REPORT OF THE

TEXAS FORENSIC SCIENCE COMMISSION

HOUSTON FORENSIC SCIENCE CENTER
TOXICOLOGY SECTION
ANALYST SELF-DISCLOSURE

Approved by Unanimous Vote at Quarterly Meeting:

January 23, 2014
Austin, Texas

I. BACKGROUND AND STATUTORY AUTHORITY

A. History and Mission of the Texas Forensic Science Commission

The Texas Legislature created the Texas Forensic Science Commission ("Commission") during the 79th Legislative Session by passing House Bill 1068 (the "Act"). The Act amended the Texas Code of Criminal Procedure to add Article 38.01, which describes the composition and authority of the Commission. *See* Act of May 30, 2005, 79th Leg., R.S., ch. 1224, § 1, 2005. During the 83rd Legislative Session, the Legislature amended the act again to clarify and expand the Commission's jurisdictional authority. *See* Acts 2013, 83rd Leg., ch. 782 (S.B.1238), §§ 1 to 4, eff. June 14, 2013.

The Act requires the Commission to "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)(2). The Act also requires the Commission to 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 Commission released guidance for accredited crime laboratories regarding the categories of non-conformances that may require self-reporting; this guidance is provided with the self-disclosure form located on the Commission's website.

The Commission has nine members appointed by the Governor of Texas. *Id.* at art. 38.01 § 3. Seven of the nine commissioners are scientists and two are attorneys (one prosecutor nominated by the Texas District and County Attorney's Association and one

criminal defense attorney nominated by the Texas Criminal Defense Lawyer's Association). *Id.* The Commission's Presiding Officer is Dr. Vincent J.M. Di Maio, as designated by the Governor. *Id.* at § 3(c).

II. INVESTIGATIVE PROCESS

A. Complaint and Disclosure Process

When the Commission receives a complaint or self-disclosure, the Complaint and Disclosure Screening Committee conducts an initial review of the document at a publicly noticed meeting. (*See* Policies and Procedures at 3.0). After discussing the disclosure or complaint, the Committee votes to recommend to the full Commission whether the complaint or disclosure merits any further action. *Id.*

In this case, the Committee discussed the disclosure and posed questions to the Houston Forensic Science Center's ("HFSC")[1] Director of Forensic Analysis Division ("Lab Director") at a publicly noticed meeting of the Complaint and Disclosure Screening Committee in Fort Worth, Texas on July 31, 2014. The following day, on August 1, 2014, the Commission held its quarterly meeting, also in Fort Worth, Texas. The Commission again discussed the disclosure and posed follow-up questions to the Lab Director. After deliberation, the Commission voted unanimously to create a 3-member investigative panel to review the disclosure pursuant to Section 3.0(b)(2) of the Policies

[1] Effective April 3, 2014, responsibility for and control of substantially all of the forensic operations formerly managed by the Houston Police Department ("HPD") including the HPD Crime Lab, were transferred to the Houston Forensic Science Center, Inc., ("HFSC") a local government corporation created by the City of Houston. Though many of the facts described in this report occurred *before* the transfer of operations, the Commission received the disclosure *after* the transfer. To minimize confusion, this report refers to the laboratory as "HFSC" consistently throughout.

and Procedures. Members voted to elect Mr. Richard Alpert, Dr. Nizam Peerwani and Dr. Sarah Kerrigan[2] as members of the panel, with Mr. Alpert serving as Chairman.

Once a panel is created, the Commission's investigation includes: (1) relevant document review; (2) interviews with members of the laboratory as necessary to assess the facts and issues raised; (3) collaboration with the laboratory's accrediting body and any other relevant investigative agency (*e.g.,* ASCLD/LAB, Inspector General's Office, District Attorney's Office, Texas Rangers, etc.) to minimize disruption at the laboratory; (4) requests for follow-up information where necessary; (5) hiring of subject matter experts where necessary; and (6) any other steps needed to meet the Commission's statutory obligations.

At the time the Commission began its investigation in this case, the HFSC toxicology section was accredited by ASCLD/LAB under the International Organization for Standardization ("ISO") accreditation standard 17025.[3] Thus, the Commission worked with ASCLD/LAB investigator Patti Williams to conduct joint interviews. Though the two entities review the case from distinct perspectives and reach independent conclusions, they strive to conduct interviews simultaneously whenever possible to minimize disruption at the laboratory.

On September 8-9, 2014, two members of the HFSC investigative panel, Dr. Nizam Peerwani and Assistant District Attorney Richard Alpert participated in a site visit at the HFSC with the Commission's general counsel and Patti Williams from

[2] Governor Perry announced appointment changes on October 28, 2014. Dr. Sheree Hughes-Stamm was appointed to the Commission seat designated for a faculty member from Sam Houston State University. (*See* TEX. CODE CRIM. PROC. 38.01 §3(a)(8))

[3] In a letter dated September 30, 2014, the HFSC notified ASCLD/LAB that it was withdrawing its ASCLD/LAB accreditation. The HFSC moved its accreditation to the ANSI-ASQ (FQS) National Accreditation Board.

ASCLD/LAB. The Commission interviewed the following individuals at the laboratory: four forensic analysts in the Toxicology Section including the analyst who submitted the disclosure ("Disclosing Analyst") and the analyst who accessioned the evidence ("Accessioning Analyst"); a senior technical lead in the Toxicology Section; the Acting Toxicology Manager/Acting Information Technology Director ("Interim Manager"); the Quality Director; the Human Resources Director, the Director of the Forensic Analysis Division (referred to herein as the "Lab Director") and the President and CEO of the HFSC.

The Commission's General Counsel also had telephone conversations and/or in-person meetings with the following individuals: two former analysts in the Toxicology Section; the former Toxicology Section Manager; two members (including the Chairman) of the HFSC Board; the Acting General Counsel of the HFSC; the Inspector General for the City of Houston; and the General Counsel of the Harris County District Attorney's Office. Commission staff also collected and reviewed hundreds of pages of relevant case documents, laboratory procedures and emails before, during and after the site visit.

