# REPORT OF THE

# TEXAS FORENSIC SCIENCE COMMISSION

# TEXAS DEPARTMENT OF PUBLIC SAFETY HOUSTON REGIONAL CRIME LABORATORY SELF-DISCLOSURE

# APRIL 5, 2013

# EXHIBIT LIST

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|---|---|
| **Exhibit A** | OIG Report |
| **Exhibit B** | Texas Rangers Report |
| **Exhibit C** | DPS Disclosure |
| **Exhibit D** | April Email Alert from Keith Gibson to Law Enforcement & Prosecutors |
| **Exhibit E** | Harris Co. DA Letter to Defendants |
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| **Exhibit G** | Commission Memo to Prosecutors and Judges |
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## I. BACKGROUND AND STATUTORY AUTHORITY

### A. History and Mission of the Texas Forensic Science Commission

In May 2005, the Texas Legislature created the Texas Forensic Science Commission ("TFSC" or "Commission") by passing House Bill 1068 (the "Act"). The Act amended the Code of Criminal Procedure to add Article 38.01, which describes the composition and authority of the TFSC. *See* Act of May 30, 2005, 79th Leg., R.S., ch. 1224, § 1, 2005. The Act took effect on September 1, 2005. *Id.* at § 23.

The Act provides that the TFSC "shall investigate, in a timely manner, any allegation of professional negligence or misconduct that would substantially affect the integrity of the results of a forensic analysis conducted by an accredited laboratory, facility or entity." TEX. CODE CRIM. PROC. art. 38.01 § 4(a)(3). The Act also provides that the TFSC shall develop and implement a reporting system through which accredited laboratories, facilities, or entities may report professional negligence or misconduct, *and* require all laboratories, facilities, or entities that conduct forensic analyses to report professional negligence or misconduct to the Commission. *Id.* at § 4(a)(1)-(2).

The term "forensic analysis" is defined as a medical, chemical, toxicological, ballistic, or other examination or test performed on physical evidence, including DNA evidence, for the purpose of determining the connection of the evidence to a criminal action. *Id.* at art. 38.35(4). The statute excludes certain types of analyses from the "forensic analysis" definition, such as latent fingerprint analysis, a breath test specimen, and the portion of an autopsy conducted by a medical examiner or licensed physician.[1]

[1] For complete list of statutory exclusions, *see* TEX. CODE CRIM. PROC. art. 38.35(a)(4)(A)-(F) & (f).

The statute does not define the terms "professional negligence or misconduct," though the Commission has defined those terms in its policies and procedures. (TFSC Policies & Procedures at 1.2.) The Commission also released guidance for accredited crime laboratories regarding the categories of non-conformances that may require mandatory self-reporting; this guidance is provided with the self-disclosure form located on the Commission's website at http://www.fsc.state.tx.us/documents/LABD.pdf.

The TFSC has nine members—four appointed by the Governor, three by the Lieutenant Governor and two by the Attorney General. *Id.* at art. 38.01 § 3. Seven of the commissioners are scientists and two are attorneys (one prosecutor and one defense attorney). *Id.* The TFSC's presiding officer is designated by the Governor. *Id.* at § 3(c).

The TFSC's policies and procedures set forth the process by which it determines whether to accept a complaint, as well as the process used to conduct an investigation once a complaint is accepted. (*See* TFSC Policies & Procedures at § 3.0, 4.0.) The ultimate result of an investigation is the issuance of a final report.

**B. Attorney General Opinion No. GA-0866**

On January 28, 2011, the Commission asked Texas Attorney General Greg Abbott to respond to three questions regarding the scope of its jurisdiction under its enabling statute (TEX. CODE CRIM. PROC., art. 38.01). On July 29, 2011, the Attorney General issued the following legal guidance:

1. The TFSC lacks authority to take any action with respect to evidence tested or offered into evidence before September 1, 2005. Though the TFSC has general authority to investigate allegations arising from incidents that occurred prior to September 1, 2005, it is prohibited, in the course of any such investigation, from considering or evaluating evidence that was tested or offered into evidence before that date.

2. The TFSC's investigative authority is limited to laboratories, facilities, or entities that were accredited by the Texas Department of Public Safety ("DPS") at the time the analysis took place.

3. The Commission may investigate a field of forensic science that is neither expressly included nor expressly excluded on DPS' list of accredited forensic disciplines, as long as the forensic field meets the statute's definition of "forensic analysis" (*See* Article 38.35 of the Act) and the other statutory requirements are satisfied.

The Commission's investigation of the Texas Department of Public Safety, Houston Regional Crime Laboratory's ("DPS") self-disclosure falls within its statutory jurisdiction for the following reasons: (1) the negligence or misconduct occurred after the effective date of the Act; (2) DPS is accredited by ASCLD-LAB; and (3) controlled substance analysis is an accredited forensic discipline.

