Texas Forensic Science Commission

Second Complaint

April 18, 2018

1. PERSON COMPLETING THIS FORM

Name: Amanda Culbertson
Address: 4008 Louetta Road, #248
City: Spring
State: Texas Zip Code: 77388
Home Phone:
Work Phone: [redacted]
Email Address *(if any)*: previoushpdts@gmail.com

2. SUBJECT OF COMPLAINT

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

Individual/Laboratory: DPS El Paso Regional Lab
Address:
City:
State: Zip Code:
Date of Examination, Analysis, or Report:
Type of forensic analysis: Blood Alcohol/Quality
Laboratory Case Number *(if known)*: many

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: many
* Case Number/Cause Number: *(if unknown, leave blank)*
* Nature of Case: *(e.g burglary, murder, etc.)*
* The county where case was investigated, prosecuted or filed:
* The Court:
* The Outcome of Case:
* Names of attorneys in case on both sides *(if known)*:

Your relationship with the defendant:

Self	☐	Family Member	☐
Parent	☐	Friend Attorney	☐
None	☒	Other *(please specify)*:	

Retained expert

If you are not the defendant, please provide us with the following information regarding the defendant:
Name:
Address *(if known)*:
Home Phone:
Work Phone:

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:
Address:
Daytime Phone:
Evening Phone:
Fax:
Email Address:

Second Witness *(if any)*:
Name:
Address:
Daytime Phone:
Evening Phone:
Fax:
Email Address:

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

4. DESCRIPTION OF COMPLAINT

Please write a brief statement of the event(s), acts or omissions that are the subject of the disclosure.

Please see the attached

5. EXHIBITS AND ATTACHMENT(S)

Whenever possible, disclosures should be accompanied by readable copies **(NO ORIGINALS)** of any laboratory reports, relevant witness testimony, affidavits of experts about the forensic analysis, or other documents related to your disclosure. Please list and attach any documents that might assist the Commission in evaluating the complaint. Documents provided will **NOT** be returned. List of attachments:

1) "Original Complaint"
2) "March 12, 2014 Batch"
3) "Second Complaint"

6. YOUR SIGNATURE AND VERIFICATION

By signing below, I certify that the statements made by me in this disclosure are true. I also certify that any documents or exhibits attached are true and correct copies, to the best of my knowledge.

Signature: Amanda Caldwell

Date Signed: 4/16/18

Summary of complaint:
Generally, failure to adhere to accreditation standards and Laboratory Operations Guidelines (LOG) such as failure to promptly notify customers of non-conforming work and failure to timely issue corrective actions for non-conforming work. Additionally, failure to define the "peer review" process (which is different than a technical review) in either a SOP or quality manual.

Background:
This complaint centers around the cases and blood alcohol batches described in another complaint I submitted simultaneously with this complaint which is attached for reference.

A Quality Incident Report (QIR) with tracking number QI-ELP-2017-0831-BA was issued in response to the March 12, 2014 batch referenced in the previous complaint. This QIR discussed the problems seen in this batch observed during the "peer review" process (reviewing a case to be able to provide "surrogate testimony"). Specifically, Laura Hernandez, the person conducting the peer review stated that data for 3 controls were "listed incorrectly on the batch log." She went on to state that "the concentrations reported for line 107 are actually the concentrations for line 108 . . . in addition, the last control that was analyzed was not present on the log . . . on closer inspection by LH, it appears that the concentration for one of the samples belonged to the missing control sample." The QIR concluded that all of this was due to a simple "transcriptional error."

Missing control samples, logs that do not align with the data that is generated, and "transcription errors" should have been a red flag to investigate this issue further. Since the QIR stated that this was a peer review and "all data pages were present," it would appear that the case folder — which should have contained the chromatograms from both February 7 and March 12, 2014 — was available for review. As stated in the other complaint, the activities of Ana Romero should have been caught both during the initial review and subsequently in this "peer review" process which, even according to Ms. Hernandez, was "really thorough."

According to the QIR, these problems were first identified in August 2017. However, defense counsel for at least one of those cases whose client's case was still pending and might possibly have even necessitated the peer review, was not notified of any potential issue when first identified in August 2017 or thereafter. This particular case was scheduled for trial in January 2018, a fact the peer reviewer, who was reviewing for the purpose of providing surrogate testimony, would have known. However, the QIR itself shows that the customers were not notified.

Finally, the QIR listed some, but not all of the cases in this batch. The author could have listed the batch by precise file name to alert anyone with cases in this batch to the problems described or provided every case identifier. Instead, only select cases were listed (or shown on the printed QIR). The case for which I was retained was in this batch with these samples but was NOT listed on the QIR.