In addition, in early October 2014 the Chairman of the HFSC Board informed the Commission that the Board requested a review of the matter by City of Houston's Office of Inspector General ("OIG"). The OIG's final report is attached hereto as **Exhibit A**.

B. Components of this Report

Under Section 38.01 of the Texas Code of Criminal Procedure, a Commission investigation of a DPS-accredited crime laboratory and a DPS-accredited forensic discipline 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; (C) any corrective

action required of the laboratory, facility, or entity; (D) observations of the Commission regarding the integrity and reliability of the forensic analysis conducted; (E) best practices identified by the Commission during the course of the investigation; and (F) other recommendations that are relevant, as determined by the Commission. TEX. CODE CRIM. PROC. § 38.01, Sec. 4(b)(1).

In addition, the 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 Sec. 4(b)(2).

C. Limitations on the Commission's Authority

All DPS-accredited crime laboratories are required to cooperate with the Commission during the course of an investigation pursuant to Section 411.0205(b-3) of the Texas Government Code. This section provides that the DPS director "shall require that a laboratory, facility, or entity that must be accredited under this section, as part of the accreditation process, agree to consent to any request for cooperation by the Texas Forensic Science Commission that is made as part of the exercise of the commission's duties under Article 38.01, Code of Criminal Procedure."

However, the Commission's authority contains important statutory limitations. For example, no finding contained herein constitutes a comment upon the guilt or innocence of any individual. TEX. CODE CRIM. PROC. 38.01 at § 4(g); Policies and Procedures at § 4.0(d). In addition, the Commission's written reports are not admissible in a civil or criminal action. (*Id.* at § 11; *Id.* at § 4.0(d).)

The Commission also does not have the authority to issue fines or other administrative penalties against any individual or laboratory. The information it receives during the course of any investigation is dependent upon the willingness of the forensic laboratory or other entity under investigation and other 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, during on-site and telephone interviews, 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.

Moreover, documents obtained during the course of interviews have not been subject to any independent validation. For example, if the Commission receives an email from a laboratory or individual, and the email indicates it was sent on a given date at a given time, the Commission assumes this information is accurate and has not been altered. The Commission requests information from the laboratory and other concerned parties based on its understanding of the facts as presented in the complaint or self-disclosure, and relies on the parties to provide supplemental information if they believe such information will shed light on the Commission's review of a given complaint or self-disclosure. Because the Commission has no authority to subpoena documents, it relies on the parties' willingness to cooperate with the investigation.

Finally, the investigation discussed herein concerns an error in the laboratory's toxicology section and the HFSC leadership's response to that error. The Commission conducted limited interviews with current and former members of the Toxicology Section, HFSC management and related stakeholders. Not every section of the laboratory

has the same challenges or face the same opportunities for improvement at the same time. Thus, the observations and recommendations herein, unless specifically designated for broader application, are limited to the Toxicology Section and do not impact other forensic divisions of the HFSC.

D. Concerns Regarding "Human Resource" Issues and the Commission's Investigative Role

The primary purpose of this report is to address the concerns raised in the self-disclosure in a manner that encourages the integrity and reliability of forensic science at the HFSC. The Commission has no authority or desire to interfere with the human resource decisions of the HFSC or any other crime laboratory or entity subject to its jurisdiction. To the contrary, the Commission understands management must have the authority and flexibility to make personnel-related decisions in a manner it deems appropriate based on the totality of circumstances. While the Commission's review of a given case captures a limited amount of information related to a specific incident in the laboratory, management typically has a more comprehensive understanding of the overall circumstances of a forensic analyst's employment at the laboratory. The Commission has dismissed complaints in the past based on personnel conflicts that had little or no bearing on the integrity of forensic analyses in the crime laboratory, and will continue to do so in the future when appropriate.

However, management decisions, including those labeled as "human resource" decisions, can have a tremendous impact on the laboratory's overall transparency as a key player in the criminal justice system. For example, a critical component of every laboratory's quality program is effective root cause analysis. The ability of the laboratory to conduct a fair and thorough root cause analysis in the wake of a non-conformance is

essential to the integrity of the laboratory. When the laboratory issues a root cause analysis that inequitably attributes responsibility to one analyst while downplaying management's contribution to the same incident, the resulting environment may be one in which analysts are hesitant to report mistakes. This dynamic can have a chilling effect on laboratory self-disclosure, which contradicts fundamental concepts in both the established accreditation standards under ISO-17025 and Article 38.01 of the Texas Code of Criminal Procedure.

Moreover, as further discussed below, when laboratory management makes an affirmative decision *not to document* concerns about an analyst's performance under the guise of "protecting" the analyst from criminal discovery and possible defense cross-examination, they risk: (1) impeding the prosecutor's ability to assess her disclosure obligations regarding potential impeachment information under the law; (2) withholding impeachment information from the defense to which they may be entitled; (3) creating a greater long-term adverse impact on the affected analyst and the laboratory than if they had just dealt with errors and related corrective action directly upfront; (4) sending a message to analysts that it is acceptable to hold back potentially relevant impeachment information to avoid a difficult cross-examination; and (5) in this particular case, impeding the HFSC Board's long-term objective of encouraging crime laboratory service to *both* law enforcement *and* defense customers.

Thus, to the extent "human resource" decisions impact the integrity and reliability of the crime laboratory, the Commission will continue to address these issues in its written reports.

III. SUMMARY OF KEY FACTS AND DISCLOSURE TIMELINE

A. Summary of Allegations

On June 4, 2014, the Disclosing Analyst submitted a self-disclosure to the Commission regarding a blood alcohol report issued with the wrong defendant's name, which the Disclosing Analyst discovered and reported to her supervisors on April 15, 2014. (*See* **Ex. B.**) The Disclosing Analyst alleged the laboratory failed to: (1) amend the erroneous report; (2) notify the Harris County District Attorney's office regarding the error; and (3) issue a corrective and preventative action ("CAPA") report as required by laboratory policy and associated accreditation standards. The Disclosing Analyst also alleged the Interim Manager removed the Disclosing Analyst from casework on April 16, 2104 because of the error without a coherent explanation for why she was being removed or a plan for returning her to casework.