**C. Limitations of this Report**

No finding contained herein constitutes a comment upon the guilt or innocence of any individual. A final report by the TFSC is not prima facie evidence of the information or findings contained in the report. TEX. CODE CRIM. PROC. art. 38.01 § 4 (e); FSC Policies and Procedures § 4.0 (d). The Commission does not currently have enforcement or rulemaking authority under its statute. The information it receives during the course of any investigation is dependent upon the willingness of concerned parties to submit relevant documents and respond to questions posed. The information gathered has not been subjected to the standards for admission of evidence in a courtroom. For example, no individual testified under oath, was limited by either the Texas or Federal Rules of Evidence (*e.g.,* against the admission of hearsay) or was subjected to formal cross-examination under the supervision of a judge. The primary purpose of this report is to encourage the development of forensic science in Texas.

## II. SUMMARY OF KEY FACTS AND DISCLOSURE TIMELINE

### A. Key Facts

The facts of this self-disclosure are straightforward. On January 26, 2012, DPS examiner Andrew Gardiner was attempting to diagnose a problem with his gas chromatograph-mass spectrometer ("GCMS") as part of the normal course of his work in the laboratory. (*See* OIG Report at **Exhibit A;** Texas Rangers Report at **Exhibit B, 1.7**). To verify the problem he experienced was not with the sample itself but rather with his instrument, Gardiner attempted to run the sample on examiner Jonathan Salvador's GCMS. *Id.* Salvador was out of the office at the time, assisting the drug section supervisor with routine evidence destruction duties. *Id.* In the process of troubleshooting his instrument, Gardiner determined he should run an alprazolam sample on his own instrument to assess how it would perform. *Id.* Gardiner noticed on Salvador's sequence log that the sample directly above the sample he had just run on Salvador's machine was alprazolam, so he decided to use that vial to run on his machine. *Id.* On the sequence log, the sample was labeled L2H-222396 item 1, and it was in location 18. *Id.* Gardiner attempted to retrieve the vial in location 18, but it was labeled L2H-222403. *Id.* Gardiner's first thought was that Salvador had mistyped the label number or inadvertently swapped the vial's location. *Id.* However, no other location in the tray contained vial L2H-222396, so it was apparent to Gardiner the sample's location had not been switched accidentally. *Id.*

Gardiner then pulled the case folder for L2H-222396 and noticed Salvador had experienced difficulty analyzing a pharmaceutical exhibit that appeared to be a slow-release alprazolam tablet. The mass spectral data for L2H-222396 was insufficient to

report a positive finding, while case file L2H-222403 was complete and needed no further analysis. *Id.* Gardiner then sought input from colleague Haley Yaklin regarding her impression of whether Salvador had used the data from L2H-222403 to support the result for L2H-222396. *Id.* Ms. Yaklin agreed it looked suspicious, and both examiners decided to wait to see if Salvador would correct his own mistake during the review process over the next week. *Id.* On January 30, 2012, Gardiner observed that Salvador completed file L2H-222396 and submitted it for technical review (*See* **Exhibit B**). He also observed the data used to support the results in file L2H-222396 was the same data he saw in file L2H-222403. *Id.* Gardiner reported his concerns to section supervisor Severo Lopez on February 3, 2013, while the case was in administrative review. *Id.*

On February 3, 2012, Lopez pulled the case folder and evidence for L2H-222396 and re-tested the sample himself. He confirmed the evidence from L2H-222396 was in fact alprazolam, but that Salvador had used the evidence from L2H-222403 to generate the data supporting his results in L2H-222396. The report Salvador drafted for L2H-222396 was not issued outside the laboratory, and Lopez removed Salvador from casework immediately. On February 6, 2012, DPS management informed the Texas Rangers and the Office of Inspector General. On February 10, 2012, DPS suspended Salvador. (*See* DPS Disclosure Form at **Exhibit C**.) On July 24, 2012, DPS notified Salvador of the agency's intent to terminate his employment (*See* OIG Report at **Exhibit A**). On August 6, 2012, Salvador resigned from DPS.

### B. DPS Management Consults Texas Rangers and Office of Inspector General

On February 6, 2012, DPS management reported the situation to the Texas Rangers and the Office of Inspector General. The Rangers assigned investigators on

February 7, 2012, and began interviewing crime lab management and staff on February 8, 2012.

