



**THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON**

April 28, 2026

Ambassador Jamieson Greer
Acting Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Dear Ambassador Greer:

Thank you for your office's August 25, 2025, letter to the Department of Veterans Affairs (VA) regarding whistleblower allegations involving the Carl T. Hayden VA Medical Center (hereinafter Phoenix).

VA has investigated the matter and prepared the enclosed report.

Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in black ink, appearing to be "D. Collins", with a long horizontal flourish extending to the right.

Douglas A. Collins

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

**Report to the
Office of Special Counsel
OSC File Number DI-25-001991**

**Carl T. Hayden VA Medical Center
Phoenix, Arizona**



Report Date: February 25, 2026

Content Manager 2025-C-28

Executive Summary

The Office of the Secretary of the Department of Veterans Affairs (VA) received a referral from the Office of Special Counsel (OSC) on August 25, 2025, requesting formal resolution. Subsequently, the Acting Under Secretary for Health, Veterans Health Administration (VHA), directed the Office of the Medical Inspector to assemble and lead a VA team to investigate allegations concerning the Carl T. Hayden VA Medical Center (hereinafter Phoenix) located in Phoenix, Arizona. The whistleblower alleged conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; and a substantial or specific danger to public safety. We conducted an onsite visit on October 21, 2025, through October 23, 2025, to investigate these allegations.

Specific Allegations of the Whistleblower

- 1. For approximately the past 2½ [two and a half] years, the Send Out Lab has not verified as complete in VistA [Veterans Health Information Systems and Technology Architecture] hundreds of specimens sent to outside labs [laboratories] for testing or analysis, including Pharmacogenetics panels, Germline Genetics tests, Post Vasectomy analyses, Semen analyses, and Special Send Out tests.*
- 2. Per OSC, any related allegations of wrongdoing discovered during the investigation of the foregoing allegations.*

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place and **do not substantiate** allegations when the facts and findings showed the allegations are unfounded. We are **unable to substantiate** allegations when the available evidence was insufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of the findings, we make the following conclusions and recommendations:

Conclusions for Allegation 1

- We **substantiate** that during approximately the past two and a half years, the Send-Out Lab did not timely verify as complete in Veterans Health Information Systems and Technology Architecture (VistA) hundreds of specimens that Phoenix sent to outside labs for testing and analysis. Currently, staff have reduced the backlog and monitor and address the incomplete reports on business days.
- The incomplete backlog developed primarily due to short staffing in the Send-Out Lab and the prioritization of the time-consuming process of preparing send-out specimens.
- Pathology and Laboratory Medicine Service leadership did not provide sufficient oversight of the Send-Out Lab as they were not aware of the incomplete backlog issue until July 2025.

- Phoenix Referral 1001, Send Out Quality Assurance Plan, version 1.1, dated May 2, 2022, is vague and subjective, and the Send-Out Lab Quality Assurance (QA) manager does not monitor Send-Out Lab metrics.

Recommendations to Phoenix

1. Conduct a workflow optimization project for the Send-Out Lab from specimen processing through result verification.
2. Establish a plan for continued sufficient staff coverage for the Send-Out Lab.
3. Strengthen Phoenix Referral 1001 and develop QA monitoring with specific pull intervals for reporting Send-Out Lab incompletes. Require monthly reporting to a higher-level committee, such as the QA Committee, and Pathology and Laboratory Medicine Service leadership.

Conclusions for Allegation 2

- We **do not substantiate** that two patients died as a result of [REDACTED] send-out test results for infectious organisms that were not verified in over a month for one patient and not at all for the second patient.
- We **do not substantiate** that there is no Standard Operating Procedure (SOP) for reporting reportable diseases and that reporting has not been done for several months.

Recommendations to Phoenix

None.

Summary Statement

We developed this report in consultation with other VHA and VA offices to address OSC concerns that for two and a half years, the Phoenix Send-Out Lab has not verified as complete in VistA hundreds of specimens sent to outside laboratories resulting in the death of two patients; that there is no SOP for reporting reportable diseases; and reporting has not been done for several months. We reviewed the allegations and determined the merits of each. We found the Send-Out Lab did not timely verify as complete in VistA hundreds of specimens that Phoenix sent to outside laboratories for testing and analysis. However, we found no evidence that the delay in verifying laboratory results played a significant role in the care or death of the two identified patients. We also found that Phoenix has two guidance documents, one SOP and one service level policy, for reporting communicable diseases and has reported appropriately.