B. Facts Underlying Blood Alcohol Reporting Error

On October 5, 2013, a Houston Police Department officer ("Submitting Officer") turned in a submission form to the HFSC for a defendant (referred to herein as "Defendant R") corresponding to the wrong blood alcohol evidence. The blood evidence actually belonged to a another defendant (referred to herein as "Defendant H"). The Submitting Officer should not have turned in a blood evidence submission form for Defendant R, as he had administered a breath test to Defendant R, **not** a blood test. Shortly after the Submitting Officer turned in the incorrect submission form, the

Accessioning Analyst noted the discrepancy between the name on the blood tubes (Defendant H) and the name on the submission form (Defendant R). (*See* **Ex. D.**)

On October 15, 2013, the Accessioning Analyst sent an email to the Submitting Officer indicating the name on the submission form did not match the submission envelope and the blood tubes. (*See* **Ex. D.**) The Accessioning Analyst asked the Submitting Officer to resolve the issue by submitting a corrected submission form. (*See* **Ex. D.**) The Submitting Officer acknowledged he wrote the wrong case information on the submission form, and told the Accessioning Analyst he would provide a corrected form. (*See* **Ex. D.**)

On October 31, 2013, the Accessioning Analyst sent another email to the Submitting Officer again requesting a corrected submission form. (*See* **Ex. E.**) On November 5, 2013, the Submitting Officer apologized to the Accessioning Analyst, saying he "forgot all about it," but that he had "dropped it off" and stapled a note on it with the Accessioning Analyst's name. (*See* **Ex. E.**) On December 5, 2013, the Accessioning Analyst sent yet another email to the Submitting Officer stating that she still had not received the corrected submission form, and that it "must have gotten lost in transit." She requested the Submitting Officer fax the form to the laboratory. (*See* **Ex. F.**)

On December 9, 2013, the Disclosing Analyst examined the blood evidence with permission of the Toxicology Section Manager at the time. The laboratory's practice was to analyze evidence with discrepancies in submission information, but to set the evidence aside and <u>not</u> release a report until the information could be clarified by the officer who submitted the evidence. In conformance with this practice, the Disclosing Analyst

examined the blood evidence and set the case aside without signing the report until the name discrepancy could be resolved by the Submitting Officer. The Disclosing Analyst also made a notation on the batch technical review report for December 9, 2013 to indicate the blood evidence belonged to Defendant H, not Defendant R. (*See* **Ex. G.**) The Toxicology Section manager conducted a technical review of the batch data on December 10, 2013. (*See* **Ex. H.**)

The Toxicology Section Manager who originally supervised the Disclosing Analyst departed from the laboratory at the end of December 2013. His departure had been planned for a number of months preceding his end date. While searching for a permanent Toxicology Section Manager to replace him, the laboratory, which at that time was managed by HPD, appointed the Interim Manager to run the toxicology section while he was simultaneously tasked with managing the information technology system for the entire laboratory.

On January 2, 2014, the Harris County Assistant District Attorney responsible for Defendant H's case ("ADA") sent an email to the laboratory requesting the results associated with the blood alcohol evidence for Defendant H. (*See* **Ex. I.**) The ADA stated that he "checked in LIMS and it is not even pulling up this case." (LIMS is the laboratory's electronic case management system.) The HFSC employee who received the ADA's inquiry forwarded it to the Interim Manager. (*See* **Ex. I.**) The Interim Manager responded to the ADA on January 3, 2014, confirming he also was unable to find Defendant H's case in the LIMS or the property room system and requesting the name of the officer who submitted the evidence. (*See* **Ex. I.**) On January 7, 2014, the ADA responded with the Submitting Officer's name. (*See* **Ex. I.**) On the same day, the

Interim Manager sent an email to the Submitting Officer inquiring about the blood evidence for Defendant H, which at that time appeared to be missing since it was in the LIMS under the wrong defendant's name. (*See* **Ex. I.**)

On January 10, 2014, the Disclosing Analyst mistakenly signed off on the blood alcohol report for Defendant R, which she had originally set aside to wait for clarification from the Submitting Officer. (*See* **Ex. J.**) The Disclosing Analyst was not copied on any of the correspondence with the ADA or the Submitting Officer described above. By signing the report, the Disclosing Analyst released it for administrative and technical review with the wrong name (Defendant R) still assigned to the blood alcohol results for Defendant H. On the same day, the Interim Manager technically and administratively reviewed the case. He also did not pick up on the name discrepancy noted in the case folder, (*See* **Ex. C.**) or make a connection between the ADA's inquiries about the missing Defendant H evidence and the information noted in the case folder. (*See* **Ex. I.**) In addition, the fact that the case was from an earlier December 10, 2013 batch technical review (for which Defendant R's name had been crossed out and Defendant H's name was handwritten as a correction) did not appear to raise any red flags. (*See* **Exs. G, H.**) After technical and administrative review was complete, the report was released in the LIMS.

On January 15, 2014, the Submitting Officer responded via email to the Interim Manager's January 7, 2014 email regarding Defendant H, explaining "the case was mixed up with another case," due to "an error on my part on the submission form." (*See* **Ex. K.**) The Disclosing Analyst was not copied on this email either. The email from the Submitting Officer referencing this case being "mixed up with another case" did not

trigger any follow-up or investigation in LIMS by the Interim Manager or the Accessioning Analyst. When asked, the Accessioning Analyst explained it was her understanding that the Interim Manager was taking over any necessary follow-up on the case.