The purpose of the Texas Rangers' investigation was to determine whether there was evidence of criminal activity by Salvador, and to report their conclusions to the Harris County District Attorney's office. The Rangers reviewed relevant case documents and interviewed Salvador, Gardiner, Yaklin, Lopez and Keith Gibson, the director and quality manager of the laboratory. (*See* **Exhibit B**.) The Rangers observed that Salvador was defensive throughout their interview and was "unable to provide a consistent, plausible reason explaining why or how the evidence from file L2H-222403 ended up being used to generate the results report which was submitted for file L2H-222396." (*See* **Exhibit B**.) Though Salvador "conceded he might have made a mistake," he denied that he engaged in any intentional wrongdoing. *Id.*

The Rangers reported their findings to the Harris County District Attorney's office. On May 5, 2012, the Harris County District Attorney's office presented the case to a Harris County grand jury. (*See* **Exhibit B**.) The grand jury returned a no-bill, and the Rangers closed their file on September 12, 2012. *Id.*

The DPS Office of Inspector General ("OIG") interviewed crime lab management and staff in April 2012, after the Rangers completed their investigation. (*See* **Exhibit A**.) The OIG's investigation was internal to DPS and administrative in nature. *Id.* OIG investigators reviewed relevant documents and interviewed Salvador, Gardiner, Yaklin, Lopez and Gibson. *Id.* The investigators concluded the following:

> The evidence supports that on Thursday, 01-26-2012, at approximately 8:55 a.m., while performing his duty as a forensic scientist, Jonathan Salvador improperly acted with total disregard for policy and procedure by testing sample L2H-222403 and recording those results for sample L2H-222396. *Id.*

Both the OIG and Texas Ranger investigations focused narrowly on alleged wrongdoing by Salvador during the alprazolam incident. As discussed below, the Commission's investigation incorporated the work of the Rangers and OIG without duplicating efforts. Because conclusions regarding the specific incident were clear, the Commission focused its investigation on the circumstances and environment in the laboratory leading to the incident; lessons learned from the incident; and recommendations for DPS and other laboratories going forward. The Commission's work is intended to benefit Texas crime laboratories that may face similar circumstances, and also to educate the criminal justice system regarding challenges faced in cases involving high volume disciplines such as controlled substance.

## III. COLLABORATIVE EFFORTS TO PROVIDE NOTICE TO AFFECTED DEFENDANTS AND MEMBERS OF CRIMINAL JUSTICE SYSTEM

### A. Step One: DPS Notice to TFSC, ASCLD-LAB, Prosecutors and Submitting Law Enforcement Agencies

On February 21, 2012, DPS management alerted the Commission, ASCLD-LAB, prosecuting attorneys and submitting law enforcement agencies about the alprazolam incident (*See* **Exhibit C**). The email communication advised affected parties that all evidence worked by Salvador in the previous 90 days would be re-analyzed. *Id.* On April 26, 2012, DPS management emailed a second notice to the agencies explaining that two additional errors were discovered in Salvador's work during the review of 148 cases constituting 90 days of work. (*See* **Exhibit D**.) DPS also identified 4,944 total drug cases by county (equaling 9,462 pieces of evidence) worked by Salvador during his employment from 2006-2012, and advised law enforcement and prosecutors they could request re-analysis of any case in which the evidence has not yet been destroyed. *Id.* On

June 30, 2012, DPS submitted a follow-up written disclosure to the Commission, including the results of re-testing conducted. (*See* **Exhibit C**.)

The Commission contacted submitting law enforcement agencies in an attempt to estimate the percentage of the 4,944 total cases for which evidence was destroyed as part of the normal course. Evidence submitted by DPS officers constituted a total of 1,978 cases, and only 21 of those cases were destroyed. Though the Commission did not receive answers from all agencies, staff estimate that between 50-75% of the evidence is available for re-testing, including evidence submitted by DPS officers.

On April 27, 2012, immediately after DPS released the re-testing results, the Texas District and County Attorneys' Association ("TDCAA") posted a notice on its website advising affected members of a suggested protocol for alerting stakeholders, including: (1) notifying the courts of the issue; (2) notifying the local criminal defense bar; (3) pulling all of the cases on the list provided by DPS and checking the disposition for convictions; (4) locating the evidence, and if it still exists, submitting it for retesting (DPS or local departments); and (5) for any case where re-testing yielded inconsistent results (or cases with now-destroyed evidence) requesting that the court appoint an attorney to take the case through a writ process if appropriate.

**B. Step Two: Notice to Defendants**

*1. Counties Affected*

Salvador performed casework for 36 Texas counties during his employment, including: Angelina; Austin; Brazoria; Brazos; Burleson; Chambers; Colorado; Fort Bend; Galveston; Grimes; Hardin; Harris; Hidalgo; Houston; Jackson; Jasper; Jefferson; Leon; Liberty; Madison; Matagorda; Montgomery; Nacogdoches; Newton; Orange; Polk;

Sabine; San Augustine; San Jacinto; Shelby; Trinity; Tyler; Walker; Waller; Washington; and Wharton.

