

Documentation, Reporting and Testimony

1.0 Principle, Spirit and Intent

Laboratory documentation should be prepared in a systematic and organized manner conducive to authentication and verification. The integrity and traceability of notes, reports and testimony should be maintained at all times.

2.0 Purpose and Scope

This policy outlines procedures for preparing and controlling field and technical notes, test reports, and other documentation that regulate or are produced by forensic anthropology laboratories, and provides guidelines for testimony.

This policy applies to all forensic anthropology laboratories regardless of the number of personnel or the extent of the scope of testing. Practitioners of forensic anthropology should implement these guidelines to the fullest extent as applicable, practical, and appropriate. In the absence of specific guidance or in the case of conflicting procedures, the principle, spirit and intent should be met.

3.0 Documentation

Laboratory documentation defines and regulates how the laboratory and its testing activities are operated and managed. Documentation may exist in various media including hard copy, electronic, digital, analog, photographic or written. Authorized current versions of appropriate documents should be available at all locations where operations essential to the effective functioning of the laboratory are performed to include field sites. The following is a general outline of laboratory documentation.

3.1 External Documents

External documents are generated by external agencies and establish or regulate the laboratory as an institution. External documents may include:

- Legislative statutes or regulations
- Policy statements, standards, or other normative documents from the parent agency or organization
- Accreditation manuals and their subordinate documentation

3.2 Internal Documents

Internal documents are generated within the laboratory and regulate or facilitate practices within the laboratory. Examples of internal documentation include, but are not limited to, laboratory manuals, forms, records, technical notes and field notes.

3.2.1 Laboratory Manual

A Laboratory manual is a body of written policies, procedures, and methods that provides guidance and sets standards to ensure that the laboratory's forensic casework is scientifically sound and legally defensible.

The laboratory manual should establish guidelines for reaching the laboratory's mission and goals. Each major subsection of the laboratory manual should have a principle, spirit, and intent statement (however named).

The laboratory manual should:

- Document laboratory policies, systems, programs, procedures and instructions to the extent necessary to assure the quality of its test results.
- Be communicated to, understood by, available to, and implemented by the appropriate personnel.
- Establish uniformity and standardization of recovery and analysis.
- Address topics such as the work environment (management practices, personnel policies, etc.), non-technical general laboratory procedures (security, safety, administration, etc.), logistics, and quality assurance. Quality assurance policies and procedures may form a subsection of the laboratory manual or may be dealt with in a separate document known as a quality manual (however named).
- Define terms, nomenclature, acronyms, abbreviations, and jargon specific to the laboratory.

The procedures and guidelines detailed in the laboratory manual should be used for typical laboratory cases. In the case of deviations, the practitioner should exercise professional judgment in a manner designed to best uphold the principle, spirit and intent of the procedures and guidelines and to minimize any adverse impact that may arise from such deviations. Deviations from the standard should be documented.

3.2.2 Subordinate Documentation

Subordinate documentation refers to documentation that is based on the content of the laboratory manual, and provides a framework for documenting and controlling laboratory operations.

Subordinate documentation consists of documents and records. Documents are relatively unchanging and provide a framework for documenting and controlling laboratory operations. Documents should not be confused with records which are products of laboratory operations. For example, a blank technical form is a document until it is filled in, at which point it becomes a

record.

3.2.2.1 Forms

A form is a designed data or information collection medium. Anything that can be “filled in” (by hand writing and/or computer) should be considered a form. Examples of forms include report and memo templates, chain of custody, measurement or data collection forms, or communication logs.

3.2.2.2 Records

Records contain products of laboratory procedures. Examples of records include:

- Casework examination and administrative documentation such as technical notes (laboratory and field), completed forms and reports
- Quality assurance files and records such as audit reports training records, performance check, calibration, and maintenance records, corrective and preventive actions taken and physical security logs

The laboratory should have policies and procedures for controlling, managing, identifying, collecting, indexing, accessing, filing, storing, maintaining, securing, and disposing of records, including case files in particular.

The laboratory should have a numbering system or program for uniquely identifying case related test items and activities. The case number should be used as the case identifier for identifying and indexing technical case records, administrative records related to case management, and evidence accessioning records and documentation. The original case number should be retained throughout the life of the item or activity in the laboratory.

