

TEXAS FORENSIC SCIENCE COMMISSION

Justice Through Science

HOUSTON FORENSIC SCIENCE CENTER
TOXICOLOGY SECTION
ANALYST SELF-DISCLOSURE

Finalized at Quarterly Meeting on
January 23, 2015



**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

LIST OF EXHIBITS
HFSC FINAL REPORT (TOXICOLOGY DISCLOSURE) (#14-13)

EXHIBIT A	City of Houston Office of Inspector General's Report (12/18/14)
EXHIBIT B	Analyst Disclosure to Forensic Science Commission (6/4/14)
EXHIBIT C	Evidence Description and Review Form
EXHIBIT D	E-mail Correspondence (Accessioning Analyst, Submitting Officer) (10/13/13-10/15/13)
EXHIBIT E	E-mail Correspondence (Accessioning Analyst, Submitting Officer) (10/31/13-11/5/13)
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EXHIBIT R	Amended Report (Defendant H) (8/15/14)
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EXHIBIT X	Corrective and Preventive Action #2014-016
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EXHIBIT AA	Announcement of Dr. Peter Stout as Chief Operations Officer
EXHIBIT BB	Third Party Communications Policy

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 Kerrigan² 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 not 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 aggravated⁴ 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. (Policies 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. (*See Ex. BB.*)

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.

January 30, 2015

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HOUSTON FORENSIC
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Re: Report of the Texas Forensic Science Commission (the "Commission")
concerning the "Houston Forensic Science Center Toxicology Section
Analyst Self-Disclosure" (the "Report").

Ms. Garcia:

As you know, I am Acting General Counsel to Houston Forensic Science Center, Inc., d/b/a Houston Forensic Science Center ("HFSC" or the "Center"), the subject of the Report. During the Commission's public deliberations on January 23, 2015, I objected to a number of statements in the draft Report. At the conclusion of the deliberations, you stated the Commission would accept a document committing HFSC's objections to writing and would include the document in the bound version of the Commission's Final Report. The Center appreciates the opportunity to memorialize its objections,¹ which are set out below.²

* * * *

Objection No. 1 (regarding paragraph beginning at bottom of Page 8):

This paragraph exemplifies the Report's unfortunate use of innuendo to imply a misdeed by HFSC without actually finding wrongful conduct. The paragraph makes beyond-dispute observations about laboratories in general, never mentioning the Center by name. In the context of the Report as a whole, however, even a casual reader is likely to understand that, in the Commission's view, HFSC issued "a root cause analysis that inequitably attribute[d] responsibility to one analyst while downplaying management's contribution to the same incident"

¹ At the request of HFSC's Board of Directors, the City of Houston's Inspector General ("OIG") conducted a lengthy investigation of the same events reviewed by the Commission. Certain of HFSC's objections rely on the OIG's written report (the "OIG Report"), a copy of which is Exhibit "A" to the Commission's Final Report.

² As I advised the Commission's on January 23, HFSC's silence with regard to any particular statement in the Report should not be construed as agreement.

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The vagueness of the Commission's criticism is exacerbated by its use of "inequitable attribution," a phrase appearing in several passages of the Report. To be sure, a post-error review that inaccurately shifts responsibility from management to a lower-level employee is both unfair to the employee and problematic for the enterprise as a whole. That said, the evidence of "inequitable attribution" in this case is exceedingly thin. Judging by the Report and its exhibits, the proof apparently consists of a Corrective and Preventive Action Report ("CAPA") that refers to the "Disclosing Analyst" by name but to her supervisor (the "Interim Manager") by title. If the Commission's conclusions had been stated more directly, together with objective facts supporting those conclusions, the Report would have been significantly more valuable to HFSC's management, providing a clear path to improve the Center's policies or procedures. The Final Report, however, appears more bent on identifying a bogey man than on recommending solutions.

Objection No. 2 (regarding first complete paragraph on Page 9):

Unfortunately, the Report's innuendo continues in this paragraph. The Commission refers to an apparent decision by the Interim Manager (specifically, not to document shortcomings³ in the job performance of the Disclosing Analyst) as having been made under a "guise of 'protecting' the analyst" The Commission's use of "guise" implies that the reason given by the Interim Manager for not documenting the Analyst's performance problems was a pretext for some different reason, although the Report never reveals what the actual reason might have been. Similarly, the Report's use of quotation marks before and after "protecting" suggests that, despite what the Interim Manager apparently told the Commission's investigative panel, in reality the manager had no interest in protecting the Analyst's reputation.

Clearly, the Commission rejected the OIG's finding that the Interim Manager "attempted to shield [the] Analyst from the consequences of her error by removing her from casework and retraining rather than formal documentation." OIG Report at 17. But if the Commission did not believe the Interim Manager's explanation (or the OIG's) for the failure to document, what *did* the Commission believe motivated the failure? The Report never says. By inviting the reader to view the Interim Manager as untrustworthy (with no factual support), the Commission has skipped an opportunity to assist the Center's management and treated the Interim Manager's reputation in a manner charitably described as cavalier.

Objection No. 3 (regarding first complete paragraph on Page 23):

This paragraph, part of the Report's Section V(A), includes the following statement:

³ As you know, since the events in question HFSC's Board of Directors has made clear that any shortcoming in an employee's job performance must be documented. See video of Board meeting held October 10, 2014 (available at www.houstonforensicscience.org).

The Lab Director's representation [to the Commission at a meeting on July 31 and August 1, 2014] that the Disclosing Analyst was removed from casework for concerns regarding courtroom testimony *independent* from the case with the name error do[es] not comport with the timeline of facts.... [I]t is difficult to understand how [the Disclosing Analyst] 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. (emphasis in original)

The passage broadly implies that the Lab Director made a false statement to the Commission at its July-August meeting. In contrast to the Commission's implication, the Lab Director's statement was true.

As HFSC noted during the Commission's deliberations on January 23, the lynchpin of the Report's Section V(A) is an assumption that Center management could not possibly have had "concerns" about the Disclosing Analyst's testimony until the Disclosing Analyst had actually testified in court. The assumption is incorrect and reflects a lack of understanding about cross-examination by skillful defense counsel in a blood alcohol case.

HFSC temporarily removed the Disclosing Analyst from casework because the Interim Manager realized the Analyst did not understand the workings of the instrument used to measure the defendant's blood alcohol level. As a result, she faced a serious risk of being discredited during her testimony. The OIG found that the Interim Manager recognized this critical shortcoming on March 13, 2014, weeks before she was removed from casework. See OIG Report at 4.⁴ In other words, HFSC removed the Analyst from casework *not because of testimony she had given but because of testimony HFSC management feared she would give* without first receiving additional training and testing. In short, the Lab Director did not misrepresent anything to the Commission at its July-August meeting. The implication of the Report excerpt quoted above is misleading and deeply unfair to HFSC in general and to the Lab Director in particular.

Objection No. 4 (regarding paragraph beginning at bottom of Page 28):

This paragraph, also, is a Jenga tower of innuendo and suppositions. It opens with the

⁴ The Commission never explains its rejection of the OIG's finding. Similarly, the Commission states no facts to support its dismissal of certain comments made by the Disclosing Analyst to the OIG. Instead, the Commission simply relies on *its* interview of the Analyst to conclude the OIG must have misinterpreted the Analyst's remarks. See Final Report at 24, n. 6.

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Commission's "concern" about a potential "chilling effect" in a laboratory purportedly characterized by "fear of adverse consequences" and concludes with apparently unshakeable confidence in the Commission's ability to discern what "every analyst [the panel] interviewed (current and former)" *really* thought about the circumstances. According to the Commission, every such analyst believed "the Disclosing Analyst was unfairly blamed for the reporting error." In support of this conclusion, the Report offers ... nothing. The Commission's interviews were conducted in private, either in person or by telephone, and the Report offers no transcripts or summaries of the interviews or even a list of interviewees.

Under these circumstances, the reader would have little choice but to accept the Commission's overwrought characterizations at face value but for the OIG's Report. Where the Commission implies that "fear of potential adverse consequences" discouraged the Disclosing Analyst from communicating information to management, the OIG reached the opposite conclusion, finding that the Interim Manager's decision to remove the Disclosing Analyst from casework did not "chill" her from coming forward with her own error. "[I]n fact[,] the reverse." See OIG Report at 17. As the OIG noted, the "Analyst suffered no adverse employment action ... and in fact was rated "Meets Expectations" after her error; therefore OIG finds *no* retaliatory 'chilling.'" *Id.* (emphasis supplied).⁵

* * * *

The Houston Forensic Science Center appreciates the many hours expended by the Commission investigating the series of significant errors that began in October 2013. As noted at the January 23 meeting, HFSC already has made important changes as a result of the Commission's draft Report. The Commission and the Center have much in common, certainly including their respective mandates to reform what has been an exceedingly troubled part of our state's criminal justice system. Notwithstanding the above, the Center looks forward to working with the Commission in the years to come.

Very truly yours,



Tom P. Allen

⁵ HFSC never asked, and did not expect, the Commission to make a wholesale adoption of the OIG's findings. HFSC did expect the Commission, however, to provide at least cursory explanations for why its findings should be given credence over the OIG's.

EXHIBIT A

CITY OF HOUSTON

INTER OFFICE CORRESPONDENCE

DATE: December 18, 2014

SUBJECT: **Request for Investigation by
HFSC Dr. Daniel Garner
OIG #1111400200**

CONFIDENTIAL ATTORNEY – CLIENT COMMUNICATION ATTORNEY WORK PRODUCT

OFFICE OF INSPECTOR GENERAL REPORT

This Office of Inspector General (OIG) Report responds to a request from Dr. Daniel Garner, Houston Forensic Science Center (HFSC) Executive Director, to review HFSC's handling of the chain of events initiated when Houston Police Department (HPD) OFFICER submitted an evidence envelope barcoded **HPD Incident #124796613** on the outside of the envelope, showing the suspect's name as SUSPECT #1. However, inside the evidence envelope were two vials of blood labeled with SUSPECT #1's name but marked **with a different incident number (HPD incident # 124607913)** but also showing SUSPECT #1 as the suspect.

CHRONOLOGY (All dates indicated are considered to be "on or about" dates)

July 9, 2012 – HPD lab hired ANALYST as an entry level Criminalist for blood alcohol analysis, a position later renamed Analyst.

Sept/October, 2012 – HPD Lab purchased the assets of Sam Houston State University (SHSU) lab and offered employment to certain of its employees, including FORMER TOXICOLGY MANAGER. Per INTERIM TOXICOLOGY MANAGER, the former SHSU employees, including FORMER TOXICOLOGY MANAGER, "came on board and abandoned all the methods and things I set up and they went with their method for analysis."

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May 13, 2013 – FORMER TOXICOLGY MANAGER and DIRECTOR-FORENSIC ANALYSIS DIVISION rated ANALYST 4.00 (Exceeds Expectations) on her 10-month probationary evaluation.

June 26, 2013 – FORMER TOXICOLGY MANAGER cleared ANALYST for independent case work under ISO accreditation. While a year is a long period for a lab to train a new-hire blood-alcohol analyst before releasing her to independent work, no documentation indicates ANALYST had performance issues.

October 5, 2013 – HPD OFFICER submitted to HPD lab an evidence envelope barcoded **HPD Incident #124796613** on the exterior of the envelope and showing the suspect's name as SUSPECT #1. Inside the envelope are two vials of blood marked **with a different incident number (HPD incident # 124607913)** but also showing SUSPECT #1 on the label.

October 15, 2013 – RECEIVING ANALYST contacted OFFICER via email pointing out the mistake and asking "How can this issue be resolved?"

October 16, 2013 - OFFICER emailed RECEIVING ANALYST, "I see that I wrote the wrong case information on the submission form. Case 124796613 belongs to SUSPECT #2 which is a breath case, no blood involved. Case 124607913 belongs to SUSPECT #1. The envelope and tubes belong to the SUSPECT #1 case." OFFICER asks if he needs to fill out a corrected submission form. [These emails remained in each employee's individual email account until. By the end of any analysis HPD lab expected emails to be part of the "case record," a term that includes both paper and email and electronic information. The lab had no written policy requiring either an email search for missing items or for emails such as this to be placed in either an electronic case file or a paper case file early enough in the analysis process for a later search to have located these emails.]

October 17, 2013 – RECEIVING ANALYST emailed OFFICER another submission form.

October 31, 2013 – RECEIVING ANALYST emailed OFFICER asking if he has yet to submit the submission form for case #124796613.

November 5, 2013 – OFFICER emailed RECEIVING ANALYST stating he forgot, "But just dropped it off and stapled a note with your name on it." RECEIVING ANALYST responded asking if OFFICER dropped it off to CER. (Central Evidence Receiving). OFFICER responds he dropped it off "where we drop off the blood vials."

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December 5, 2013 – RECEIVING ANALYST again emailed OFFICER indicating she had yet to receive the form and “It must have got lost in transit.” She asks him to email or fax the form to her.

December 9, 2013 –ANALYST analyzed evidence with name discrepancy and set it aside. There was no written policy regarding analyzing samples with discrepancies pending resolution of the discrepancy, but the HPD Lab did this as a common lab practice for minor discrepancies.

December 31, 2013 –FORMER TOXICOLOGY MANAGER resigned from the HPD Lab. The HPD Lab added FORMER TOXICOLOGY MANAGER’ duties to those of INTERIM TOXICOLOGY MANAGER, making him “Police Administrator,” functioning as the Assistant Lab Director; LIMS administrator; as well as the Lab’s Acting Toxicology Manager.

January 1, 2014 – Effective date that INTERIM TOXICOLOGY MANAGER began his duties as Acting Toxicology Manager for the HPD Lab.

January 3, 2014 - The Harris County ADA assigned to the SUSPECT #1 case asked INTERIM TOXICOLOGY MANAGER about the tests results for SUSPECT #1 because he could not find the results in LIMS. INTERIM TOXICOLOGY MANAGER replies that he found two earlier cases in LIMS for SUSPECT #1 but none with incident #124607913. Unknown to INTERIM TOXICOLOGY MANAGER at that time, the blood analysis and blood vials were in the evidence envelope barcoded to the incident number in SUSPECT #2’s case which ends in 613.

January 7, 2014 – INTERIM TOXICOLOGY MANAGER emailed ADA and OFFICER saying “We are trying to find a sample on a case involving SUSPECT #1” mentioning case # 124607913 and asking if the evidence was submitted to the property room or another lab. ADA responds that OFFICER was the arresting and transporting officer stating “I’m assuming he also submitted the sample.”

January 10, 2014 –ANALYST signed under oath the “certificate of analysis” that the blood sample barcoded to the incident involving SUSPECT #2 tested at “0.168 grams of ethanol per 100 milliliters of blood,” when in fact that blood sample belonged to SUSPECT #1. She placed the inaccurate report in the queue for technical and administrative review. INTERIM TOXICOLOGY MANAGER performed both reviews of the case on the same day and failed to review the case file in sufficient detail to note that the incident number did not match the blood vials or that the alleged suspect never had blood drawn, but rather only had a breath test. With INTERIM TOXICOLOGY MANAGER’s approval, the report was released to LIMS.

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January 15, 2014 – OFFICER emailed INTERIM TOXICOLOGY MANAGER copying RECEIVING ANALYST as follows:

INTERIM TOXICOLOGY MANAGER, I just looked over my report and it says the blood specimen was turned in to 1200 Travis lab. I know this case was mixed up with another case (if I remember correctly). Due to an error on my part with the evidence submission form. But now I am confused:

RECEIVING ANALYST, I read your email (again) and now I am confused. The case you need an evidence submission form was mixed up with this other case that [he] is looking for.

[Had INTERIM TOXICOLOGY MANAGER and RECEIVING ANALYST read this email addressed to both of them and communicated with each other, the paperwork mix-up would have been revealed, leading to the discovery of ANALYST's report filed on the wrong suspect. However, OIG notes that ANALYST admits: "I remember [INTERIM TOXICOLOGY MANAGER] coming to me earlier that year about case...he was looking for a case...and he was like if you have time can you find this number. But I don't know which case it was. It was a number...but we couldn't find it. It was not in LIMS, it was not in our coolers."]

March 13, 2014 – An ADA asked ANALYST to create a power point to use in her testimony in an upcoming trial, which ultimately did not go forward. She had never done this before and ran it by INTERIM TOXICOLOGY MANAGER requesting feedback. During this discussion INTERIM TOXICOLOGY MANAGER became concerned about ANALYST's understanding and ability to explain how the blood alcohol instrument known as the PerkinElmer worked. He gave her a case study to assist her.

March 26, 2014 – The DA on the case dismissed the aggravated DWI charge against third-time offender SUSPECT #1 because the HPD lab could not find the blood sample. The DA issued SUSPECT #1 a new lesser charge of "failure to provide information."

March 28, 2014 –OFFICER emailed INTERIM TOXICOLOGY MANAGER with a copy to RECEIVING ANALYST and his own chain of command to clear up the mixed submission form issues verbatim as follows:

INTERIM TOXICOLOGY MANAGER, --Case number 124796613-F, which belongs to SUSPECT #2 is a breath case, therefore no blood involve. --Case number 124607913-Q is for SUSPECT #1.

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RECEIVING ANALYST and I had emailed back and forth several time about this issue. When I tagged the blood the first time, I turned in a submission form. I believe I messed it up by putting that other case number. While emailing RECEIVING ANALYST she told me to turn another submission form in and I dropped off another one at 1200 Travis drop box with a note on it. I believe RECEIVING ANALYST never got that one either so she asked me to fax it over. I faxed it over (never checked confirmation). I never heard about it again so I thought it was good to go...

I have one that I can email you or fax it today. As soon as you get this email let me know how you want me to do it. I will be up for a while. Give me a call.

OFFICER's email triggered no action on the part of either INTERIM TOXICOLOGY MANAGER or RECEIVING ANALYST. INTERIM TOXICOLOGY MANAGER admitted to OIG this email triggered no action, but stated he may not have ever seen the email as he was overwhelmed with emails having accepted the toxicology responsibilities in addition to his two other positions.

April 3, 2014 – Pursuant to an Interlocal agreement signed by Houston City Council in February 2014, management and oversight of the lab changed from HPD to the local government corporation, HFSC.

April 15, 2014 – Per her memo to INTERIM TOXICOLOGY MANAGER dated April 17, 2014, ANALYST noticed an unsealed piece of evidence in Cooler #2 with a post-it that read "Waiting on Officer Reply already analyzed.— ANALYST" Upon further investigation in LIMS, ANALYST discovered a report under incident number 124796613 with subject name of SUSPECT #2. The unsealed evidence name read: SUSPECT #1, and there were two incident numbers on the envelope, one hand written (124607913) and the other was a barcode label (124796613). ANALYST's memo reads:

[ANALYST] went downstairs to the 24th floor to retrieve the case folder for 124796613, where [ANALYST] found a submission form with SUSPECT #2, a final report, a print out from OLO with suspect information on SUSPECT #2, and an evidence description and review form with case notes from RECEIVING ANALYST that read "The name on the submission form and LIMS is "SUSPECT #2." The name on the envelopes and blood tubes is "SUSPECT #1." The tubes have the incident # "124607913," which is not on LIMS". [ANALYST] contacted DIRECTOR-FORENSIC ANALYSIS DIVISION who instructed [her] to follow-up with QA/QC Supervisor, ANALYST also informed interim Toxicology Manager INTERIM TOXICOLOGY MANAGER.

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On this same date INTERIM TOXICOLOGY MANAGER confirmed in LIMS that no one had accessed ANALYST's erroneous report of SUSPECT #2's blood alcohol level. INTERIM TOXICOLOGY MANAGER showed ANALYST the evidence that no one had accessed the report.

April 15 – June 13, 2014 -- During this date range, the "QA/QC database" revealed that QUALITY MANAGER opened a "place-saver" for the Corrective and Preventive Action Report (CAPA) with tracking number 2011. She indicates she must have originally given INTERIM TOXICOLOGY MANAGER tracking number 2010 to draft the CAPA because that is the number he used to create the CAPA eventually dated 8/4/14 such that QUALITY MANAGER had to strike through the "2010" and initial her change to tracking number "2011."

April 16, 2014 – INTERIM TOXICOLOGY MANAGER reports he met with ANALYST in the Library on the 26th floor to remove her from casework and she told him: "I already worked 1500 cases why are you pulling me now?" He followed up that conversation up with an email requiring ANALYST to "focus solely on documenting the issues surround the case we discussed yesterday (124796613)" and "do not handle any evidence, process any data, or generate any reports or documentation that is unrelated to your research on this case." The email also notes:

You expressed that you have photographs that were taken previously but were not uploaded into the LIMS as were others from this batch. I also understood that you had partially marked the evidence at the time it was analyzed but did not complete your labeling at that time.

April 21, 2014 – ANALYST reported she spoke with INTERIM TOXICOLOGY MANAGER who told her the SUSPECT #1 case was resolved but that she could not return to doing casework. INTERIM TOXICOLOGY MANAGER was aware that ANALYST was due to give her first court testimony and be subject to cross examination in less than 10 days in an unrelated case.

April 29, 30, 2014 – After testimony began, the ADA called INTERIM TOXICOLOGY MANAGER to stand by to testify in ANALYST's first court testimony in incident #035791513. While present, INTERIM TOXICOLOGY MANAGER made lengthy notes evaluating her testimony. Later he checked boxes on form indicating she needed improvement in the areas of Lab Examinations, Clarity, Conclusions, and Impartiality.

May 5, 2014 – Per ANALYST, she spoke to INTERIM TOXICOLOGY MANAGER a second time about returning to casework. The documentation indicates that beginning this date and

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continuing through June 30, 2014, INTERIM TOXICOLOGY MANAGER had ANALYST train individually on courtroom testimony.

May 12, 2014 – Per ANALYST, she spoke to INTERIM TOXICOLOGY MANAGER a third time and he told her she could not return to casework because she needed to improve her testimony based on his evaluation of her testimony on April 30, 2014.

May 21, 2014 – ANALYST requested a meeting with HR DIRECTOR.

May 22, 2014 – ANALYST met with HR DIRECTOR stating she didn't understand how to get back to case work and that she was embarrassed about being underutilized.

May 23, 2014—HR DIRECTOR met with INTERIM TOXICOLOGY MANAGER to discuss ANALYST's concerns about returning to casework. INTERIM TOXICOLOGY MANAGER explained that he was sensitive about documenting concerns about ANALYST's performance which would make ANALYST subject to painful cross examination; instead he preferred having her retrain until he was comfortable that she would do well on the stand. He also mentioned his workload regarding his lack of time.

