute, the CMLI is comprised of the Attorney General, the Secretary of Public Safety, the Commissioner of Public Health or their designees, and thirteen people appointed by the governor, including a dean of a medical school in Massachusetts, a representative of the Massachusetts Medico-Legal Society, two certified forensic pathologists, a criminal defense attorney, two district attorneys, a chief of police for a city or town, and two representatives of the public. The Chief Medical Examiner serves as the secretary to the commission. The OCME Review found that the CMLI had not met for years and that its then-members’ terms had expired. It recommended that the CMLI be revitalized to provide oversight to the OCME.<sup>36</sup>

It is unclear whether adequate steps have been taken to properly address these issues. A February 2013 report prepared by OCME found that staffing and funding levels for fiscal 2014 lagged considerably behind those levels recommended in 2008 and that, as a result of budget shortfalls, the number of autopsies that can be performed effectively had been reduced.<sup>37</sup> The report concluded “OCME is facing a crisis without sufficient staffing ... [has] not met [2008] staffing recommendations ... [c]urrent staff [is] overwhelmed ... OCME is in danger of slipping back to pre-2008” levels.<sup>38</sup> Although the National Association of Medical Examiners provisionally accredited OCME in 2013, it refrained from fully accrediting OCME because of delays in completing autopsies of six months or more as well as the excessive number of autopsies performed by each medical examiner. In fact, OCME’s goal of conducting autopsies in 80% of its cases, a standard adapted from New York City’s standard, remains unmet; as of

---

<sup>33</sup> Findings and Recommendations, Office of the Chief Medical Examiner, Prepared for The Executive Office of Public Safety, July 24, 2007 (“OCME Report”), at 1, available at [http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCkQFjAA&url=http%3A%2F%2Fboston.com%2Fnews%2Fdaily%2F03%2Fmedical\\_examiner\\_report.pdf&ei=IlHEUrDXK6iayAGlj4HQcw&usg=A FQjCNEsJmR1iKc-7zs1icP16006HEIKQ](http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&ved=0CCkQFjAA&url=http%3A%2F%2Fboston.com%2Fnews%2Fdaily%2F03%2Fmedical_examiner_report.pdf&ei=IlHEUrDXK6iayAGlj4HQcw&usg=A FQjCNEsJmR1iKc-7zs1icP16006HEIKQ).

<sup>34</sup> OCME Report, at 17.

<sup>35</sup> See M.G.L. ch. 6, § 184.

<sup>36</sup> OCME Report, at 10.

<sup>37</sup> Massachusetts Office of the Chief Medical Examiner, February 2013 Power Point, available from the Executive Office of Public Safety.

<sup>38</sup> *Id.*

November 2013, OCME conducted autopsies in less than 50% of its cases (2,038 autopsies in 5,286 total cases).<sup>39</sup>

## **E. Changes in Forensic Oversight**

Oversight and management of forensic services, especially of drug labs, has changed since the Lab Crisis.

As noted above, the DPH laboratories in Jamaica Plain and Amherst have been closed and their functions transferred from DPH to the Massachusetts State Police. As a result, all of the Commonwealth's lab functions are now part of the State Police Forensic Services Group (the "Forensic Services Group"), a statewide entity that provides forensic services for the Commonwealth's criminal justice system.<sup>40</sup> Its main laboratory is located in Maynard and includes Forensic Biology Units (e.g., DNA and Criminalistics), a Firearms Identification Section, and a Digital Evidence Multimedia Section. Another laboratory located in Sudbury, Massachusetts includes Forensic Chemistry Units (e.g., Trace Analysis, Arson and Explosives Unit, Toxicology, and Drugs) and the State Identification Section and Evidence Control Unit.