On March 26, 2014, the Harris County District Attorney's Office dismissed the aggravated[4] DWI charge against Defendant H. According to the Harris County District Attorney's Office, they dismissed the alcohol-related charge for no other reason than they were unable to find the blood alcohol evidence. The District Attorney issued a lesser charge of "failure to provide information." (*See* **Ex. A.**)

On March 27, 2014, the Interim Manager sent an email to the HPD Captain in charge of the Submitting Officer, stating the laboratory ***still had not received*** the corrected submission form. (*See* **Ex. L.**) On the same day, the Captain instructed the Submitting Officer to "take care of this ASAP." (*See* **Ex. L.**) The following day, the Submitting Officer explained in an email to the Interim Manager that he believed the laboratory had received the faxed version of the corrected submission form he sent to the Accessioning Analyst on December 5, 2013 because he had not heard anything to the contrary. (*See* **Ex. L.**)

On April 15, 2014, the Disclosing Analyst was working in one of the evidence coolers when she noticed some blood evidence had been set aside with a note on it with her handwriting. She went into the LIMS to research the case number for the evidence, and realized the report had been released with the wrong defendant's name. She

[4] The blood specimen contained 0.168 grams of ethanol per 100 milliliters of blood according to the January 10, 2014 laboratory report. *See* **Exhibit J**. This result exceeds the 0.15 threshold at which the offense increases to a Class A misdemeanor under Section 49.04(d) of the Texas Penal Code. The term "aggravated" commonly refers to charges for which an enhanced penalty is available.

immediately notified the Interim Manager, the Lab Director and Quality Director. The Interim Manager researched the case in LIMS and determined that no one outside the laboratory had accessed the report. He then "recalled" the report from the LIMS, preventing anyone outside the laboratory from being able to access it.

The following day, the Interim Manager informed the Disclosing Analyst that she was being removed from casework. (*See* **Ex. M.**) The Interim Manager instructed the Disclosing Analyst to write a memo about the case and everything she did related to the case, as well as to include all relevant correspondence regarding the case in the case folder. *Id.* In attempting to fulfill the request of the Interim Manager, the Disclosing Analyst discovered the email correspondence referenced above between the Accessioning Analyst and the Submitting Officer, the Interim Manager and the ADA, and the Interim Manager and the Submitting Officer, which had not previously been documented in the case folder.

According to the Disclosing Analyst and the email correspondence, it took her no more than a few days after April 16, 2014 to prepare the memo requested by the Interim Manager and complete the case file with correspondence. She believed she was being taken off casework temporarily to draft the memo and ensure related case documentation was placed in the file. However, the Interim Manager informed the Disclosing Analyst she would remain off casework until further notice. During the period from April 16, 2014 when she was removed from casework until she was returned to casework on July 28, 2014, the Disclosing Analyst sent various email communications to the Interim Manager, the Laboratory Director, the Quality Manager, the Human Resources Director and the President and CEO of the HFSC expressing concerns about the laboratory's need

to issue an amended report, and inquiring about a plan for her return to casework. (*See* **Ex. N.**)

The Human Resources Director, Disclosing Analyst and Interim Manager met in person three times during the month of June 2014 to discuss this matter. (*See* **Ex. A.**)

The Commission held its quarterly meeting in Fort Worth on August 1, 2014, and discussed this case in detail as previously described. On the same day (August 1, 2014), the laboratory issued a first amended report for Defendant R. (*See* **Ex. O.**) On August 4, 2014, the laboratory issued a second amended report for Defendant R. (*See* **Ex. P.**) Also on August 4, 2014, the laboratory released CAPA #2014-11 and CAPA #2014-16. (*See* **Exs. T, X.**) On August 15, 2014, the laboratory issued a third amended report for Defendant R. (*See* **Ex. Q.**) On August 15, 2014, the laboratory issued an amended report for Defendant H. (*See* **Ex. R.**) The four amended reports corrected the original erroneous results, and stated that Defendant R had been given a breath alcohol test, while the blood alcohol results actually belonged to Defendant H.

IV. CONCLUSIONS REGARDING NEGLIGENCE AND MISCONDUCT

Article 38.01 of the Texas Code of Criminal Procedures requires the Commission to describe whether professional negligence or misconduct occurred in this case. Neither "professional negligence" nor "professional misconduct" is defined in the statute. The Commission has defined both terms in its policies and procedures. (Policies and Procedures at 1.2.)

In sum, the Commission did not identify any evidence of "professional misconduct," in this case as that term is identified in Section 1.2 of the Commission's Policies and Procedures. However, the Commission did find evidence of "professional

negligence" as described in detail below. The term "professional negligence" is defined in Section 1.2 of the Commission's Policies and Procedures as follows:

> "Professional Negligence" means 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 would substantially affect 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. (Polices and Procedures at 1.2)

A. Negligence Finding

The Commission finds the HFSC Interim Manager was professionally negligent in failing to issue timely amended reports to the Harris County District Attorney's Office for Defendants H and R once the mistake in the report names was identified by the Disclosing Analyst. (*See* **Ex. S,** HFSC Quality Manual ("QM") at C.9.) In addition, the Commission finds the HFSC Interim Manager and the HFSC Quality Manager were negligent in failing to issue a timely Corrective and Preventive Action report ("CAPA") that accurately and completely described the root cause of the non-conformance. HFSC management should have used the laboratory's existing quality system to address the errors promptly once they were discovered. Issuance of the amended reports and the related CAPA were essential components of ensuring the case records for the forensic analyses were accurate and complete, and for ensuring the integrity of the forensic analyses performed by the laboratory.

Accredited crime laboratories are engaged in an ongoing process of continual improvement. (*See e.g.,* **Ex. S.,** HFSC QM at 4.10) Though every effort is made to safeguard against errors in the laboratory, they are an inevitable part of any human

endeavor. This includes forensic disciplines with a high volume of cases containing various components, some of which are outside the laboratory's control. For this reason, accredited crime laboratories have standard operating procedures in place to address errors promptly when they occur. Action steps include amending reports as needed (*See* **Ex. S.,** QM at C.9), and issuing a corrective and preventative action (*See* **Ex. S.,** QM at 4.11) which includes a root cause analysis (*See* **Ex. S.,** QM at 4.11.2). Corrective actions should be of an "appropriate degree and magnitude to correct the problem and reduce the risk of recurrence." (*See* **Ex. S.,** QM at 4.11.3)

B. Analysis of Facts Underlying Negligence Finding

The Disclosing Analyst alerted management regarding the error in the blood alcohol report on April 15, 2014. It took the laboratory almost four months (until early August 2014) to amend the affected reports and issue CAPAs. When the Commission's investigative panel asked the Interim Manager why it took so long to issue amended reports, he explained that once he determined no customer had accessed the erroneous information in the LIMS, the need to issue the amended reports "took on less urgency." This explanation is inadequate. The integrity of the laboratory's quality system depends upon all members of the laboratory following the quality process and ensuring appropriate and timely notification of errors in the form of established documentary methods. In fact, customers depend on this quality system to ensure they are able to fulfill their broader obligations to the criminal justice system, including the dismissing or re-filing of charges where appropriate and providing notice to defense counsel and the court system where necessary.