The following table divides the counties into tiers by volume of cases. Commission staff tabulated the total number of cases using DPS case identification numbers. The vast majority of Salvador casework is concentrated in 23 counties. The numbers represent all cases worked by Salvador, including *both* felonies *and* misdemeanors. The table also includes cases with a wide range of dispositions, including but not limited to dismissals, plea agreements and jury convictions.

| **TIER** | **COUNTIES BY TIER** |
|---|---|
| **ONE: > 250 cases** | **5 Counties:**<br>Fort Bend, Galveston, Harris, Liberty, Montgomery |
| **TWO: 101-250 cases** | **10 Counties**:<br>Brazoria, Chambers, Grimes, Hardin, Jasper, Matagorda, Polk, Walker, Waller, Wharton |
| **THREE: 10-100 cases** | **8 Counties:**<br>Austin, Jefferson, Newton, Orange, San Jacinto, Trinity, Tyler, Washington |
| **FOUR: < 10 cases** | **13 Counties:**<br>Angelina, Brazos, Burleson, Colorado, Hidalgo, Houston, Jackson, Leon, Madison, Nacogdoches, Sabine, San Augustine, Shelby |

*2. Responses of Harris, Galveston and Montgomery*

The top three counties affected (by volume of cases) are Montgomery (1,287), Galveston (849), and Harris (327), in that order. In Harris County, the District Attorney sent letters to potentially affected defendants (*See* **Exhibit E**) informing them of the non-conformance and referring them to the Harris County Public Defender's Office, which

will handle requests for re-testing and initiate the writ process where appropriate. The Harris County Public Defender then sent a letter to each defendant (*See* **Exhibit F**) alerting him or her that the office is available to assist with re-testing requests and related court filings.

The Montgomery County District Attorney has taken the position that all cases for which evidence still exists shall be re-tested by DPS. The District Attorney's office also sent notice to the last known address of each potentially affected defendant and/or defense counsel. In addition, the District Attorney suggested the most prudent course would be for the county to appoint specific counsel for the purpose of handling writs for affected cases. Since that time, Montgomery County has been working with DPS to achieve re-testing using a systematic approach that prioritizes cases in which defendants are serving or have served jail time.

In Galveston County, the District Attorney sent letters to potentially affected defendants. The Galveston County courts also appointed specific defense counsel to assist defendants with the writ process. The Galveston County District Attorney has adopted a general policy to dismiss charges in cases where no evidence is left to test or where evidence was ever left in Salvador's custody.

At its October 2012 meeting, the Commission concluded the policies established by the three most affected counties, while not identical, were all reasonable methods of ensuring defendants are: (1) notified of the issue in the crime lab; and (2) given access to designated counsel for assistance with re-testing and/or the writ-filing process. However, Commissioners were concerned the notice process may not be equally robust in the other 33 counties affected. Because courts, prosecutors and defendants in smaller counties may

not have access to the same resources as Montgomery, Galveston and Harris Counties, the Commission instructed its staff to work with TDCAA, the Texas Criminal Defense Lawyers' Association ("TCDLA"), the Texas Commission on Indigent Defense and the Innocence Project of Texas ("IPOT"), to determine whether a notice protocol could be offered to ensure affected defendants in smaller counties have the same notice and access to counsel as defendants in larger counties. Commissioners determined such a protocol could be used as a model in future cases involving high volume forensic analyses, such as in the controlled substance discipline.

On November 14, 2012, Investigative Panel Chair Dr. Sarah Kerrigan and the Commission's General Counsel held a conference call with representatives from the Texas Commission on Indigent Defense, the Harris County Public Defenders' Office, and IPOT. The group agreed to the following approach during the call:

1. Harris, Montgomery and Galveston Counties have notice methods in place already, using the Harris County Public Defender's Office as a contact point for Harris County defendants and court-appointed counsel in Montgomery and Galveston Counties for defendants in those counties. Those three counties should continue to implement their approaches as discussed.

2. For the remaining counties, IPOT will serve as the point of contact for assisting defendants with re-testing requests and the related writ-filing process as necessary. Because IPOT has extensive experience with high volume case screening, they are well positioned to review cases and work with courts and prosecutors in the various counties affected.

3. The Commission will request the list of affected defendants from DPS so that IPOT may send letters similar to the Harris County Public Defender's letter.

4. Using Harris County as a model, the Commission will put together a model notice letter and distribute it to affected prosecutors (*See* **Exhibit G**.)

5. The Commission on Indigent Defense will discuss the model notice with the judge responsible for the affected administrative region and ask for his support in distributing the notice to other affected judges.

6. IPOT will inform the Texas State Bar Committee on Indigent Defense and the Governor's Office regarding the collaborative process envisioned and seek their feedback. The Commission will seek similar input from DPS.

On November 16, 2012, the Commission's General Counsel met with TDCAA's Director of Government Relations, who agreed to assist with review of the model notice and distribution to TDCAA's affected members. The issue was also discussed during TDCAA's December 2012 conference for elected district and county attorneys. TDCAA canvassed its members to determine whether any additional information or assistance would be helpful, and provided updated contact information to the TFSC for counties in which prosecutor turnover occurred as a result of the November 2012 election.

On December 3, 2012, the Commission distributed the model notice to prosecutors and responded to emails and follow-up questions. On December 17, 2012, the Commission on Indigent Defense briefed the regional presiding judges on the non-conformance and the model notice. The regional presiding judges agreed to forward the memo describing the incident and the model notice to the judges in each of the affected counties in their region.