As the result of the Forensic Services Groups' absorption of the drug labs, the State Police have faced a backlog of approximately 14,000 cases, with 1,000 new cases submitted monthly. An aggressive program is underway to hire more chemists and increase lab space to accommodate services formerly performed by the labs.<sup>41</sup>

With the exception of the lab services assumed from DPH, all other subdivisions of the Forensic Services Group were fully accredited by the American Society of Crime Laboratory Directors, Laboratory Accreditation Board (ASCLD/LAB)<sup>42</sup> on February 11, 2009<sup>43</sup> and again on September 24, 2013. The Group is currently accredited under the ASCLD/LAB - ISO International Program. ASCLD/LAB's accreditation of testing labs is recognized by the Inter American Accreditation Cooperation (IAAC) and the International Laboratory Accreditation Cooperation (ILAC). Obtaining accreditation was a long and detailed process which required the Forensics Group to pass an on-site examination conducted by the ASCLD/LAB concerning lab management, quality assurance processes, lab proficiency, and other structural elements. The ISO accreditation involves a rigorous review of 400 measures and criteria that

---

<sup>39</sup> Executive Office of Public Safety autopsy data, November 2013.

<sup>40</sup> See <http://www.mass.gov/eopss/law-enforce-and-cj/criminal-investig/crime-lab/>.

<sup>41</sup> Drug testing for Worcester County is done by the University of Massachusetts Medical School. The Forensic Services Group is working to bring within its oversight the testing done at UMass.

<sup>42</sup> The American Society of Crime Laboratory Directors/Laboratory Accreditation Board is a not-for-profit organization specializing in the accreditation of public and private crime laboratories. ASCLD/LAB has over 30 years of experience accrediting federal, state and local crime laboratories throughout the United States, as well as forensic laboratories in various additional countries. See <http://www.ascl-d-lab.org>.

<sup>43</sup> On February 11, 2009, the Department of State Police Forensic Services Group received system-wide accreditation from the ASCLD/LAB. The Forensic Services Group was previously accredited by the ASCLD/LAB in 2002, and was re-accredited in 2007. A re-organization of the State Police Forensic Services Group in 2007 placed all forensic entities under a single director and enabled the State Police to accredit the additional forensic disciplines. See <http://www.mass.gov/eopss/law-enforce-and-cj/criminal-investig/crime-lab/historymilestones.html>.



include management oversight, training, proficiency testing, evidence control and laboratory notes and reports review.

In addition to the ISO audits, the Massachusetts State Police conduct internal Quality Assurance Audits on its forensic services, including the new lab functions taken over from DPH, on a roughly annual basis. The audits are designed to assess compliance with quality standards and management processes, and include a review of Quality Records, Health and Safety Records, Security, Evidence Control, and Technical Procedures (e.g., case file reviews). Such internal audits are carried out by trained and qualified personnel who, whenever resources permit, are independent of the unit or section being audited.<sup>44</sup> Massachusetts State Police Lab management and supervisors perform routine and random audits of the bench work including a technical review of the forensic scientist's casework.

## RECOMMENDATIONS

As laudable as many of the steps taken to improve forensic services over the past several years have been, they have not fully addressed the issues the Task Force has identified. The Task Force thus makes the following three recommendations.

### **Continue Combined Efforts to Resolve Open Dookhan Cases.**

First, there must be continued efforts by prosecutors, defense lawyers, judges and policy makers to resolve open cases impacted by Dookhan's misconduct. There are thousands of defendants who have been convicted or who stand accused of offenses in which Dookhan's misconduct played a role. All of the participants in the criminal justice system -- prosecutors, defense lawyers, judges and policy makers -- should continue the extraordinary cooperation fostered by Meier and the stakeholders to fully remedy Dookhan's wrongdoing. It is in the interests of every participant in the criminal justice system to resolve these cases as soon as possible and thereby remove the cloud of doubt that hangs over them. The same is true regarding any cases impacted by Farak and Corbett's misconduct.

### **Further Enhance Oversight of Drug Labs and Other Forensic Services.**

Second, the Commonwealth should adopt further enhanced oversight practices, including an independent audit process and revitalized oversight to review the performance of drug labs and any other forensic services.

As the facts summarized above make clear, the lack of any meaningful internal or external audit and review of the work performed by Dookhan and Farak facilitated the misconduct at issue. No mechanisms were in place to proactively and thoroughly review and audit the performance of lab technicians like Dookhan. Moreover, obvious evidence that Dookhan's level of productivity was inexplicably high was essentially ignored,<sup>45</sup> and when concerns about Dookhan's credibility were

---

<sup>44</sup> Massachusetts State Police Forensic Services Group QAMS-D001-v.02.1 Quality Assurance Manual, September 10, 2013, at 34.