May 27, 2014 – HR DIRECTOR met with ANALYST to tell her INTERIM TOXICOLOGY MANAGER's concern, i.e., his preference not to document his performance concerns but rather to handle matters by retraining until he felt comfortable returning her to casework. ANALYST told HR DIRECTOR she did not "care" and "did not agree" with INTERIM TOXICOLOGY MANAGER's concerns on her behalf. She requested that the concerns that were keeping her from returning to casework be documented.

May 29, 2014 – ANALYST wrote an email to EXECUTIVE DIRECTOR titled "nonconformance and casework" stating:

It has been brought to my attention by HR DIRECTOR that you are aware of my current casework status. It was unclear of how much you knew about the situation so I have written a memo explaining the situation. I have also attached the original memo that was sent to INTERIM TOXICOLOGY MANAGER and QUALITY MANAGER. If there are any questions or concerns please feel free to contact me at any time.

EXECUTIVE DIRECTOR forwarded ANALYST's email to HR DIRECTOR and QUALITY MANAGER for handling in the normal course.

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May 30, 2014 –INTERIM TOXICOLOGY MANAGER gave ANALYST a retraining exercise she describes as “a sheet of calculations to perform.” Later that day, ANALYST emailed the ASCLD/LAB expressing concern with her laboratory’s lack of documentation stating: “On April 16, 2014 I was taken off casework with no explanation of why. I have asked repeatedly for documentation containing a root cause analysis or a CAPA form, but nothing has transpired thus far.” However, ANALYST did not copy HFSC, which did not receive a copy of her ASCLD/LAB complaint until June 23, 2014.

June 3, 2014 – ANALYST emailed [] ASCLD/LAB, Accreditation Program Manager restating the April 15, 2014 error in the passive voice without listing herself as the person preparing the erroneous report and indicating the matter was resolved on April 21, 2014 based on a conversation with INTERIM TOXICOLOGY MANAGER. ANALYST states: “After discussing the facts of the case with the quality and interim managers, the interim manager decided I should not continue with any other casework until this was resolved... “It is my opinion that this is a level 3 nonconformance were the report should have been recalled and amended serving as the customer’s notification. Being taken off casework was not justified. Furthermore none of the above was documented as per ASCLAD/LAB procedure because it was said to me by my interim manager, this would be informal to protect my professional career. To date the report has not been corrected with the correct incident number and name nor has the customer been notified.”

June 4, 2014 – ANALYST submitted a Lab Disclosure Form to the Texas Forensic Science Commission citing case #124796613 and disclosing that the subject in DWI case 124796613 (SUSPECT #2) was found guilty and sentenced and case 124607913 was dismissed.

June 5, 2014 – ANALYST testified a third time in court.

June 13, 2014 – HR DIRECTOR set up a meeting with both ANALYST and INTERIM TOXICOLOGY MANAGER. He stated his concerns that were keeping her from returning to casework and she asked him to write them down. They agreed to meet again once he had done so. INTERIM TOXICOLOGY MANAGER shared a draft of his “write up” with HR DIRECTOR before sharing it with ANALYST. HR DIRECTOR advised INTERIM TOXICOLOGY MANAGER to split the write-up into two parts: (1) his concerns about her testimony; and (2) his other concerns including his concerns about her handling of the SUSPECT #1 case.

June 19, 2014 – As agreed, HR DIRECTOR, ANALYST and INTERIM TOXICOLOGY MANAGER met a second time for INTERIM TOXICOLOGY MANAGER to review with ANALYST a draft of his concerns. INTERIM TOXICOLOGY MANAGER agreed that if she

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had a factual concern about the write-up, he would change it. She took a copy of the draft and agreed to review and change factual errors and they agreed to meet a third time.

June 23, 2014 –HFSC received notice of ANALYST’s complaint to ASCLD/LAB.

June 24, 2014 – As agreed, HR DIRECTOR, ANALYST and INTERIM TOXICOLOGY MANAGER met a third time, but ANALYST had not made any changes to INTERIM TOXICOLOGY MANAGER’s write up. They agreed instead to go through the draft word-for-word. They agreed on a final version of the facts of the “Court Testimony Evaluation.” According to HR DIRECTOR’s contemporaneous notes of the meeting, ANALYST stated: “The only thing I disagree with you on is taking me off casework,” and as to the concerns he raised with her originally, she stated: “I didn’t take you seriously.” INTERIM TOXICOLOGY MANAGER told ANALYST what she had to do to get back on casework--a proficiency test.

June 27, 2014 – ANALYST took the proficiency test prepared by INTERIM TOXICOLOGY MANAGER and acknowledged receipt of the “Court Testimony Evaluation” they had worked on through three meetings in the presence of HR.

July 15, 2014 – Harris County ADA, provides written statement re: the conviction of SUSPECT #2 and his third DWI offense. SUSPECT #2 pled guilty and was sentenced to two years TDC. Ms. Knecht stated that the blood vials of SUSPECT #1 which were mistakenly submitted and analyzed under the SUSPECT #2 case were not submitted as evidence and played no part in the SUSPECT #2 conviction.

July 16, 2014 – HFSC responded to ANALYST complaint to ASCLD/LAB. INTERIM TOXICOLOGY MANAGER responded, “After reviewing the data in the system I determined at that time the report had not been emailed and that no one had accessed the final report through the web based interface prior to withdrawal. “Currently we are waiting on a formal response from the District Attorney’s Office regarding how they would like to proceed with the blood alcohol case.”

July 18, 2014 – ANALYST signed her annual evaluation (7/1/13 to 7/1/14) rating her 3.25 (Meets Expectations). ANALYST stated that the “significant error” that lowered her score was the blood vial incident that she caught and reported to INTERIM TOXICOLOGY MANAGER, implying that if she self-reported her error, the error itself should not affect her evaluation. In normal HR practice however, no employee could expect to get as good a rating after she made an error as without.

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July 28, 2014 – INTERIM TOXICOLOGY MANAGER emailed ANALYST, releasing her to casework and notifying her that a confirmatory memo was in process.

August 1, 2014 –ANALYST amended and submitted case #124796613/version 2 indicating “The original report was retracted due to discrepancies between the submission form and the physical evidence received.” DIRECTOR-FORENSIC ANALYSIS DIVISION appeared before the Commission confirming that ANALYST was back on casework. DIRECTOR-FORENSIC ANALYSIS DIVISION also referred to concerns about ANALYST’s testifying ability as the basis for ANALYST’s lengthy removal from case work.

August 4, 2014 – (a) Four months after the error came to light on April 15, 2014, INTERIM TOXICOLOGY MANAGER, QUALITY MANAGER and DIRECTOR-FORENSIC ANALYSIS DIVISION submitted the first CAPA 2014-010, on which QUALITY MANAGER corrected the tracking number from 2014-010 to 2014-011 in her own handwriting and initialed it. They also issue CAPA 2014-016 to document the delay in documentation. CAPA 2014-016 listed as the root cause of the delay that INTERIM TOXICOLOGY MANAGER’s “oversight of the section was diminished by his other IT related duties.” [Investigative Note—CAPA numbers are often discussed in shortened form as 2010 or 2011.] (b) On this same date, INTERIM TOXICOLOGY MANAGER amended case report #124796613/3 to state:

Evidence from incident 124607913 was submitted in this case. Because of this discrepancy, results will not be reported. This case was a breath alcohol case. This laboratory does not perform breath alcohol testing.

However, DIRECTOR-FORENSIC ANALYSIS DIVISION did not approve of INTERIM TOXICOLOGY MANAGER performing the amendment because it caused the CAPA format to show him signing as the analyst. Therefore, DIRECTOR-FORENSIC ANALYSIS DIVISION required ANALYST to amend the CAPA so the correctly-positioned individuals would show as having signed the CAPA.

August 15, 2014 - ANALYST amended case report #124796613/3 indicating:

Blood evidence from incident #124607913 with the name SUSPECT #1 was submitted under incident #124796613 with the name of SUSPECT #2. The evidence for incident #124796613 was a breath alcohol test. This laboratory does not perform breath alcohol testing. Due to this discrepancy, the original report dated 1/10/2014 has been retracted.” She also amended incident #124607913/4 to read “This report supersedes the reports dated August 4, 2014. Blood evidence from this case was submitted under incident #124796613. Due to this discrepancy no results will be reported.

September 4, 2014 – ANALYST was informed she would not receive a salary increase due to “performance issues,” but would be re-evaluated in three months.

October 14, 2014 -- INTERIM TOXICOLOGY MANAGER reported to HR DIRECTOR: “For the past three months, I have monitored ANALYST’s work activities... Based on my observations, her performance during this time period is satisfactory. I propose that she be given the two-year pay increase at this time.”

November 8, 2014 -- ANALYST’s raise became effective.

FINDINGS

A. Perfect Storm

December 9, 2013, HPD lab ANALYST analyzed the blood vials at issue and set them aside. The FORMER TOXICOLOGY MANAGER resigned effective December 31, 2013, leaving a large backlog of blood “batches,” one of which was the blood at issue here. He left that backlog for INTERIM TOXICOLOGY MANAGER, who also continued to function as the head of IT and the Assistant Lab Director.

On January 10, 2014, ANALYST signed the “certificate of analysis” that the blood sample barcoded to the incident involving SUSPECT #2 tested at “0.168 grams of ethanol per 100 milliliters of blood,” when in fact that blood sample belonged to SUSPECT #1. She placed the inaccurate report in the LIMS queue for technical and administrative review. INTERIM TOXICOLOGY MANAGER performed both reviews of the case on the same day and failed to review the case file in sufficient detail to note that the incident number did not match the blood vials or that the alleged suspect never had blood drawn, but rather only had a breath test. With INTERIM TOXICOLOGY MANAGER’s approval, the report was released to LIMS and became available to the District Attorney’s office and others outside the lab permitted access to LIMS.

The lab never opened an electronic file on SUSPECT #1, having switched his blood evidence file with the breath evidence file of SUSPECT #2, because the lab does not analyze breath. Therefore, HPD lab’s many attempts to locate the missing blood under the SUSPECT #1 case number were futile since the information was in the SUSPECT #2 file.

April 3, 2014, HFSC assumed ownership and management of the former HPD lab. On April 15, 2014, ANALYST discovered and reported the error in the SUSPECT #1 case. INTERIM

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TOXICOLOGY MANAGER checked LIMS and withdrew the inaccurate report after checking that no one had accessed the inaccurate report. INTERIM TOXICOLOGY MANAGER had never written a CAPA before. QUALITY MANAGER deemed the matter CAPA-worthy and initiated a CAPA “placeholder” on the matter in the QA/QC database at some point after April 28 and before June 13, 2014. However, in coordination with DIRECTOR-FORENSIC ANALYSIS DIVISION and INTERIM TOXICOLOGY MANAGER, QUALITY MANAGER failed to finalize it until August 4, 2014.

Both CEO and DIRECTOR-FORENSIC ANALYSIS DIVISION seemed to indicate to the Commission that a CAPA on the ANALYST/INTERIM TOXICOLOGY MANAGER error existed before the one dated August 4, 2014. Obviously, HFSC would have liked to have shown that a CAPA was already in place before the complaint to the Commission. However, OIG’s investigation revealed that Quality Manager Wilson had a CAPA “placeholder” in the data base entered between April 28, 2014 and June 13, 2014. HFSC management had much discussion about the CAPA and each draft, even if only placeholder draft language, was overwritten without leaving underlying evidence or metadata. OIG understands from this evidence that the parties used the word CAPA as if one were final when it was not. OIG understands HFSC expects to have the ability to maintain these drafts electronically and by version in the future.

Conclusion #1

OIG would find this a Level III error and understands that the Commission has voted to issue such a finding. OIG recommends that moving forward, HFSC avoid a structure or a situation where a person involved in an error is part of the decision-making about whether that error is CAPA-worthy or otherwise reportable. OIG also recommends that HFSC make clear to its employees that the Quality Manager is responsible for that decision-making.

CAPA’s are not disciplinary documents and their purpose is to document errors and the corrective action to assure that particular error does not recur. CAPA 2011 could be improved by using best practices to write it: (1) avoiding passive voice for clarity of actors and actions; (2) using positions rather than names to assure universal rather than individual use; and (3) avoiding HR discussions. OIG recommends that CAPA 2011 be amended again as follows:

DESCRIPTION OF ISSUE:

The receiving analyst found inconsistent information on the samples and evidence packaging and sought a revised submission form from the submitting officer. Meanwhile, a different analyst acknowledged the discrepancy and analyzed the sample while awaiting the revised officer submission—an action normal for minor discrepancies and not a violation of any written policy. The analyst labeled the item to indicate that analysis was complete but being held pending the revised submission form from the officer. On January 8, 2014, the analyst generated a report,

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signed the report, and submitted it for technical and administrative review with the inconsistencies still unresolved by the submitting officer. The examination documentation in the case folder included a note regarding the discrepancy, and both analysts acknowledged it. The analyst's supervisor conducted the technical and administrative review of the case without acknowledging the inconsistency or catching the error.

ROOT CAUSE:

A lack of attention by both the analyst and the analyst's supervisor allowed the report containing inaccurate information from the submitting officer to be reported to the District Attorney's office.

ACTION STEPS:

On April 15, 2014, the analyst realized the report was released with incorrect information and reported it to laboratory management. The analyst's supervisor withdrew the incorrect report before it was reviewed by the customer. At the direction of the supervisor, the analyst placed all correspondence in the case record. Moving forward, reports of analysis will be augmented to include information regarding inconsistencies when they are identified. Of the 447 reports that were reviewed by the section supervisor, half underwent a secondary technical and administrative review and the remainder underwent an administrative review.

MANAGEMENT REVIEW AND RESOLUTION:

The lab changed its Standard Operating Procedure and now halts any analysis where there is a possibility that evidence is associated with an incorrect case. Inconsistencies are now noted in the body of the final report as standard practice. At the time an inconsistency is detected, an analyst may issue a report stating that an issue has been identified and analysis will not be performed until the issue is rectified. Technical and Administrative reviews are now conducted by multiple members of the section rather than a single individual.

B. Policy on Analyzing Evidence with Discrepancies and Setting Aside

As of January 10, 2014, when ANALYST signed off on the erroneous report, the practice in the toxicology lab for minor errors had been to conduct the sample analysis, get the results, and set the case aside waiting for the discrepancy to be corrected. ANALYST stated she set the report aside and does not remember digitally signing the report, which required her password and employee ID. INTERIM TOXICOLOGY MANAGER stated he signed off on the TR and AR reviews because he trusted that the FORMER TOXICOLOGY MANAGER had previously reviewed the batch containing the SUSPECT #1 vials. INTERIM TOXICOLOGY MANAGER stated he initialed what FORMER TOXICOLOGY MANAGER had previously reviewed. INTERIM TOXICOLOGY MANAGER also stated that ANALYST should not have run the blood vials belonging to SUSPECT #1 because the discrepancy was not "minor," but admits there is no written policy or procedure.

Conclusion #2

The revised SOP halting the process for any discrepancy resolves this matter.

C. Concerns about Chilling Effects of Toward Analyst Self-Reporting Error

The facts are not in dispute and all actors have admitted their shortcomings in this event. After ANALYST self-reported and INTERIM TOXICOLOGY MANAGER admitted he erred in approving her report, the lab had to decide two matters: (1) how to handle the cause of the error; and (2) how to document the error. HFSC removed ANALYST from casework for 3 ½ months, documented concerns about her performance at her request; and delayed her expected raise for four months. HFSC verbally counselled INTERIM TOXICOLOGY MANAGER for his part of the error and re-evaluated a large sample of his prior case reviews, finding them acceptable.

(1) Removal From Casework & Documentation of Performance Concerns

INTERIM TOXICOLOGY MANAGER met with ANALYST in the library on the 26th floor to remove her from casework on the day ANALYST self-reported and told her he had concerns with her performance. In her meeting with HR DIRECTOR on June 24, 2014, ANALYST admitted she did not take INTERIM TOXICOLOGY MANAGER seriously when he discussed these concerns. INTERIM TOXICOLOGY MANAGER knew:

(1) ANALYST made the error on January 10, 2014, six (6) months after completion of her one-year probation, during which she performed no independent case work;

(2) The error came to light April 15, 2014 and ANALYST was scheduled to testify in her first case less than 10 days later;

(3) 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; and

(4) ANALYST's lab training occurred under protocols replacing those he wrote, where he felt his own were more strict and would have provided better training.

While INTERIM TOXICOLOGY MANAGER may have benefitted as well from a lack of documentation, he sincerely felt ANALYST would suffer both in testimony and in cross-examination. INTERIM TOXICOLOGY MANAGER told ANALYST he planned to handle it informally, so as not to damage her career.

He removed her from casework immediately upon the revelation of the error on April 15, 2014. ANALYST stated both that: (1) she spoke to INTERIM TOXICOLOGY MANAGER three

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OIG Report #1111400200

times about returning to casework; and (2) she had no idea that he had concerns about her performance or what she needed to do to return to casework. In her first conversation with him less than a week later on April 21, 2014, ANALYST said she understood only that the SUSPECT #1 case was resolved but that she could not return to doing casework. ANALYST testified in her first trial on April 29, 30, 2014. While present at that testimony, INTERIM TOXICOLOGY MANAGER made lengthy handwritten notes evaluating her testimony and reported she needed improvement in the areas of Lab Examinations, Clarity, Conclusions, and Impartiality.

ANALYST states she spoke to INTERIM TOXICOLOGY MANAGER about returning to casework a second time less than a week after her first trial testimony. The documentation indicates that beginning this date and continuing through June 30, 2014, INTERIM TOXICOLOGY MANAGER had ANALYST train on courtroom testimony-- mostly testimony review and some calculation practice.

ANALYST states she spoke to INTERIM TOXICOLOGY MANAGER a third time on May 12, 2014 and he told her she could not return to casework because she needed to improve her testimony based on his evaluation of her testimony on April 30, 2014.

Unhappy with INTERIM TOXICOLOGY MANAGER's decision not to allow her to return to casework, ANALYST went to HR DIRECTOR in HR on May 22, 2014 stating she didn't understand how to get back to case work and that she was embarrassed about being underutilized. On May 23, 2014, HR DIRECTOR met with INTERIM TOXICOLOGY MANAGER to discuss ANALYST's concerns about returning to casework and INTERIM TOXICOLOGY MANAGER explained his sensitivity to documenting his concerns and then having ANALYST testify and be subject to cross examination, rather than after verbal discussion and retraining. On May 27, 2014, HR DIRECTOR met with ANALYST to discuss INTERIM TOXICOLOGY MANAGER's preference that the issues keeping her from returning to casework not be documented but rather handled informally with verbal discussion and retraining.

ANALYST indicated she did not agree with INTERIM TOXICOLOGY MANAGER's preference to handle informally, apparently feeling that documentation would hasten her return to casework which would allow her to put the SUSPECT #1 error behind her. She did not feel the documentation would reflect negatively on her abilities as an analyst. ANALYST firmly requested that INTERIM TOXICOLOGY MANAGER's concerns that were keeping her from returning to casework be documented. On June 13, 2014, HR DIRECTOR facilitated a meeting with both ANALYST and INTERIM TOXICOLOGY MANAGER. He stated his concerns that were keeping her from returning to casework and she asked him to write them down. They agreed to meet again once he had done so.

As agreed, HR DIRECTOR, ANALYST and INTERIM TOXICOLOGY MANAGER met a second time on June 19, 2014, for INTERIM TOXICOLOGY MANAGER to review with ANALYST a draft of his concerns. INTERIM TOXICOLOGY MANAGER agreed that if she had a factual concern about the write-up, he would change it. She took a copy of the draft and agreed to review and change factual errors and they agreed to meet a third time. June 24, 2014 – As agreed, HR DIRECTOR, ANALYST and INTERIM TOXICOLOGY MANAGER met a third time on June 24, 2014, but ANALYST had not made any changes to INTERIM TOXICOLOGY MANAGER's write up. They agreed instead to go through the draft "word for word." They agreed on a final version of the facts of the "Court Testimony Evaluation." According to HR DIRECTOR's contemporaneous notes of the meeting, ANALYST stated: "The only thing I disagree with you on is taking me off casework," and as to the concerns he raised with her originally, she stated: "I didn't take you seriously." INTERIM TOXICOLOGY MANAGER told ANALYST what she had to do to get back on casework--a proficiency test.

ANALYST took the proficiency test prepared by INTERIM TOXICOLOGY MANAGER June 27, 2014 and acknowledged receipt of the "Court Testimony Evaluation" they had worked on through three meetings in the presence of HR on the same day. Ultimately INTERIM TOXICOLOGY MANAGER kept ANALYST off casework 3 ½ months--from April 16, 2014 to July 28, 2014. ANALYST testified in three trials during that period without documentation of the SUSPECT #1 error.

(2) Weekly Progress Meetings

According to ANALYST, "It's like ever since they found out about TFSC and ASCLD I have been under a microscope. I started having these weekly progress meetings which I never had to do." DIRECTOR-FORENSIC ANALYSIS DIVISION ordered the weekly progress meetings because she felt the communication between INTERIM TOXICOLOGY MANAGER and ANALYST could improve. DIRECTOR-FORENSIC ANALYSIS DIVISION stated her reason for doing such was that she also had a concern that ANALYST's training was not being documented by INTERIM TOXICOLOGY MANAGER because of his lack of time and this program helped him take the time. These meetings occurred on three occasions and have not recurred. INTERIM TOXICOLOGY MANAGER rated ANALYST as "Meets Expectations" after the progress meetings and documentation of his concerns.

(3) 4-month delay in raise

ANALYST expected a raise in July 2014 based on her two years of service. However, ANALYST's mistake on the SUSPECT #1 matter was not a "no harm, no foul" typographical error--a person guilty of his third DWI avoided prosecution. INTERIM TOXICOLOGY MANAGER and DIRECTOR-FORENSIC ANALYSIS DIVISION did have some concerns

about her performance. The raise was not automatic under the new HFSC and raises are usually considered a reward for good performance. HFSC made a decision to postpone her raise.

Conclusion #3

INTERIM TOXICOLOGY MANAGER attempted to shield 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 TOXICOLOGY 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.

Whether for HR best practices or legal best practices, HFSC must take the position that such errors matter, require documentation, and that the person making the error may not return to prior duties until management feels comfortable that the person will not make further similar errors. The HFSC Board has publicly instructed that performance errors be documented without regard for the effect such documentation may have on the employees credibility in a legal proceeding.

