INTERNAL AFFAIRS INVESTIGATIVE SUMMARY

IA2017-038

FORENSIC SCIENTIST AMY LANGAN (FORMER EMPLOYEE)

1. INTEGRITY VIOLATION

Investigator: SGT. M. PALOPOLI #759

ALLEGATION

It is alleged that former employee, Forensic Scientist II, Amy Langan, committed an integrity violation by falsifying lab work while she was still employed with the Scottsdale Police Department.

INVESTIGATION

On Wednesday, April 5, 2017, I was notified by Director Steve Garrett that there were some issues with work that Langan did prior to resigning from the police department. Director Garrett sent two emails regarding this investigation. Both are included in this investigation. One is a memo that he prepared and that is copied and pasted below:

April 7, 2017

TO: Assistant Chief Scott Popp
Investigative Services Bureau

FROM: Steve Garrett
Director, Forensic Services Division

RE: Amy Langan and Work Performance Issues under DR#[redacted]

This memorandum is written to document the series of events that resulted in the discovery of a contamination issued of one of the blood tubes submitted to the crime laboratory for blood alcohol analysis in DR#[redacted]

A request was submitted by the City Prosecutor's Office to reanalyze this case due to the fact that the examiner who performed the initial analysis, Amy Langan, was resigning from her position with the laboratory. The original analysis of the first vial of blood was performed by Amy Langan and resulted in a blood alcohol result of 0.136 g/100ml. A report was issued with those results dated 8/5/16. A second analysis was conducted using the second vial of blood by Dr. Allan Kosecki on 3/21/17 and resulted in a blood alcohol result of 0.090 g/100ml (the blood alcohol kits contain two separate vials of blood). This inconsistency between the two results from this two separate blood vials prompted an investigation, which was conducted as follows:

1. After the discrepancy between analyses was detected, both vials of blood were then re-analyzed by Dr. Kosecki and the pipetting of the samples was witnessed to ensure that the samples were properly identified and aliquoted. The same results were obtained from the respective tubes as detailed above. This confirmed it was not a sampling error.

2. ILEADS documentation was reviewed by lab personnel and the case officer's sergeant to determine if any other blood draws occurred at the same time period as the draw of DR#[redacted]. Only one other draw was conducted and OBC video was reviewed to determine that there was not a sample switch that occurred between cases at the time of the blood draws by the officers.

3. Additional examination of the blood tubes was conducted and additional laboratory experiments were run which determined that the second vial, which had been processed by Dr. Kosecki, had been contaminated with the same internal standard solution that is used within the lab for the quantitative analysis of blood samples. This type of contamination can occurs when the analyst is interrupted in their work or they are not paying attention to the work process. However, once this event occurs it is very self-evident that contamination has occurred and the event must then be documented in the case notes since that vial of blood is no longer suitable for blood alcohol quantitation analysis. Dr. Kosecki stated that this contamination did not occur during his analysis.

4. Amy Langan stated that she did not recall an internal standard sample contamination problem with any analyses that she conducted between 8/1/16 – 8/3/16, which included the report for DR#[redacted] dated 8/5/16. She further commented that if there was a problem with the analysis, she would have documented the issue in the case notes. She stated that though she could not recall any such event happening she was sure that it did not; otherwise, it would have been in her case notes. A review of her case notes showed that no such event was documented. This conversation took place on 3/28/17, which was two days before her scheduled last day of work.

5. Laboratory case notes are taken electronical through the laboratory's LIMS system and can therefore be audited. On Monday 4/3/17 an audit trail was performed on the case notes for DR#16-00804. The audit showed that a change had been made in the

documented blood volume of the second tube analyzed by Dr. Kosecki from 7 ml to 9 ml. This increase in volume in the second vial of blood would be consistent with internal standard being added directly to the blood vial. That volume documentation change was made by Amy Langan on 8/3/16, two days after she recorded her original notes and one day after she had analyzed the sample.