Another, somewhat unrelated QIR, QI-ELP-2017-0608-BA, was finalized in January 2018. The subject of this QIR was an "unexplained glitch in the computer software" that caused the instrument to

"miscalculate[] the concentration of two controls . . . [that resulted in] the numbers [being] off to a degree that the standard would not qualify as acceptable." According to the QIR, an amended report was issued in November 2017 – 5 months after this issue was discovered. This is in violation of the Laboratory Operations Guidelines which state "the report and/or certificate should be amended as expeditiously as possible within ten business days from the date the results were confirmed to be incorrect. A longer timeframe for amended reports may be allowed if there is documentation that the relevant customers have been notified." As with the previous QIR, it does not appear that the customers (beyond the one case referenced) were notified of this "glitch" that causes miscalculations.

In light of the events described in both this complaint and the other complaint submitted contemporaneously, it is also important for the Commission to be aware of concerning statements made by Laura Hernandez during the November 2017 Southwestern Association of Forensic Scientists (SWAFS) meeting. During her presentation, Ms. Hernandez began discussing a specific but unidentified case that had "200 pounds of baggage." In regard to this case, she made it very clear that the issues described had not been relayed to the defense or prosecution. When asked if she would feel comfortable testifying on a case that had so many problems, she indicated that in such situations she preferred a pre-trial meeting with the prosecutor, "especially" in cases where peer review was involved and "the law is not quite there yet." She further indicated that she liked to have a pre-trial meeting with the prosecutor, to make them aware of the issues so that they can "preemptively lay that out" in court. She never once, however, indicated that such information was disclosed to the defense.

Also during her presentation, which was a "how to" on testifying to cases in which one did not perform any testing, she made the following comment: "dry-benching, dry-labbing, or just falsifying records – like that happens, unfortunately, I wish it didn't — it would make my job so much easier if I could say that I was, you know, truly in a reliable place." Despite this, I have seen no corrective action, Quality Incident Report (QIR), or any other disclosure to defense bar or the Texas Forensic Science Commission regarding instances of dry-labbing or falsifying records.

It is my hope that the Commission will investigate these issues.

TEXAS FORENSIC SCIENCE COMMISSION • COMPLAINT FORM *(Cont.)*

1. PERSON COMPLETING THIS FORM

Name: Amanda Culbertson
Address: 4008 Louetta Road, #248
City: Spring
State: Texas Zip Code: 77388
Home Phone:
Work Phone: 832-514-1818
Email Address *(if any)*: previoushpdts@gmail.com

2. SUBJECT OF COMPLAINT

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

Individual/Laboratory: DPS El Paso Regional Lab
Address:
City:
State: Zip Code:
Date of Examination, Analysis, or Report: 2/7/14 - 3/12/14
Type of forensic analysis: Blood Alcohol
Laboratory Case Number *(if known)*: many

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: many
* Case Number/Cause Number: *(if unknown, leave blank)*
* Nature of Case: *(e.g burglary, murder, etc.)*
* The county where case was investigated, prosecuted or filed:
* The Court:
* The Outcome of Case:
* Names of attorneys in case on both sides *(if known)*:

Your relationship with the defendant:

Self	☐	Family Member	☐
Parent	☐	Friend Attorney	☐
None	☒	Other *(please specify)*:	

Retained expert

If you are not the defendant, please provide us with the following information regarding the defendant:
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Email Address:

Third Witness *(if any)*:
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6. YOUR SIGNATURE AND VERIFICATION

By signing below, I certify that the statements made by me in this disclosure are true. I also certify that any documents or exhibits attached are true and correct copies, to the best of my knowledge.

Signature: Amanda Caldwell

Date Signed: 6/10/18

Summary of the Complaint:

An employee of the Texas DPS El Paso Regional Crime Lab reused previously analyzed defendant data and appears to have gone to considerable lengths to pass said data off as having been generated at a different time than what actually occurred. This should have easily been caught by the technical reviewer, but seemingly went unnoticed. The ability of the analyst to perform this act and the apparent lack of detection (or possible complicit acceptance) by lab personnel demonstrates a breakdown of the laboratory's quality system.