<sup>45</sup> In Massachusetts, state employees have protection under state law to act as whistleblowers. See M.G.L. c. 149, Section 185; M.G.L. c. 12A, § 14(c). Such employees may report waste, fraud and abuse to the Attorney General,

squarely presented to management at Hinton Lab in June 2011, the response was woefully inadequate, and no process was in place which ensured that laboratory management promptly reported the issues to both DPH and proper law enforcement agencies. These failures were a major contributor to Dookhan's ability to initially commit, and thereafter to continue, the serious misconduct in this case.

The closure of the Jamaica Plain and Amherst labs, and the consolidation of their functions under the supervision of the Massachusetts State Police and Undersecretary for Forensic Services, has improved the oversight over lab operations. Since the Massachusetts State Police have assumed responsibility for the labs, they will be subject to some audits and eventually to the accreditation process.

Nevertheless, the Task Force believes it would a mistake to assume that these changes are necessarily sufficient, or that, in light of them, the misconduct highlighted above is not repeatable. In light of the facts, the Task Force believes that ongoing, independent and thorough audit oversight is appropriate to deter, identify and/or address intentional fraud or misconduct or other unacceptable practices such as are at issue here.<sup>46</sup> The Task Force believes that had such audit tools been in place, they may well have deterred Dookhan's misconduct or identified it well before it came to light in 2011. Further, the existence of an independent audit oversight process would have provided lab employees with a valuable mechanism by which to report their concerns about Dookhan's performance.

The Task Force thus makes two specific recommendations to ensure that oversight practices are enhanced.

#### **A. Independent Auditing Process**

First, the Commonwealth should create an independent auditing process specifically designed to review the performance of those engaged in forensic services and to conduct investigations of any identified issues. This audit function need not supplant the internal audits currently conducted by the Massachusetts State Police, but should supplement them.

The Task Force believes that it is crucial that this audit mechanism be objective and be perceived as such. Accordingly, the Task Force recommends that this audit function be established separately and independently from the agencies responsible for the investigation and prosecution of criminal cases (*i.e.*, the Executive Office of Public Safety, Massachusetts State Police, the Attorney General's Office and the District Attorney's Offices). The Task Force takes no position as to whether this recommended audit function be established through a new entity focused on forensic science oversight or that it be added to the responsibilities of an existing state oversight entity such as the State Auditor or Inspector General.

---

Inspector General and State Auditor, among others. It appears that none of these mechanisms were accessed by Hinton Lab employees regarding their concerns about Dookhan.

<sup>46</sup> The need to implement mechanisms to eliminate substandard forensic work, as opposed to outright fraud, was discussed by the Supreme Court in the Melendez-Diaz decision: "Serious deficiencies have been found in the forensic evidence used in criminal trials. One commentator asserts that '[t]he legal community now concedes, with varying degrees of urgency, that our system produces erroneous convictions based on discredited forensics.' ... One study of cases in which exonerating evidence resulted in the overturning of criminal convictions concluded that invalid forensic testimony contributed to the convictions in 60% of the cases." 509 U.S. at 319.

This auditing function should be available to all forensic services employees to permit them to confidentially report any concerns about co-workers' performance. Further, at a minimum, this auditing function must have access to all internal or external complaints about or allegations made regarding forensic services, including but not limited to existing internal audit results and whistleblower complaints; have access to all information in the possession of state forensic facilities; and have the authority to conduct full and complete investigations of any concerns, including the power to subpoena witnesses and documents and to take sworn testimony as necessary. To ensure this function is effective, policies and training at the Forensic Services Group should be reviewed to ensure that lab employees understand this audit function is available to confidentially address any concerns about co-workers' performance.

### **B. Enhancement of the Commonwealth's Forensic Science Advisory Board**

Second, the already-existing state Forensic Science Advisory Board (FSAB) should be enhanced.

