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**TOM SELLECK**  
CRIMINAL DISTRICT ATTORNEY  
BRAZORIA COUNTY

March 13, 2024

Members of the Brazoria County Bar Association  
& Indigent Defense Counsel


RE: Texas Department of Public Safety DNA Analyst Disclosure

Dear Counsel:

Pursuant to Rules 304 and 309 of the Texas Rules of Professional Responsibility, as well as the Schulz decision, I am releasing the following statements regarding a sample switch which occurred at the Houston DPS Regional Crime Laboratory.

Please be advised that on or about November 16, 2023, Richard Hopper, a DNA analyst in the Texas Department of Public Safety Houston Crime Laboratory was involved in a sample switch. The sample switch occurred during the normalization/amplification setup process and as a result the DNA report for one lab number was released with results pertaining to another lab number. Attached is the Texas Department of Public Safety Crime Laboratory Quality Incident Report and notification letter.

We are sending this to you consistent with our continued disclosure duties and in the interest of laboratory transparency.

  
Tom Selleck  
Brazoria County Criminal District Attorney

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# TEXAS DEPARTMENT OF PUBLIC SAFETY

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02/27/2024

**To: District/County Attorney's Office**

**Subject: Updated Analyst Disclosure Form**

Dear Customer,

On 11/16/2023, a significant quality event in the Houston DPS Regional Crime Laboratory was identified pertaining to Richard Hopper and a sample switch. Additional information may be located in the associated quality incident documentation obtained under this lab and tracking number [insert number] via <https://www.dps.texas.gov/CrimeLaboratory/qualIncidents.htm>.

A list of cases from your county worked or reviewed by the employee is attached. Please contact the laboratory if you feel re-analysis or review of the case is needed based on the circumstances of the incident.

This event has additionally been self-disclosed to the Forensic Science Commission. Please refer to <https://txcourts.gov/fsc/case-status/> for related documents.

Sincerely,

A handwritten signature in black ink, appearing to read 'Andrew Gardiner', with a long horizontal flourish extending to the right.

Andrew Gardiner  
Houston Regional Crime Laboratory Manager  
[Andrew.gardiner@dps.texas.gov](mailto:Andrew.gardiner@dps.texas.gov)  
281-517-1216

*Encl. Richard Hopper Disclosure Form dated 11/20/2023  
Case List*



TEXAS DEPARTMENT OF PUBLIC SAFETY  
CRIME LABORATORY

Page 1 of 1  
TxDPS 10.06.2023

**Disclosure Form**

LAB-302 LIMS Rev.02 (10/2023) p.1 Issued by: SQM

The information included on this document is required by Texas DPS Crime Laboratory policy, specifically the Crime Laboratory Division Manual which is published online at <https://www.dps.texas.gov/section/crime-laboratory/publications>. The Forensic Disclosure and Compliance chapter of this manual outlines laboratory requirements for disclosure and is provided in accordance with Brady, Giglio, and Michael Morton Act.

Any events requiring disclosure for the indicated employee are listed below. If there are no events requiring disclosure, this will be indicated by listing "None." A full list of disclosable events is outlined in the policy referenced above.

All Quality Incidents are available online to the public for viewing any time at:  
<https://www.dps.texas.gov/section/crime-laboratory-service/crime-laboratory-quality-incidents>.

The Quality Incident Search Index can be accessed here:  
<https://txdpslabs.qualtraxcloud.com/ShowDocument.aspx?ID=61117>.

Quality Incidents and corrective actions that are determined to be significant quality events are included on this form below.

NOTE: Entries listed below do not necessarily relate to the case to which this Disclosure Form may be attached.