On January 18, 2013, DPS provided the list of defendants to the Commission for distribution to IPOT. IPOT is currently in the process of contacting affected defendants in the 33 counties outside of Harris, Galveston and Montgomery. To facilitate this process, IPOT developed a partnership with TCDLA to request volunteer attorneys who accept court appointments and will represent defendants in smaller counties. Assistance from TCDLA is critical in light of the resource limitations and lack of uniformity among

the 33 counties. In addition, IPOT prepared standardized notice and pleading documents to assist volunteer attorneys. IPOT is also tracking data on the number of defendants in each county who have been contacted by either IPOT or a volunteer attorney. IPOT will submit this data to the Commission at the end of the notification process.

## IV. TFSC INVESTIGATION

### A. Statutory Requirement for Written Report

An investigation under the TFSC's enabling statute "must include the preparation of a written report that identifies and also describes the methods and procedures used to identify: (A) the alleged negligence or misconduct; (B) whether the negligence or misconduct occurred; and (C) any corrective action required of the laboratory, facility, or entity." *Id.* at 4(a)(3)(b)(1). A TFSC investigation may include one or more: (A) retrospective reexaminations of other forensic analyses conducted by the laboratory, facility, or entity that may involve the same kind of negligence or misconduct; and (B) follow-up evaluations of the laboratory, facility, or entity to review: (i) the implementation of any corrective action required . . . . ; or (ii) the conclusion of any retrospective reexamination under paragraph (A). *Id.* at 4(a)(3)(b)(2).

### B. TFSC Review Process

On July 27, 2012, the Commission voted to elect a three-member investigative panel to review the DPS disclosure. Panel members include: Dr. Sarah Kerrigan (Chair), Dr. Nizam Peerwani, and Atty. Bobby Lerma. Commission staff reviewed thousands of pages of documents and audio/video material submitted by DPS over the course of the investigation and made those documents available to Commissioners for review. Panel members also held non-deliberative conference calls on December 20, 2012 and January 17, 2013, to assess whether sufficient documentary evidence had been gathered to allow

Commissioners to conduct substantive deliberations, and instructed staff regarding requests for additional information. Dr. Kerrigan and Commission staff visited the DPS Houston Regional Crime Laboratory on January 8, 2013, at which time they conducted interviews of Gardiner, Yaklin, Lopez, and Gibson. Dr. Kerrigan and staff also met with D. Pat Johnson, DPS Deputy Assistant Director of Law Enforcement Support, Crime Laboratory Service. General Counsel Lynn Garcia contacted Salvador and his attorney, informed them of the Commission's deliberative process and the timing of this report, and provided contact information and an opportunity to speak with the Commission at any time leading to the release of this report. The Commission has not been contacted by either party.

On October 5, 2012, Dr. Kerrigan and the investigative panel provided an update regarding the status of the investigation to the full Commission. On January 25, 2013, the full Commission deliberated regarding the contents of this report, voted to issue a finding of professional misconduct against Salvador, and instructed staff regarding the contents and recommendations to be provided in this report. The Commission's findings are reflected below.

### C. Observations

#### *1. Crime Laboratory Transparency and Cooperation*

The Commission commends DPS for its transparency in disclosing the issues described to the Commission, ASCLD-LAB, law enforcement and other stakeholders. The panel was particularly impressed by the honest and forthcoming nature of discussions with staff and management during the site visit. It is clear this incident affected the examiners and management at DPS in a profound way. Despite being

chronically understaffed, management worked hard to provide the Commission with follow-up information and additional data when requested.

*2. Ethical Standards of Forensic Scientists*

The act of using evidence in one case to support the results issued in another case is one of the most serious ethical violations that can occur in a crime laboratory. As set forth in ASCLD-LAB's *Guiding Principles of Professional Responsibility for Crime Laboratories and Forensic Scientists*, forensic scientists are obligated to conduct full and fair examinations. Conclusions must be based on "the evidence and reference material relevant to the evidence, not on extraneous information, political pressure, or other outside influences." (*See* **Exhibit H**.) In addition, forensic scientists must "honestly communicate with all parties (the investigator, prosecutor, defense and other expert witnesses) about all information relating to their analyses, when communications are permitted by law and agency practice." *Id.*

The specific incident involving the alprazolam analysis in case #L2H-222396 was investigated thoroughly by the Rangers and OIG, and nothing in the record provides an alternative explanation for Salvador's actions. Fortunately, DPS performs technical review on 100% of the controlled substance casework prior to administrative review and release to the submitting agency. This review ensures that results meet the reporting criteria and standards set by DPS. However, the misrepresentation of the data would not be identified during the technical review process. During interviews with the Rangers, it was clear Salvador struggled to maintain acceptable performance. It was well-recognized by those performing technical reviews, and his supervisor, that his work was frequently returned for administrative and technical corrections. Therefore, the Commission

decided it was more important to focus on the circumstances and environment in the laboratory leading up to the violation itself. The Commission's inquiry included a review of Salvador's performance over his six years at DPS. The Commission focused on identifying systemic issues that may have allowed the incident to occur so that improvements may be made to protect against future recurrence.