The policies and procedures for records control should include provisions for maintaining their confidentiality, as appropriate, and backing up and protecting electronically stored records stored against unauthorized access or amendments.

3.2.2.3 Technical Notes

Technical notes are a type of record and consist of any examination items created or used during the testing process, including:

- Laboratory notes (inventories, observations, diagrams and charts) documenting tests undertaken
- Photographs and radiographs that form the basis for analysis or technical conclusions
- Computer printouts produced or used in the course of testing (*e.g.*, Fordisc results)
- Non-rewritable CDs containing examination documentation
- Copies of medical and dental records, items of personal correspondence, and other documentation if they formed the basis for analysis or technical conclusions

The laboratory should have policies and procedures for the compilation of technical notes (also called analytical notes or examination documentation). Standardizing the methods used in taking technical notes provides consistency in recording the results of tests and in maintaining case file records, establishes traceability, and preserves the integrity of the documentation.

Technical notes for each test should contain sufficient information to record observations pertaining to the evidence and to facilitate the traceability and replication of casework and the evaluation and interpretation of tests performed. The detail of the technical notes should be such that another practitioner could independently reach the same conclusion.

Observations, data, and calculations should be recorded at the time they are made. The date(s) the analysis is conducted should be recorded. Technical notes should be made in ink. Practitioners should authenticate laboratory notes by annotating each page with:

- Case identifier
- Signature or initials of practitioner
- Date(s) of examination

The following procedures should be used to correct technical notes:

- Deletions or corrections to notes should be made by placing one line through the undesired text, entering the correct annotation alongside, and initialing. Handwritten deletions, corrections, or changes to computer generated notes should be similarly annotated on the hard copy.
- Write-overs as corrections should be avoided. To correct write-overs, use one line to cross out the write-over, insert the desired text, and initial.
- Handwritten additions or insertions to notes should be initialed
- Masking agents such as blank labels, white-out, correction tape, etc. should not be used to correct notes.

Computer-generated notes are permissible. The following guidance should be used:

- Electronic changes to computer-generated notes may be made until the notes are authenticated.
- Hard copies of digital radiographs should be treated as computer-generated notes and annotated accordingly
- In the case of a combination of handwritten and computer-generated notes, the handwritten portions should be treated as a correction/addition

3.2.2.4 Field Notes

Field notes are a type of record and consist of any examination items created or used during scene processing.

Field notes should be sufficient to record the context from which evidence was observed and/or recovered. Field notes may be made using a variety of media including field notebooks, maps/diagrams, photography, and sketches. Field documentation may also include spatial, contextual, and temporal information upon which subsequent decisions about field strategy, methods, techniques, and evidence handling are made.

A scene diagram is a representation of the spatial distribution of evidence or other pertinent reference points. The specificity of diagrams can range from a hand-drawn sketch to a scaled, electronically generated map. In addition to the items listed above, diagrams should include:

- Scene location/reference
- Scale (or “not-to-scale” notation)
- North arrow
- Datum establishing a geographic reference point

As appropriate or relevant, field notes should also include:

- Description of the scene environment
- Current weather conditions
- Narrative of other relevant details
- Photographs, including the overall scene and relevant items of evidence

Field notes should be corrected and authenticated in the same manner as technical notes.

3.2.2.5 Retention of Records

Records retained for each case should contain sufficient information to enable the test(s) to be repeated under conditions as close as possible to the original, and such that another competent analyst could evaluate what was done and interpret the data. Retained records should establish a clear audit trail that facilitates the traceability and replication of casework.

3.3 Document Control

The laboratory should have policies, procedures, and programs that control all internal and external documents that fall within the quality assurance program. A document control program allows a snapshot of documents in use at any given time and ensures that invalid and/or obsolete documents are not used should be in place.

To facilitate the control of documents, the following information should appear on all documents:

- Unique identifier: This can be the title of the document or its unique number if a numbering system is used
- Date: The effective date that the document or document version was adopted (not to be confused with the dates that personnel complete the document)
- Issuing authority: The person responsible for the issuance, updating, content, etc. of a particular document

- Document stop: Shows which page of the document is present and how many pages there are to the document or document packet (e.g., the pages of a three page form will be consecutively identified as Page 1 of 3, 2 of 3, 3 of 3)

Inventory, traceability and control of documents should be maintained by utilizing master lists or equivalent document control procedures.