**Name:** Hopper, Richard  
**Title:** Forensic Scientist III

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**Date:** 11/20/2023

**Disclosure Event:** Sample switch discovered after results were reported.

**Tracking Number:** QI-HOU-2023-1120-DNA

**Description of Incident:** Sample switch discovered after results were reported to the customer.

**Reviewed by Andrew Gardiner on 01/26/2024**

**Link to Incident:**

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TEXAS DEPARTMENT OF PUBLIC SAFETY  
CRIME LABORATORY

**Quality Incident Report**

LAB-510 Rev.01 (04/2023) p.1 Issued by: SQM

<b>Tracking ID</b>  <b>QI-HOU-2023-1120-DNA</b>
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Lab	Houston	Discipline	DNA	Date Discovered	11/20/2023	Page 1 of 2
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Date of Incident	11/16/2023	End Date of Incident (if applicable)	01/24/2024
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Related Policy/Procedure/Specification	DNA-07-03
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Related Work # (case/batch/instrument#)	HOU-2309-11652 01-03-AA-01; HOU-2309-11612 01-09-AA-02-AA
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**Incident Description:**

A sample switch of casework samples occurred during the normalization/amplification (amp) setup process and as a result, a DNA report for HOU-2309-11612 was released with results that pertain to HOU-2309-11652. During batch review on 11/20/2023, the profile comparison tool matched multiple samples in HOU-2309-11612 to HOU-2309-11652 01-03-AA-01 at high percentages and when manually compared, the profiles matched or were very similar. The profile for HOU-2309-11652 01-03-AA-01 did not correlate with the case scenario since the victim was not present on items where it would be reasonable to expect a victim profile. At this point, this was investigated as a possible contamination or double-pipetting of a HOU-2309-11612 sample into the well for HOU-2309-11652 01-03-AA-01. HOU-2309-11652 01-03-AA-01 was reset up and re-injected providing the same results. The sample was then re-amplified providing a different result that included the victim which is more in line with the case scenario, indicating that the error occurred at the amplification step. The issue was presumed to be resolved, so both cases were reported by two different analysts and released. A deduced single source male profile was entered into CODIS from HOU-2309-11652 01-03-AA-01. A forensic mixture was entered into CODIS from HOU-2309-11612 01-09-AA-02-AA, since the victim in that case was excluded from the mixture. On 12/08/2023, the Local CODIS Administrator notified the Assistant Technical Leader that there was a contamination concern due to a benchwork match that did not make sense in the context of the case scenario for the two cases - HOU-2309-11612 and HOU-2309-11652. The electropherograms for the two entered profiles appeared nearly identical. A secondary review of the analytical worksheets in both cases, indicated that the two samples were adjacent to one another at all steps of the analytical process. It became apparent that HOU-2309-11652 01-03-AA-01 and HOU-2309-11612 01-09-AA-02-AA had been switched at amp setup and only HOU-2309-11652 01-03-AA-01 had been caught and corrected prior to release of the report. The Quality Manager, Laboratory Manager, DNA Section Supervisor, and amplification analyst/reporting analyst were promptly notified in person, and the Technical Leader was notified via email.

**Cause Analysis:**

Multiple factors may have contributed to the sample switch, and it being missed prior to the CODIS benchwork match. At the time of this incident, the Houston DNA section was working with increased batch sizes. DPS has recently implemented a new sexual assault kit workflow which requires every sample from the kit to be sent forward for DNA analysis. This change has resulted in significantly larger batches of samples which are manually setup for the quantification and amplification processes. To ensure the laboratory continued to meet legislatively mandated turnaround times during the holiday season, DNA supervisors increased batch sizes to accommodate the number of cases. The analyst was not performing analytical work for an extended period while undergoing DNA interpretation training and subsequent casework. Upon returning to analytical work, the analyst's previous routine processes were no longer ideal for the new workflow's larger batches. Because of this, the amplification analyst varied his process for this amp setup from routine practice, orienting a sample tray horizontally instead of vertically. This may have contributed to the analyst varying their process. The amplification analyst's routine process is to label the lids of the dilution tubes with the well number of the amp plate into which the dilution will be pipetted. The analyst kept eight tubes open which then prevented the analyst from verifying the labeling on the lids. Having multiple extract and dilution tubes open at once also increased the opportunity for contamination to occur. During the process of amp setup, moving samples to and from multiple locations increases the risk of sample switching. Working larger batch sizes has a downstream impact on use of the GeneMapper comparison tool. Larger batches inherently result in an increased number of sample-to-sample matches, the majority of which are expected and nonprobative. Sixteen samples from HOU-2309-11612 were amplified and included in this GeneMapper project. One sample was amplified for HOU-2309-11652. The single sample from HOU-2309-11652 was able to be identified as an outlier when compared to the sixteen samples from HOU-2309-11612. Due to the number of similar profiles in HOU-2309-11612, it was not recognized during batch review that one profile was an outlier. Analysts are usually looking for the presence of matching profiles between cases as an indicator of contamination. Case circumstances involved multiple males and caused the analyst and reviewer not to question the presence of a profile inconsistent with the case. Once the profile from HOU-2309-11652 was re-amplified, the new profile was only compared to the original profile in HOU-2309-11652 to determine that it was a different result. The re-amplified sample was never compared to each of the profiles from HOU-2309-11612.