While ANALYST may have found it embarrassing not to be pulling her share of the load in the lab, she was retraining and it was non-disciplinary. However, having insisted on: (1) "getting it in writing" after being told that INTERIM TOXICOLOGY MANAGER preferred not to document his performance concerns, ANALYST is poorly positioned to complain about the very documentation she requested, including three meetings with HR going through the documentation she requested point by point until she agreed it contained no factual errors. Similarly, after complaining about the lack of documentation of her retraining, ANALYST is poorly positioned to complain about DIRECTOR-FORENSIC ANALYSIS DIVISION' decision to require three (3) weekly progress meetings. ANALYST suffered no adverse employment action through the documentation and in fact was rated "Meets Expectations," after her error; therefore OIG finds no retaliatory "chilling."

The raise ANALYST expected in July 2014 was not automatic. Normal HR practice would not reward an employee with a raise where she is quite junior and has also made an error as serious as reporting a blood alcohol level on the wrong suspect. This was not a "no harm, no foul" typographical error--a person guilty of his third DWI avoided prosecution. Similarly, normal HR practice would not rate an employee as high as previously after such an error. In the same vein, normal HR practice would be to increase oversight in such a circumstance. Therefore, OIG finds the four-month delay appropriate and not "chilling." Since the 4-month postponement of the raise is the only adverse employment action occurring after ANALYST's complaint to an

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accrediting body or the Commission, OIG also formally finds that the decision to postpone the raise appropriate and not to be retaliation for the complaint.

Others would more readily perceive these HR practices as the "normal course" had they been implemented by a person not involved in the error. Therefore, within the realities of small groups and single supervisors, HFSC should remove a supervisor from decision-making or involvement if that supervisor is part of the underlying error.

A handwritten signature in black ink, appearing to read "R. E. Curtis", written over a horizontal line.

Robin E. Curtis, Inspector General
Office of the Inspector General

EXHIBIT B



TEXAS FORENSIC
SCIENCE COMMISSION

Justice Through Science

1700 North Congress Ave., Suite 445
Austin, Texas 78701

TEXAS FORENSIC SCIENCE COMMISSION
LAB DISCLOSURE FORM

Please complete this form and return to:

Texas Forensic Science Commission
1700 North Congress Avenue, Suite 445
Austin, Texas 78701
Email: info@fsc.texas.gov
[P] 1.888.296.4232
[F] 1.888.305.2432

The Texas Forensic Science Commission ("FSC") is legislatively mandated to require crime laboratories that conduct forensic analyses to report professional negligence or professional misconduct to the Commission. (See Tex. Code Crim. Proc. 38.01 as amended by Tex. S.B. 1238, 83rd Leg., R.S. (2013)).

Please keep in mind that the FSC investigates matters subject to its statutory authority only. The term "forensic analysis" includes any medical, chemical, toxicological, ballistic, or other examination or test performed on physical evidence, including DNA evidence, for the purpose of determining the connection of the evidence to a criminal action. The term does not include the portion of an autopsy conducted by a medical examiner or other forensic pathologist who is a licensed physician. The term "crime laboratory" is defined in Article 38.35 of the Texas Code of Criminal Procedure to include "a public or private laboratory or other entity that conducts a forensic analysis subject to this article."

The FSC will examine the details of your disclosure to determine what level of review to perform, if any. All disclosures are taken seriously. Because of the complex nature and number of complaints and disclosures received by the FSC, we cannot give you any specific date by which that review may be completed. However, we aim to resolve all disclosures in a timely and expeditious manner, and to minimize disruption in the laboratory.

The Commission's statute allows it to withhold from disclosure information submitted in the context of an investigation but only until the final report is released. Upon release of the final report, all information provided to the Commission is subject to disclosure under the Texas Public Information Act ("PIA") (Texas Government Code Chapter 552).

IMPORTANT: If your disclosure involves a pending criminal matter(s), please be sure to indicate that on the form below because certain PIA exceptions may apply.

TEXAS FORENSIC SCIENCE COMMISSION • LAB DISCLOSURE FORM (Cont.)

1. PERSON COMPLETING THIS FORM

Name: Andrea Gooden
Laboratory: Houston Forensic Science Center
Address: [REDACTED]
City: [REDACTED]
State: [REDACTED] Zip Code: [REDACTED]
Home Phone: [REDACTED]
Work Phone: _____
Email Address (if any): [REDACTED]

2. SUBJECT OF DISCLOSURE

List the full name, address of the laboratory, facility or individual that is the subject of this disclosure:

Individual/Laboratory: William Arnold / Houston Forensic Science Center
Address: 1200 Travis St.
City: Houston
State: Texas Zip Code: 77002
Year Laboratory Accreditation Obtained: 2005
Name of National Accrediting Agency: ASCLD/LAB
Date of Examination, Analysis, or Report: January 10, 2014
Type of Forensic Analysis: Toxicology
Laboratory Case Number (if known): 124796613

Is the forensic analysis associated with any law enforcement investigation, prosecution or criminal litigation?

Yes No

* If you answered "Yes" above, provide the following information (if possible):

* Name of Defendant: [REDACTED]

* Case Number/Cause Number:
(if unknown, leave blank)

* Nature of Case: DWI
(e.g burglary, murder, etc.)

* The county where case was investigated, prosecuted or filed: Harris county

* The Court: _____

* The Outcome of Case: _____

124796613 was guilty and sentenced 124607913 was dismissed

* Names of attorneys in case on both sides (if known):

Matt Fass ADA, Harris county 1201 franklin, CCCL #12

3. WITNESSES

Provide the following about any person with factual knowledge or expertise regarding the facts of the disclosure. Attach separate sheet(s), if necessary.

First Witness (if any):
Name: Dwan Wilson
Address: _____
Daytime Phone: 713-308-2628
Evening Phone: _____
Fax: _____
Email Address: dwan.wilson@houstonpolice.org

Second Witness (if any):
Name: Lori Wilson
Address: _____
Daytime Phone: 713-308-2641
Evening Phone: _____
Fax: _____
Email Address: lori.wilson@houstonpolice.org

Third Witness (if any):
Name: _____
Address: _____
Daytime Phone: _____
Evening Phone: _____
Fax: _____
Email Address: _____

4. DESCRIPTION OF DISCLOSURE

Please write a brief statement of the event(s), acts or omissions that are the subject of the disclosure. See Page 6 of this form for guidance on what information should be disclosed to the Commission.

Yes I work for the Houston Forensic Science Center as a criminalist. According to my recollection the following events are what occurred leading up to my being removed from casework. A submission form was submitted with the wrong piece of evidence. The submission form received stated it contained 2 blood vials from incident number 124796613 subject name: [REDACTED]. The actual evidence envelope stated subject name: [REDACTED], with a barcoded incident numbers 124796613 and handwritten incident number 124607913. The blood vials had incident number 124607913 and subject name: [REDACTED]. All of the above discrepancies were documented in the case records. Our reporting database (LIMS) is generated from the submission form.

After analyzing the sample it was technically and administratively reviewed by the interim manager, and the report was generated with subject name: [REDACTED] incident number 124796613 on 01/10/2014. On April 16, 2014 I discovered evidence with subject name: [REDACTED] incident number 124607913 only had a breath alcohol test administered. I then tried to notify my interim manager, he could not be located so I went up the chain and discussed with the laboratory director who then instructed me to discuss it with the QA manager. After discussing the facts of the case with the quality and interim managers, the interim manager decided I should not continue with any other casework until this issue was resolved. I was told to write a memo about the case and everything I did related to the case, and the report was also recalled for reissuance. Soon after I discovered email correspondence between the officer, ADA, interim manager, and another analyst that was never documented in the case record. This correspondence stated that incident number 124796613 subject name [REDACTED] should have been incident number 124607913 subject name [REDACTED].

On 04/21/2014 I spoke with my interim manager and the case was resolved, but I was never placed back on casework contrary to how I interpreted his previous statement. Two weeks later I inquired again about returning to case work and my interim manager felt I still should not return to casework. I inquired a third time about returning to casework, and I was told my court room testimony needed improvement after the evaluation of my first testimony on 04/30/2014. A month later, I received a sheet of calculations to perform. To date I have yet to receive an itinerary or procedure detailing a plan/training schedule to place me back on casework.

It is in my opinion that this issue is a level 3 nonconformance were the report should have been recalled and amended serving as the customers notification. Being taken off casework was not justified. Furthermore none of the above was documented as per ASCLD/LAB procedure because it was said to me by my interim manager, this would be informal to protect my professional career. To date the report has not been corrected with the correct incident number and name, nor has the customer been notified.

I still do not understand why I was taken off of casework, not allowed to touch evidence and why nothing was documented. If further documentation is needed a written request should be faxed or emailed to me. For further clarification or explanation please call me on my cell [REDACTED] or office (713) 308-2657.

Thank you for your time and attention on this matter,

TEXAS FORENSIC SCIENCE COMMISSION • LAB DISCLOSURE FORM (Cont.)
GUIDELINES FOR LABORATORY SELF-DISCLOSURE

One of the Commission's statutory duties is to require crime laboratories that conduct forensic analyses to report professional negligence or professional misconduct. (See Tex. Code Crim. Proc. 38.01 as amended by Tex. S.B. 1238, 83rd Leg., R.S. (2013).

This document is designed to provide guidance to laboratories in determining whether they should disclose particular events to the Commission. Any questions regarding these guidelines should be directed to the Commission's general counsel at **512.936.0770**.

SELF-DISCLOSURE CATEGORIES

Probation: If the national accrediting body responsible for accrediting your laboratory and/or the Department of Public Safety¹ notifies you that it intends to put your laboratory on probation, you should inform the Commission as soon as possible, but no later than five (5) business days from receiving notification from the accrediting body.

Suspension of Accreditation: If the national accrediting body responsible for accrediting your laboratory and/or the Department of Public Safety notifies you that it intends to suspend your laboratory's accreditation for any reason, you should inform the Commission as soon as possible, but no later than five (5) business days from receiving notification from the accrediting body.

Nonconformances: Laboratories shall disclose any nonconformance that may rise to the level of professional negligence or misconduct using this disclosure form. Forms may be submitted online: **<http://www.fsc.state.tx.us/webform/disclosure>**. The disclosure should be submitted to the Commission as soon as possible, but no later than thirty (30) days after discovery of the nonconformance in question. If the laboratory needs a longer period to assess the scope of the nonconformance and submit its disclosure, it should contact the Commission's general counsel with a request for additional time.

If your self-disclosure involves a pending criminal case, or you believe that anyone involved in the disclosure may be the subject of criminal investigation, please alert the Commission when submitting your disclosure, as certain law enforcement exceptions to the Public Information Act may apply to the information submitted.

¹DPS currently recognized the following accrediting bodies: (1) American Board of Forensic Toxicology (for accreditation of toxicology discipline only); (2) American Society of Crime Laboratory Directors, Laboratory Accreditation Board (recognized for accreditation of all disciplines that are eligible for accreditation); (3) Forensic Quality Services (recognized for accreditation of all disciplines that are eligible for accreditation); (4) Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (recognized for accreditation of toxicology discipline only in the sub-discipline of urine drug testing for all classes of drugs approved by the accrediting body); (5) College of American Pathologists (recognized for accreditation of toxicology discipline only; and (6) American Association for Laboratory Accreditation (recognized for accreditation of all disciplines that are eligible for accreditation).

EXHIBIT C

HOUSTON POLICE DEPARTMENT
CRIME LABORATORY
Toxicology Section

EVIDENCE DESCRIPTION AND REVIEW FORM

Incident/Case Number: 124796613:001 Accd. By/Date: DON 11/15/13

Evidence Container: Envelope Box Other: _____

Evidence Sealed: Y N If NO Sealed by: _____

EVIDENCE RECEIVED:

Item(s) / Specimen(s)	Quantity	Comments
1. One grey top tube .1	~ 7 mL	
2. One grey top tube .2	~ 7 mL	
3.		
4.		
5.		
6.		

CASE NOTES:

Blood Alcohol: 12/9/13 ~~at~~ and LIMS
 The name on the submission form is [REDACTED]
 [REDACTED] The name on the envelope & blood tubes is "[REDACTED]"
 [REDACTED] The tubes have the incident # "124667913", which is not on LIMS.

EXHIBIT D

email correspondence and investigative documentation.

Wilson, Dwan

From: Wilson, Dwan
Sent: Thursday, October 17, 2013 8:07 AM
To: Quezada, Joel
Subject: RE: DWI Case
Attachments: 124796613 Roman.pdf

I get that all the time! Here is a copy of the submission form!

-----Original Message-----

From: Quezada, Joel
Sent: Wednesday, October 16, 2013 2:24 PM
To: Wilson, Dwan
Subject: RE: DWI Case

I apologize for the Mr., Miss Wilson. Can I fax the submission form to you? I work 9pm-7am

From: Wilson, Dwan
Sent: Wednesday, October 16, 2013 10:55 AM
To: Quezada, Joel
Cc: Bellamy, Craig; Gonzales, ROBERTC
Subject: RE: DWI Case

Officer Quezada,

I am Miss Wilson by the way and yes if you can come fill out the another submission form that will be great!

Thanks,

Dwan Wilson, B.S.
Criminalist - Toxicology
Houston Police Department
Crime Lab
Phone: 713-308-2628
Fax: 713-308-2648
Dwan.Wilson@houstonpolice.org

-----Original Message-----

From: Quezada, Joel
Sent: Wednesday, October 16, 2013 8:53 AM
To: Wilson, Dwan
Cc: Bellamy, Craig; Gonzales, ROBERTC
Subject: RE: DWI Case

1
174796613

Placed in folder on 4/16/14 ~~AK~~

email correspondence and investigative documentation.

Good Morning Mr. Wilson,

I see that I wrote the wrong case information on the submission form.

- Case 124796613 belongs to [REDACTED] which is a breath case, no blood involved.
- Case 124607913 belongs to David Hurtado. The envelope and tubes belong to the [REDACTED] case.

Do you need me to fill out a corrected submission form? Let me know what I need to do to correct this issue.

If you have any questions, please feel free to email me back or call me [REDACTED].

Thanks

J. Quezada

From: Wilson, Dwan
Sent: Tuesday, October 15, 2013 2:58 PM
To: Quezada, Joel
Cc: Bellamy, Craig; Gonzales, ROBERTC
Subject: DWI Case

Good Afternoon Officer Quezada,

I am Dwan Wilson, an analyst in the Toxicology section of the crime laboratory. I came across an issue with the evidence for case# 124796613. The issue is that the name on the submission form, [REDACTED], does not match the envelope and the tubes. The name on the envelope and the tubes is [REDACTED] and the incident on tubes is "124607913". The "124607913" is associated with another case on OLO. How can this issue be resolved?

Dwan Wilson, B.S.
Criminalist - Toxicology
Houston Police Department
Crime Lab
Phone: 713-308-2628
Fax: 713-308-2648
Dwan.Wilson@houstonpolice.org

EXHIBIT E

email correspondence and investigative documentation.

Wilson, Dwan

From: Wilson, Dwan
Sent: Thursday, October 31, 2013 3:06 PM
To: Quezada, Joel
Subject: DWI Case

Hey Officer Quezada,

I am following up with you about case# 124796613. Did you submit the submission form yet?

*Dwan Wilson, B.S.
Criminalist - Toxicology
Houston Police Department
Crime Lab
Phone: 713-308-2628
Fax: 713-308-2648
Dwan.Wilson@houstonpolice.org*

email correspondence and investigative documentation.

Wilson, Dwan

From: Quezada, Joel
Sent: Tuesday, November 05, 2013 2:50 AM
To: Wilson, Dwan
Subject: RE: DWI Case

I'm so sorry for the delay, i forgot all about it. i just dropped it off and stapled a note with your name on it.

From: Wilson, Dwan
Sent: Thursday, October 31, 2013 3:06 PM
To: Quezada, Joel
Subject: DWI Case

Hey Officer Quezada,

I am following up with you about case# 124796613. Did you submit the submission form yet?

*Dwan Wilson, B.S.
Criminalist - Toxicology
Houston Police Department
Crime Lab
Phone: 713-308-2628
Fax: 713-308-2648
Dwan.Wilson@houstonpolice.org*

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124796613 Placed in Folder on 4/16/14 AS

EXHIBIT F

email correspondence and investigative documentation.

Wilson, Dwan

From: Wilson, Dwan
Sent: Thursday, December 05, 2013 1:53 PM
To: Quezada, Joel
Subject: RE: DWI Case 124796613

Hey Officer Quezada,

I haven't received the submission form for that case 124796613. It must have gotten lost in transit! So if possible can you email it to me or fax it #713-308-2645?

Dwan

-----Original Message-----

From: Quezada, Joel
Sent: Tuesday, November 05, 2013 8:34 AM
To: Wilson, Dwan
Subject: RE: DWI Case

No I dropped it off in the bin where we drop off the blood vials.

From: Wilson, Dwan
Sent: Tuesday, November 05, 2013 8:01 AM
To: Quezada, Joel
Subject: RE: DWI Case

That's ok! You dropped it off to CER?

From: Quezada, Joel
Sent: Tuesday, November 05, 2013 2:50 AM
To: Wilson, Dwan
Subject: RE: DWI Case

I'm so sorry for the delay, I forgot all about it. I just dropped it off and stapled a note with your name on it.

From: Wilson, Dwan
Sent: Thursday, October 31, 2013 3:06 PM
To: Quezada, Joel
Subject: DWI Case

Hey Officer Quezada,

I am following up with you about case# 124796613. Did you submit the submission form yet?

Dwan Wilson, B.S.

1
124796613 Placed in folder on 4/16/14 

email correspondence and investigative documentation.

Criminalist - Toxicology
Houston Police Department
Crime Lab
Phone: 713-308-2628
Fax: 713-308-2648
Dwan.Wilson@houstonpolice.org<mailto:Dwan.Wilson@houstonpolice.org>

EXHIBIT G



Houston Police Department
Forensic Services Command
Assignment Report



Incident	Names	Priority	Case Comments
Amirae Gooden			12092013A
124796613 / 1	[REDACTED]	Normal	
143049913 / 1	[REDACTED]	Grand Jury	
146869113 / 1	[REDACTED]	Normal	Retest from 12042013A
147095113 / 1	[REDACTED]	Normal	
147418913 / 1	[REDACTED]	Normal	
148460913 / 1	[REDACTED]	Normal	
148499413 / 1	[REDACTED]	Normal	
148504113 / 1	[REDACTED]	Normal	no label
148518613 / 1	[REDACTED]	Normal	
148597013 / 1	[REDACTED]	Grand Jury	
148605713 / 1	[REDACTED]	Normal	
149140913 / 1	[REDACTED]	Normal	
117927413 / 1	[REDACTED]	Inv. Priority	1:100 Dilution 990ul of DI H ₂ O 10ul of Sample
117927413 / 1	[REDACTED]	Inv. Priority	1:100 Dilution 990ul DI H ₂ O 10 ul of Sample

AL

EXHIBIT H

HOUSTON POLICE DEPARTMENT

CRIME LABORATORY

Toxicology Section ASCLD-International Program Certificate ALI-193T

Volatiles Batch QC Data

Batch Date: 12092013A

Examiner: *Andrea Guaden*

Internal QC

Quantitative QC

Aqueous Control

Ethanol 0.081 .

Blood Control

Ethanol 0.084 .

Qualitative QC

Mixed Volatiles

Negative

External QC

Quantitative QC

Aqueous Control

Ethanol 0.082 .

Blood Control

Ethanol 0.079 . Manufacturer Range: 0.0614 - 0.0920

Methanol 0.034 . Manufacturer Range: 0.0245 - 0.0421

Acetone 0.041 . Manufacturer Range: 0.0257 - 0.0557

Isopropanol 0.038 . Manufacturer Range: 0.0294 - 0.0440

Technical Review: *MUNA*

Date: *12/10/13*

LAB-63
Version 03
Issue Date: 11-14-2012

J. Mayor 8/1/14 (case 124796613)

Uncertainty Budget: Expanded Uncertainty for Ethanol at 0.1 g/100mL at 95% is 5.5% on Papa Smurf.

EXHIBIT I

email correspondence and investigative documentation.

Wilson, Dwan

From: Quezada, Joel
Sent: Wednesday, January 15, 2014 5:55 AM
To: Arnold, WILLIAMB
Cc: Wilson, Dwan
Subject: RE: Case 124607913Q

Mr. Arnold,

I just looked over my report and it says the blood specimen was turned in to 1200 Travis lab. I know this case was mixed up with another case (if I remember correctly). Due to an error on my part with the evidence submission form. But now I am confused...

Miss Wilson,

I read your email (again) and now I'm confused. The case you need an evidence submission form was mixed up with this other case that Mr. Arnold is looking for.

I went on vacation and trying to catch up on a million and one emails and requests. Miss Wilson can you please let me know again which one you need and evidence submission form for. That will be done today, since I will be at work all day. If you can pls send me a text or leave me a voicemail when you have emailed me back.

Thank you and again sorry.

cell: 281-796-7725

From: Arnold, WILLIAMB
Sent: Tuesday, January 07, 2014 3:08 PM
To: Fass, Matthew; Quezada, Joel
Subject: RE: Case 124607913Q

Joel:

We are trying to find a sample on a case involving [REDACTED]. The only incidents I have been able to located were from 2011. The DA has indicates the HPD incident number is 124607913. We evidence on this case submitted to the property room or was it taken to another lab?

Thanks,

William B. Arnold
Houston Police Department
Crime Laboratory Division
1200 Travis, 24th Floor
Houston, TX 77002
Phone: 713-308-2600

This email message is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient,

124607913 Placed in Fld. on 4/16/14 *AK*

email correspondence and investigative documentation.

please contact the sender by reply email and destroy all copies of the original message. If you are the intended recipient, please be advised that the content of this message is subject to access, review and disclosure by the sender's Email System Administrator.

From: Fass, Matthew [mailto:FASS_MATTHEW@dao.hctx.net]
Sent: Tuesday, January 07, 2014 2:28 PM
To: Arnold, WILLIAMB
Subject: RE: Case 124607913Q

I'm showing J. Quezada, PR #133955, as the arresting and transporting officer. I'm assuming he also submitted the sample.

From: Arnold, WILLIAMB [<mailto:WILLIAMB.Arnold@HoustonPolice.Org>]
Sent: Friday, January 03, 2014 1:56 PM
To: Sustaita, Hector; Fass, Matthew
Subject: RE: Case 124607913Q

Matthew:

The only two cases I see in LIMS for [REDACTED] are 105081511 & 122802611. I don't find this case in LIMS or WebPrelog using the incident number 124607913. I also searched the property room system using the name and 124607913 as well. They have no record of the sample either. Do you know who the collecting officer was?