3.3.1 Document Disposition

Policies and procedures for the treatment and disposition of obsolete documents should be established. These should include:

- Immediate removal of the obsolete document from the document system
- Marking the document in some manner as obsolete or superseded
- Converting obsolete electronic documents to a permanent type of electronic file
- Moving the unalterable file to an appropriate archive

4.0 Reporting

The test report is a record. The test report should include results of each test or series of tests carried out by the laboratory, and results should be reported accurately, clearly, unambiguously, objectively, and in accordance with any specific instructions in the test methods. The reported results should include all information necessary for the interpretation of the test results.

The author(s) of a report should have conducted, participated in, observed, or supervised the testing, or technically reviewed the examination documentation. This includes those whose authorship constitutes signature by proxy.

The laboratory should have policies and procedures regarding the release of test reports and case information.

4.1 Report Content

While practitioners may have varying needs and constraints based on the laboratory with which they are associated or their customers, the following provides guidance on recommended administrative content, report organization, reporting significance of results, and additional report content.

4.1.1 Administrative Content

Each report should include at least the following information. If omitted from the report, the information should be included elsewhere in the case file.

- Title (e.g., Forensic Anthropology Report)
- The laboratory name and address
- The location where the tests were carried out, if different from the laboratory location

- Unique identification of the report (usually the case number/identifier), which should be included on each page of the report
- A clear identification of the end of the report (usually accomplished by page numbering, e.g., page 4 of 4).
- The name and address of the customer
- Identification of the methods used
- A description of, the condition of, and unambiguous identification of the item(s) received and/or examined
- The date of receipt of the item(s)
- Reference to the sampling plan or procedures used by the laboratory or other bodies where these are relevant to the validity or application of the results
- The results or conclusions, however named
- The name(s), function(s), and signature(s) or equivalent identification of person(s) authorizing the report (usually the practitioner who authored the report)

4.1.2 Report Organization

As appropriate, reports should contain results organized according to the type(s) of test(s) performed, such as:

- Biological profile (sex, age, ancestry, stature)
- Minimum number of individuals
- Traits relevant to identification
- Identification comparison
- Skeletal alterations (antemortem trauma or pathological conditions, perimortem trauma, postmortem damage)

4.1.3 Reporting Result Significance

When results, opinions and interpretations (however named) are included in the report, the basis upon which they have been made (i.e., supporting evidence) should be documented. Opinions and interpretations should be clearly marked as such in a test report. Additionally, the below guidance should be applied:

- When the testing method permits, result significance or confidence intervals should be reported.
- When associations are made, the significance of the association should be communicated clearly and qualified properly in the report.
- When no definitive conclusions can be reached (*e.g.*, results are “inconclusive”), the reason(s) should be documented in the report.

4.1.4 Additional Report Content

In addition, the report or the case file should include the following, when relevant:

- Deviations from, additions to, or exclusions from the test method, and information on

- specific test conditions, such as environmental conditions
- A statement of compliance/non-compliance with requirements or specifications
- A statement on the estimated uncertainty of measurement of results when it is relevant to the validity or application of the test results, when a customer's instruction so requires, or when the uncertainty affects compliance to a specification limit
- Opinions and interpretations (however named)
- A statement on the limitations of the analysis or results.

4.2 Amendments to Reports

Substantive or material amendments to a report after its formal issue should be made only in the form of a supplemental document or addendum. Such amendments are considered reports and should meet all the guidelines of this policy.

When it is necessary to issue a complete new test report, it should be uniquely identified and should contain a reference to the original that it replaces.

5.0 Testimony

Any practitioner who handles anthropological evidence, performs testing, or issues a report may be requested to testify in court regarding the results and/or tests performed. When testifying in court, practitioners should:

- Testify only within the scope of expertise
- Decline to answer if asked questions beyond expertise
- Testify accurately
- Completely disclose involvement in the case
- Be clear, straightforward and objective in answers on direct and cross-examination
- Limit conclusions to those logically following from the data and analytical results

If testifying as a summary witness (to another practitioner's testing results), the practitioner should:

- Testify clearly that he/she did not perform the examination(s) under discussion
- Accurately and completely describe the analyses or conclusions made by others