Because the issuance of amended reports and appropriate corrective actions where needed is standard, generally accepted practice among accredited laboratories, and because HFSC management in charge of the Toxicology Section and the quality process failed to meet this standard, the Commission issues a finding of professional negligence for these omissions.

In addition and of significant concern to the Commission, the original CAPA issued by the laboratory on August 4, 2014 did not accurately or equitably describe the root cause of the non-conformance. An accurate root cause analysis in this case would include (but is not limited to) the following contributing factors:

1. The laboratory's practice in December 2013 was to analyze evidence with inconsistencies/discrepancies from the submitting officer but to set those cases aside. That practice has been changed so that such cases are no longer analyzed until the inconsistencies/discrepancies are resolved (*See* **Ex. T.**) This greatly reduces the risk of a report being released with incorrect information.

   NOTE: The original CAPA stated the Disclosing Analyst worked the evidence in December 2013 "independently," which implies her actions were outside the scope of laboratory practice and management direction at the time. This is not true.

2. On October 16, 2013, well before the evidence was analyzed, the Accessioning Analyst received an email from the Submitting Officer stating the breath alcohol case belonged to Defendant R, and the blood alcohol case belonged to Defendant H. However, this email was not placed in the case folder until the Disclosing Analyst identified the mistake in April and was instructed to gather all email correspondence. While the Accessioning Analyst was waiting for the corrected submission form from the Submitting Officer, she could have placed a copy of the submitting officer's email in the case file, which would have given both the Disclosing Analyst and the Interim Manager more accurate information when analyzing the case and conducting the administrative and technical reviews.

   NOTE: Relevant case emails should be included in the case folder under the QM Section entitled "Case Records."

3. On January 10, 2014, the blood alcohol report with the wrong defendant's name was released in the LIMS because *both* the Disclosing Analyst *and* the Interim Manager failed to review and/or act upon the note in the case folder regarding the Submitting Officer's name discrepancy. (*See* **Ex. C.**) The Disclosing Analyst made this error when she signed off on the case and the Interim Manager made the same error during administrative review, the purpose of which is to identify exactly these type of errors. (*See* **Ex. S.**, QM at F.) In addition, the fact that the case was from an earlier December 10, 2013 batch technical review (for which Defendant R's name had been crossed out and Defendant H's name was handwritten as a correction) does not appear to have triggered any red flags. All contributing causes should be described accurately in the CAPA.

4. On January 15, 2014, the Interim Manager received an email from the Submitting Officer on which the Accessioning Analyst was copied. This was in response to the Interim Manager's request regarding Defendant H's blood evidence as a follow-up to the ADA's inquiries during the first two weeks of January. If the Interim Manager and the Accessioning Analyst had *communicated with each other* and followed up on the Submitting Officer's reference to Defendant H's case being "mixed up with another case," they would have identified the issue. This would have allowed amended reports to be issued in both cases just five days after the erroneous report was released in the LIMS. If timely amended reports had been issued, the Harris County District Attorney's office would not have been forced to dismiss the aggravated DWI charge against Defendant H, which they ultimately did on March 26, 2014.

5. Similarly, on March 27, 2014—one day after the ADA dropped the charges—the Interim Manager sent an email to the Submitting Officer's captain acknowledging the evidence for Defendant H appeared to have been submitted under Defendant R's name, yet neither the Interim Manager nor the Accessioning Analyst checked in the LIMS to determine whether a report had been issued in Defendant R's case.

6. On March 28, 2014, the Submitting Officer stated again via email that the case against Defendant R was a breath case, and the case against Defendant H was a blood case. This email also did not prompt either the Accessioning Analyst or the Interim Manager to research the defendants' names in the LIMS, which would have uncovered the erroneous report.

7. On April 15, 2014, the Disclosing Analyst ultimately discovered the problem when she noticed blood evidence set aside in one of the coolers and researched its status in the LIMS. The Disclosing Analyst then brought the mistake to the attention of laboratory management.

   NOTE: The "actions steps" discussion in the original CAPA omitted this fact, which is a critical component of the case from a quality control and

laboratory integrity perspective. Self-disclosure should be encouraged for all analysts in the laboratory whenever they identify mistakes.

V. ADDITIONAL OBSERVATIONS

The Commission has significant concerns regarding some of the management decisions made after the Disclosing Analyst identified and reported the mistake in the blood alcohol report. These concerns are described below.

A. Inconsistent Explanations Regarding Removal from Casework

Removing an analyst from casework for an extended period is a significant decision for most accredited crime laboratories because it has the potential to impact both workflow for the section as well as the individual analyst's career. The Disclosing Analyst expressed concern regarding her removal from casework as well as a perceived lack of communication from HFSC management regarding the reason for her removal and a plan to reinstate her to casework. During its July 31, 2014 and August 1, 2014 meetings, the Commission asked the Lab Director why the Disclosing Analyst was removed from casework. The Lab Director stated the reason for her removal was ***independent*** from the error in the blood alcohol case described above and subsequent disclosure. The Lab Director explained the reason the Disclosing Analyst was removed from casework was due to concerns about her ability to testify in court.