Background:

I had been hired by a defendant and his counsel to review a blood alcohol case occurring between February and March 2014. The data in this case was first analyzed by Ana L. Romero on Friday, February 7, 2014. The batch in which this case was analyzed consisted of a total of 107 headspace vials with 64 being defendant samples/vials (in duplicate; 32 individual defendant cases). According to the documentation, within a few hours of starting this run, the helium tanks supplying the carrier gas ran dry. On Monday, February 10, 2014, the batch was restarted with no leading calibrator or control. The batch was allowed to continue to run until completion on February 11, 2014.

The "Alcohol Analysis Worksheet" for this case showed that the data for the run beginning February 7, 2014 was not used due to the gas cylinder being replaced during the run. The "Blood Alcohol Batch Log" noted that the data for this run **would not be used** and that **all** samples would be **resampled and rerun**.

On March 12, 2014, the entire batch from February 7, 2014 was allegedly reanalyzed in its entirety and exact sequential order. It appeared that new calibrators, controls, and method blanks were prepared and analyzed. However, the data for 27.5 of the 32 defendants' cases (55 vials of the 64 total defendant vials) were **identical** to the data generated on February 7 – 11, 2014.[1] Furthermore, one defendant's case had identical data (area counts) to the previous run but the order was reversed (data from the first batch, aliquot 1 was now appearing as the data for the second batch, aliquot 2).

The chances of analyzing another sample that results in all 7 digits of the area counts of the internal standard being identical to any other case, in any other batch, is extremely low. Having all 7 digits of the internal standard area counts and all the area counts for acetaldehyde, ethanol, acetone, methanol, and other unidentified peaks (when detected) being identical to a previous run for 55 out of 64 defendant samples is beyond measure. In other words, there is no way that what was seen in these two batches is the result of coincidence or a random event.

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[1] More specifically, the area counts for all peaks, identified or not, were identical for the cases mentioned. The actual reported results for each sample were different between the first run in February 2014 and the second run in March 2014. This, however, is easily explained because a new calibrator – which results in a new calibration curve (i.e. equation) – was used in the March 2014 run. By using the identical area count ratios in a new equation (re-processing), this resulted in a new reported result, despite the underlying data (area counts) being the same data from a previous run.

It is my opinion — as someone with years of experience with this type of analysis on similar instrumentation/software, in consultation with the software manufacturer's support personnel, and viewing the raw data from the February 7, 2014 run on the manufacturer's software — that the acts described herein are not due to accident or negligence, but an intentional act on the part of the analyst.

Furthermore, comparing the Blood Alcohol Batch Log from the February 7, 2014 run with the same log from the March 12, 2014 run, both were technically reviewed by the same person and on the same date: March 21, 2014. Because this technical review analyst appeared to have reviewed both batches and all chromatograms, including those from the failed run simultaneously, this act should have been caught. The fact that it was not seriously undermines the credibility of the technical review process and the quality system as a whole.

It is my sincere hope that the Texas Forensic Science Commission conducts a thorough review of this situation.

TEXAS DEPARTMENT OF PUBLIC SAFETY
CRIME LABORATORY

Quality Incident Report

LAB-QA-04e (05/2017)p.1 Issued by: QAC

Tracking ID

QI-ELP-2017-0831-BA

Lab	El Paso	Discipline	BA	Date Discovered	8/31/2017	**Page 1 of 2**

Date of Incident	3/12/2014	End Date of Incident (if applicable)	3/14/2014

Related Policy/Procedure/Specification	BA-01-04 3.A.1
Related Work # (case/batch/instrument)	ELP-1312-02057 ELP-1312-02074 ELP-1312-02086 ELP-1312-02058 ELP-1312-02075 1312-02080 ELP-1312-02093 ELP-1312-02070 ELP-1312-02082 ELP-1312-02095 ELP-1312-02071 ELP-1312-02083 ELP-1312-02096 ELP-1312-02072 ELP-1312-02084

Incident Description:

During a peer review BA analyst LH noticed that the data for three samples (Volatile mixture (line 3 of the batch log), Control sample (0.08 ethanol standard from Lipomed lot 14112011-A), and Control sample (0.08 ethanol standard from Cerillinat lot FN011712-02)) was listed incorrectly on the batch log. Specifically, the concentrations on the data pages were incorrectly transcribed for the volatile mixture (line 3) and the 0.080 control (line 107). In addition, there is data for an additional 0.080 control analyzed in position 108 and it is documented on a batch summary but it does not appear in the batch log. Furthermore, the concentrations reported for line 107 are actually the concentrations for line 108. In addition, the last control that was analyzed was not present on the log. On closer inspection by LH, it appears that the concentration for one of the samples belonged to the missing control sample.

