



Quality Division Use Only	
Quality Tracking #: <input type="text" value="2018-081"/>	Classification: <input type="text" value="Corrective Action"/>
Non-Conformance Level: <input type="text" value="Class II"/>	Section: <input type="text" value="Crime Scene"/>
Date of Discovery: <input type="text" value="08/17/18"/>	Date of Incident: <input type="text" value="07/25/18"/>

Forensic Case Number(s), if applicable:	Agency Case Number(s), if applicable:
2018-10859 2018-10523 2018-09595	094786618 091202418 081500418

Description of Non-conformance:
This nonconformance involves three instances in which crime scene investigators (CSIs) failed to document the transfer of evidence on a chain of custody form when receiving evidence from an officer at the scene. The transfers were documented in the CSIs' case notes and/or reports instead of the chain of custody form. This is a violation of clause 5.2.2. of the Crime Scene Unit (CSU) SOP and clause 5.8.1.1. of the HFSC Quality Manual.

Actions Taken:
A refresher training on the use of the chain of custody form was provided to the CSIs on June 7, 2018. This training covered the requirement to use separate forms when evidence is received from different officers. Additional refresher training on the chain of custody form was provided to the CSIs on Thursday, August 23, 2018. This training covered the requirement that signatures are captured from the person relinquishing the evidence as well as the person receiving the evidence. The CSU SOP chain of custody clause was revised to provide clearer instructions on how and when to utilize the chain of custody form. The Chain of Custody form was also revised to include a designed line for both printed names and signatures of those involved in the transfer of evidence. Training on the revised SOP and new Chain of Custody form was provided to all CSIs via self-paced PowerPoint presentations. Testing through Qualtrax was completed by October 18, 2018.

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



The root cause of this nonconformance was lack of training regarding when to use a chain of custody form for evidence transfers.

Additional Information/Follow-Up:

In 2018-10859 and 2018-10523, a CSI trainee did not appropriately document the chain of custody for items transferred to her from an officer at the scene. The trainee documented the transfers in her notes at both scenes; however, she did not utilize the required CSU chain of custody form nor did the officer acknowledge the transfer by signature or initials. The CSI's trainer, who was present at the scene, also failed to notice the nonconformance. In 2018-09595, a CSI received an evidence item (a phone) from a Houston Police Department (HPD) detective. This person to person transfer occurred while both the CSI and the detective were actively working the same crime scene. While the transfer of this evidence item was noted in the CSI's report and case notes, there was not an official chain of custody form filled out with signatures or initials.

Section Manager: Domingo Villarreal

Date: 11/01/18

Division Director: Jerry Pena

Date: 11/05/18

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: 11/05/18