The only document provided to the Commission explicitly addressing the reasons the Disclosing Analyst was removed from casework is an August 4, 2014 memorandum from the Interim Manager to the Disclosing Analyst authorizing her to return to casework. The explanation includes the following:

1. During a March 2014 conversation in which the Disclosing Analyst sought the Interim Manager's feedback on a PowerPoint presentation requested by a prosecutor, the Disclosing Analyst was unable to answer basic questions and convey her understanding of the concepts associated with

the function and operation of Headspace Gas Chromatography using the Perkin Elmer instrument;

2. The Disclosing Analyst "erred in generating a report for evidence submitted under incorrect case information"; and

3. The Interim Manager had concerns regarding the Disclosing Analyst's April 30, 2014 testimony in court, which were documented in a memorandum dated June 26, 2014.

This memorandum contradicts representations made by the Lab Director at the Commission's July 31st and August 1st meetings that the error in the blood alcohol case was ***independent*** from the other reasons the Disclosing Analyst was removed from casework. The Disclosing Analyst was removed from casework the day after she notified management of the erroneous report, on April 16, 2014. However, she did not testify for the first time in court until April 29, 2014. That testimony carried over until April 30, 2014. The Disclosing Analyst testified again on May 6, 2014. She testified a third time on June 5, 2014, and on subsequent occasions as well. The Disclosing Analyst did not receive a written evaluation of her April 29-30 testimony from the Interim Manager until June 26, 2014.[5] (*See* **Ex. U.**)

The Interim Manager's testimony evaluation was generally positive, though it listed many areas for improvement:

> This evaluation is being offered based on my observations during your first court testimony experience. Outside defense attorneys who were present were heard telling the Assistant Chief of Court 8 that you presented well, had a good attitude and were well spoken.

[5] The final version of the testimony evaluation document was dated June 26, 2014, though earlier drafts were discussed among the Interim Manager, Disclosing Analyst and Human Resources Director in the first part of June 2014.

> Overall, your testimony regarding the analysis in incident 35791513 was good. I can say that I have not seen an attorney be as personal with an expert witness in my career.
>
> Your appearance was long and undoubtedly, exhausting. With that being said, it is imperative that you always ensure you understand the question that is being asked.
>
> Your testimony regarding the processes used by the instrument to detect and quantitate ethanol was good, overall. The following observations [sic] made while observing your testimony:

The Interim Manager then offered a series of detailed observations regarding improvements the Disclosing Analyst could make in future court appearances. The Lab Director's representation that the Disclosing Analyst was removed from casework for concerns regarding courtroom testimony ***independent*** from the case with the name error do not comport with the timeline of facts. Perhaps the Disclosing Analyst was not allowed to return to casework because of concerns regarding her testimony, but it is difficult to understand how she could have been removed from casework as early as April 16, 2014 because of concerns regarding her courtroom testimony when she did not testify for the first time until April 29, 2014.

During the investigative panel's site visit, the Interim Manager described another reason for removing the analyst from casework. On March 13, 2014, the Disclosing Analyst approached the Interim Manager for feedback regarding a PowerPoint she was preparing for use in court based on a request from a Harris County Assistant District Attorney. During that discussion, the Interim Manager became concerned about the Disclosing Analyst's understanding of the "function and operation of Headspace Gas Chromatography using the Perkin Elmer instrument." In his memorandum dated August 4, 2014, the Interim Manager explained that he questioned the Disclosing Analyst's

overall knowledge base as a result of the discussion. (*See* **Ex. V.**) He further stated that he and the Disclosing Analyst "went to the laboratory and reviewed the function and operation of Headspace Gas Chromatography using the Perkin Elmer equipment. *Id.* This included a review of the parts and function of the headspace and gas chromatograph." (*See* **Ex. V.**) The Interim Manager also gave the Disclosing Analyst a case study to assist her understanding further, which she reviewed in compliance with his instructions. (*See* **Ex. A.**)

Section 4.11.3 of the QM discusses the possibility of providing additional training as a component of corrective action. (*See also* **Ex. S**, QM at 5.2.1.1.) It states that if the error rests with the analyst, "it will be determined if the error was the result of inadequate or inappropriate training or is an isolated incident and not likely to recur. If the original training is found to be faulty, appropriate additional training, evaluation and revision will be devised." *Id.* Though the Interim Manager's training on the Perkin Elmer instrument resulted from the PowerPoint discussion and not a corrective action, the Interim Manager took appropriate training steps as described in the QM. During interviews, analysts in the Toxicology Section as well as the former manager of the Toxicology Section conveyed their understanding that toxicology examiners first learn how to perform the forensic analysis in question, and then learn more about the parts and function of the instrumentation as they progress through their careers. This type of issue would commonly be addressed through in-house training, as it was in this case.[6]

[6] The OIG report recounts a statement made by the Disclosing Analyst that she did not take the Interim Manager "seriously" when he raised concerns about her understanding of the Perkin Elmer instrument. During interviews, we understood this to be a frustrated expression of disbelief that she would be removed from casework for this reason, not that she did not take the Interim Manager's training directives seriously. While her choice of words was undoubtedly poor, at no point did anyone (including the Interim Manager) express a concern that the Disclosing Analyst does not take her responsibilities in the laboratory seriously.

The Interim Manager did not offer any additional reasons for concern regarding the Disclosing Analyst's competency in conducting blood alcohol analyses. In fact, in a memorandum from the Interim Manager to the Disclosing Analyst dated August 4, 2014, the Interim Manager stated "I had the opportunity to review some of your analytic work after January 1, 2014 when I assumed the position of Acting Toxicology Manager." The technical reviews I had conducted during that time frame had not caused me any particular concern." (*See* **Ex. V.**) When asked, the Disclosing Analyst's colleagues (including those who assisted with her training) and the previous manager described her as hardworking, dedicated and *technically competent*.

B. "Keeping Things Informal" to Avoid Discovery by Defense Counsel

During interviews, the Human Resources Director and the Interim Manager described the Interim Manager's motivation for not documenting the Disclosing Analyst's removal from casework. The Interim Manager wanted to "keep things informal to protect her career." This rationale is discussed in detail in the City of Houston Inspector General's report (*See* **Ex. A**). "While [Interim Manager] may have benefitted as well from a lack of documentation, he sincerely felt [Disclosing Analyst] would suffer both in testimony and in cross-examination. [Interim Manager] told [Disclosing Analyst] he planned to handle it informally, so as not to damage her career."

