TEXAS FORENSIC
SCIENCE COMMISSION

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

August 23, 2023

Via email to *jmorale@hfsctx.gov*

Ms. Jackeline Morale
Houston Forensic Science Center
500 Jefferson Street, 13th Floor
Houston, TX 77002

Re: Texas Forensic Science Commission ("Commission") Laboratory Self-disclosure No. 23.24; Houston Forensic Science Center (Seized Drugs)

Dear Ms. Morale:

At its July 21, 2023, quarterly meeting, the Commission voted to take no further action on the referenced self-disclosure given the root cause analysis and corrective actions taken by the laboratory.

Should the laboratory obtain new information that changes the core facts or corrective actions described in the disclosure, please update the Commission accordingly.

Thank you and please feel free to contact Commission staff with any questions or concerns.

Sincerely,

Leigh M. Tomlin

Leigh M. Tomlin
Associate General Counsel

cc: Peter Stout, via email to *pstout@hfsctx.gov*

Quality Division Use Only

Quality Tracking #:	2023-014	**Classification:**	Corrective Action
Non-Conformance Level:	Class II	**Section:**	Seized Drugs
Date of Discovery:	03/15/23	**Date of Incident:**	03/14/23

Forensic Case Number(s), if applicable:	Agency Case Number(s), if applicable:
2022-08495 2022-00090 2021-35459 2022-08508 2022-10599 2021-35012 2021-35454 2021-35115 2022-35829 2022-00229 2022-00339 2022-00374 2022-00510 2022-01382 2022-01450 2022-02418 2022-03611 2022-04619 2022-04284 2022-04472	029481621 001686222 170130921 093866622 119307522 164662321 169612021 166636021 174343721 002606222 002895322 003905422 004734722 014543522 015114622 024773022 037461522 048974422 045198622 047972222

Description of Non-conformance:

Twenty-two samples from a total of eighteen cases were analyzed by a Seized Drugs analyst using the incorrect sample vial causing the results to be improperly reported.

Additional Information/Follow-Up:

The decision point assay is a GCMS instrumental analytical technique used for the characterization and differentiation of hemp from marihuana using an administratively determined threshold. This analytical method analyzes suspected marihuana samples in a batch because of the variety of controls that need to be run concurrently.

On March 15, 2023, an analyst was reviewing batch data for suspected marihuana samples that had been analyzed by GCMS decision-point assay on March 14, 2023, when she discovered that injections for two of the samples in the batch were made from an incorrect sample vial. The analyst made this discovery by comparing the manual logbook entries for each sample against each sample entry in the instrument's sequence run log. She found that the sample vial number was incorrectly entered in the instrument's sequence log for two samples.

The analyst reanalyzed the two samples in a new GCMS decision-point assay batch using the same prepared sample extracts. The results from the second batch runs were used to support the conclusions that were reported on March 22, 2023. All sample runs were documented in the case record.

The Seized Drugs section conducted an audit of batch runs made during the six-month period prior to March 14, 2023, and found that each of the 11 batches run between November 30, 2022, to March 8, 2023, included two sample injections from an incorrect vial for a total of 22 samples from 18 cases. The affected cases and sub-items of evidence that corresponded to these incorrect sample vial injections were identified and the evidence was transferred to HFSC for reanalysis. Since the audit was able to isolate the initial error in the sequence log to the batch run on November 30, 2022, the audit was not extended any further.

Following reanalysis of the 22 samples, all results agreed with the previously reported results. The amended reports were issued for the 18 cases to document the additional analysis and that none of the reported results were affected. The amended report included the following statement in the header: "This report amends Laboratory Report #: 000X dated XX/XX/XXXX at XX:XX:XX to document that additional analysis has been conducted as a result of an incorrect sample vial originally being analyzed for item(s) XXX. Reanalysis of these item(s) has been completed and the original reported results were not affected. This case is associated with quality report 2023-014, please refer to this quality report for more details."

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 attributed to the decision-point assay workflow not having an independent visual verification process that checks that manual logbook entries, instrument's sequence table log, and sample vial location correspond with each other. This lack of verification process in combination with the analyst's general practice of editing the instrument's sequence run log from a previous batch contributed to causing this nonconformance.

Actions Taken:

All decision-point assay GCMS batch sequences run after the discovery of the incorrect sample vial injections (including the reanalysis of the affected samples) will be verified by a second person who will document that the sample identifiers, logbook entries, and instrument vial positions are all in agreement. This verification shall be documented in the logbook by initialing and dating the sequence.

James Miller — 04/25/23

Section Manager: _____ **Date:** _____

Division Director: Amy Castillo **Date:** 05/04/23

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

Technical Leader: N/A **Date:** _____

CODIS Administrator: N/A **Date:** _____

Quality Director: Jackeline Moral **Date Closed:** 05/04/23