The FSAB was established under state law<sup>47</sup> within the Executive Office of Public Safety to "advise the secretary on all aspects of the administration and delivery of criminal forensic sciences in the commonwealth." The members of the FSAB are the Undersecretary of Public Safety for Forensic Sciences, the Attorney General, the Colonel of the State Police, the President of the Massachusetts Chiefs of Police Association, the President of the Massachusetts Urban Chiefs Association, the President of the Massachusetts District Attorney's Association, a district attorney designated by the Massachusetts District Attorney's Association and the commissioner of the Department of Public Health or their designees. Under the statute, the Undersecretary for Forensic Sciences is to advise the FSAB on the administration and delivery of forensic services in the Commonwealth, including the volume of forensic services required for each county, and the costs and the length of time from submission for testing or procedures and return of results; the capacity of the Commonwealth's forensic services and funding requirements; the accreditation of forensic facilities and training of personnel.<sup>48</sup>

The Task Force recommends that the FSAB be strengthened to address the Dookhan issues it has identified. This is not the first time that the BBA has made such a recommendation. In 2009, the BBA's Task Force to Prevent Wrongful Convictions released Getting it Right: Improving the Accuracy and Reliability of the Criminal Justice System in Massachusetts. The Task Force To Prevent Wrongful Convictions was charged with identifying reforms needed to reduce the risk of convicting innocent

---

<sup>47</sup> See M.G.L. c. 6, §184A.

<sup>48</sup> In addition to the FSAB, another commission exists in the Executive Office of Public Safety, the Commission on Medicolegal Investigation ("CMLI"), which provides guidance and oversight to effectively carry out investigations by medical examiners, establishes qualifications for appointment of medical examiners, forensic pathologists, and related professionals; advises the chief medical examiner regarding the annual budget; and reviews and approves the comprehensive system for the delivery of medicolegal services in the Commonwealth. See M.G.L. ch. 6, Section 184. The CMLI is comprised of the Attorney General, the Secretary of Public Safety, the Commissioner of Public Health or their designees, and thirteen people appointed by the governor, including a dean of a medical school in Massachusetts, a representative of the Massachusetts Medico-Legal Society, two certified forensic pathologists, a criminal defense attorney, two district attorneys, a chief of police for a city or town, and two representatives of the public. The Chief Medical Examiner serves as the secretary to the commission. Id.

people and recommending how those reforms should be implemented.<sup>49</sup> The goal of Getting it Right was “to focus on practical, achievable means to accomplish a goal that every participant in the criminal justice system shares: maximizing the likelihood that the system produces reliable, accurate, and just results. The Task Force’s members were unanimous in agreeing that a wrongful conviction is not only a human tragedy for the defendant and his family, but also a devastating blow to a crime victim and to the administration of justice itself. For every defendant wrongly convicted, a criminal goes free, and society remains unprotected while the individual who has escaped the consequences of his actions is free to commit other crimes against other victims.”<sup>50</sup> Among the enhancements promoted in Getting it Right, the BBA recommended that the legislature expand the membership and function of the FSAB by adding forensic scientists and three members of the bar with criminal and forensic experience to its membership.<sup>51</sup>

In the wake of the Dookhan allegations coming to light, the BBA again recommended enhancements to the FSAB to add members of the defense bar and scientists.<sup>52</sup> The BBA filed a bill, S 1204, "An Act Relative to the Forensic Sciences Advisory Board", initially as a companion to the BBA’s DNA access bill and again after the Dookhan allegations became public, to add members of the defense bar and scientists to the FSAB.<sup>53</sup>

The Task Force again urges that the FSAB membership be changed to add forensic scientists and three members of the bar with criminal and forensic experience to its membership. Even with this change, the composition of the FSAB under S1204 would still be heavily weighted to prosecutors and government investigators, which remains problematic. A think tank focused on issues involving the justice system, the Justice Project Education Fund, has proposed a model policy suggesting that at least half of the independent advisory board members be scientists.<sup>54</sup> Nevertheless, S 1204 would be a step in the right direction.

In addition to adding the additional members identified above, the Lab Crisis Task Force recommends that the responsibilities of the FSAB should be clarified to ensure that it plays an active role in ensuring that high standards are set and enforced for forensic services. The Task Force does not recommend that the FSAB be directly responsible for the audit function it suggests above. The FSAB is part of the Executive Office of Public Safety, and the Lab Task Force believes that the audit process it recommends should be independent of any direct connection with law enforcement agencies or those which oversee

---

<sup>49</sup> The Task Force was co-chaired by David Meier, who led the investigation into the Dookhan misconduct, and Martin Murphy, a member of the Lab Crisis Task Force.

<sup>50</sup> Id. at 2.

<sup>51</sup> Id. at 52.