6. In addition, the vial that was run by Dr. Allan Kosecki had the ILEADS item number written on the tube which was placed there by Amy Langan. Per procedure, the analyst will mark the tube that they sample with the ILEADS item number, leaving the untested tube unlabeled. In this case, the second vial was labeled with the ILEADs item number, which was not the one sampled by Amy Langan. The vial that was analyzed by Amy Langan did not contain an ILEADS number. The tubes were also marked 1 and 2 respectively by the impounding officer. Examination of this labelling showed that the numbers had been over written, changing the 1 to a 2 and the 2 to a 1. This could have been done by the impounding officer or by Amy Langan.

Based on the investigation conducted by the laboratory it was determined that the laboratory's internal standard testing solution had been added to the second vial. The addition of this solution to the tube of blood caused a dilution of the sample and a corresponding decrease in the blood alcohol concentration. By policy this event should have been recorded and reported. Through the examination of the volume of blood in each vial, the addition of the internal standard solution could have only been added prior to Dr. Kosecki's analysis. Given the audit trail, and inconsistency and re-writes on the blood vials, it is the laboratory's position that Amy Langan accidently added the internal standard solution to the blood tube that Dr. Kosecki later analyzed and she did not notify anyone or document the event in the case record. In addition, there is evidence to support that there was an attempt by Amy Langan to cover up this error by changing the officer's numbering of the blood sample vials to indicate that during her analysis she had never opened the vial that was later shown to be contaminated with the internal standard testing solution. The failure to document this error in the case notes could have resulted in the second tube of blood being released to the defense council for standard defense retesting, resulting in the defense obtaining a significantly lower blood alcohol results which would then be used to discredit the accuracy and reliability of the laboratory's blood alcohol program.

Director Garrett stated that after Langan resigned she relocated to Ireland. I attempted to contact Langan more than once and she failed to return my calls.

FINDINGS

The allegation of **Integrity Violation** is **SUSTAINED**.

Document Review:

- Emails from Director Garrett

Analysis and Applicable Policies

The City Prosecutor's Office requested that the laboratory reanalyze a case due to the fact that Langan was resigning from her position. Dr. Kosecki completed a second analysis and found a discrepancy in the results. Further testing was done. Dr. Kosecki determined that the discrepancy was not a sampling error, that the blood had actually been contaminated with an internal standard solution that is used within the lab for the quantitative analysis of blood samples. Director Garrett and Manager Cano interviewed Langan about this prior to her last day with the City. She stated that she did not remember ever contaminating a tube of blood from a case sample with internal standard solution and in particular, the case in question, where she would have to go to the second vial to complete the analysis. She told them that she did not ever remember doing that and if she did, she would have recorded it in her notes. It was also noted that the labeling on the two vials seemed to have been altered. It appeared as if vial #1 was changed to a #2 and vial #2 was relabeled to vial #1. It is believed that Langan contaminated vial #1 during the analysis process by accidentally adding the internal standard solution to that vial. She then tried to cover the error up by changing the labeling of the vials from vial #1 to vial #2 and vial #2 to vial #1 so that her noted would still be correct in showing that she analyzed vial #1 even though she was actually working with vial #2.

It is believed that Langan should have remembered relabeling the vials and that she provided false or inaccurate information when interviewed by her supervisors. It is also believed that she

attempted to cover up her error by relabeling the vials. By doing this she falsified or inadequately recorded information related to the police department. When questioned by her superiors, it is believed that Langan was dishonest and did not provide an accurate account of the events in question.

Scottsdale Police General Orders 2503 – Misconduct - Offenses that may warrant disciplinary action include, but are not limited to:

> *5. "Failure to accurately report all facts pertaining to an investigation or other matter of concern to the department."*
>
> *6. "Failure to honestly report all facts pertaining to an investigation or other matter of concern to the department."*
>
> *7. "Relating a false, deceptive, or misleading account of an incident or fact at issue in an investigation or other matter of concern to the department."*

Therefore, the allegation of **INTEGRITY VIOLATION** is **SUSTAINED**.

Sergeant Melissa Palopoli #759

Internal Affairs Unit