Quality Division Use Only

Quality Tracking #:	2018-041	**Classification:**	Corrective Action
Non-Conformance Level:	Class I	**Section:**	Crime Scene
Date of Discovery:	05/15/18	**Date of Incident:**	05/07/18

Forensic Case Number(s), if applicable:	Agency Case Number(s), if applicable:
2018-06886	**056517318**

Description of Non-conformance:

A Crime Scene Unit (CSU) Supervisor was notified on May 15, 2018, that a Crime Scene Investigator (CSI) found two swab boxes inside a crime scene vehicle. The boxes were labeled 'seat belt' and 'radio/dashboard', respectively. There was no unique identifier (agency case number) listed on the swab boxes. This is a violation of the HFSC Quality Manual and clause 4.1.1.2. of the CSU SOP. The CSU Supervisor investigated the nonconformance and determined to what case the swabs belonged and that the swab boxes were not stored in a manner that prevents loss nor were they clearly marked for identification. This is a violation of the HFSC Quality Manual and clause 5.1.3. of the CSU SOP. The CSU Supervisor began a chain of custody for the swabs starting from the time she was notified of the nonconformance on May 15, 2018. However, the chain of custody cannot be documented for the time period between May 7 and May 15. This is a violation of the HFSC Quality Manual and clause 5.2. of the CSU SOP. An additional nonconformance to Quality Manual clause 4.3.2.2 was noted after a Quality Specialist reviewed the case record. Specifically, the CSI used an outdated Latent Print/DNA Swab Notes form and took notes using the Field Notes form instead of the Vehicle Notes form (the scene involved processing a vehicle). This is a violation of clause 4.3.2.2. of the Quality Manual. The use of the incorrect form and the use of an outdated form should have been documented during the technical and administrative review process. This is a violation of the HFSC Quality Manual and Appendix A Technical Review Checklist of the CSU SOP. Nonconformances included: •Evidence that was not labeled according to policy •Evidence that was not protected from loss or deleterious change •An incomplete chain of custody •Document control procedures that were not followed resulting in scene notes being documented on an outdated form and a Field Notes form being used instead of the Vehicle Notes form •Ineffective documentation/implementation of the technical review process.

Actions Taken:

On May 15, the swab boxes were found by a CSI inside a swab kit (a plastic container used to hold new swabs and swab boxes for collecting DNA at scenes) located in one of the crime scene vehicles. The CSI removed the swab boxes from the vehicle and placed them in a secure CSU locker on the same day. The CSI notified her supervisor who then investigated the nonconformance. The CSU Supervisor removed the swab boxes from the secured evidence locker and found only the descriptions 'seat belt' and 'radio/dashboard' written on the boxes in red ink. The supervisor reviewed the vehicle log and determined the last time that crime scene vehicle had been taken to the Vehicle Examination Building (VEB) was on May 7, 2018. The crime scene vehicle had been used by a specific CSI to process a vehicle in reference to agency case number (ACN) 056517318. The Supervisor then reviewed the CSI's notes from that case and found no mention of DNA swabs collected from a 'seat belt' or 'radio/dashboard'. When the Supervisor questioned the CSI about the swabs, the CSI recalled collecting them but could not explain why he left them in the swab kit inside the vehicle. The Supervisor completed a paper chain of custody and signed the swabs boxes over to the CSI who collected them, so that they could be submitted to the property room in accordance with CSU SOP. The CSI transferred the evidence to the property room on May 15. However, HFSC is not able to provide a chain of custody from the time the swabs were collected on May 7, until the time the swabs were found on May 15. The CSU Deputy Director and CSU Director were also made aware of this incident and the CSI was removed from casework on May 17, 2018, while this nonconformance was being investigated. The investigation into this nonconformance included a review of the case record by a Quality Specialist. The Quality Specialist documented the additional nonconformances listed above in the Nonconformance box. The review showed that the CSI had added documentation regarding the swabs to the case record. The date he added the information was not included on all the note pages. This is a violation of Quality Manual clause 4.13.2.2. but this cannot be corrected because the CSI is no longer employed at HFSC. The labeling on the swab boxes was checked by a Quality Specialist and CSU Supervisor. Both boxed had been properly labeled by the CSI prior to being submitted to the property room. CSU is currently fully staffed but at the time of this nonconformance, it was not. Being fully staffed ensures that there are CSIs available to provide additional help when processing complex scenes. This will help reduce the impact from external influences at scenes. All CSIs received training on the proper use of the new forms as well as processing vehicles for DNA. Moving forward, training is provided by CSU management on all new and newly revised forms and SOPs. CSU recognized they had a problem with their review process and have hired two new supervisors in part to help with the review backlog. They are also training one of their more senior analysts to perform technical and administrative reviews. The goal is to have one of the new supervisors and the CSI authorized to perform reviews by the end of August. The other supervisor should be authorized by the end of September. On August 17, the Quality Division provided additional training to CSU management regarding HFSC's quality system. The training included a review of the requirements for document control, technical documentation, nonconforming work, and technical and administrative reviews.