*3. Low Case Output*

Salvador's performance evaluations show he had difficulty maintaining adequate case output throughout the course of his employment. (*See* **Exhibit I.**) In his evaluations, drug section supervisor Severo Lopez noted a "lower case output than expected" for multiple years. Though DPS does not have a quota requirement, most examiners in the drug section are expected to complete between 85-100 cases per month, absent extraordinary circumstances. Salvador often had difficulty meeting the minimum expectation. He often "scrambled" toward the end of the month and was frequently concerned about whether he would meet expectations.

*4. High Correction Rate*

In addition to problems analyzing a sufficient number of cases per month, Salvador had problems with too many corrections. His evaluations stated that "more than 1 in 3 of Salvador's case folders were returned for corrections." *Id.* Most of the corrections were administrative in nature, but some technical corrections were noted as well. Salvador's evaluations also indicated that he should "pay careful attention to details especially when encountering difficult or unusual samples." *Id.* The evaluations further stated that he should "carefully explore and determine possible causes for negative results before reaching a conclusion of negative." *Id.* The evaluations instructed Salvador to

"avoid short cuts" and "strive to minimize clerical and technical errors on reports to less than 10% returned for correction." *Id.*

Meetings with examiners further supported the conclusion that Salvador struggled with corrections and an overall understanding of the chemistry, especially in difficult cases. One examiner who performed a large percentage of the technical reviews on Salvador's cases observed that he "just made so many mistakes." While most of the mistakes were administrative, a few were technical. Examiners were consistent in their view that Salvador was very friendly and helpful, just not the right type of person for the job. More than one examiner shared concerns about Salvador's high error rate and lack of understanding of the chemistry with the drug section supervisor.

In retrospect, examiners and management observed that Salvador might have been afraid to ask for help with the alprazolam analysis in case #L2H-222396, because he had been spoken to about two other analysis-related problems in the months before the alprazolam case. One involved the contamination of his instrument by tadalafil and another involved his failure to positively identify hydrocodone. There was a perception that Salvador simply "could not afford" to have another mistake, such as the failure to positively identify the alprazolam in L2H-222396.

Interviews with management further support the conclusion that the quality of Salvador's work was not optimal. Issues with Salvador's work were described as "very systemic." At one point, the laboratory director maintained an error log to monitor the number of cases returned for correction per examiner. The log revealed that Salvador's work was sent back for correction in more than 1 in 3 cases. Management tried to work with Salvador, conducting remedial training and providing coaching and counseling.

Salvador was very accepting of the criticism, and always corrected issues immediately and vowed to do better. When asked whether the quality of Salvador's work was acceptable under DPS standards, management described the quality of Salvador's work as "right on the edge" of acceptability.

Salvador's high error rate caused the drug section supervisor concern, which he shared with the laboratory director. The laboratory relied on the review process—both technical and administrative review—to provide a safety net for Salvador's work product. The drug section supervisor described his attempts at "compassion" toward Salvador because despite his limitations, Salvador's attitude was always positive, he accepted redirection, and was a valuable member of the laboratory—often volunteering for routine tasks and duties that other examiners preferred to avoid. It was clear management made good-faith efforts to help Salvador improve, and were completely shocked that Salvador would ever use evidence from one case to support the results in another.

When asked why Salvador's written evaluations do not appear to fully capture the concerns about Salvador shared by employees and management, management explained they tried to note the concerns in the written section of the evaluation, but conceded the evaluations may have been "too polite." When asked why he received "meets expectations" in the vast majority of the categories, the drug section supervisor explained that Salvador was always "on the line" between "meets expectations" and "needs improvement." The laboratory manager also explained that he and the section supervisor struggled in deciding which of the two categories was appropriate. When asked why Salvador was promoted despite the concerns regarding his lack of attention to detail and understanding of the chemistry, the section supervisor indicated that promotions at DPS

are standard based on years of service, and he did not feel it was appropriate to deny a promotion unless the person was totally inept, which Salvador was not. There was also a perception that forensic scientists at DPS are paid below their peers in the field, and thus they try not to deny people salary increases. The lab manager explained that in running a laboratory, management recognizes that "everyone has their strengths and weaknesses," and the issues raised about Salvador's work were never anything "catastrophic" until the incident with the alprazolam.

*5. Salvador's Value in Other Areas of Laboratory Work*

As indicated above, there was consensus among management and examiners that Salvador was a major asset in the laboratory when it came to volunteering for difficult jobs that no one wanted to do. He was friendly and easy to work with, accepted criticism and direction well, and assisted during difficult projects such as when the laboratory moved buildings in 2011. Salvador's easygoing and collegial demeanor contributed to management's reluctance to more aggressively discipline or dismiss him before the alprazolam incident. Because he accepted criticism well, management tried very hard to work with him by providing verbal counseling and remedial on-the-job training.