William B. Arnold
Houston Police Department
Crime Laboratory Division
1200 Travis, 24th Floor
Houston, TX 77002
Phone: 713-308-2600

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From: Sustaita, Hector
Sent: Friday, January 03, 2014 8:18 AM
To: Arnold, WILLIAMB
Subject: FW: Case 124607913Q

Can you verify what the case # using the cause # ? I'm not seeing this in EMS.

From: Fass, Matthew [mailto:FASS_MATTHEW@dao.hctx.net]
Sent: Thursday, January 02, 2014 5:18 PM

2

124607913 placed in folder 4/16/14

email correspondence and investigative documentation.

To: 'hector.sustaita@houstontx.gov'
Subject: Case 124607913Q

Hector,

I checked in LIMs and it is not even pulling up this case. I tried to request the labs, and it said they have already been requested. I'm wondering if it got filed under a different number. The court cause is 1922419, and the defendant is [REDACTED] Please advise if you need anything else from my end.

Thanks,

Matt Fass
Assistant District Attorney, Harris County
1201 Franklin, CCCL #12
Houston, Tx 77002
Phone: 713-755-0669
Fax: 713-755-1839

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EXHIBIT J

Forensic Case Number: 13-28695

Analysis Completed: 01/08/2014

Date of Report: 01/10/2014

Type of Offense: Driving While Intoxicated (DWI) - Unclassified

Admin Reviewed By: William B Arnold

Location of Offense: 4600 NORTH FWY

Date of Offense: 10/05/2013

Chain of Custody

1 - TWO BLOOD VIALS

10/05/2013	20:23	CER & Property Room	Item Collected
10/09/2013	10:15	CER & Property Room	CER Window 25th Floor 1200 Travis
10/09/2013	10:42	CER & Property Room	Crime Lab Vault Refrigerator Aisle 2
10/10/2013	8:04	CER & Property Room	CER Bin for Evidence Release
10/10/2013	8:31	Toxicology Personnel	Andrea Gooden
10/10/2013	8:43	Toxicology Location	Tox Evidence Fridge A
10/15/2013	13:09	Toxicology Personnel	Dwan A Wilson
10/15/2013	14:14	Toxicology Location	Tox Evidence Fridge A
10/16/2013	8:08	Toxicology Personnel	Dwan A Wilson
10/16/2013	14:02	Toxicology Location	Tox Evidence Fridge A
12/06/2013	7:52	Toxicology Personnel	Andrea Gooden
12/06/2013	9:05	Toxicology Location	Tox Evidence Fridge A
12/09/2013	7:46	Toxicology Personnel	Andrea Gooden
12/09/2013	11:25	Toxicology Location	Tox Evidence Fridge A
12/19/2013	13:15	Toxicology Personnel	Andrea Gooden
12/19/2013	13:15	Toxicology Location	Cooler #2 - Toxicology
1.1 - one grey top tube			
12/06/2013	8:21	Subitem Location	Packaged with Parent
1.2 - one grey top tube			
12/06/2013	8:21	Subitem Location	Packaged with Parent

EXHIBIT K

email correspondence and investigative documentation.

Wilson, Dwan

From: Quezada, Joel
Sent: Wednesday, January 15, 2014 5:55 AM
To: Arnold, WILLIAMB
Cc: Wilson, Dwan
Subject: RE: Case 124607913Q

Mr. Arnold,

I just looked over my report and it says the blood specimen was turned in to 1200 Travis lab. I know this case was mixed up with another case (if I remember correctly). Due to an error on my part with the evidence submission form. But now I am confused...

Miss Wilson,

I read your email (again) and now I'm confused. The case you need an evidence submission form was mixed up with this other case that Mr. Arnold is looking for.

I went on vacation and trying to catch up on a million and one emails and requests. Miss Wilson can you please let me know again which one you need and evidence submission form for. That will be done today, since I will be at work all day. If you can pls send me a text or leave me a voicemail when you have emailed me back.

Thank you and again sorry.

cell: 281-796-7725

From: Arnold, WILLIAMB
Sent: Tuesday, January 07, 2014 3:08 PM
To: Fass, Matthew; Quezada, Joel
Subject: RE: Case 124607913Q

Joel:

We are trying to find a sample on a case involving [REDACTED] The only incidents I have been able to located were from 2011. The DA has indicates the HPD incident number is 124607913. We evidence on this case submitted to the property room or was it taken to another lab?

Thanks,

William B. Arnold
Houston Police Department
Crime Laboratory Division
1200 Travis, 24th Floor
Houston, TX 77002
Phone: 713-308-2600

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12/27/2012 Placed in File on 4/16/14 *AK*

EXHIBIT L

email correspondence

Wilson, Dwan

From: Quezada, Joel
Sent: Friday, March 28, 2014 7:15 AM
To: Arnold, WILLIAMB
Cc: Bellamy, Craig; Baimbridge, Larry; Gonzales, ROBERTC; Wilson, Dwan
Subject: RE: [REDACTED]

Mr. William,

-Case number 124796613-F, which belongs to [REDACTED] is a breath case, therefore no blood involve.
-Case number 124607913-Q, is for [REDACTED]

Miss Wilson and I had emailed back and forth several time about this issue. When I tagged the blood the first time, I turned in a submission form. I believe I messed it up by putting that other case number. While emailing Miss Wilson she told me to turn another submission form in and I dropped off another one in the 1200 Travis drop box with a note on it. I beleive Miss Wilson never got that one either and she asked me to fax it over. I faxed it over (never checked confirmation). I never heard about it again so I thought that was good to go...

I have one that I can email you or fax it today. As soon as you get this email let me know how you want me to do it. I will be up for a while. Give me a call 281-796-7725.

From: Gonzales, ROBERTC
Sent: Thursday, March 27, 2014 10:13 PM
To: Quezada, Joel
Subject: FW: [REDACTED]

Take care of this ASAP...

R. C. Gonzales, Sergeant
Traffic Enforcment Division-DWI Task Force
713-447-9219

From: Baimbridge, Larry
Sent: Thursday, March 27, 2014 1:32 PM
To: Arnold, WILLIAMB
Cc: Wilson, Dwan; Bellamy, Craig; Gonzales, ROBERTC
Subject: RE: [REDACTED]

Craig,
Can you please look into this and determine what happened? Also, we need to remind everyone to double-check the case number when tagging evidence.

From: Arnold, WILLIAMB
Sent: Thursday, March 27, 2014 1:29 PM
To: Baimbridge, Larry
Cc: Wilson, Dwan
Subject: [REDACTED]

¹
124796613 placed in folder on 4/16/14 ^{AK}

email correspondence

Cpt. Baimbridge:

Sorry to bother you again, but I have another case that has come through we are struggling with. The DA has been calling regarding 124607913, suspect [REDACTED] This evidence appears to have been submitted under 124796613, suspect [REDACTED] We have been unable to locate the correct submission information for Mr. [REDACTED]

This appears to be a similar situation to the case we requested assistance with a couple of weeks ago. Can someone let us know how to proceed?

Thanks,

William B. Arnold
Houston Police Department
Crime Laboratory Division
1200 Travis, 24th Floor
Houston, TX 77002
Phone: 713-308-2600

Tell us how we are doing: www.surveymonkey.com/s/HYFQL8D

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EXHIBIT M

email correspondence and investigative documentation. .

Gooden, Andrea

From: Arnold, WILLIAMB
Sent: Wednesday, April 16, 2014 7:59 AM
To: Gooden, Andrea
Cc: Rios, Irma; Wilson, Lori
Subject: 124796613

Importance: High

Andrea:

Until further notice you are to focus solely on documenting the issues surround the case we discussed yesterday. Do not handle any evidence, process any data or generate any reports or documentation that is unrelated to your research on this case. Ensure that the associated evidence is photographed as it is at this point, prior to any additional writing or changes to existing documentation including the [REDACTED] evidence you showed me yesterday. You expressed that you have photographs that were taken previously but were not uploaded into the LIMS as were others from this batch. I also understood that you had partially marked the evidence at the time it was analyzed but did not complete your labeling at that time.

Generate a document with your findings in memo format in as much detail as you can accurately recall and/or demonstrate via existing documentation. If you don't remember details, simply say so in your documentation. Provide me a copy of your findings as they stand before you leave this afternoon even if you have not completed your research and documentation.

Thanks,

William B. Arnold
Houston Police Department
Crime Laboratory Division
1200 Travis, 24th Floor
Houston, TX 77002
Phone: 713-308-2600

Tell us how we are doing: www.surveymonkey.com/s/HYFQL8D

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EXHIBIT N

From: Gooden, Andrea
To: Arnold, WILLIAMB
Subject: Status for casework
Attachment(s): 2

Hi William

I just wanted to check on the progress of my current status including my training and case analysis, please see the following attachment.

Thank you,

Andrea S. Gooden, B.S.

Criminalist

Houston Forensic Science Center

Phone-(713) 308-2657

Fax- (713) 308-2645

Andrea.Gooden@HoustonPolice.org

From: Arnold WILLIAMB
To: Gooden Andrea
Date: Mon, 21 Jul 2014 16:31:34 -0500
Subject: report

Andrea,

Please go ahead and sign the report in LIMS and I'll do the admin review in the morning.

William B. Arnold

Acting Director of Information Technology

Houston Forensic Science Center

713-308-2600

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From: Dan Garner
To: Gooden Andrea
Date: Thu, 29 May 2014 18:49:28 +0000
Subject: Read: Nonconformance and casework

Your message

To:
Subject: Nonconformance and casework
Sent: Thursday, May 29, 2014 1:49:34 PM (UTC-06:00) Central Time (US & Canada)

was read on Thursday, May 29, 2014 1:49:28 PM (UTC-06:00) Central Time (US & Canada).

From: Caresse Young
To: Gooden Andrea
Date: Fri, 30 May 2014 21:03:47 +0000
Subject: RE: Training documents
Attachment(s): 1

Andrea,

I am so sorry I haven't written you sooner. I've been intending to send you an e-mail since this morning and my day simply got away from me.

I didn't realize that Will had a scheduled day off today when I told you we could have the written documentation to you by the end of the week. He does have the documentation almost complete, but it will be next week before it is finalized. I know you will be in class next week, but perhaps we can catch you before or after. Based on what he told me, he wants you to complete the class on Courtroom Testimony scheduled for next week as well as come written proficiency tests. Once you have successfully completed those things, he plans to put you back on casework. He is the best person to fill you in on the details, and I will continue to follow-up so that meeting can occur as soon as possible.

Thank you for your patience,

Caresse

Caresse Young, SPHR
Director of Human Resources
Houston Forensic Science LGC, Inc.
1200 Travis, 20th Floor
Houston, TX 77002
713/929-6763
cyoung@houstonforensicscience.org

From: Gooden, Andrea [mailto:Andrea.Gooden@HoustonPolice.Org]
Sent: Friday, May 30, 2014 3:22 PM
To: Caresse Young
Subject: Training documents

Good Afternoon,

Have you heard from Will about my training to get back on casework?

Andrea S. Gooden, B.S.

Criminalist

Houston Forensic Science Center

Phone-(713) 308-2657

Fax- (713) 308-2645

Andrea.Gooden@HoustonPolice.org

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From: Arnold WILLIAMB
To: Gooden Andrea
Date: Tue, 27 May 2014 15:42:23 -0500
Subject: RE: Status of training1*
Attachment(s): 1

We can discuss this with Dr. Logan tomorrow.

William B. Arnold

Acting Director of Information Technology

Houston Forensic Science Center

713-308-2600

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From: Gooden, Andrea
Sent: Tuesday, May 27, 2014 2:46 PM
To: Arnold, WILLIAMB
Subject: RE: Status of training

Will there be more training after the court training? If so what is the ETA on me getting back to casework?

Andrea S. Gooden, B.S.

Criminalist

Houston Forensic Science Center

Phone-(713) 308-2657

Fax- (713) 308-2645

Andrea.Gooden@HoustonPolice.org

From: Arnold, WILLIAMB
Sent: Tuesday, May 27, 2014 2:25 PM
To: Gooden, Andrea
Subject: RE: Status of training

Yes - the court training is included.

William B. Arnold

Acting Director of Information Technology

Houston Forensic Science Center

713-308-2600

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From: Gooden, Andrea
Sent: Tuesday, May 27, 2014 2:04 PM
To: Arnold, WILLIAMB
Subject: Status of training

Hey Will,

I just wanted an update on my training, not sure if you had a chance to look at the worksheet I completed yet. I'm also assuming the court training for next week will count as part of my training?

Andrea S. Gooden, B.S.

Criminalist

Houston Forensic Science Center

Phone-(713) 308-2657

Fax- (713) 308-2645

Andrea.Gooden@HoustonPolice.org

From: [Caresse Young](#)
To: [Gooden Andrea](#)
Date: Tue, 27 May 2014 20:21:08 +0000
Subject: RE: Status
Attachment(s): 1

Andrea,

I talked with Will and would like to set up a time to follow-up with you.
Are you available tomorrow morning at 10:00 am?

Thanks,

Caresse

Caresse Young, SPHR
Director of Human Resources
Houston Forensic Science LGC, Inc.
1200 Travis, 20th Floor
Houston, TX 77002
713/929-6763
cyoung@houstonforensicscience.org

From: Gooden, Andrea [<mailto:Andrea.Gooden@HoustonPolice.Org>]
Sent: Tuesday, May 27, 2014 2:52 PM
To: Caresse Young
Subject: Status

Good Afternoon,

I'm just checking on the status of what we discussed on Thursday of last week, with my concerns with the documentation of my training and casework status?

Andrea S. Gooden, B.S.

Criminalist

Houston Forensic Science Center

Phone-(713) 308-2657

Fax- (713) 308-2645

Andrea.Gooden@HoustonPolice.org

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From: Gooden, Andrea
To: 'dgarner@houstonforensicscience.org'
Subject: Nonconformance and casework
Attachment(s): 3

Good Afternoon,

It has been brought to my attention by Mrs. Caresse that you are aware of my current casework status. It was unclear of how much you knew about the situation so I have written a memo explaining the situation. I have also attached the original memo that was sent to William Arnold and QA Manager Lori Wilson. If there are any questions or concerns please feel free to contact me at any time.

Andrea S. Gooden, B.S.

Criminalist

Houston Forensic Science Center

Phone-(713) 308-2657

Fax- (713) 308-2645

Andrea.Gooden@HoustonPolice.org

From: Gooden, Andrea
To: 'dgarner@hosutonforensicscience.org'
Subject: Nonconformance and casework
Attachment(s): 3

Good Afternoon,

It has been brought to my attention by Mrs. Caresse that you are aware of my current casework status. It was unclear of how much you knew about the situation so I have written a memo explaining the situation. I have also attached the original memo that was sent to William Arnold and QA Manager Lori Wilson. If there are any questions or concerns please feel free to contact me at any time.

Andrea S. Gooden, B.S.

Criminalist

Houston Forensic Science Center

Phone-(713) 308-2657

Fax- (713) 308-2645

Andrea.Gooden@HoustonPolice.org

From: Gooden, Andrea
To: Wilson, Lori
Subject: FYI
Attachment(s): 1

Good Afternoon,

I sent the following memo to Dr. Garner earlier today, since it involves quality assurance I realized I should have sent you a copy as well. So I have attached a copy of the memo for your convenience.

Andrea Gooden

CITY OF HOUSTON

INTER OFFICE CORRESPONDENCE

TO: Dr. Daniel Garner

FROM: Andrea Gooden, Criminalist
Forensic Analysis Division

DATE: May 29, 2014

Memo

SUBJECT: **Nonconforming Testing Work**

On April 16, 2014 I discovered that a report (inc # 124796613) that I generated had both clerical and evidence mishaps created by the submitting officer Joel Quezada. The discrepancies were noted in the case file on 10/15/2013 and the officer was notified for clarification. The clerical error made by Officer Joel Quezada caused LIMS to have the same incorrect suspect name which lead to the report having the same incorrect suspect name. This report was later technically reviewed by interim toxicology supervisor William Arnold. To my knowledge the report was later recalled by William Arnold, but never amended nor was the customer contacted about the correction. All of these actions lead to me being taken off casework without documentation of a root cause, corrective action, preventative action plan, or an additional training procedure for placing me back on casework. I am concerned that there is not a documented plan for putting me back on casework. I am not excusing my involvement in this situation or feel action is not needed. It is in my opinion that the situation is not an adequate reason for taking me off casework on 04/16/2014. There are complete details of this case available if needed.

I have included guidelines from "ISO/IEC 17025" and "HPD Crime Laboratory Quality Assurance Manual" for your reference:

ISO/IEC 17025 (4.9.1) "Correction is taken immediately, together with any decision about the acceptability of the nonconforming work; where necessary, the customer is notified and work is recalled; the responsibility for authorizing the resumption of work is defined."

ISO/IEC 17025 (4.11.3) "Corrective actions shall be to a degree appropriate to the magnitude and the risk of the problem. The laboratory shall document and implement any required changes resulting from corrective action investigations."

CL-QA-QM (4.9.1) "Class III errors are inconsistencies having minimal effect or significance on quality, are unlikely to recur, are not systemic, and do not affect the fundamental reliability of the laboratory's work product. The investigation includes a review of any affected case work, root cause analysis and corrective action(s) taken to prevent a recurrence. The nature of the nonconformity dictates whether immediate action is necessary. Common sense must be employed when determining what constitutes nonconformity. Minor departures from accepted policy would normally require a correction. The issuance of an amended report will serve as customer notification. Class III nonconformances include administrative or transcript errors. Class III errors are corrected and the correction is documented. If the same error occurs routinely for the same employee or under the same circumstances, then the error may be elevated in class. The section manager is responsible for initiating a corrective action report. Non-technical issues

may be addressed through the appropriate chain of command. If necessary, the Director, section manager, and/or quality manager may work together to address this type of concern. Customers will be notified if their casework is recalled.”

CL-QA-QM (4.11.1) “The laboratory’s corrective action policy includes: identifying the person responsible for carrying out the corrective action, establishing the scope of measures taken, notifying customers when reports are amended, identifying the root cause of the problem, implementing a long-term solution to prevent a recurrence, and monitoring the effectiveness of the corrective action(s) taken. A laboratory Corrective and Preventive Action Form (CAPA) will be completed to address potential nonconforming issues. The form will be forwarded to the sectional manager and/or the quality manager. Action is then taken as needed to address the nonconformance.”

CL-QA-QM (4.11.2) “**Root Cause Analysis** – The first step in the corrective action investigation is an effort to determine the root cause of the apparent nonconformance. If the cause is not obvious, an analysis of potential causes will be conducted. The investigator may seek guidance or input from others during this process.”

CL-QA-QM (4.11.3) “**Selection and Implementation of Corrective Actions** – The quality manager and Director have the authority to direct the cause analysis, monitoring, and corrective actions, as necessary to address the problem. Documentation will be maintained to describe the action(s) taken. If the error is determined to be administrative or clerical in nature, the documentation and review process will be studied and revised, if appropriate, to minimize the recurrence of this error. Corrective actions will be of the appropriate degree and magnitude to correct the problem and reduce the risk of recurrence.”

All referenced documents can be found in “ISO/IEC 17025 General Requirements for the Competence of Testing and Calibration Laboratories” and “HPD Crime Laboratory Quality Assurance Manual.”

Andrea Gooden, Criminalist
Forensic Analysis Division

ag:ag

Cc:
Dr. Daniel Garner
President and CEO of the Houston Forensic Science Center, LGC

From: Gooden, Andrea
To: Arnold, WILLIAMB
Subject: Court Room Training status
Attachment(s): 1

Good Afternoon,

I have completed the Widmark/retrograde calculations on 05/23/2014, the court room testimony training as of 06/06/2014, what else is needed for me to return to casework?

Thanks in advance,

Andrea S. Gooden, B.S.

Criminalist

Houston Forensic Science Center

Phone-(713) 308-2657

Fax- (713) 308-2645

Andrea.Gooden@HoustonPolice.org

From: Arnold WILLIAMB
To: Gooden Andrea
Date: Mon, 28 Jul 2014 07:15:45 -0500
Subject: Casework

Andrea:

I am still working to finalize the memo returning you to casework. Until that is done, this e-mail serves to return you to casework. Any alcohol tests that you complete are to be technically reviewed by me.

William B. Arnold

Acting Director of Information Technology

Houston Forensic Science Center

713-308-2600

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From: Arnold WILLIAMB
To: Gooden Andrea
CC: Rios Irma, cyoung@houstonforensicscience.org
Date: Fri, 27 Jun 2014 10:20:06 -0500
Subject: Case follow up

Andrea:

Please do the following. Do not sign the report until the language you use has been evaluated and approved:

Prepare another report stating that the report dated 1/10/14 was retracted due to discrepancies between the submission form information and evidence analyzed. Describe the discrepancies ie that the incident number and suspect name listed on submission form were not consistent with the incident number and name on the evidence blood tubes. Notify them that "the LIMS report dated 1/10/14 was removed on ___ due to these discrepancies identified and further corrective action will be forthcoming.

The discussion of discrepancies would parallel that used for the comments in the second matrix panel that is used in normal reports to convey information to our customers beyond that of the normal report. We will review this Monday and finalize the report for release.

Thanks,

Will

From: Arnold WILLIAMB
To: Gooden Andrea
CC: Rios Irma, Wilson Lori
Date: Wed, 16 Apr 2014 07:58:52 -0500
Subject: 124796613

Andrea:

Until further notice you are to focus solely on documenting the issues surround the case we discussed yesterday. Do not handle any evidence, process any data or generate any reports or documentation that is unrelated to your research on this case. Ensure that the associated evidence is photographed as it is at this point, prior to any additional writing or changes to existing documentation including the [REDACTED] evidence you showed me yesterday. You expressed that you have photographs that were taken previously but were not uploaded into the LIMS as were others from this batch. I also understood that you had partially marked the evidence at the time it was analyzed but did not complete your labeling at that time.

Generate a document with your findings in memo format in as much detail as you can accurately recall and/or demonstrate via existing documentation. If you don't remember details, simply say so in your documentation. Provide me a copy of your findings as they stand before you leave this afternoon even if you have not completed your research and documentation.