<sup>52</sup> BBA Issue Spot, “Expanding the Forensic Sciences Advisory Board is a Step in the Right Direction,” October 25, 2012.

<sup>53</sup> The Act would add to the FSAB “three scientists, experienced in delivery, management or oversight of scientific services, one of whom shall be a forensic scientist with practical experience in an accredited crime lab, one of whom shall have a specialty in the natural or biological sciences and one of whom shall have a specialty in the physical sciences, and two members of the bar with experience in criminal practice and forensic science issues, one each to be appointed on recommendation of the Massachusetts Bar Association and Boston Bar Association.”

<sup>54</sup> Improving the Practice and Use of Forensic Science, at 18, available at [ag.ca.gov/meetings/tf/pdf/Justice\\_Project\\_Report.pdf](http://ag.ca.gov/meetings/tf/pdf/Justice_Project_Report.pdf).

them. Nevertheless, the FSAB should work closely with the audit function and act upon any findings suggesting compliance shortcomings.

### **C. Review Funding Levels For Forensic Services**

The Task Force also recommends that the Governor and Legislature look closely at funding levels for forensic services. As the BBA noted shortly after the Dookhan misconduct was disclosed:

Surely, the criminality of this one person is egregious, but this may actually point to a more fundamental problem in the entire justice system – inadequate resources. Decades of underfunding our courts, district attorneys’ offices, crime labs, public defense counsel offices and civil legal service organizations has contributed to an overburdened system where everyone is struggling to find efficiencies, do more with less and provide every single person equal access to justice. One of the most unsettling results of the drug lab crisis is that it exposes a broader potential flaw – that there may be other areas in our justice system that are just as vulnerable due to inadequate resources.<sup>55</sup>

The Task Force is troubled that a lack of funding was among the underlying weaknesses that permitted the Dookhan misconduct to occur and to go uncurbed. Certainly the audit and enforcement mechanisms identified above will serve to detect such abuses, but they do little to address workload issues that may have permitted such misconduct to occur. In light of these facts, and the other issues in forensic services discussed above, the Task Force is concerned that a lack of steady, predictable funding for forensic services leaves the Commonwealth vulnerable to another crisis in forensic services. Such a shortage of funds is not unique to Massachusetts. In *Strengthening Forensic Science in the United States*, the National Research Council of the National Academy of Sciences observed:

Existing data suggest that forensic laboratories are underresourced and understaffed, which contributes to case backlogs and likely makes it difficult for laboratories as much as they could to (1) inform investigation, (2) provide strong evidence for prosecutions, and (3) avoid errors that could lead to imperfect justice. Being underresourced also means that the tools of forensic science - and the knowledge base that underpins the analysis and interpretation of evidence -- are not as strong as they could be, thus hindering the ability of forensic science disciplines to excel at informing, providing strong evidence, and avoiding errors in important ways.<sup>56</sup>

Consistent with the concerns expressed by the National Academy of Sciences, the State Police’s Forensic Services Group saw a reduction in its appropriations for 5 of the six fiscal years between fiscal 2008 and

---

<sup>55</sup> BBA Issue Spot, October 25, 2012.

<sup>56</sup> Strengthening Forensic Science, National Research Council, 2009, at 14-15.

fiscal 2012, with the deepest cut, of more than 18%, occurring in fiscal 2010. The last two fiscal years have seen increases of 16% and 26% respectively, but it is unclear if these increases represent a real growth in funding for forensic services, as they also reflect the increased responsibilities the Forensic Services Group assumed when it absorbed the Hinton and Amherst labs and the investment of substantial resources to coping with the Lab Crisis. Further, the facts summarized above regarding the OCME also suggests a lurking funding crisis.

Since forensic services require investment over the relatively long term, funding levels for forensic services should be sustained and consistent over time so that forensic services can proceed regardless of economic fluctuations. The Task Force thus recommends that the budget for the Forensic Services Group and all other forensic services be examined closely as part of a comprehensive review of funding levels to ensure that adequate funding is in place not only to cope with current workloads but to address chronic issues.

### CONCLUSION

The Lab Crisis has imposed serious financial costs on Massachusetts and has damaged the integrity of Massachusetts' justice system. The Task Force believes that without the reforms suggested above, the Commonwealth faces a serious risk of another such crisis.