*6. Perceptions Regarding Discipline*

Until recently, there was a perception in the laboratory (among both examiners and management) that it was extremely difficult to discipline or terminate an employee within the DPS system. During Director McCraw's tenure, greater efforts have been made to re-vamp the evaluation system and roll out new evaluation procedures. Management will begin using a new evaluation form in the next evaluation cycle, beginning at the end of 2013. In addition, DPS top management has reminded all

laboratory managers and section supervisors—both verbally and in writing—of their obligation to accurately report employee performance on evaluations, and to use the various disciplinary tools and forms available.

*7. Laboratory Staffing Challenges*

During on-site interviews in January, the Commission observed that examiners displayed competence, diligence and great concern for the integrity and reliability of the work performed in the laboratory. While the Commission was impressed with the quality of the current examiners, the DPS Houston regional laboratory is operating under tremendous budgetary strain. Though the laboratory has new examiners in training for drug analysis, the drug chemistry section had only three people actively performing full-time casework during the Commission's on-site visit in January 2013. Two of the section's most experienced examiners were not working controlled substance cases at the time of the visit because they were being cross-trained to perform blood-alcohol analysis to alleviate the tremendous backlog in that area. As of April 5, 2013, the laboratory has an additional two examiners who just completed training and are performing supervised casework, while one additional examiner still in training. The under-resourcing of the crime lab has also impacted management's staffing decisions. Terminating an employee means hiring and training a replacement, which takes many months and is difficult to bear when the laboratory is already understaffed.

**D. Negligence/Misconduct Finding**

While the terms "professional negligence" and "professional misconduct" are not defined in the Commission's enabling statute, the Commission has defined these terms in its policies and procedures, as follows:

> "Professional Misconduct" means, after considering all of the circumstances from the actor's standpoint, the actor, through a material act or omission, deliberately failed to follow the standard of practice generally accepted at the time of the forensic analysis that an ordinary forensic professional or entity would have exercised, and the deliberate act or omission substantially affected the integrity of the results of a forensic analysis. An act or omission was deliberate if the actor was aware of and consciously disregarded an accepted standard of practice required for a forensic analysis." (TFSC Policies & Procedures at 1.2.)

> "Professional Negligence" means, after considering all of the circumstances from the actor's standpoint, the actor, through a material act or omission, negligently failed to follow the standard of practice generally accepted at the time of the forensic analysis that an ordinary forensic professional or entity would have exercised, and the negligent act or omission substantially affected the integrity of the results of a forensic analysis. An act or omission was negligent if the actor should have been but was not aware of an accepted standard of practice required for a forensic analysis." (TFSC Policies & Procedures at 1.2.)

At its January 25, 2013 meeting, the Commission voted unanimously that Salvador's actions in this case constituted "professional misconduct" as defined in the Commission's policies and procedures. This conclusion was based on the following analysis: (1) by using the evidence in case #L2H-222403 to support the results issued in case #L2H-222396, Salvador failed to follow the standard of practice generally accepted at the time, both as expressed in DPS policies and procedures and in the ASCLD-LAB Guiding Principles of Professional Responsibility (*See* **Exhibit A**, **Exhibit H**); (2) the report generated by Salvador for case #L2H-222396 substantially affected the integrity of the results of the forensic analysis because it was based on evidence from case #L2H-

222403, thereby requiring the laboratory to re-analyze the evidence and re-issue a report. Though the re-analysis confirmed the initial scientific findings reported by Salvador, the results were based upon accurate supporting data from the case in question.

Salvador fraudulently misrepresented data after attempting analysis on a pharmaceutical drug exhibit. However, during the course of the Commission's investigation, there was no evidence to suggest that there were property control issues of a systemic nature that might preclude future re-testing of evidence.

**E. Results of DPS Re-Testing to Date**

Re-analysis of Salvador's casework during the 90-day period surrounding the incident resulted in four additional corrective actions, referred to by DPS as "Quality Action Plans" (QAPs). Following is a description of each QAP:

1. One exhibit containing two packets of powder, visibly different in color. Salvador reported that both contained Cocaine-HCl. Upon retesting, one contained Cocaine-HCl, and one contained Cocaine base (crack). Salvador had conducted the FTIR confirmation test on only the Cocaine-HCl item.

2. Smoking pipe exhibit. Salvador reported contained Tetrahydrocannabinol. Upon retest, 0.46 gram of Marihuana was scraped from the pipe bowl.

3. One completed item of evidence discovered unsealed in Salvador's work station.

4. Plant material identified as Marihuana despite only a faint color test; re-analysis indicated it was not Marihuana.

In addition, examiners who reviewed the cases during the 90-day period described "poor documentation, poor technique and poor decision-making" by Salvador. In the months since the initial 90-day re-analysis was performed, examiners have re-analyzed 440 additional cases. The laboratory also has 155 requests for re-testing pending as of April 5, 2013. The re-analysis of the 440 cases resulted in the following QAPs:

1. Weight of Cocaine exhibit reported by Salvador as 8.06 kg. Upon retest, the weight was corrected to 6.95 kg. The incorrectly reported weight was attributable to a math error, not a weighing error or a loss of weight.