**Risk Assessment:**

Severity is major because this sample switch was caught after the report was issued to the customer, which is a disclosable event. Likelihood of occurrence is uncommon because this was an isolated incident regarding this analyst. As a part of determining root cause, the assistant technical leader supervised a tube setup by the analyst leading up to the amplification



TEXAS DEPARTMENT OF PUBLIC SAFETY  
CRIME LABORATORY

**Quality Incident Report**

LAB-510 Rev.01 (04/2023) p.1 Issued by: SQM

<b>Tracking ID</b> <b>QI-HOU-2023-1120-DNA</b>
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Lab	Houston	Discipline	DNA	Date Discovered	11/20/2023	Page 2 of 2
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setup to determine if there were any notable deficiencies. No concerns were noted with the analyst's processes. Risk level is medium because, while there could have been an impact to adjudication, the mistake was caught and remedied almost immediately and before any adjudication occurred. There also could have been a potential impact in the CODIS database after upload of this profile in the form of incorrect or adventitious hits. However, the mistake was caught during the CODIS hit review process and the incorrect profile was removed immediately. An amended report was issued soon thereafter to correct the conclusion of the original report for HOU-2309-11612.

**Risk Level:** Medium

**Correction(s) to the Original Work (Indicate if not performed at this time):** **Corrected Report?** Yes  
 For HOU-2309-11612 01-09-AA-02-AA the sample was re-amplified and an amended report was released. The incorrect profile was removed from CODIS. No additional work needed to be completed for HOU-2309-11652 01-03-AA-01 as it was caught prior to the report being released. All casework amplifications previously performed by the analyst were reviewed. Data was thoroughly checked in the GeneMapper Comparison Tool, and reported results from those batches were reviewed to ensure that they were consistent with case details. No concerns were noted during this review. A sampling of the analyst's DNA interpretation casework (14 of 56 total cases, or 25%) were pulled to be technically reviewed. This review revealed some administrative errors but no technical concerns. As a result, the analyst was permitted to return to DNA interpretation casework. The analyst was also asked to limit casework activities to administrative review while his past work was reviewed for any technical concerns. After all review was complete, no additional incidents were noted, and the analyst was able to perform all casework activities.

**Customer Notification (Indicate if not performed at this time or not applicable):**  
 An email was sent to the submitting agency and the district attorney's office explaining a sample switch occurred and an amended report was being issued. The analyst's disclosure form was updated. The laboratory manager will send disclosure and quality incident information to all agencies that are impacted.

**Corrective Action Necessary?** Yes      **Significant Disclosure?** Yes      **Inclusion on Disclosure Form?** Yes

**Approval**

Collaborator(s) Temple, Angelina, Hopper, Richard, McKinney, Kathleen, Dean, Tanya (electronically signed)

Subject Matter Expert(s) McWhorter, Andrew, Ehmann, Jessica (electronically signed)

Lab QA Zalekian, Somiyeh (electronically signed)

Management Wimsatt, Kristi, Gardiner, Andrew, McWhorter, Andrew (electronically signed)

System QA Richardson, Kayla (electronically signed)

Date of Final Approval 02/20/2024