The Inspector General concluded the Interim Manager knew the following facts: "The error came to light April 15, 2014 and the Disclosing Analyst was scheduled to testify in her first case less than 10 days later; the [Disclosing Analyst's] cross-examination would be difficult at best if it started with documentation that she reported a

blood analysis indicating a legal violation to the wrong individual." The Inspector General further concluded:

> [Interim Manager] attempted to shield [Disclosing Analyst] from the consequences of her error by removing her from casework and retraining rather than formal documentation. Negative personnel reports are discoverable by defense counsel and can do great damage to an analyst's credibility. Interim Manager's attempt to shield her from that damage does not support a finding that his decision to remove her from casework "chilled" her from coming forward with her own errors, in fact the reverse.

In interviews with the Human Resources Director, she explained the Interim Manager's desire to "keep things informal" seemed unusual to her based on her prior experience in an industry unrelated to forensic science. As a result of this, she asked the President and CEO of the HFSC about it, and he responded that things are done "differently" in a forensic laboratory.

When the investigative panel spoke with the President and CEO during the site visit, he did not have any recollection or familiarity with the case, and indicated he would wait until the Commission released a report in writing before commenting. The Commission finds this position troubling in light of the Human Resource Director's discussion with him as well as the fact that the Disclosing Analyst sent him an email on May 29, 2014 describing her concerns, to which he did not reply. While the Commission understands that a CEO and President would not necessarily have intimate knowledge of daily casework in the laboratory, both the conversation with the Human Resources Director regarding the decision to "keep things informal" and the May 29, 2014 email should have raised red flags significant enough to merit further follow-up.

C. The Potential Chilling Effect on Transparency of Inaccurate Root Cause Analysis and "Keeping Things Informal"

The Commission is concerned about the Interim Manager's post-hoc explanation of the decision to remove the Disclosing Analyst from casework based on the timeline of facts. However, we assume for purposes of the discussion in this section that the Interim Manager's concerns regarding the Disclosing Analyst's performance were legitimate. In other words, we assume for purposes of this discussion that the Disclosing Analyst's performance and understanding of analytical concepts were so concerning to the Interim Manager that he decided she should be removed from casework for over three months. His decision *not to document* the reasons regarding her removal from casework is more troubling than any other aspect of this investigation.

The legal system imposes on prosecutors a Constitutional obligation to disclose information that is "favorable to the defense." *Brady v. Maryland* (1963) 373 U. S. 83. Prosecutors are responsible for what they know or have in their files. The *Brady* disclosure responsibility extends out to the "team" that works with the prosecutor or law enforcement agencies in helping investigate the case. The Supreme Court has held: "[T]he individual prosecutor has a duty to learn of any favorable evidence known to the others acting on the government's behalf in the case, including the police. But whether the prosecutor succeeds or fails in meeting this obligation (whether, that is, a failure to disclose is in good faith or bad faith, [citation]), the prosecution's responsibility for failing to disclose known, favorable evidence rising to a material level of importance is inescapable." (*Kyles v. Whitley* (1995) 514 U.S. 419, 437–438.)

During the 83rd Legislative Session, the Texas Legislature amended Article 39.14 of the Texas Code of Criminal Procedure to include the following provision:

> Notwithstanding any other provision of this article, the state shall disclose to the defendant any exculpatory, impeachment, or mitigating document, item or *information* in the possession, custody, or control of the state that tends to negate the guilt of the defendant or would tend to reduce the punishment for the offense charged. TEX. CODE CRIM. PROC. 39.14(h). [emphasis added]

By not documenting the reasons for removing the Disclosing Analyst from casework and not sharing information regarding the Disclosing Analyst's removal from casework with the Harris County District Attorney's office, the Interim Manager:

1. Deprived the prosecutor of the opportunity to determine whether any action was required by the United States Supreme Court's decision in *Brady v. Maryland* and/or Article 39.14 of the Texas Code of Criminal Procedure regarding disclosure of "impeachment information";

2. May have deprived the defense of impeachment information to which it was entitled;

3. Created a greater long-term adverse impact on the Disclosing Analyst and the laboratory than if the laboratory had just addressed the errors and related corrective action upfront, as the Disclosing Analyst rightly expected would be done in accordance with the QM and related accreditation standards;

4. Sent the message to a member of the Toxicology Section that it is acceptable to not to document issues that arise in the laboratory for fear of a tough cross-examination from the "other side"; and

5. Undermined the HFSC Board's long-term goal of providing service to both law enforcement and defense counsel.[7]

When the Commission describes concerns regarding a potential "chilling effect," it refers to a laboratory culture in which fear of potential adverse consequences discourages information from being communicated, either to management internally or to stakeholders outside the laboratory. In this case, the inequitable root cause analysis could certainly have a "chilling effect" on the inclination of analysts to self-disclose in the

[7] HFSC Board members have expressed deep concerns regarding the issues raised herein. HFSC Board deliberations are public and may be viewed at: http://www.houstonforensicscience.org/meeting.php.

future. In fact, every analyst we interviewed (current and former) with knowledge of the case expressed the opinion that the Disclosing Analyst was unfairly blamed for the reporting error. This commonly shared perception was of great concern to the Commission, as was the Interim Manager's decision to "keep things informal" for reasons discussed above.

Notwithstanding these observations, the Commission noted during its site visit that the analysts in the Toxicology Section—including the Disclosing Analyst—appear to be hardworking, dedicated and honest people. Many of the analysts are early in their careers with tremendous potential for future growth. The Commission is optimistic that with the appropriate leadership, the staff will flourish and counteract any potential "chilling" concerns described above.