Thanks,

William B. Arnold
Houston Police Department
Crime Laboratory Division
1200 Travis, 24th Floor
Houston, TX 77002
Phone: 713-308-2600

Tell us how we are doing: www.surveymonkey.com/s/HYFQL8D

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CITY OF HOUSTON

INTER OFFICE CORRESPONDENCE

TO: William Arnold

FROM: Andrea Gooden, Criminalist
Forensic Analysis Division

DATE: May 14, 2014

Memo

SUBJECT: Court Room Testimony Training

On April 16, 2014 I was instructed by the toxicology interim supervisor, William Arnold, to stop any and all casework until a specific case (inc # 124607913) was resolved. That case was resolved by 04/21/2014 but I still was not allowed to do casework, with no clear explanation. On 05/01/2014 William Arnold informed me I was still off casework pending training on court room testimony. On 05/06/2014 the ADA on case (inc # 035791513) informed me via email that I performed well. On 5/7/2014 I testified on another case (inc # 123461413) where another ADA also gave my testimony satisfactory results. I have yet to receive an evaluation of this case, a training schedule/procedure, or an ETA on when casework will continue from William Arnold. I am concerned that there is not a documented plan for putting me back on casework.

The Laboratory must have a written procedure which it uses to initiate a review and to take corrective action when the laboratory has an indication of a significant problem with a technical procedure or the work of an analyst.

ASCLD/LAB (1.4.2.25 E) "If the Laboratory has an indication of a significant technical problem, is there a procedure in writing and in use whereby the laboratory initiates a review and takes any corrective action required?"

ASCLD/LAB (5.2.1.1) specifically states that "lab management should include procedures for retraining and maintenance of skills and expertise."

ASCLD/LAB (5.9.6) "Each individual shall be given feedback, both positive and in any area needing improvement and the monitoring procedure shall prescribe the remedial action that is to be taken should the evaluation be less than satisfactory."

ASCLD/LAB (4.10-4.12) "For training, corrective actions, and improvements there must be written documentation, cause analysis, selection and implantation of corrective actions, monitoring of corrective actions and preventative actions"

All referenced documents can be found in "Supplemental Requirements for the Accreditation of Forensic Science Testing Laboratories" and "ASCLD.LAB 2008 Manual."

Andrea Gooden, Criminalist
Forensic Analysis Division

ag:ag

Cc:
William Arnold
Acting Director of IT

CITY OF HOUSTON
INTER OFFICE CORRESPONDENCE

TO: William Arnold

FROM: Andrea Gooden, Criminalist
Forensic Analysis Division

DATE: April 17, 2014

Memo

SUBJECT: 124796613/124607913

On 4/15/2014 I noticed an unsealed piece of evidence in Cooler #2 with a post-it that read "Waiting on Officer Reply already analyzed. -Andrea" Upon further investigation in LIMS I discovered a report under incident number 124796613 with subject name of [REDACTED]. The unsealed evidence name read: [REDACTED] and there were two incident numbers on the envelope, one hand written (124607913) and the other was a barcode label (124796613).

I went downstairs to the 24th floor to retrieve the case folder for 124796613, where I found a submission form with [REDACTED]; a final report, a print out from OLO with suspect information on [REDACTED], and an evidence description and review form with case notes from analyst Dwan Wilson that read "The name on the submission form and LIMS is [REDACTED]. The name on the envelope and blood tubes is [REDACTED]. The tubes have the incident # "124607913," which is not on LIMS". I contacted Irma Rios who instructed me to follow up with the QA/QC Supervisor Lori Wilson, I also informed interim Toxicology Manager William Arnold.

On 4/16/2014 I further investigated the matter and these are my findings:

- 10/10/13 - I received evidence from CER and placed evidence into Tox A cooler.
- 10/15/13 - According to the evidence form, Dwan accessioned the evidence. She filled out the "evidence description and review form" wrote the incident number, item number, and initialed both blood tubes. The information on both tubes was then crossed out by analyst Dwan Wilson.
- 12/6/13 - I placed 124796613 into my custody to sub itemize parent item into 1.1 and 1.2. I also spoke with analyst Dwan Wilson, because her initials were already on both blood tubes, she gave me the folder and explained the situation with the sample.
- 12/9/13 - I analyzed the sample, I wrote the date on the tubes but not my initials. I also corrected my batch sheet by crossing out [REDACTED] name and placing the name that was on the actual blood tube [REDACTED]. I also took pictures of the evidence but I did not upload them into LIMS. My only logical conclusion for my actions is that I was waiting for the issue with the tubes to be resolved before placing pictures with this case into LIMS
- 12/10/13 - I submitted every other sample (except this one) in this batch to be TR by Mike Manes.
- 12/19/13 - I moved the case from Tox A cooler to Cooler #2 to not confuse it with "pending analysis" casework.
- 01/8/14 - The report for this case was submitted.
- 01/10/14 - The report was TR by William Arnold.

April 17, 2014

- **04/15/14** - I took additional pictures of the evidence and placed back into Cooler #2. I notified Crime Lab Director Irma Rios, QA/QC Supervisor Lori Wilson and interim Toxicology Manager William Arnold of my findings.
- **04/16/14** - After investigating this case and reading all the emails associated with the submitting officer Joel Quezada, analyst Dwan Wilson, and Toxicology Supervisor William Arnold I have come to this conclusion, I analyzed this sample with the thought of holding onto the case until all of its issues were resolved. However, it somehow was sent for Technical review by mistake. The email on 10/16/13 from Officer Joel Quezada to analyst Dwan Wilson states "I see that I wrote the wrong case information on the submission form. Case 124796613 belongs to [REDACTED] which is a breath case, no blood involved. Case 124607913 belongs to [REDACTED]. The envelope and tubes belong to the [REDACTED] case." My conclusion is the blood that I analyzed on 12/9/13 belonged to [REDACTED] but the report that was written and technical reviewed under the name of [REDACTED] I scanned all documents to the case file in LIMS.

Andrea Gooden, Criminalist
Forensic Analysis Division

ag:ag

Cc:
William Arnold, Police Administrator

EXHIBIT O

Forensic Case Number: 13-28695

Analysis Completed: 01/08/2014

Date of Report: 08/01/2014

Type of Offense: Driving While Intoxicated (DWI) - Unclassified

Admin Reviewed By: William B Arnold

Location of Offense: 4600 NORTH FWY

Date of Offense: 10/05/2013

Chain of Custody

2 - This specimen was not taken by this laboratory.

07/21/2014	13:42	Toxicology Personnel
07/24/2014	11:40	Toxicology Location

Andrea Gooden
Cooler #2 - Toxicology

EXHIBIT P



Houston Forensic Science Center

Forensic Analysis Division
Alcohol Analysis Report
1200 Travis Street, Houston, Texas 77002
Phone: 713-308-2600

The Toxicology Section is accredited by ASCLD-LAB International (17025:2005) and the Texas DPS.

NOT FOR DISTRIBUTION TO OTHER AGENCIES



Incident/Seq Number: 124796613/3

Analysis Completed: 01/08/2014

Date of Report: 08/04/2014

Forensic Case Number: 13-28695 - 3

Admin Reviewed By: Lori Wilson

Type of Offense: Driving While Intoxicated (DWI) - Unclassified

Review Date: 08/04/2014

Location of Offense: 4600 NORTH FWY

Related Individuals:

[Redacted]

Cause Number(s): 1403873

Related Evidence:

Item Number	Description
1	(Blood Specimen(s)) - Two blood vials collected from [Redacted]
1.1	(Blood Specimen(s)) - One grey top tube collected from [Redacted]
1.2	(Blood Specimen(s)) - One grey top tube collected from [Redacted]

Results and Interpretations:

If analysis was performed, dual column head space gas chromatography with flame ionization detection was utilized.

This amended report supercedes the report generated on August 1, 2014.

Evidence from incident 124607913 was submitted in this case. Because of this discrepancy, results will not be reported.

This case was a breath alcohol case. This laboratory does not perform breath alcohol testing.

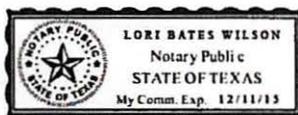
Certificate of Analysis

Before me, the undersigned authority, personally appeared William B Arnold, who being duly sworn, stated as follows:

My name is William B Arnold. I am of sound mind, over the age of 18 years, capable of making this affidavit, and personally acquainted with the facts stated in this affidavit. I am employed by the Houston Forensic Science Center which was authorized to conduct the analysis referenced in this affidavit. Part of my duties for this laboratory involve the analysis of physical evidence for one or more law enforcement agencies. This laboratory is accredited by ASCLD-LAB International (17025:2005) and the Texas Department of Public Safety.

My training and experience that qualify me to perform the tests or procedures referred to in this affidavit and determine the results of those tests or procedures are a Bachelors of Science in Biochemistry, a Bachelors of Science in Biology and a Bachelors of Science in Medical Technology.

I received the physical evidence listed on this report as stated in the Chain of Custody. On the date indicated above I completed analysis for alcohol using headspace gas chromatography. This is a recognized technique in the scientific community for determining the ethyl alcohol concentration of blood. The tests and procedures used were reliable and approved by the laboratory.



Analyst: William B. Arnold
William B Arnold

SWORN TO AND SUBSCRIBED before me on the 4th of August, 2014.

[Signature]
Notary Public-State of Texas

Forensic Case Number: 13-28695

Analysis Completed: 01/08/2014

Date of Report: 08/04/2014

Type of Offense: Driving While Intoxicated (DWI) - Unclassified

Admin Reviewed By: Lori Wilson

Location of Offense: 4600 NORTH FWY

Date of Offense: 10/05/2013

Chain of Custody

1 - Two blood vials collected from [REDACTED]

10/05/2013	20:23	CER & Property Room	Item Collected
10/09/2013	10:15	CER & Property Room	CER Window 25th Floor 1200 Travis
10/09/2013	10:42	CER & Property Room	Crime Lab Vault Refrigerator Aisle 2
10/10/2013	8:04	CER & Property Room	CER Bin for Evidence Release
10/10/2013	8:31	Toxicology Personnel	Andrea Gooden
10/10/2013	8:43	Toxicology Location	Tox Evidence Fridge A
10/15/2013	13:09	Toxicology Personnel	Dwan A Wilson
10/15/2013	14:14	Toxicology Location	Tox Evidence Fridge A
10/16/2013	8:08	Toxicology Personnel	Dwan A Wilson
10/16/2013	14:02	Toxicology Location	Tox Evidence Fridge A
12/06/2013	7:52	Toxicology Personnel	Andrea Gooden
12/06/2013	9:05	Toxicology Location	Tox Evidence Fridge A
12/09/2013	7:46	Toxicology Personnel	Andrea Gooden
12/09/2013	11:25	Toxicology Location	Tox Evidence Fridge A
12/19/2013	13:15	Toxicology Personnel	Andrea Gooden
12/19/2013	13:15	Toxicology Location	Cooler #2 - Toxicology
04/15/2014	15:06	Toxicology Personnel	Andrea Gooden
04/15/2014	15:22	Toxicology Location	Cooler #2 - Toxicology

1.1 - One grey top tube collected from [REDACTED]

12/06/2013	8:21	Subitem Location	Packaged with Parent
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1.2 - One grey top tube collected from [REDACTED]

12/06/2013	8:21	Subitem Location	Packaged with Parent
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EXHIBIT Q



Houston Forensic Science Center

Forensic Analysis Division
Alcohol Analysis Report
1200 Travis Street, Houston, Texas 77002
Phone: 713-308-2600

The Toxicology Section is accredited by ASCLD-LAB International (17025:2005) and the Texas DPS.

NOT FOR INFORMATION PURPOSES ONLY



Incident/Seq Number: 124796613/4 Analysis Completed: 01/08/2014 Date of Report: 08/15/2014
Forensic Case Number: 13-28695 - 4 Admin Reviewed By: Laura Mayor
Type of Offense: Driving While Intoxicated (DWI) - Unclassified Review Date: 08/15/2014
Location of Offense: 4600 NORTH FWY

Related Individuals:

[Redacted]

Cause Number(s): 1403873

Related Evidence:

Table with 2 columns: Item Number, Description. Row 1: 1 (Blood Specimen(s)) - Two blood vials collected from [Redacted] Inc. #124607913. Row 2: 1.1 (Blood Specimen(s)) - One grey top tube collected from [Redacted]. Row 3: 1.2 (Blood Specimen(s)) - One grey top tube collected from [Redacted].

Results and Interpretations:

If analysis was performed, dual column head space gas chromatography with flame ionization detection was utilized.

This amended report supersedes reports generated before August 14, 2014.

Blood evidence from incident #124607913 with the name [Redacted] was submitted under incident #124796613 with the name [Redacted]. The evidence for incident #124796613 was a breath alcohol test.

This laboratory does not perform breath alcohol testing. Due to this discrepancy, the original report dated 01/10/2014 has been retracted.

Certificate of Analysis

Before me, the undersigned authority, personally appeared Andrea Gooden, who being duly sworn, stated as follows:

My name is Andrea Gooden. I am of sound mind, over the age of 18 years, capable of making this affidavit, and personally acquainted with the facts stated in this affidavit. I am employed by the Houston Forensic Science Center which was authorized to conduct the analysis referenced in this affidavit. Part of my duties for this laboratory involve the analysis of physical evidence for one or more law enforcement agencies. This laboratory is accredited by ASCLD-LAB International (17025:2005) and the Texas Department of Public Safety.

My training and experience that qualify me to perform the tests or procedures referred to in this affidavit and determine the results of those tests or procedures are a Bachelor of Science in Chemistry.

I received the physical evidence listed on this report as stated in the Chain of Custody. On the date indicated above I completed analysis for alcohol using headspace gas chromatography. This is a recognized technique in the scientific community for determining the ethyl alcohol concentration of blood. The tests and procedures used were reliable and approved by the laboratory.



Analyst: [Signature] Andrea Gooden

SWORN TO AND SUBSCRIBED before me on the 15th of August, 2014.

[Signature] Notary Public-State of Texas

Forensic Case Number: 13-28695

Analysis Completed: 01/08/2014

Date of Report: 08/15/2014

Type of Offense: Driving While Intoxicated (DWI) - Unclassified

Admin Reviewed By: Laura Mayor

Location of Offense: 4600 NORTH FWY

Date of Offense: 10/05/2013

Chain of Custody

1 - Two blood vials collected from [REDACTED] (Inc. #124607913).

			Item Collected
10/05/2013	20:23	CER & Property Room	CER Window 25th Floor 1200 Travis
10/09/2013	10:15	CER & Property Room	Crime Lab Vault Refrigerator Aisle 2
10/09/2013	10:42	CER & Property Room	CER Bin for Evidence Release
10/10/2013	8:04	CER & Property Room	CER Bin for Evidence Release
10/10/2013	8:31	Toxicology Personnel	Andrea Gooden
10/10/2013	8:43	Toxicology Location	Tox Evidence Fridge A
10/15/2013	13:09	Toxicology Personnel	Dwan A Wilson
10/15/2013	14:14	Toxicology Location	Tox Evidence Fridge A
10/16/2013	8:08	Toxicology Personnel	Dwan A Wilson
10/16/2013	14:02	Toxicology Location	Tox Evidence Fridge A
12/06/2013	7:52	Toxicology Personnel	Andrea Gooden
12/06/2013	9:05	Toxicology Location	Tox Evidence Fridge A
12/09/2013	7:46	Toxicology Personnel	Andrea Gooden
12/09/2013	11:25	Toxicology Location	Tox Evidence Fridge A
12/19/2013	13:15	Toxicology Personnel	Andrea Gooden
12/19/2013	13:15	Toxicology Location	Cooler #2 - Toxicology
04/15/2014	15:06	Toxicology Personnel	Andrea Gooden
04/15/2014	15:22	Toxicology Location	Cooler #2 - Toxicology
1.1 - One grey top tube collected from [REDACTED]			
12/06/2013	8:21	Subitem Location	Packaged with Parent
1.2 - One grey top tube collected from [REDACTED]			
12/06/2013	8:21	Subitem Location	Packaged with Parent

EXHIBIT R



Houston Forensic Science Center

Forensic Analysis Division
Alcohol Analysis Report

1200 Travis Street, Houston, Texas 77002
Phone: 713-308-2600

The Toxicology Section is accredited by ASCLD-LAB International (17025:2005) and the Texas DPS.

Barcode/ID number



Incident/Seq Number: 124607913/4 Analysis Completed: 08/04/2014 Date of Report: 08/15/2014
Forensic Case Number: 2014-16669 - 4 Admin Reviewed By: Laura Mayor
Type of Offense: Driving While Intoxicated (DWI) - Unclassified Review Date: 08/15/2014
Location of Offense: 1810 Sadler

Related Individuals:

[Redacted]

Related Evidence:

Table with 2 columns: Item Number, Description. Contains 3 rows of blood specimen evidence.

Results and Interpretations:

If analysis was performed, dual column head space gas chromatography with flame ionization detection was utilized.
This report supersedes the reports dated August 4, 2014. Blood evidence from this case was submitted under incident number 124796613. Due to this discrepancy, no results will be reported.

Certificate of Analysis

Before me, the undersigned authority, personally appeared Andrea Gooden, who being duly sworn, stated as follows:
My name is Andrea Gooden. I am of sound mind, over the age of 18 years, capable of making this affidavit, and personally acquainted with the facts stated in this affidavit. I am employed by the Houston Forensic Science Center which was authorized to conduct the analysis referenced in this affidavit. Part of my duties for this laboratory involve the analysis of physical evidence for one or more law enforcement agencies. This laboratory is accredited by ASCLD-LAB International (17025:2005) and the Texas Department of Public Safety.
My training and experience that qualify me to perform the tests or procedures referred to in this affidavit and determine the results of those tests or procedures are a Bachelor of Science in Chemistry.
I received the physical evidence listed on this report as stated in the Chain of Custody. On the date indicated above I completed analysis for alcohol using headspace gas chromatography This is a recognized technique in the scientific community for determining the ethyl alcohol concentration of blood. The tests and procedures used were reliable and approved by the laboratory.



Analyst: [Signature] Andrea Gooden

SWORN TO AND SUBSCRIBED before me on the 15th of August, 2014.

[Signature]
Notary Public-State of Texas

Forensic Case Number: 2014-16669

Analysis Completed: 08/04/2014

Date of Report: 08/15/2014

Type of Offense: Driving While Intoxicated (DWI) - Unclassified

Admin Reviewed By: Laura Mayor

Location of Offense: 1810 Sadler

Date of Offense: 10/04/2013

Chain of Custody

08/04/2014 9:17

08/04/2014 9:17

08/04/2014 9:17

EXHIBIT S

Case Records

A case record will be maintained for each request for analysis accepted by the crime laboratory.

The case record may be comprised of documentation in varied formats. These formats include, but are not limited to:

- paper records
- digital information
- photographs
- electronic data
- microfiche

Case records must be in a retrievable format and must be stored in a secure location and in an environment suitable to prevent damage, deterioration and loss. Case records and copies of case records will be made available to authorized entities only. Authorized entities include, but are not limited to, officers with a legitimate need for the records, internal affairs, prosecuting attorneys and those with valid court orders or subpoenas. Distribution to unauthorized sources is prohibited. All questions related to distribution of records will be directed to **key** management. Records will be kept for at least five years. Records pertaining to DNA testing will be kept for at least ten years. The City of Houston records retention schedule will be followed when disposing of records. When files are removed from storage locations, they will remain in the care, control and custody of laboratory employees.

Electronic case record storage systems are backed up to protect the records and to prevent unauthorized access or amendment of these records. The LIMS database is password protected and backups are stored in a secure data center maintained by the Department.

A. ADMINISTRATIVE DOCUMENTATION:

Administrative documentation includes records such as case related conversations, evidence receipts, description of evidence packaging and seals and other pertinent information.

1. Examples of administrative documents include: subpoenas, evidence receipts, phone logs, court orders, and laboratory reports
2. All administrative documentation received or generated by the Crime Laboratory for a specific case must, at a minimum, contain the HPD incident number or laboratory number.
3. **Because paper-based records may be scanned into the LIMS, the associated incident number must appear on all pages of administrative documentation. It is recommended that staples and double-sided pages not be used.**
4. It is recommended that the date and **handwritten or secure electronic** initials of individuals adding administrative documentation to a case record be recorded.

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5. When data from multiple cases is recorded on a single printout, a unique identifier for each case for which data is generated will be recorded on those printouts.

B. EXAMINATION DOCUMENTATION:

Includes reference to procedures followed, tests conducted, standards and controls used, diagrams, printouts, photographs, observations, and results of examinations

1. Examples of examination documents include: notes regarding test charts, graphs, printouts, photographs, and results of testing.
2. The incident number or lab number and the analyst's handwritten initials or secure electronic equivalent must be on each page of the examination documentation in the case record.
3. Examination documentation will be generated at the time the original observations are made during the course of analysis.
4. It is recommended that when examination documentation consists of multiple pages, a page numbering system indicating total number of pages be used (e.g., page __ of __).
5. When examination documentation is prepared by individuals other than the one who interprets the findings, prepares the report and/or testifies concerning the documentation, the individuals who prepare the documentation must initial their work product and the person preparing the report must initial each page of the associated documentation.
6. When examination documentation is recorded on both sides of a page, each side must be treated as a separate page. **It is recommended that staples and double-sided pages not be used.**
7. Notes, worksheets and other writings in a case record shall be legible and shall be made in ink. Exceptions to this rule may be made when environmental conditions, such as extreme cold or rain, prevent the use of ink. Pencil (including color) may be appropriate for diagrams or making tracings. The use of anything other than ink is subject to the written approval of the section supervisor.
8. While original notes may be recopied on occasion as allowed by section policy, all original notes will be maintained as a permanent component of the case record. Once a secure electronic equivalent is obtained, notes (such as those made at a crime scene) may be destroyed.
9. Changes made to existing hardcopy examination records must be initialed by the person making the change. When striking out information on a case record document, a single line is to be drawn through the error and initialed. Errors will not be erased, made illegible or deleted. In the case of electronic records, equivalent measures will be taken to preserve original data. If an error is found in a report after it has been reviewed and approved, an amended report will be issued. This amended report will document any corrections or changes made to the previous report.