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

Some of the information reported in this cause analysis is based upon an initial interview with the CSI but follow-up discussions were not possible because he left HFSC employment before cause analysis was completed. Root causes of this nonconformance included lack of training on the use of new forms, lack of document control measures, ineffective technical/administrative reviews, lack of a policy concerning external influence at scenes, and poor communication. This scene involved a stolen box truck containing an automated teller machine (ATM). The CSI did not follow his normal workflow when processing the vehicle and ATM because of pressure from the

ATM company representative to finish work on the machine so it could be released to the representative. The CSU does not have policy concerning external influence at scenes and the CSI did not contact his supervisor for direction on handling this scenario. The DNA swabs lacked proper labels because CSIs usually finish labeling evidence once they have completed processing the scene. The CSI forgot about the evidence before he finished processing the scene and therefore it wasn't labeled. We are not aware of any other scenes in which evidence was not properly labeled or scenes in which evidence was forgotten and left unattended in CSU vehicles for extended periods of time. Concerning the use of incorrect forms, the CSI processed the scene without referencing the Vehicle Notes form which includes a checklist of suggested areas on vehicles from which DNA can be collected. Had he looked at the form, he would have realized he needed to collect swabs from additional areas of the vehicle (namely the seat belt and radio/dashboard). The form had been in use for approximately one month prior to this nonconformance. Required use of the Vehicle Notes form was communicated to CSIs via an email but is not a requirement of the CSU SOP. Although we are not aware of other CSIs not using this form, it is possible that, in addition to poor communication regarding the required use of this form, lack of training on the new form led to this CSI not using it. Concerning the use of outdated forms, document control violations, specifically the use of incorrect worksheets, was not being documented by CSU management through the Quality Division and therefore there was no accountability for insuring that correct forms were being used by CSIs. The use of the incorrect Vehicle Notes form and the outdated Latent Print/DNA Swab form should have been caught during the technical/administrative review process. Ineffective reviews were documented as a nonconformance during the 2018 internal audit. Please refer to Corrective Action Report 2018-IA-41 for further information. An underlying cause of this nonconformance is a lack of communication between CSU Management and the Quality Division. HFSC hired CSU supervisors with crime scene experience from outside agencies. However, these supervisors have not processed crime scenes while employed at HFSC and therefore, lack familiarity with the application of HFSC's quality system to crime scene processing.

Additional Information/Follow-Up:

The CSI involved in this nonconformance left HFSC's employment prior to completion of this corrective action report. He was interviewed on June 8, 2018, regarding the circumstances that contributed to this nonconformance but was not available for follow-up questions. His immediate supervisor assumed responsibility for the completion of this nonconformance. Some of the CSIs using the new Vehicle Notes form have found the new checklist confusing. CSU management is in the process of removing the checklist from the form and allowing CSIs to collect DNA based on their training and experience.

Section Manager: Domingo Villarreal **Date:** 08/28/18

Division Director: Jerry Pena **Date:** 08/30/18

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:**	08/30/18