2. Failure to properly identify mushrooms which contained psilocin, likely due to incorrect extraction method or insufficient sample.

3. Weight on a Cocaine exhibit incorrectly reported by Salvador as 33 gm. Upon retest, it was reported as 0.33 gm. This was not a weighing error, but a data entry error on the lab report.

The attached QAPs correspond to the cases cited above. (*See* **Exhibit J**.) The Commission will release an addendum to this report reflecting any additional QAPs when all re-analysis is completed.

## V. APPELLATE COURT DECISIONS IN SALVADOR CASES

The Texas Court of Criminal Appeals has begun hearing applications for writs of habeas corpus in cases where Salvador analyzed the evidence. The Court releases its decisions on a weekly basis. Decisions may be accessed by clicking on the "Hand Down List" tab on the Court's website at http://www.cca.courts.state.tx.us. As of this writing, all published decisions have involved cases from Galveston County, though the Commission anticipates cases from other counties will follow in the near future. To date, the Court has overturned convictions *both* in cases where the evidence was destroyed *and* in cases where there is still evidence remaining to re-test. The Court reasoned that because the evidence was in Salvador's custody, ". . . custody was compromised, resulting in a due process violation." (*See e.g., Ex Parte Sereal*, No. 76,972 (Tex. Crim. App. 2013), *Ex Parte Hobbs*, No. AP-76,980 (Tex. Crim. App. 2013).)

The potential impact of these decisions on convictions obtained in Salvador cases is difficult to overstate. Though it is too early to tell whether every conviction for which a writ application is filed will be overturned, these decisions emphasize the absolutely

critical role played by forensic scientists in the criminal justice system. It is imperative that Texas crime laboratories use this experience as a tool for improving quality standards, especially with respect to identifying red flags in employee performance. As this case so powerfully demonstrates, the safety and security of our communities often depend upon the integrity and reliability of the work performed in our state's crime laboratories.

## VI. LESSONS LEARNED AND RECOMMENDATIONS

The Commission makes the following recommendations:

1. Texas crime laboratories should develop methods to reduce the likelihood of ethical violations. For example, laboratories should re-examine evidence at random (where possible) to ensure reported results are consistent, and to discourage examiners from taking short-cuts, even when there are severe backlogs.

2. Texas crime laboratories should ensure their evaluation systems effectively reflect staff performance. Evaluations containing consistent questions about an examiner's understanding of analytical processes, attention to detail, or tendency to take "short cuts" demand special attention.

3. Texas crime laboratories should review their hiring systems to flag issues early during the probation period. If current recruiting and probation programs are ineffective, management should initiate appropriate changes to strengthen them.

4. Laboratory management should be cautious not to allow an examiner's positive and collegial demeanor to mask inadequate or marginal performance. Though "compassion" is an admirable quality in many circumstances, the potential impact of a major non-conformance is simply too great to justify or minimize signs of underperformance in a crime laboratory.

5. Consequences of examiner underperformance should be clear and consistent. Government bureaucracy should not impede laboratory management's ability to make key hiring and termination decisions. Moreover, laboratory supervisors and managers, who are ultimately responsible for the performance of their employees, should have effective means to recommend changes in employment scope or status where necessary.

6. DPS should continue to provide re-analysis results for Salvador cases to the Commission. The Commission will publish final results in an addendum to this report.

7. Limited resources and the lack of centralization of legal representation pose a number of challenges regarding notification practices. In high volume cases where notice to defendants is particularly challenging, stakeholders in the criminal justice community should use the example set in this case, and work together to provide a common sense approach to notice. Such an approach should ensure actual notice is given to defendants to the extent possible, and that defendants are given a resource to consult regarding applicable legal remedies.

8. As the Commission gains more experience with crime laboratory self-disclosures and complaints, issues may emerge that were not anticipated, and for which no other agency appears to be in a position to coordinate a response. A glaring example in this case is the need to facilitate a uniform approach to communication with prosecutors and notice to defendants, especially considering: (a) numerous counties with disparate resources have been affected; (b) large volumes of evidence have been brought into question; and (c) many defendants are indigent with limited access to legal representation. Statewide policymakers and members of the Legislature should consider these issues when crafting future policies affecting the criminal justice system.

9. All laboratories should follow DPS's example by taking a proactive approach to disclosure, including but not limited to reporting facts that may rise to the level of negligence or misconduct.

10. The Texas Forensic Science Commission should sponsor a crime laboratory management training program for all publicly funded Texas laboratories addressing such issues as interviewing and selecting quality examiners, succession planning, leadership development, and performance management.

11. The Texas Legislature should adequately fund crime laboratories to support high quality examiners and reduce the impact of financial pressures on management decisions related to the hiring and termination of staff.