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10. Dates should be recorded throughout the documentation to indicate when the work was performed. At a minimum, beginning and ending dates of analysis will be recorded.
11. When instrumental analyses are conducted, operating parameters must be recorded or cited if already established, and must be retrievable. The incident number or lab number for each case for which data are generated must be appropriately recorded on the printout along with the **handwritten or secure electronic equivalent** initials of the analyst.
12. Examination documentation will be of sufficient detail to support the conclusions reached. Documentation to support conclusions must be such that in the absence of the analyst or the final report, another competent analyst or supervisor could evaluate what was done and interpret the data.
13. Abbreviations and symbols are acceptable in examination documentation if the meanings of the abbreviations and/or symbols are readily comprehensible to a reviewer and the meaning of the abbreviations or symbols are clearly documented in the sectional SOPs. Abbreviations that are common in a discipline and understood by anyone in that discipline do not have to be listed in a table of abbreviations. Examples include, but are not limited to, symbols for chemical elements or standard units of measure.

C. REPORTS:

A lab report is generated for all analytical work performed and is the official document used to provide results of analysis to laboratory customers. This report will contain the conclusions and opinions that address the purpose for which the analytical work was undertaken and should be formatted so as to minimize the possibility of misunderstanding or misuse. Laboratory reports will **typically** be generated by the LIMS. Data entered into EMS or LIMS by laboratory employees will match the information provided on the submission form. Data entered by non-laboratory employees (such as Property Room personnel) will not be changed. If conflicts exist between the information provided on paper submission forms and the data entered by non-laboratory employees, then a comment will be added to the report to reflect the discrepancy. **Alternatively, item descriptions may be properly characterized in reports issued by LIMS without changing information entered by non-laboratory employees.** If it becomes necessary to contact the submitting officer or another officer with knowledge of the case in order to resolve a conflict, then those communications will be documented within the case record.

1. A report is generated when the analysis/examination of exhibits is complete. A signed and reviewed copy of the report, or a secure electronic equivalent, will be stored in the case record as the official laboratory report. In addition, any modifications to the report will be maintained in the case record. Those individuals with Department-recognized log-in and password combinations will have access to electronic reports. Copies of signed laboratory reports may be made available to appropriate individuals.

Questions pertaining to this matter should be directed to the appropriate section manager or designee.

2. For each case, there may be separate reports for each individual and/or section that performs analysis.
3. Only the signed, printed copy of the report, or a secure electronic equivalent, that has completed both technical and administrative review will be considered the finalized, official report.
4. It is recommended that reports be made available to individuals outside the lab only after a technical review of the work performed has been completed.
5. The author of a report must have conducted, participated in, observed, supervised, or technically reviewed the examination or testing.
6. A report of analysis will include the following:
 - a. An appropriately completed header, including a title and the name and address of the laboratory
 - b. The exhibits identified by quantity and description, if requested by the customer. If not specifically requested, information pertaining to the quantity of items analyzed will be available in the case record but does not have to be included in the written report unless the information is necessary for the interpretation of test results. Items that are requested by the customer but not analyzed will be referenced on the report. However, it is not necessary for the report to include a quantity for any item that is not analyzed by the laboratory.
 - c. The findings
 - d. The name and signature of the individual(s) accepting responsibility for the content of the report.
7. When the report contains opinions or interpretations, they will be clearly denoted in the report.
8. Infrequently, results of presumptive testing will not be included in a report, but may be provided informally to an officer as information to aid an on-going investigation. These communications shall be documented in the case record. All verbal results of a technical nature shall be included in the written report. Only the assigned analyst, section supervisor, or supervisor's designee may verbally release results of testing and this release of information must be documented within the case record. This may be done by initialing and dating a communication log or other documentation showing that results were released verbally.
9. If it becomes necessary to amend a signed supplement, then the incorrect report must be documented so as not to be confused with the corrected report. It is recommended that a single line be drawn through the incorrect information. The initials of the employee making the change must also be included. The original, corrected report must be maintained within the case record. If a new report is issued, the new report

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will be uniquely identified, will contain a reference to the original report that it replaces and should clearly state why an amended report was issued.

10. When associations are made, the significance of the association (e.g. "consistent with", "match", "common source") will be clearly communicated in the report. The reason for "inconclusive" results must be clearly stated.
11. The following supporting information, if applicable, will be included in the case record and may be included in the laboratory report: identification of the method(s) used; deviations from the testing method; condition of the items, including outer packaging; reference to the sampling plan or procedures used; the date of sampling; location of sampling; reference to the sampling plan and procedures used; reference to the sampling standard used and any deviations, additions or exclusions to the sampling standard; specific test conditions, such as environmental conditions during sampling that affect the interpretation of results; estimation of uncertainty; a statement that results relate only to items tested; name and address of the customer requesting the laboratory report; evidence disposition; 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; additional information required by the customer.
12. Signed laboratory reports may be sent to appropriate individuals through email, mail, fax or LIMS. Hard copies may also be made available for pick-up at the laboratory.

D. DISPOSITION OF CASE RECORDS:

1. Case records, in which work has been completed, are maintained in designated areas by **incident number or laboratory number.**
2. Printed case records will generally be stored in the 24th floor file room but some case records may be stored within the sections.
3. Documentation should be kept when case records are removed from designated storage areas. These records should show who is taking responsibility for the record while it is outside the storage location.
4. Case records may be scanned into an imaging system for long-term storage in an electronic format. Once the scanned images are of a quality suitable for archiving, the original records may be shredded according to the City's records retention policy. Houston Police Department personnel and City approved vendors may assist with the scanning of records and/or files.
5. Except for those documents pertaining to DNA, records referencing proficiency tests, corrective actions, audits, training, continuing education, and testimony monitoring will be maintained for the length of the accreditation cycle or as long as administratively valuable, whichever is longer. Administrative value is outlined in the laboratory's records retention schedule. Those same records, if pertaining to DNA, will be kept for at least 10 years or the length specified in prevailing quality assurance standard documents.

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6. Court orders for expunction of records will be followed according to Texas Code of Criminal Procedure Chapter 55. See **Disclosure of Information/ Court Orders** for further information.

E. TECHNICAL REVIEWS (TR)

1. A final report does not have to be generated before a technical review can be conducted. This laboratory conducts a technical review on all casework.
2. Every effort will be made to complete the technical review before the final report is released from the laboratory.
3. A technical review is a review of the report(s) to ensure that the conclusion(s) are reasonable and within the constraints of the analysts' scientific knowledge.
4. Technical reviews will be conducted by individuals having expertise gained through training and experience in the discipline being reviewed. An individual conducting the technical review need not be an active analyst or currently being proficiency tested. The reviewer must have sufficient knowledge of the discipline to verify compliance with the laboratory's technical procedures and that conclusions reached are supported by the examination documentation. Experience means that the individual has conducted analysis in the discipline being reviewed.
5. Technical reviews will not be conducted by the author or co-author(s) of the examination records or test report under review.
6. Technical reviews should not be carried out to the extent that it shifts the perceived responsibility for the scientific findings from the analyst to the reviewer.
7. At a minimum, the technical review will include a review of all examination records and the test report to ensure:
 - a. conformance with proper technical procedures and applicable laboratory policies and procedures
 - b. accuracy of test reports and that the data supports the results and/or conclusions
 - c. associations, if any, are properly qualified in the report
 - d. the test report contains required information
8. When an area of concern is identified that cannot be resolved between the analyst and the technical reviewer, it will be referred to the section's technical management for resolution. Even when resolved, sectional management should be notified if technical issues arise. For those sections with only one trained analyst, conflicts arising through case work or proficiency testing will be reviewed by the Director, Quality Manager or a designee. After consultation with the parties involved and, if necessary, other trained individuals, resolution will come from the Director, Quality Manager or a designee.
9. Technical reviews will be documented.

F. ADMINISTRATIVE REVIEWS (AR)

1. Administrative reviews shall be conducted before the final report is issued.
2. The administrative review shall be documented.
3. Administrative reviews may be conducted by any individual following these guidelines. An individual other than the author of the report will complete the administrative review.
4. Administrative reviews are used to check case record documentation and case reports for consistency with laboratory policy and for editorial correctness.
5. Items to be evaluated when performing an administrative review may include, but are not limited to:
 - a. Initials of the appropriate analyst and the incident number or lab number are on each page of examination documentation
 - b. Dates included on examination records to reflect, at a minimum, the beginning and ending dates of analysis
 - c. Page numbering, if required by sectional policies
 - d. Each page of administrative documentation contains the incident number or corresponding lab number
 - e. Spelling

to address this type of concern. (See 4.7 and 4.8)

Customers will be notified if their casework is recalled.

4.10 Improvement

The laboratory continually improves the effectiveness of its management system through the use of quality policies, objectives, audit reports, data analysis, corrective and preventive actions, management reviews, laboratory meetings, proficiency testing, employee performance evaluations, testimony monitoring and/or customer feedback.

4.11 Corrective Action

4.11.1 General

The laboratory may have to correct existing technical or administrative procedures when nonconforming work or departures from management system policies and procedures or technical operations are identified. The Director, quality manager, sectional manager/supervisor, DNA technical leader and (in some instances) the CODIS Administrator may delegate or initiate an investigation into the nature of nonconforming issues. Other individuals may be used as resources based upon their background, position in the forensic community, or skill set, either inside or outside the laboratory. The laboratory's corrective action policy includes:

- Identifying the person responsible for carrying out the corrective action
- Establishing the scope of measures taken
- Notifying customers when reports are amended
- Identifying the root cause of the problem
- Implementing a long-term solution to prevent a recurrence
- Monitoring the effectiveness of the corrective action(s) taken

The purpose of this policy is to maintain and improve the quality of work performed by the laboratory. 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. Efforts are made to maintain confidentiality of the parties involved.

A laboratory Corrective and Preventive Action Form (CAPA) will be completed to address potential nonconforming issues. The form will be forwarded to the sectional manager and/or the quality manager. Action is then taken as needed to address the nonconformance.

4.11.2 Root Cause Analysis

The first step in the corrective action investigation is an effort to determine the root cause of the apparent nonconformance. If the cause is not obvious, an analysis of potential causes will be conducted. The investigator may seek guidance or input from

others during this process.

4.11.3 Selection and Implementation of Corrective Actions

Corrective actions will be taken, where needed, to prevent a recurrence. The appropriate key management is responsible for selecting the corrective action(s) most likely to eliminate the problem. The quality manager and Director have the authority to direct the cause analysis, monitoring, and corrective actions, as necessary to address the problem. Documentation will be maintained to describe the action(s) taken. This information shall be documented on a Corrective and Preventive Action (CAPA) form. The quality manager is given a copy of the CAPA that has been signed by the involved employee(s) and the section manager.

Depending upon the nature of the problem or error, appropriate corrective action(s) may include the following:

- If the error is determined to be in the method, the method may be removed from use on casework, modified, or given other additional controls as necessary. Other cases in which the same method was used may be reviewed.
- If the error is determined to be with an instrument or other equipment used in the test, the error will be corrected and documented. Other cases in which the same instrument or equipment was used may be re-evaluated and appropriate action taken.
- 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. If the original training is determined to be adequate, the review will attempt to identify the specific cause of the problem or error. Actions taken to address personnel issues may be confidential and may be handled by personnel outside of the laboratory (i.e., Human Resources, etc.).
- If the error is determined to be administrative or clerical in nature, the documentation and review process will be studied and revised, if appropriate, to minimize the recurrence of this error.

Corrective actions will be of the appropriate degree and magnitude to correct the problem and reduce the risk of recurrence.

4.11.4 Monitoring Corrective Actions

The section manager, quality manager and/or the Director monitors the results of corrective actions to ensure that the actions taken are effective. Documentation will be maintained to monitor the effectiveness of the action(s). The corrective action

process will be reviewed during the annual management review.

4.11.5 Additional Audits

Key management has the authority to request and/or conduct a special audit if the nonconformance casts doubt on the laboratory's compliance with its own policies, procedures, or with accreditation standards.

4.12 Preventive Actions

4.12.1 All employees are encouraged to monitor work flow, technical procedures, and management system practices for potential improvements or sources of nonconformance.

4.12.2 These opportunities for improvement shall be directed to the appropriate key management for evaluation.

Suggestions received from customers should also be forwarded to appropriate key management.

Preventive actions will be formulated, reviewed and, if approved by the appropriate key management, documented using a CAPA form. Completed CAPA forms will be forwarded to the quality manager. Key management will be responsible for implementing and monitoring its effectiveness. The implementation of the action plan should be communicated to affected employees in a timely fashion. Preventive actions will be evaluated during the yearly management review.

4.13 Control of Records

4.13.1 General

4.13.1.1 A case record is maintained for each request for analysis accepted by the crime laboratory. Effective with the issuance of this manual, case records are identified by the forensic case number. Prior to this, these records may be identified by the forensic case number, agency case number, laboratory number, or other unique identifier.

Quality records, including but not limited to internal audit reports, management reviews, corrective and preventive actions, performance verification, maintenance, and validations are also maintained. These records will be named in such a way to facilitate appropriate filing and storage.

Technical records are examination documents that are of sufficient detail to reproduce or to allow for the review of the examination results. This includes raw data, photographs, worksheets, and case associated notes.

Case specific administrative records include but are not limited to communication logs, chains of custody, submission forms, subpoenas, and discovery requests.

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- 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. If the original training is determined to be adequate, the review will attempt to identify the specific cause of the problem or error. Actions taken to address personnel issues may be confidential and may be handled by personnel outside of the laboratory (i.e., Human Resources, etc.).
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Technical records are examination documents that are of sufficient detail to reproduce or to allow for the review of the examination results. This includes raw data, photographs, worksheets, and case associated notes.

Case specific administrative records include but are not limited to communication logs, chains of custody, submission forms, subpoenas, and discovery requests.

- A review of all administrative records to ensure that the assigned incident number is on each page
- A review of all examination records to ensure that the unique case identifier and analyst initials are on each page
- A review of the report to ensure that all key information (refer to 5.10.2 and 5.10.3) is included

5.9.6 The testimony of applicable crime laboratory personnel is monitored at least once each calendar year. More frequent monitoring may be appropriate for inexperienced personnel. A copy of the completed evaluation form is stored in a retrievable format. Testimony may be monitored through direct observation (preferably by the section supervisor or designee), a review of court transcripts, through solicitation of court officials, videotaped testimony, or other means whereby the following can be evaluated:

- Appearance and poise
- Clarity of communication
- Identification of evidence
- Ability to present scientific information in an easily understood manner
- Consistency of testimony with case documentation
- Performance under cross-examination

The completed evaluation form is reviewed with the witness. The witness is given appropriate feedback, both positive and in any area needing improvement. This review is acknowledged by the witness and reviewer by placement of their signatures on the evaluation form.

If the evaluation indicates the possibility of a serious problem (either with the witness or with a procedure) or the overall presentation is unacceptable, then a corrective action procedure is implemented. The corrective action process may include input from the section supervisor and quality manager, as appropriate. Recommendations for corrective action may include, but are not limited to, communications training, remedial technical training, additional mock court training, or a review of technical procedures or methods. Additional and documented actions are taken as necessary.

5.9.7 Testimony monitoring records are kept for at least one accreditation cycle or five years, whichever is longer. DNA records are kept for at least ten years.

5.10 Reporting the Results

5.10.1 General

The results of testing conducted by the laboratory are reported accurately, clearly, unambiguously, and objectively. These results are reported in the LIMS and include

5.10.9 Amendments to Test Reports

An amended report will be issued when necessary and will clearly communicate the reason for the amendment. If a new report is necessary, the new report will be clearly identified and will contain a reference to the original report that it is replacing.

Amending reports may require the assistance of the laboratory's LIMS administrator.

upon education, training, experience and/or demonstrated skills, as required.

New employees also complete new employee orientation and training if required by the parent agency.

5.2.1.1 Each section of the laboratory has a training program. Newly hired analysts, including contract employees, will complete the appropriate training program and demonstrate competence before beginning casework. Sectional training manuals also include information related to retraining and maintenance of skills.

Training is carried out under the direction of the appropriate key management personnel or qualified designee. Training may include, but is not limited to:

- Review of written materials such as journal articles, books, and in-house procedure manuals
- Laboratory exercises to demonstrate practical skills
- Discipline specific written and/or oral examinations to demonstrate understanding of the scientific subject matter and the laboratory activities associated with it
- Successful completion of a competency test to demonstrate the employee's ability to properly convey results and conclusions and the significance of those results and conclusions

Training may be modified for analysts with previous training and/or experience at another laboratory. However, all analysts, whether previously trained or not, will undergo technical competency testing before beginning casework.

Technical competency can be achieved through the following:

- demonstrated competency
- training
- experience
- casework supervision
- continuing education through professional development
- proficiency testing
- compliance with established scientific protocols and proper professional ethics

The section manager or designee will evaluate the new employee's credentials and modify the training program if applicable. Previous training records summarizing court-qualifications, courses taken, and other supporting documentation will be obtained when practical.

In order to maintain competency, skills, and expertise, analysts are encouraged to participate in continuing education. Section specific continuing education requirements, such as for DNA analysts and CODIS administrators, must be met.

Skills and expertise can be maintained by:

- Attendance at meetings, seminars and conferences
- Participation in scientific working groups
- Review of current and applicable literature
- Presentation and submittal of journal articles
- Presentations at technical meetings
- Participation in college-level and other specialized courses
- Completion of webinars or other on-line training opportunities

Webinars or other on-line training opportunities used to meet DNA continuing education purposes must be approved by the Technical Leader.

Documentation of training is maintained. Documentation will include statements of qualifications and/or resumes/CVs, and records of specialized training received. Transcripts will be maintained for those employees in positions that require a college education.

5.2.1.2 If applicable, analysts will undergo training in the presentation of evidence in court. This will include mock courtroom testimony. Non-analytical employees and those who do not analyze evidence associated with active cases are not required to undergo mock trial training. The mock trial does not have to be conducted before the analyst begins casework. However, whenever possible, the mock trial will be conducted before the analyst testifies in court for the first time.

5.2.2 Key laboratory management formulates goals with respect to the education, training, and skills of laboratory personnel. Laboratory training goals are evaluated in light of present and perceived workload demands during annual management review to align competencies with customers' needs, to promote professional development and to ensure that mandated training is provided. These goals are outlined in each discipline training manual. Training is provided if relevant to present and anticipated tasks of the laboratory and if financially feasible. The effectiveness of in-house training is evaluated by the trainer and/or section supervisor. Effectiveness may be evaluated by meeting stated goals or objectives and through the completion of quizzes, competency tests, oral examinations, and/or proficiency testing.

Trainees are responsible for maintaining a training notebook which includes documentation of goals and objectives, exercises, exams, and other documentation supporting their training activities. Further details may be found in sectional training manuals. Letters of authorization are issued upon successful completion of the section-specific training manual and a competency exam. New letters are issued as an analyst develops new competencies. Competency is evaluated annually through the proficiency testing program. Critical tasks that require competence include, but

EXHIBIT T

HOUSTON FORENSIC SCIENCE CENTER

CORRECTIVE AND PREVENTIVE ACTION REPORT

CHECK IF ADDITIONAL PAGES ARE USED

SECTION 1

Date: Aug 4, 2014

CAPA #: ~~2014-0010~~ ²⁰¹⁴⁻⁰¹¹ 8/11/2014

DESCRIPTION OF ISSUE/NON-CONFORMANCE: A submission was found to have inconsistent information on the samples and evidence packaging relative to the submission paperwork and electronic information in the LIMS and EMS. This was noted by the receiving analyst who also initiated contact with the submitting officer regarding the inconsistency. Another analyst working independently, took the evidence, acknowledged the discrepancy and analyzed the sample. The item itself was labeled that analysis was complete but being held pending a response from the submitter, this was not in the case record. A report was generated, signed and submitted for review by Andrea Gooden. The examination documentation did include a note regarding the discrepancy and had been acknowledged by both analysts involved. The report passed through technical and administrative review without an acknowledgment of the inconsistency.

CLASSIFICATION OF NONCONFORMANCE: see Quality Manual for description CLASS II PREVENTIVE ACTION ONLY

ROOT CAUSE ANALYSIS: A lack of attention to detail allowed a sample to be analyzed and ultimately reported despite the identification of inconsistencies in the submission documentation and the evidence.

PROPOSED CORRECTIVE ACTIONS/RECOMMENDATIONS TO ADDRESS THE DEFICIENCY AND PREVENT RECURRENCE:

The report was withdrawn by William Arnold. It was verified on the day the error was detected that no one had accessed the report and that it had not been disseminated through the report distribution list. Once it was realized that the missing case and the erroneous report were related, all correspondence was placed in the case record by the analyst. This incident, coupled with other performance issues led to retraining of the analyst. Moving forward, reports of analysis will be augmented to include information regarding

SECTION MANAGER: William B. Arnold

Digitally signed by William B. Arnold
DN: cn=William B. Arnold, o=Houston Forensic Science Center, ou=Houston Forensic Science Center, email=William.B.Arnold@houstonforensiccenter.com, c=US
Date: 2014.08.04 11:38:01-0500

Date: Aug 4, 2014

SECTION 2 (MANAGEMENT REVIEW AND RESOLUTION)

FINAL RESOLUTION: The section initiated practices to halt any analysis where there is the possibility that evidence is associated with an incorrect case. This has been incorporated into the Standard Operating Procedure. Inconsistencies are now noted in the final report as standard practice. At the time an inconsistency is detected, an analyst may issue a report stating that an issue has been identified and analysis will not be performed until the issue is rectified. The District Attorney has requested that photographs be collected at the time of evidence receipt. The section is working to identify a practical avenue to make photographs of the evidence available at the time reviews are conducted. Technical and

QUALITY MANAGER:

Southern

Date: 8/4/2014

LABORATORY DIRECTOR:

Arma Riva

Date: 8-4-14

CAPA: 2014-0010
Date: 08/04/2014

Statement Of the Issue

A submission was found to have inconsistent information on the samples and evidence packaging relative to the submission paperwork and electronic information in the LIMS and EMS. This was noted by the receiving analyst who also initiated contact with the submitting officer regarding the inconsistency. Another analyst working independently, took the evidence, acknowledged the discrepancy and analyzed the sample. The item itself was labeled that analysis was complete but being held pending a response from the submitter, this was not in the case record. A report was generated, signed and submitted for review by Andrea Gooden. The examination documentation did include a note regarding the discrepancy and had been acknowledged by both analysts involved. The report passed through technical and administrative review without an acknowledgement of the inconsistency.

Root Cause

A lack of attention to detail allowed a sample to be analyzed and ultimately reported despite the identification of inconsistencies in the submission documentation and the evidence.