Cause Analysis:

Since the data pages are correct and the analyst at the time typed the alcohol concentrations into the batch log file, LH concluded that this incident appears to be due to a transcriptional error made by the original analyst Ana Romero in typing the values from the data pages to the batch log. The error only affects the batch log; not the data or the results.

Involved Parties (who by direct actions caused the quality incident):

Not Applicable

Correction(s) to the Original Work (Indicate if not performed at this time) **Corrected Report?** NA

The alcohol concentrations on the data pages were verified correct by LH and all data pages were present. LH verified that the data pages have correct information and the report lists the correct information. It is only the batch log that contains the error, and it appears to be transcriptional in nature. The information on the report was correct. LH manually calculated the results and verified their accuracy. Since there was no error in the reported alcohol concentration in the case, there is no need to have an amended report. This case was originally analyzed at a time when more manual entries were required for blood alcohol analysis. Since the time of testing, there have been steps made to automate the entry of results. This automation helps to limit these types of errors.

Customer Notification (Indicate if not performed at this time or not applicable):

N/A

Corrective Action Necessary? No **Significant Disclosure?** No

TEXAS DEPARTMENT OF PUBLIC SAFETY
CRIME LABORATORY

Quality Incident Report

LAB-QA-04e (05/2017)p.1 Issued by: QAC

Tracking Number
QI-ELP-2017-0831-BA

Lab	El Paso	Discipline	BA	Date Discovered	8/31/2017

Approval

Requestor	*Condel, Kevin (electronically signed)*	Date: 1/23/2018
TL/TPOC	*Hernandez, Laura(electronically signed, non-technical if blank)*	Date: 1/23/2018
Lab QA	*Condel, Kevin (electronically signed)*	Date: 2/12/2018
Management	*Correa, Joseph (electronically signed)*	Date: 2/19/2018
System QA	*Young, Wilson (electronically signed)*	Date: 2/20/2018

TEXAS DEPARTMENT OF PUBLIC SAFETY
CRIME LABORATORY

Quality Incident Report

LAB-QA-04e (05/2017)p.1 Issued by: QAC

Tracking ID

QI-ELP-2017-0608-BA

Lab	El Paso	Discipline	BA	Date Discovered	6/8/2017	**Page 1 of 1**

Date of Incident	9/28/2013	End Date of Incident (if applicable)	9/28/2013

Related Policy/Procedure/Specification	BA-02-01
Related Work # (case/batch/instrument)	ELP-1309-01569

Incident Description:

During a peer review, BA analyst LH noticed that the instrument miscalculated the concentration of two controls used in a batch (0.100 and 0.300 were used). LH verified by manually calculating the concentration using the area counts of the instrument. In the case of the 0.100 standard, the numbers were off to a degree that the standard would not qualify as acceptable. Since this was an error that was only seen by doing the manual calculations, LH pulled every case analyzed in the batch and found one case where this error occurred (case number ELP-1309-01569). In that case, because of the difference in the concentration, it changes the reported value from 0.149 to 0.147. The remainder of the cases in the batch were not subject to the same error.

Cause Analysis:

The cause was determined to be the result of a unexplained glitch in the computer software that was not observed in other cases in the batch. The error has not been observed in any other cases outside the batch, and since the affected instrument was removed from service in 2014, the incident is not expected to reoccur. Routinely, manual calculations are not performed to verify calculations initially performed by the computer software. This contributed to the amount of time between when the incident occurred and when it was discovered during a peer review.

Involved Parties (who by direct actions caused the quality incident):

Not Applicable

Correction(s) to the Original Work (Indicate if not performed at this time) **Corrected Report?** Yes

Because of the difference in the concentration, the reported value changed from 0.149 to 0.147. Since there is an acceptable standard on each end of the run, the batch still passes. An amended report was generated for ELP-1309-01569 noting this difference and was released as of 11/27/17. Since the technology leading to this incident is no longer utilized in current cases, and the difference observed was not significant enough to alter the outcome on the case, no further action is needed.

Customer Notification (Indicate if not performed at this time or not applicable):

Amended report released to client as of 11/27/17.

Corrective Action Necessary? No **Significant Disclosure?** No

Approval

Requestor	*Condel, Kevin (electronically signed)*	Date: 12/4/2017
TL/TPOC	*Hernandez, Laura(electronically signed, non-technical if blank)*	Date: 12/4/2017
Lab QA	*Condel, Kevin (electronically signed)*	Date: 12/5/2017
Management	*Correa, Joseph (electronically signed)*	Date: 1/15/2018
System QA	*Turner, Valerie (electronically signed)*	Date: 1/18/2018