VI. LESSONS LEARNED AND RECOMMENDATIONS

A. Corrective Actions Taken by HFSC Management

The HFSC has implemented corrective actions and made policy changes in response to the concerns described herein. These initiatives include (but are not limited to) the following items:

As described in HFSC CAPA 2014-11 and 2014-16,[8] the Toxicology Section has suspended analyses where evidence may be associated with an incorrect case. The laboratory now includes in its reports any information related to identified inconsistencies in the analysis. At the time any inconsistency is detected, analysts may issue a report

[8] On December 22, 2014, the Commission's General Counsel received an additional CAPA from the HFSC's Acting General Counsel that appears to have been drafted by the Disclosing Analyst on October 30, 2014 with a memorandum from the Interim Manager dated December 19, 2014. Commission recommendations regarding CAPA resolution are contained in Section VI.C. below.

stating the issue has been identified, and subsequent analysis will not be performed until the issue is resolved. (*See* **Ex. T.**)

In addition, the HFSC Quality Division reviewed 142 (26%) of 544 case records that had been previously technically and administratively reviewed by the Interim Manager. (*See* **Ex. W.**) The purpose of the case record review was to evaluate the Interim Manager's case record review process to determine "whether the fact that the Interim Manager missed the name error on technical and administrative review was an isolated event." The Quality Division did not identify any major administrative issues nor suspect name and/or incident discrepancies in the reviewed case records. Minor administrative findings were noted and are described in **Exhibit W** to this report.

The Harris County District Attorney also requested photos be taken of the evidence upon receipt by the laboratory. The Toxicology Section is working to identify practical avenues to make those photos available at the time reviews are conducted.

The laboratory also will have multiple employees conduct technical and administrative reviews on a particular case, as opposed to a single reviewer for both technical and administrative review.

The laboratory also addressed the failure to track and resolve the submission form discrepancy through the appropriate CAPA process. At the time the CAPA in this case should have been resolved, the Interim Manager was in charge of both the Toxicology Section and information technology for the entire laboratory. The Quality Division had one manager and one quality assurance criminalist. The laboratory has now hired additional staff in the toxicology and quality assurance units. A total of five additional

quality assurance specialists were added to the laboratory's budget this year to implement various quality control measures throughout the laboratory. (*See* **Ex. X.**)

In addition, on November 26, 2014, the laboratory issued (and the Board subsequently approved) a Progressive Corrective Action Policy (*See* **Ex. Y.**) Its purpose is "to establish procedures for addressing the need for improvement in behavior and/or performance of employees of and civilians managed by" the HFSC. This policy is distinct from the laboratory's CAPA policy in that it addresses the conduct of people working for the HFSC, whereas the CAPA process focuses on procedures those same people are expected to follow. In some circumstances the substance of the two documents may overlap, as the QM acknowledges. (*See* **Ex. S.**, QM at 27.) ("While it is not the purpose or intent of this policy to single out an individual or section, it may occur as a byproduct of the process."). The new policy emphasizes the need for equitable corrective action, which should address the concerns outlined in this report as the laboratory moves forward.

The HFSC is also in the process of instituting a policy allowing members of the laboratory who are complainants to accrediting bodies and/or investigative agencies like the Commission to communicate openly (and without fear of adverse consequences) regarding the subject of the complaint.

B. Additional Policy Improvements Made by HFSC Board

As reported to the Commission on December 9, 2014 by HFSC Board Chairman Scott Hochberg, the HFSC Board directed HFSC management to make several changes that have since been adopted by the laboratory. (See **Ex. Z.**) They include (but are not limited to) the following:

On September 12, 2014, the Board approved a recommendation that a contract be executed with NMS labs for technical and managerial support for the Toxicology Section. NMS personnel are now working on-site.

The Board also directed that a process be developed to officially notify Houston Police Department management of any irregularities in evidence submission forms like the one subject of this complaint.

The Board directed that a process be developed to notify the appropriate District Attorney's office of any evidence irregularities as they are discovered. The HFSC President and CEO is working with the Harris County District Attorney's office to develop this process.

On January 15, 2015, the HFSC announced the hiring of Dr. Peter Stout as its first Chief Operations Officer. Dr. Stout's background is in forensic toxicology including extensive professional experience and a recently concluded term as President of the Society of Forensic Toxicologists. (*See* **Ex. AA**.)

C. Additional Recommendations

The Commission makes the following recommendations in addition to the items initiated by the HFSC and its Board:

1. The Quality Director should revise the original CAPA (2014-11) to accurately reflect the root cause of the erroneous blood alcohol report discussed herein. While the Disclosing Analyst's contribution to the error should not be minimized, it should be represented appropriately within the context of the other facts in the case.

2. The Quality Director has the authority to provide oversight in the development and issuance of CAPAs throughout the laboratory. She should be able to exercise that authority independently. This includes ensuring individuals with responsibility for errors not be afforded excessive discretion in drafting the CAPA, determining the root cause, and implementing related personnel consequences. In situations with potential

conflicts of interest, the Quality Director should be especially vigilant in ensuring a fair and accurate root cause analysis.

3. It is essential for members of the HFSC Toxicology Section to have strong scientific leadership. The optimal solution would be to find a qualified, permanent manager for the Toxicology Section who can effectively lead the Section and nurture the development of junior analysts over time. If the only viable option is to fill this need through outsourcing to NMS, then NMS management must be continually present in the laboratory to provide oversight, guidance and training as needed.

4. In the future, managers should not be simultaneously tasked with two major responsibilities—such as directing the Toxicology Section and managing information technology for the entire HFSC. This dynamic leaves the manager in an impossible position and is unfair to analysts who need regular direction.

5. All forensic analysts and managers at HFSC (and other laboratories statewide) should receive quality training on the disclosure obligations set forth in *Brady v. Maryland* (and related case law) as well as in Article 39.14 of the Texas Code of Criminal Procedure (the "Michael Morton Act"). This training should be conducted in collaboration with the Harris County District Attorney's Office and other customers so that expectations are shared. In addition, the Commission is developing a web-based training program in collaboration with the Texas Criminal Justice Integrity Unit and will make it available to all laboratories in Texas as soon as practicable.

6. HFSC personnel with any role in root cause analysis should receive quality training on the appropriate way to conduct such analysis. It is a challenging topic that may not come naturally to many laboratory personnel. The Commission will work to develop a quality training program on root cause analysis and make it available to laboratories statewide as soon as practicable.