Action Steps

The report was withdrawn by William Arnold. It was verified on the day the error was detected that no one had accessed the report and that it had not been disseminated through the report distribution list. Once it was realized that the missing case and the erroneous report were related, all correspondence was placed in the case record by the analyst. This incident, coupled with other performance issues led to retraining of the analyst. Moving forward, reports of analysis will be augmented to include information regarding inconsistencies when they are identified. Of the 447 reports that were reviewed by William Arnold, half will undergo a secondary technical and administrative review. The remaining reports will undergo an administrative review.

Management Review and Resolution

The section initiated practices to halt any analysis where there is the possibility that evidence is associated with an incorrect case. This has been incorporated into the Standard Operating Procedure. Inconsistencies are now noted in the final report as standard practice. At the time an inconsistency is detected, an analyst may issue a report stating that an issue has been identified and analysis will not be performed until the issue is rectified. The District Attorney has requested that photographs be collected at the time of evidence receipt. The section is working to identify a practical avenue to make photographs of the evidence available at the time reviews are conducted. Technical and Administrative reviews are now conducted by multiple members of the section rather than a single individual.

EXHIBIT U

June 26, 2014

RE: Court Testimony Evaluation of Andrea Gooden - 035791513

This evaluation is being offered based upon 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.

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.

As you know, each of us is responsible for our testimony. Every analyst is required to speak the truth and convey the information requested of them in a clear, concise and transparent manner. You did borrow analogies that are used by others for your testimony, but your testimony was your own. It was based upon your understanding of the analysis conducted and the processes involved. Your testimony regarding the processes used by the instrument to detect and quantitate ethanol was good, overall. The following observations made while observing your testimony:

- In your testimony, you stated that photographs were taken after the evidence had been opened, which is correct. However, the photographs are taken just prior to resealing the evidence following analysis. The court was left with the impression that photographs were taken prior to analysis.
- You went on to explain that the calibrators functioned to set the range of the instrument. The linear range is determined during the validation. The calibrators serve to establish a curve inside of the linear range of the instrument. The actual range could exceed the calibration. For clarity, the calibrators establish the range over which values can be reported for a single sequence.
- When asked about the volume of sample analyzed, you responded stating that 100 μ l of sample was used. In response to follow up questions, you clarified that the amount was the equivalent of a drop. Remember to avoid the use of technical terms such as metric volumes where possible. This can remove the need for follow-up questions and makes your testimony easier to follow on the part of the jury.
- In your response to a question regarding the use of salt in each vial, you stated that one gram is added. The amount of salt is only approximate and is not known to be one gram. Enough salt is added to saturate the contents of the vials.
- When asked to explain the function of the internal standard, you explained that it was similar to having a broken speedometer. In actuality, it is the opposite. If you are in a car with a functioning speedometer, you are able to determine the speed of a car relative to your own speed. Like a functioning speedometer, one is able to determine if another vehicle is moving faster, slower or the same speed.



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- When discussing retrograde extrapolation, remember that is not used to calculate an individual's ethanol level at a previous point in time. It is used to estimate a value, not a known value.
- When stating a value in response to a question about concentration, you should state the units.
- Be prepared to discuss the application of the scientific method when asked. You were being asked about a situation where the prediction did not match the expected outcome of the experiment. If that is the case, during analysis you would adapt your hypothesis and pass back through the process. The basic steps are:
 - Question
 - Hypothesis
 - Prediction
 - Experiment
 - Analysis
- Always testify to what you know. If you are speaking about a situation based on experience or assumption, clearly state that this is the basis for your response. Some of the points you testified to were outside your personal knowledge but it sounded as though you were speaking definitively. Some of these are:
 - You cannot know if the police took photographs of the sample prior to submission
 - You do not know the condition of samples at the time they were received from the police; you only have the observations made within our laboratory. Any requirement to record this information would be prior to the evidence passing into the laboratory custody and we do not know what requirements the agency has or does not have. We cannot speak directly to those concerns on the part of the defense.
 - The defense brought up irregularities with the samples and it was stated that the agency should have added additional labels to the tubes. While we may prefer additional labels or particular information, we do not set policy for submitting agencies at this time. We can only set our acceptance criteria. The samples may have been irregular, but did not violate any of our policies.
- When asked if your analysis was in compliance with the Standard Operating Procedures regarding the use of instrumentation, you repeatedly stated that it was. This was not the case since the SOP stated one must use a particular instrument and method. The correct answer would have been 'no'. In actuality, the use of the other instrumentation is allowed by the validation documentation created after the procedure was written. This was the same question you were asked in your mock trial training on a previous occasion. In that instance you eventually responded correctly.
- In a review of your training manual, you confused the new instrumentation (which has a green face plate) with that of the older instrument (with a blue face plate).

Based on your testimony this information is recorded in your training records on the 4th page on November 26, 2012 and November 27, 2012.

- The defense brought up a pipette that had failed calibration verification, #2058. Discussion was also associated with a control prepared on May 30, 2013 by another analyst. This control was 'spiked' on June 2, 2013 by the preparing analyst. Always be prepared to discuss random issues that are brought forth by the attorneys but be forward in stating that the perceived issue is or is not a cause for concern when possible. If you do not have firsthand knowledge of the event, say that you do not.
- Great effort was made to convey that the stopper for the blood tube had been removed at some point between the time of the blood collection and the time the photographs used in court were taken. It was stated that the blood is not in contact with the stopper at the time the tube is opened and that while the sample was mixed, the sample may not have been in contact with the stopper. Be aware blood will adhere to the stopper and that one cannot mix a sample by inversion without bringing the blood into contact with the stopper. When the stopper is replaced, inevitably, blood will become trapped between the vial and the stopper and appears as a red, feathered halo as seen in your photographs. This is the normal appearance of the samples post analysis.
- Questions were posed regarding the chain of custody and apparent inconsistencies associated with the initial steps in the chain of custody. While it is appropriate to state what is on the Chain of Custody if asked, you cannot testify to the validity of a transfer or reasons an item is transferred by an outside agency. While we can state what is recorded in the records, do not try to explain an apparent issue; that is the responsibility of the submitting agency. It is somewhat speculative for us to conclude that an entry in the chain of custody is an error when the record is generated outside our knowledge. We are not responsible for the Property Room's procedures and we cannot speak for them.
- When questioned regarding the alleged contamination of the sample, you stated that the ethanol value would continue to grow if a sample were contaminated. You should review the scientific literature associated with the neo-formation of ethanol in contaminated specimens. This statement is not supported in the literature.
- The blood tubes in casework are child items of the parent. In our system, the chain of custody will simply state that the item is 'Packaged with Parent'. Remember that because of the way LIMS is set, the chain of custody is shared with the parent item unless it is separated and transferred separately. As an option, the chain can show the entire chain for the child items, but that option is turned off due to the excessively long Chain of Custody it creates in many submissions.
- At one point in your testimony, you were asked to calculate the highest value of ethanol concentration an individual could have if three drinks each added 0.020 g/100ml to the blood concentration. Then what would the concentration be after three hours if the individual eliminated at 0.020 g/100ml per hour. You stated that Widmark would have predicted a 0.0068 g/100ml for a male. However, that was not the question being asked. The defense council pointed out that this had nothing

to go with Widmark but you insisted that it 'wasn't fair to not use Widmark'. You should always listen to the question asked and try to answer it accordingly. When clarification is offered, do not insert your own assumptions without verifying your understanding. This point was also made by the prosecutor on your evaluation form they submitted independent of my observations.

As we discussed on May 2, 2014, two days after your court appearance, you must have a thorough understanding of the science and operation of the instrumentation you utilize. In early April we had discussions regarding your foundation of knowledge in blood alcohol analysis. To this end you have been undergoing further training and review in an effort to bolster your existing knowledge and ability to testify. The steps taken include:

- A review of your training performed under the previous manager including studying flashcards, notes and articles
- One on one discussions of the functions of the instrumentation
- A week long court training class
- Additional court appearances with overall positive reviews
- Practice problems to demonstrate your understanding of retrograde extraction and the Widmark equation

These observations are feedback regarding your testimony. It is important to accept feedback without negativity and disagreement. Learn to listen to the feedback of others, objectively discuss any disagreements you may have in an open, objective manner and move forward.

My Signature only acknowledges receipt of this Court Testimony evaluation.

X 
Andrea Gowden 6/27/14



William B. Arnold
Interim Toxicology Manager

HOUSTON POLICE DEPARTMENT
CRIME LABORATORY

TESTIMONY EVALUATION FORM

Name of Witness: Andrea Gooden Date: 5/7/14

Incident Number: 23461413R Court: 3

Evaluator: Catherine Haynes Not Monitored /
For Tracking Purposes Only

- | | | | |
|--------------------------|--|--|------------------------------|
| Appearance: | <input checked="" type="checkbox"/> Acceptable | <input type="checkbox"/> Needs Improvement | <input type="checkbox"/> N/A |
| Courtroom Demeanor: | <input checked="" type="checkbox"/> Acceptable | <input type="checkbox"/> Needs Improvement | <input type="checkbox"/> N/A |
| Qualifications: | <input checked="" type="checkbox"/> Acceptable | <input type="checkbox"/> Needs Improvement | <input type="checkbox"/> N/A |
| Evidence Identification: | <input checked="" type="checkbox"/> Acceptable | <input type="checkbox"/> Needs Improvement | <input type="checkbox"/> N/A |
| Lab Examinations: | <input checked="" type="checkbox"/> Acceptable | <input type="checkbox"/> Needs Improvement | <input type="checkbox"/> N/A |
| Clarity: | <input checked="" type="checkbox"/> Acceptable | <input type="checkbox"/> Needs Improvement | <input type="checkbox"/> N/A |
| Conclusions: | <input checked="" type="checkbox"/> Acceptable | <input type="checkbox"/> Needs Improvement | <input type="checkbox"/> N/A |
| Impartiality: | <input checked="" type="checkbox"/> Acceptable | <input type="checkbox"/> Needs Improvement | <input type="checkbox"/> N/A |

Additional Comments.
(Use a separate sheet if
necessary)

Please identify one area
where the expert might
focus to improve the ability
of the court to understand
complex testimony

[Signature]
Signature of Evaluator

Date reviewed with witness: 5/7/14

[Signature]
Signature of Witness

Total amount of time witness spent in court: 3 hrs

[Signature] 5/12/14
Signature of Laboratory Section Manager

HOUSTON POLICE DEPARTMENT CRIME LABORATORY

TESTIMONY EVALUATION FORM

Name of Witness: Andrea Gaudin Date: 4/29/14
 Incident Number: 035791513 Court: 8
 Evaluator: Araceli Gutierrez Not Monitored /
 For Tracking Purposes Only

- Appearance: Acceptable Needs Improvement N/A
- Courtroom Demeanor: Acceptable Needs Improvement N/A
- Qualifications: Acceptable Needs Improvement N/A
- Evidence Identification: Acceptable Needs Improvement N/A
- Lab Examinations: Acceptable Needs Improvement N/A
- Clarity: Acceptable Needs Improvement N/A
- Conclusions: Acceptable Needs Improvement N/A
- Impartiality: Acceptable Needs Improvement N/A

Additional Comments:
 (Use a separate sheet if necessary)

Great job testifying especially given how long she had to be in the courtroom & that it was not first time testifying.

Please identify one area where the expert might focus to improve the ability of the court to understand complex testimony.

Do not testify about calculations unless asked to do so or the court asks you to. Be comfortable during the calculation regarding answering that question. It's OK to say I don't know.

Signature of Evaluator: _____
 Signature of Witness: _____
 Signature of Laboratory/Section Manager: _____

Date reviewed with witness: 5/15/14
 Total amount of time witness spent in court: 7 hrs.

EXHIBIT V



Houston Forensic Science Center

INTEROFFICE MEMO

To: Andrea Gooden, Forensic Analyst
From: William B. Arnold, Acting Director of Information Technology
cc: Caresse Young, Director of Human Resources
Irma Rios, Director of the Forensic Analysis Division
Lori Wilson, Acting Director of Quality Assurance
Date: 8/4/2014
Re: Return to Alcohol Casework

In early April you prepared a PowerPoint at the request of a district attorney for use in court testimony. While reviewing your proposed presentation I took the opportunity to review various facets of this type of analysis with you. At that time, there were basic questions you were unable to answer. Our conversation caused me to question your ability to convey the information and also your understanding of the concepts associated with this type of analysis. We went to the laboratory and reviewed the function and operation of Headspace Gas Chromatography using the Perkin Elmer equipment. This included a review of the parts and function of the headspace and gas chromatograph.

It was at this time, I questioned your knowledge base. I had the opportunity to review some of your analytical 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. At that time, the prudent choice was to gather additional information before making any determination regarding your capabilities.

On April 15, 2014 it was found that a report had been generated for evidence submitted under incorrect case information. The report was withdrawn and it was verified on that day that the report had not been sent outside the laboratory. Based upon the records in the LIMS, no one ever viewed or downloaded the information remotely through the web-based system. The detection of this error, coupled with my previous observations led to your suspension from casework.

On April 30, 2014, you offered testimony in an unrelated case where you performed blood alcohol analysis. We discussed your testimony on May 2, 2014 and we covered many of the issues I perceived with your testimony in my office. Ultimately, the evaluation was codified into a written document for your review. On June 13, 2014 we had the first of several meetings regarding your performance with the Director of Human Resources. At this time, you stated that you refused to read the written, draft review that had been given to you prior to that meeting. On June 16, 2014 you generated a memo which states that you did not understand why you had been

taken off casework. We met again on June 19, 2014 and you expressed that you did not agree with the information. On June 24, 2014 you stated that you understood that the contents of the review were my opinion and that you did not have a problem with the contents. We also reviewed our discussion from early April and the timeline of events and meetings to that date. At this time, you acknowledged the steps that had been taken to assist you in your development but stated that you had not taken my efforts to address your performance seriously.

Over this time frame, several steps were taken to bolster your existing knowledge and performance. These include:

- A review of your training performed under the previous manager including studying flashcards, notes and articles
- One on one discussions of the functions of the instrumentation
- A week long court training class
- Additional court appearances with overall positive reviews
- Practice problems to demonstrate your understanding of retrograde extraction and the Widmark equation
- An additional mock court with participation by the District Attorney's Office
- A written exam
- You were provided a digital recorder with which you can review and practice your responses to questions
- Additional readings regarding the variations in absorption rates of alcohol in individuals

Through this period of time, you have repeatedly articulated that you did not understand why you were removed from casework. During your court testimony monitoring, you repeatedly sighed and on occasion even challenged the individuals assisting you with your training in the mock court.

Based upon the review of your written exam, practice calculations, mock court training, additional court experience and personal discussions you were released to perform casework on July 28, 2014. As stated in the e-mail, any alcohol casework you perform is to be reviewed by me until further notice even though the technical and administrative reviews may have been completed by others.

Please be assured, that the quality of the work product of this laboratory is a very serious matter. Our work directly impacts the lives of those we serve. Although this incident did not have any impact in the judicial system, it serves as a reminder to all of us of the gravity of the work we perform and potential harm that could be inflicted. As a member of our team, you are expected to engage in your own professional development rather than resist constructive efforts that are made on your behalf. An additional written evaluation will be compiled for the date range of July through September. It is imperative to your success that you develop a positive attitude and work to further your knowledge base and testimony skills.

Analyst refused to
sign as of 8/6/14,
[Signature]

8/11/14
I acknowledge that
I received but do not agree
w/ all contents of the memo
[Signature]

EXHIBIT W



Houston Forensic Science Center

INTEROFFICE MEMO

To: Lori Wilson, Quality Director
Houston Forensic Science Center

From: Jackeline Moral, Quality Specialist

Date: September 5, 2014

Re: CAPA #2014-011 and CAPA #2014-016

As a result of CAPA # 2014-011 and 2014-016, 142 (26%) of 544 case records from the Toxicology section were reviewed by the Quality Division. The case records selected were administratively and technically reviewed by the acting Toxicology section manager within the timeframe when this event occurred. The purpose of this case record review was to evaluate the acting Toxicology section manager's case record review process within the CAPA's timeframe to determine if this was a one-time occurrence.

Neither major administrative issues nor suspect name and/or incident discrepancies were noted in the reviewed case records. Minor administrative findings were noted and are included and delineated in the next section of this report.

Minor Administrative Findings

Administrative findings found during the case record review process pertained to QA manual clause 4.13.1.1, 4.13.2.8 and 4.13.2.4 which are delineated below.

4.13.1.1 A case record is maintained for each request for analysis accepted by the laboratory. Effective February 1, 2014, case records will be identified by the forensic case number. Prior to this, these records may be identified by the forensic case number, agency case number, laboratory number, or other unique identifier.

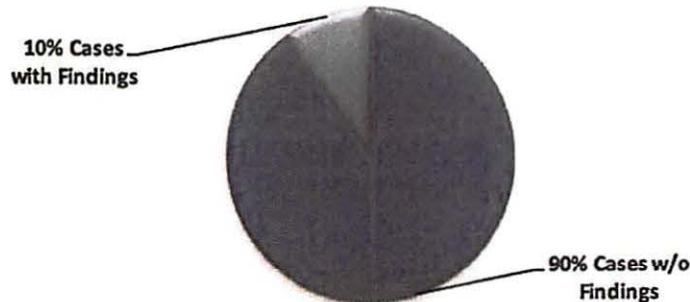
4.13.2.8 All administrative records received or generated by the laboratory for a specific case must include the unique case identifier and the identity of the individual adding the information to the case record.

4.13.2.4 Administrative documentation must contain the case number associated with the analysis. Examination documentation must contain the case number and the identity of the examiner. Laboratory generated examination records will be page numbered using a system that indicates the total number of pages.

Administrative documents from a variety of cases assigned a Forensic Case Number after February 1st, were only identified by the submitting agency's incident number. Per clause 4.13.1.1, all case record documentation will be identified by the forensic case number. Another finding for clause 4.13.2.8 was that in some instances the person adding administrative documentation to the case record was not identified. Technical records generated within the laboratory need to have a page numbering system that indicates the total number of pages within the case, in some cases this page numbering system was not observed.

After the review process was completed all findings were corrected by the appropriate analyst. There were some case records that were corrected by another analyst because the original assigned analyst is no longer employed by the HFSC. But this was noted in the case record review form. Statistics Data for these case record reviews are shown on graph 1.

Case File Review Statistics



Graph 1. Statistics on Case Record Findings

Conclusion

The Quality Division did not find any major findings or discrepancies that would question the review process for the Acting Toxicology section manager. After the review process was completed all minor findings were corrected in the case file by the analyst. In addition, the section has implemented an evidence rejection system which was also incorporated into their SOP. By policy, any major discrepancies or inconsistencies such as incorrect incident numbers and/or suspect names are noted in the case record and the evidence is returned to the property room. Once corrections are made by the customer, the section will move forward with the requested analysis. A report is also generated stating the inconsistencies found in the case by the analyst.

Additional case record review will be completed if requested by the Texas Forensic Science Commission and/or ASCLD/LAB.

Lori
Wilson

Signature Required by Commission
2011-01-01 10:00 AM
2011-01-01 10:00 AM
2011-01-01 10:00 AM
2011-01-01 10:00 AM
2011-01-01 10:00 AM

Jackeline Moral
Jackeline Moral, Quality Specialist

EXHIBIT X

HOUSTON FORENSIC SCIENCE CENTER

CORRECTIVE AND PREVENTIVE ACTION REPORT

CHECK IF ADDITIONAL PAGES ARE USED

SECTION 1

Date: Aug 4, 2014

CAPA #: 2014-016

DESCRIPTION OF ISSUE/NON-CONFORMANCE: A CAPA was not resolved promptly on a Tox report that had a discrepancy on the source of a blood sample on the submission form and the evidence. This issue was brought to the attention of management and was not addressed using the CAPA process. Reference Quality Manual Section 4.9 Control of Nonconforming Testing Work

The CAPA was not tracked nor resolution finalized through the quality system.

CLASSIFICATION OF NONCONFORMANCE: see Quality Manual for description CLASS III

PREVENTIVE ACTION ONLY

ROOT CAUSE ANALYSIS: Some of the issues preceding the first event include the fact that the Tox manager had recently resigned and an interim manager, who is also the acting IT Director due to the formation of the new Houston Forensic Science Center, was overseeing the section including conducting some of the tech and administrative review of blood alcohol cases. While the interim manager is knowledgeable in toxicology, his oversight of the section was diminished by his other IT related duties. This could have resulted in not issuing and following up with a CAPA promptly and not following up with the correction of the lab report by the analyst in a timely manner.

PROPOSED CORRECTIVE ACTIONS/RECOMMENDATIONS TO ADDRESS THE DEFICIENCY AND PREVENT RECURRENCE:

Management staff members were reminded of CAPA submission via email on 8/4/14. Immediately implemented one week follow up reminder on director's calendar when a CAPA is brought to her attention.

SECTION MANAGER:

William B. Arnold

Date: Aug 4, 2014

SECTION 2 (MANAGEMENT REVIEW AND RESOLUTION)

FINAL RESOLUTION: Additional staff have been hired both in the toxicology and quality assurance units to function in an oversight capacity. Mr. Donald Dicks was hired and functions as a lead in the Toxicology section.

The Quality Assurance Unit at the time of the event had one manager and one quality assurance criminalist. Ms. Jackie Moral was hired to assist the Quality Assurance Manager in quality related functions on June 30, 2014. Another Quality Assurance Specialist is expected to be employed on September 8, 2014.

QUALITY MANAGER:

Son Webm

Date: Aug 4, 2014

LABORATORY DIRECTOR:

Chun Rio

Date: Aug 4, 2014

August 4, 2014 CAPA #2014-016

Root Cause Analysis Continuation:

The lack of issuance of the CAPA number and follow up by the Quality Assurance manager appears to be an oversight.

Management Review and Resolution Continuation:

As previously stated, CAPA review with management staff was conducted on 8/4/14. Lastly a calendar reminder on any CAPA was immediately implemented by the Forensic Analysis Division Director on her calendar. A total of five additional quality assurance specialists were added to this years' budget to implement various quality control measures throughout the seven disciplines and the Crime Scene Unit of the Houston Forensic Science Center.

