Quality Division Use Only

Quality Tracking #:	2018-031	**Classification:**	Incident
Non-Conformance Level:	N/A	**Section:**	Client Services & Case Management
Date of Discovery:	05/29/18	**Date of Incident:**	05/17/18

Forensic Case Number(s), if applicable:	Agency Case Number(s), if applicable:
2018-06759 2018-06761 2018-06814 2018-06815 2018-06820 2018-06813 2018-06767 2018-06812 2018-06811 2018-06818 2018-06819 2018-06817 2018-06911 2018-06926 2018-06906 2018-06910 2018-06560 2018-06758 2018-06760 2018-06762 2018-06643 2018-06646 2018-06584 2018-06647 2018-06698 2018-06700 2018-06764 2018-06765 2018-06771 2018-06772	035654018 048106118 055951018 055977718 055990118 056018018 055468018 055806518 055905018 055942818 055987718 055989918 056077718 056267918 056491818 056918418 021400918 035653618 048105418 050819418 054141018 054151418 054322918 054520218 054856618 054919418 055279718 055389818 055477918 055482018

Description of Non-conformance:

After accessioning, blood tubes are transferred to a rack and these tubes inherit the rack's electronic Toxicology refrigerator location. The rack acts as a container in order to transfer items in bulk. On four separate occasions, accessioners transferred blood tubes to the rack and placed the rack in refrigerator 5 but the rack was electronically in refrigerator 3. Therefore, the chain of custody reflected this incorrect refrigerator location.

Actions Taken:

A comment was added into the chain of custody entry for all cases by the Toxicology analyst noting the physical location of the rack. The comment reads: "Container TX2017-00009 was physically located in Refrigerator-5. Moving forward, CS/CM accessioners will check the container's electronic location before transferring blood tubes into the rack. This will ensure that the chain of custody accurately reflects the physical location and movement of the blood tubes.

Summary of Root Cause Analysis:
Note: Incidents are documented for tracking purposes and trend analysis. Root Cause Analysis is not required for incidents.

N/A

Additional Information/Follow-Up:

It was not part of the accessioning process to verify the rack's refrigerator location because the same refrigerator is used to store blood tubes in the process of blood alcohol analysis. Since that evidence refrigerator was out of service at the time of these transfers, the chains of custody for these blood tubes incorrectly reflected the refrigerator location. This incident raised awareness that this verification step was needed in the accessioning process to prevent this from recurring. This administrative incident did not have an impact on the results of analysis since all blood tubes were appropriately stored under refrigeration.

Section Manager: Ashley Henry **Date:** 06/21/18

Division Director: Amy Castillo **Date:** 06/21/18

Incidents or Corrective Actions that involve the Biology/DNA section are reviewed by the Technical Leader and CODIS Administrator.

Technical Leader:	N/A	**Date:**	N/A
CODIS Administrator:	N/A	**Date:**	N/A
Quality Director:	Lori Wilson	**Date Closed:**	06/21/18