EXHIBIT Y



HOUSTON FORENSIC SCIENCE CENTER
ADMINISTRATIVE POLICY MANUAL

POLICY NAME:	<u>Progressive Corrective Action</u>	ISSUED BY:	<u>Human Resources</u> (Division Name)
APPROVED BY:	<u>[Signature]</u> (Signature of Division Director) <u>Director of Human Resources</u> (Title)	APPROVAL DATE:	<u>11-24-14</u>
APPROVED BY:	<u>[Signature]</u> (Legal Approval Signature as applicable) <u>Acting General Counsel</u> (Title)	APPROVAL DATE:	<u>11-25-14</u>
APPROVED BY:	<u>[Signature]</u> (Signature of President and CEO) <u>President and CEO</u>	APPROVAL DATE:	<u>11-25-14</u>

Policy Statement

Houston Forensic Science Center (HFSC) is committed to providing excellence in forensic science services to its customers in a cost-effective and timely manner while maintaining the highest levels of integrity and professionalism. When improvement is necessary to maintain standards of behavior and performance, it shall be the policy of HFSC to administer such corrective action fairly and consistently in accordance with positive correction techniques.

Purpose

The purpose of the progressive corrective action policy is to establish procedures for addressing the need for improvement in behavior and/or performance of employees of and civilians managed by HFSC.

Definitions

Civilian -- a person providing services to and under the management responsibility of HFSC, but employed by the City of Houston in a job classification other than a sworn peace officer.

Policy Number: 11B1
Revision Date: November 24, 2014
Uncontrolled When Printed

Author: Caresse Young
Replaces Policy No.: N/A

Decision-Making Leave – one paid leave day granted an employee/civilian to consider whether to resign or commit to full compliance during a 12-month probationary period.

Employee – a person compensated directly by Houston Forensic Science Center; a person on the payroll of HFSC.

Human Resources/ Human Resource Director -- As used in this policy, refers to the Human Resources Division and the Human Resource Director of HFSC.

Responsibilities

- A. Division Directors/Executive Administration – Division directors and members of executive administration are responsible for providing management review and oversight to the progressive correction action process. Final corrective action decisions are those of the employee/civilian's supervisor/manager with the concurrence of the division director. The President and CEO shall approve any progressive correction at the Written Conference level or above.
- B. Supervisors/Managers –Supervisors/managers are accountable for timely, fair and consistent administration of all guidelines, policies and procedures. Supervisors and/or managers are responsible for ensuring that all their direct reports receive copies of this policy. Final corrective action decisions are those of the employee/civilian's supervisor/manager with the concurrence of the division director. The President and CEO shall approve any progressive correction at the Written Conference level or above.
- C. Human Resources – Human Resources shall be consulted on every issue that has the potential to result in any level of progressive corrective action. The Human Resource Director and/or Human Resource Generalist are responsible to provide advice and counsel to employees and management regarding the progressive correction process, to guide and facilitate the process, and to review any corrective action at the Written Conference level or above prior to presentation to an employee or civilian. Human Resources may also be responsible to investigate.
- D. Employees/Civilians – Employees and civilians are responsible and accountable for their own performance, attendance, punctuality, behavior and safety habits, in accordance with good judgment and HFSC standards.

Procedures or Guidelines

- A. When the behavior or performance of an employee or civilian is inappropriate or does not meet standards, the supervisor/manager, with the assistance of HR takes positive corrective action steps. The severity of the action will determine the specific action.
- B. After the employee or civilian's supervisor/manager becomes aware of an issue that needs to be addressed, he/she shall meet with Human Resources about appropriate positive correction.

- C. The following progressive correction steps are guidelines. Corrective action need not be taken in order since the severity of the conduct may warrant a higher or lesser degree of corrective action.
- 1) **Coaching** – An informal meeting in which the supervisor/manager provides guidance, counseling or retraining to the employee to assist with the issue.
 - 2) **Written Conference** – Should the conduct be more serious than appropriate for a coaching, or if coaching has been unsuccessful, a documented Conference may be appropriate.
 - 3) **Decision-Making Leave** – Should the conduct be more serious than appropriate for lesser corrective options, or should the employee/civilian be unsuccessful in correcting behavior/performance, the employee/civilian will be provided a one-day paid leave to consider whether to commit to full compliance or to resign. If he/she decides to commit to compliance, a 12-month probationary period will follow. Inappropriate behavior or performance during this probation shall result in an employee's termination or a civilian's return to the City of Houston.
 - 4) **Investigative Leave** – An employee or civilian may be placed on paid leave pending the outcome of an investigation and required to spend work hours at home reporting in daily.

Compliance

Compliance with the Progressive Corrective Action Policy is an on-going requirement; each staff member is accountable to ensure his/her compliance to the stated guidelines.

Applicability

This policy applies to all exempt and non-exempt employees of HFSC and to civilian employees of the City of Houston managed by HFSC. Executive level employees, student interns, and temporary employees may be extended the positive corrective action process at the discretion of HFSC.

This policy is intended to compliment and coordinate with the First Interlocal Agreement between the City of Houston and Houston Forensic Science Center. In the event of a conflict between this policy and Section 6.03 of that agreement, Section 6.03 shall control.

EXHIBIT Z

December 9, 2014

Ms. Lynn Garcia
General Counsel
Texas Forensic Science Commission
1700 North Congress Avenue Suite 445
Austin, TX 78701



HOUSTON FORENSIC
SCIENCE CENTER
1200 Travis St., 20th Floor
Houston, TX 77002
(713) 929-6760

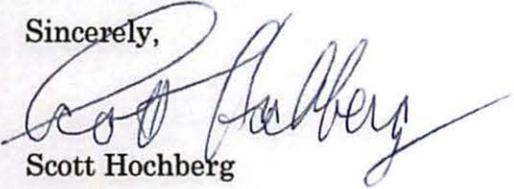
Dear Ms. Garcia:

The Board of the Houston Forensic Science Center, Inc. continues to review the complaint under investigation by TFSC (designated by TFSC as number 14-13). While the Board awaits the report from the City of Houston Office of Inspector General, as well as the TFSC's report, the Board has directed the Center's management to make several policy changes and has supported other actions initiated by management.

- 1.) At the Board's public meeting on September 12, 2014, the Board approved Dr. Garner's recommendation that a contract be executed with NMS Labs for technical and managerial support for the toxicology section. That contract is now in place and NMS personnel are working on site.
- 2.) At the Board's public board meeting on October 10, 2014, the Board directed that a process be developed to officially notify Houston Police Department management of irregularities in evidence submissions to the Center such as the one that led to this complaint. At the Board's subsequent public meeting on November 14, Dr. Garner informed the Board that he had initiated discussions with HPD executive management to develop this process.
- 3.) Also at the Board's October meeting, the Board directed that a process be developed to promptly notify the appropriate District Attorney's office of any such evidence irregularities as they are discovered. Dr. Garner has reached out to the Harris County District Attorney's office regarding this process.
- 4.) At the same meeting, the Board was briefed on the progress of the development of the Progressive Correction Action Policy. The Board encouraged completion of the policy, and assigned one of the board members who has extensive experience in governmental employment law to work with the staff on this. I understand you have recently been provided with a copy of the completed policy, which is now in place.

The Board will have further discussions upon receipt of the report from the OIG and as any new information becomes available. I will inform you of any additional resulting Board action that it believes relevant to your agency's investigation.

Sincerely,

A handwritten signature in black ink, appearing to read "Scott Hochberg", written in a cursive style.

Scott Hochberg
Chair
Board of Directors

Cc: Board members

Cc: Dr. Daniel Garner

EXHIBIT AA



HFSC Hires Chief Operations Officer

January 15, 2015

FOR IMMEDIATE RELEASE

CONTACT INFORMATION:

Ramit Plushnick-Masti

Public Information Officer

media@houstonforensicscience.org

713-929-6768

The Houston Forensic Science Center has hired Dr. Peter Stout as the corporation's first Chief Operations Officer. Dr. Stout most recently served as a senior research forensic scientist and director of operations in the Center for Forensic Sciences at RTI International, an independent not-for-profit research institute in North Carolina. Dr. Stout has more than 15 years of experience in the forensic sciences and forensic toxicology. During his career, Dr. Stout has managed commercial and government organizations through periods of change and helped them adapt to new financial structures, expertise that will help the Center as it continues to expand its revenue streams and business model.

At RTI, Dr. Stout was responsible for managing a portfolio that included commercial, federal and state grants and contracts. He also oversaw strategic and business development.

Dr. Stout finished his recent term as president of the Society of Forensic Toxicologists at the end of December. In that role, Dr. Stout has represented the Society with the Consortium of Forensic Science Organizations and been involved on the national level in the policy debate regarding the future of forensic sciences in the United States. Dr.

Stout has testified before state legislative committees and spoken before state and national gatherings on this issue.

All of these skills will be of great help to HFSC as it moves forward on a path of independence and expansion, helping it become a model to other forensic facilities nationwide seeking to improve the way they do business.

Dr. Stout and his wife and three boys will be relocating from their home in North Carolina to Houston as he takes on his new role with HFSC. He will officially begin working for the corporation on Feb 15, 2015.

Houston's forensic operations, formerly known as the Houston Police Department Crime Lab, have been managed by Houston Forensic Science Center, Inc., since April 3, 2014.

HFSC is overseen by a board of directors appointed by the Mayor of Houston and approved by the Houston City Council. HFSC manages the independent forensic operations that currently operate in eight disciplines.

Further information regarding HFSC is available at www.houstonforensicscience.org.

Follow us on Facebook <http://on.fb.me/1x1zap2>

Follow us on Twitter <https://twitter.com/HoustonForensic>

EXHIBIT BB



HOUSTON FORENSIC SCIENCE CENTER
ADMINISTRATIVE POLICY MANUAL

POLICY NAME: Policy Regarding Communications with Third Parties	ISSUED BY: Daniel D. Garner, Ph.D. Chief Executive Officer
APPROVED BY: <u>[Not Applicable]</u> (Signature of Division Director)	APPROVAL DATE: _____
_____ (Title)	
APPROVED BY: <u>[Signature]</u> (Legal Approval Signature, if applicable)	APPROVAL DATE: <u>12-18-2014</u>
<u>Acting General Counsel</u> (Title)	
APPROVED BY: <u>[Signature]</u> (Signature of Corporation's CEO)	APPROVAL DATE: <u>12-19-14</u>
EFFECTIVE DATE: <u>12-22-14</u>	REVIEW DATE: _____

Policy Statement

It is the policy of the Houston Forensic Science Center (“HFSC” or the “Corporation”) that information about the Corporation is factually accurate and communicated in a manner that is candid, timely, and in compliance with applicable law.

Purpose

To ensure that information about HFSC conveyed by persons associated with the Corporation to third parties is factually accurate and communicated in compliance with applicable law.

Definitions

In addition to other definitions appearing herein, for the purposes of this Policy each term listed below has the meaning stated.

Accrediting Entity means an entity whose accreditation of a forensic laboratory is a prerequisite to the laboratory’s accreditation by the Texas Department of Public Safety (“DPS”). *See*

Policy Number: _____
Revision Date: _____
Uncontrolled When Printed

Author: _____
Replaces Policy No.: _____

<https://www.txdps.state.tx.us/CrimeLaboratory/LabAccreditation.htm>. Examples of such entities include FQS and ASCLD/LAB. For the purposes of this Policy, *Accrediting Entity* includes DPS and any person acting under the authority of, or on behalf of, an *Accrediting Entity*.

CEO means the Chief Executive Officer of the Corporation.

Civilian means a person providing services under the management responsibility of HFSC but employed by the City of Houston in a job classification other than a sworn peace officer.

Classified means a person providing services under the management responsibility of HFSC but employed by the City of Houston in a sworn peace officer job classification.

Company Information means substantive information regarding HFSC's agreements, budgets, contracts, decisions, equipment, events, facilities, finances, funding, history, operations, personnel, plans, policies, procedures, records, services, test results, or any other substantive information related to any activity of the Corporation. *Company Information* includes electronic data or physical things from which substantive information related to an activity of the Corporation may be obtained or inferred. A Staff Member should presume that *Company Information* is confidential unless the information is generally known to persons not affiliated with the Corporation.

Employee means a person directly employed by and on the payroll of HFSC.

IAD means the Internal Affairs Division of the Houston Police Department, which Division may investigate certain complaints regarding the Corporation or a *Staff Member*. For the purposes of this Policy, *IAD* includes any person acting under the authority of, or on behalf of, *IAD*.

Investigative Entity means an entity legally authorized to investigate allegations of negligence or misconduct by the Corporation or a *Staff Member*. See, e.g., TEX. CODE CRIM. PROC. art. 38.01 (authorizing Texas Forensic Science Commission to investigate "any allegation of professional negligence or professional misconduct that would substantially affect the integrity of the results of a forensic analysis conducted by a crime laboratory"). Examples of *Investigative Entities* include the U.S. Equal Employment Opportunity Commission, the Texas Forensic Science Commission, the Texas Workforce Commission, *IAD*, and *OIG*. For the purposes of this Policy, *Investigative Entity* includes any person acting under the authority of, or on behalf of, an *Investigative Entity*.

Legal Request is a written or electronic *Third-Party Request* that reasonably appears to be (a) the lawful order of a court having jurisdiction over HFSC; (b) a lawful subpoena for the testimony (whether live or by affidavit) of a particular *Staff Member*; (c) a lawful subpoena for documents, data, or things within HFSC's possession, custody, or control; (d) a lawful discovery request made pursuant to Article 39.14, Texas Code of Criminal Procedure; (e) a lawful discovery request submitted in connection with civil litigation (interrogatories, requests for production, requests for admissions, requests for deposition on written questions, or similar methods of civil discovery); (f) a request from an *Accrediting Entity* for *Company Information*; or (g) a request from an *Investigative Entity* for *Company Information*.

Policy Number: _____
Revision Date: _____

Author: _____
Uncontrolled When Printed

OIG means the Office of Inspector General of the City of Houston, which Office pursuant to an agreement with HFSC may investigate certain complaints regarding the Corporation or a *Staff Member*. For the purposes of this Policy, *OIG* includes any person acting under the authority of, or on behalf of, *OIG*.

PIA Request is a written or electronic *Third-Party Request* that reasonably appears to have been made to HFSC pursuant to the Texas Public Information Act (Chapter 552, Texas Government Code). See https://www.texasattorneygeneral.gov/AG_Publications/pdfs/publicinfo_hb.pdf.

Staff Member means any person who is a *Civilian, Classified, Employee*, temporary employee, intern, or volunteer of the Corporation.

Third Party means any entity or person other than a *Staff Member* and HFSC's Directors and Officers.

Third-Party Communication means a transmission in any form by a *Staff Member* of *Company Information* to a *Third Party* and any response(s) from the *Third Party* to the *Staff Member*.

Third-Party Request means a request in any form from a *Third Party* either to a *Staff Member* or to the Corporation for *Company Information*.

Responsibilities

1. Members of the Corporation's executive administration are responsible for (a) overseeing the administration of this Policy and (b) ensuring the Corporation responds to Third-Party Requests in a candid, timely manner.
2. The Corporation's division directors, supervisors, and managers are responsible for (a) ensuring their direct reports receive copies of this Policy; (b) administering this Policy on a day-to-day basis, with assistance from the Corporation's public information officer and legal counsel as needed or advisable; and (c) helping to ensure the Corporation responds to Third-Party Requests in a candid, timely manner.
3. The Corporation's public information officer and legal counsel are responsible for providing advice and guidance to all Staff Members regarding the application of this Policy.

Procedures

1. A Staff Member who receives a PIA Request on paper (whether by mail, delivery, or fax) shall promptly record the date and time of the document's receipt on the face of the document, scan the document to a PDF format, and email the scanned document to pia@houstonforensicscience.org.

Policy Number: _____
Revision Date: _____

Author: _____
Uncontrolled When Printed

2. A Staff Member who receives a PIA Request by email or other electronic means shall promptly forward the request to pia@houstonforensicscience.org.
3. Unless instructed otherwise by the Corporation's public information officer, a Staff Member should not attempt to respond directly to a PIA Request.
4. A Staff Member who is a complainant to an Accrediting Entity or an Investigative Entity need not comply with Procedure Nos. 5 through 8 below, *to the extent that* the subject of the communication is directly related to the Staff Member's complaint. The Corporation requests – but does not require – that the complainant provide the CEO promptly with a copy or a summary of the complainant's Third-Party Communications with an Accrediting Entity or an Investigative Entity.
5. A Staff Member who receives a Legal Request on paper (whether by mail, delivery, or fax) shall promptly record the date and time of the document's receipt on the face of the document, scan the document to a PDF format, and email the scanned document to legal@houstonforensicscience.org.
6. A Staff Member who receives a Legal Request by email or other electronic means shall promptly forward the request to legal@houstonforensicscience.org.
7. A Staff Member who receives a Legal Request in person or by telephone shall promptly send an email to legal@houstonforensicscience.org stating (a) the date and time of the request; (b) the identity of, and contact information for, the person who made the request (to the extent known); and (c) a brief summary of the substance of the request.
8. Unless permitted by this Policy or instructed otherwise by the CEO, a Staff Member should not attempt to respond directly to a Legal Request.
9. Notwithstanding Procedure No. 8 above, a Staff Member who receives a subpoena for his or her live testimony shall promptly (a) advise his or her supervisor of the subpoena and (b) follow Procedure Nos. 5 and 6 above. The person subpoenaed should use his or her best good-faith efforts to comply with the subpoena, *provided that* such compliance does not conflict with an instruction from the person's supervisor or with a written policy or procedure of the Corporation.
10. Notwithstanding anything to the contrary in this Policy, any Staff Member may convey Company Information to a person or entity supplying services to the Corporation pursuant to a written contract, *provided that* (a) the person or entity is not an Accrediting Entity or an Investigative Entity, in which case Procedure Nos. 5 through 7 will apply; (b) the Staff Member obtains permission from his or her supervisor to convey the Company Information; and (c) the Company Information conveyed reasonably appears to be necessary for the performance of the contract.

11. Notwithstanding anything to the contrary in this Policy, any Classified may provide Company Information as necessary to comply with a direct order from a current member of the Houston Police Department with a rank of Captain or above.
12. In the event of a conflict between this Policy and the Corporation's Quality Assurance Manual (the "Quality Manual"), the Quality Manual shall control. In particular, nothing in this Policy shall be construed in a manner inconsistent with Paragraph 4.13.1.3 of the Quality Manual (confidentiality of information) or with the Corporation's Code of Ethics.
13. Notwithstanding anything to the contrary in this Policy, any Staff Member may provide a copy of this Policy to any person.

Compliance

Compliance with this Policy is an on-going requirement for all Staff Members. A circumstance from which a reasonable person would conclude this Policy may have been violated shall be reported promptly to the CEO or the CEO's designee.

Applicability

This Policy applies to every Staff Member.

Policy Number: _____
Revision Date: _____

Author: _____
Uncontrolled When Printed

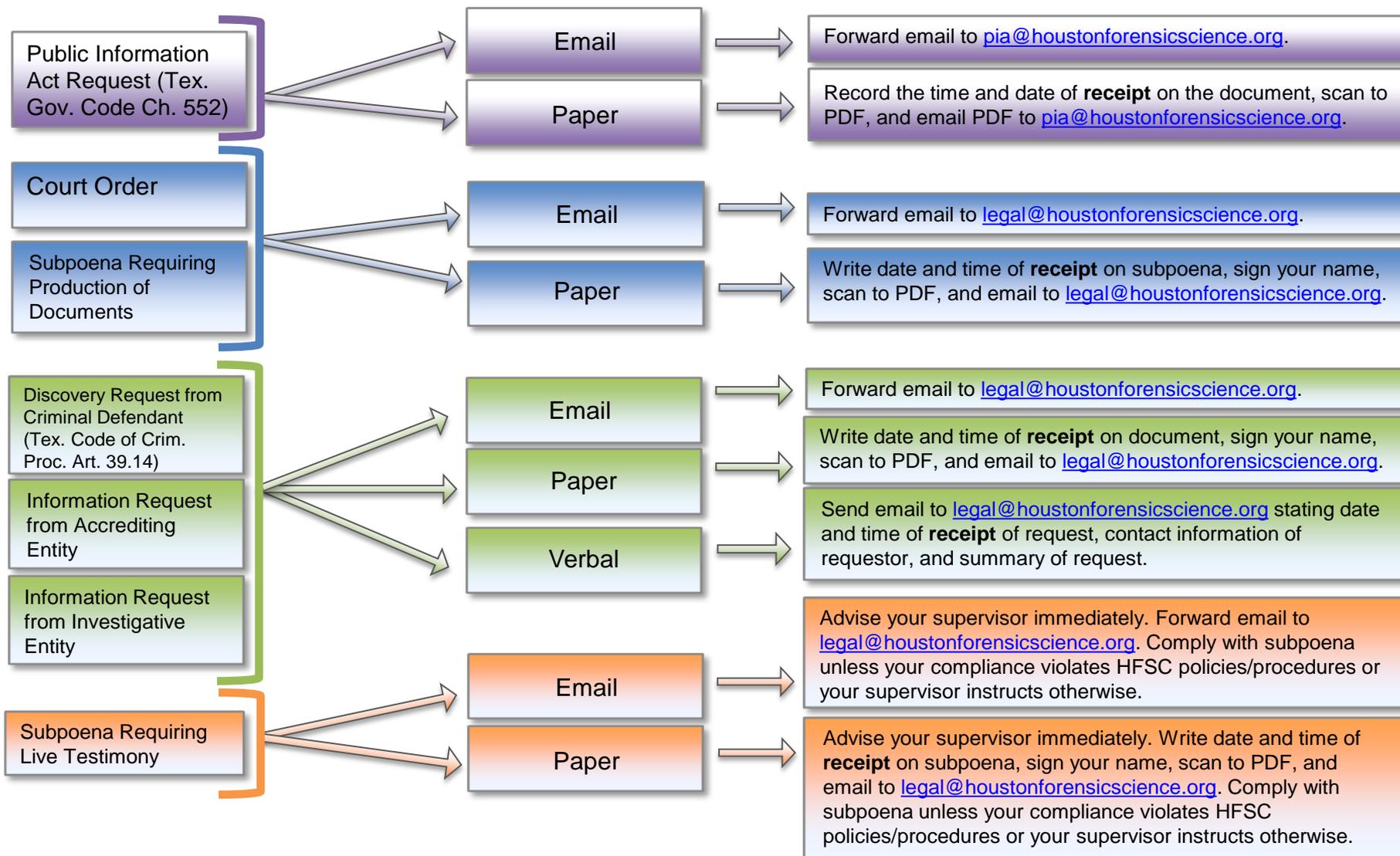
Responding to Third-Party Requests



Type of Request

Medium of Request

Procedure



NOTE: Terms in this document are defined in HFSC's Policy Regarding Communications with Third Parties. Complainants to an Accrediting Entity or Investigative Entity should consult the Policy regarding exceptions to the above procedures.