Table of Contents

Executive Summary	i
I. Introduction	1
II. Facility Profile.....	1
III. Specific Allegations of the Whistleblower.....	1
IV. Conduct of Investigation	2
V. Background, Findings, Conclusions, and Recommendations	4
Allegation 1	4
Background	4
Findings.....	7
Conclusions for Allegation 1	10
Recommendations to Phoenix	10
Allegation 2	11
Findings.....	11
Conclusions for Allegation 2	12
Recommendations to Phoenix	12
VI. Summary Statement	12
Attachment A References	13
Attachment B List of Acronyms	15

I. Introduction

The Office of the Secretary of the Department of Veterans Affairs (VA) received a referral from the Office of Special Counsel (OSC) on August 25, 2025, requesting formal resolution. Subsequently, the Acting Under Secretary for Health, Veterans Health Administration (VHA), directed the Office of the Medical Inspector (OMI) to assemble and lead a VA team to investigate allegations concerning the Carl T. Hayden VA Medical Center (hereinafter Phoenix) located in Phoenix, Arizona. The whistleblower alleged conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; and a substantial or specific danger to public safety. We conducted an onsite visit on October 21, 2025, through October 23, 2025, to investigate these allegations.

II. Facility Profile

Phoenix VA Health Care System (PVAHCS) is a part of Veterans Integrated Service Network (VISN) 22 and a complexity level 1a facility.¹ PVAHCS is a 165-bed tertiary care facility serving Veterans in Phoenix, Arizona and surrounding communities in central Arizona. PVAHCS includes Phoenix and 12 community-based outpatient clinics in Gilbert, Mesa, Phoenix, Scottsdale, Payson, Show Low, Globe, and Surprise, Arizona. Phoenix is a general medical and surgical care teaching facility and offers comprehensive primary care, behavioral health, rehabilitation medicine, and long-term care.² Phoenix's Send-Out Laboratory (hereinafter Send-Out Lab), processed 140,982 and 161,693 specimens in calendar year (CY) 2023 and CY 2024, respectively.³

III. Specific Allegations of the Whistleblower

3. *For approximately the past 2½ [two and a half] years, the Send-Out Lab has not verified as complete in VistA [Veterans Health Information Systems and Technology Architecture] hundreds of specimens sent to outside labs [laboratories] for testing or analysis, including Pharmacogenetics panels, Germline Genetics tests, Post Vasectomy analyses, Semen analyses, and Special Send-Out tests.*
4. *Per OSC, any related allegations of wrongdoing discovered during the investigation of the foregoing allegations.*

1 Complexity 1a facilities have high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs. VHA Office of Productivity, Efficiency, and Staffing, Facility Complexity Level Model Fact Sheet, undated. Available at:

<https://dvagov.sharepoint.com/sites/VHAOPES/VHAOPESFY23FacilityComplexityModelFactSheet>. last accessed January 30, 2026. **Note:** *This is an internal VA website that is not available to the public.*

2 VHA Support Service Center Trip Pack, Phoenix, dated January 29, 2026. Available at:

<https://reports.vssc.med.va.gov/ReportServer/Viewer.aspx>, last accessed January 30, 2026. **Note:** *This is an internal VA website that is not available to the public.*

3 PVAHCS PALMS Workload Statistics by Major Section Report, dated October 22, 2025. **Note:** *This is an internal VA report that is not available to the public.*

IV. Conduct of Investigation

The VA team conducting the investigation consisted of a Senior Medical Investigator and a Clinical Program Manager, both from OMI; the VHA National Laboratory Information Manager and the Laboratory Information Manager National Coordinator, both from the VHA Pathology and Laboratory Medicine Program Office; and a Human Resources Consultant, from the VHA Workforce Management and Consulting Office, Human Resources Center of Expertise. We reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A.

We interviewed the whistleblower on September 9, 2025.

We conducted an entrance briefing on October 21, 2025, with the following VISN 22 and Phoenix leadership:

- Network Director (interim), VISN 22
- Chief Medical Officer, VISN 22
- Quality Management Officer, VISN 22
- Deputy Medical Center Director
- Deputy Chief of Staff
- Associate Director, Operations
- Associate Director, Resources
- Deputy Associate Director for Patient Care Services
- Chief (interim), Quality and Patient Safety Department
- Health System Specialist, Chief of Staff Office
- Health System Specialist, Associate Director of Operations Office
- Administrative Officer, Quality and Patient Safety Department

We interviewed the following staff:

- Executive Director, VHA National Pharmacogenomics Program
- Director of Operations, VHA Pharmacogenetics Program
- Chief Medical Officer, VISN 22

- Chief, Pathology and Laboratory Medicine Service, Loma Linda VA Medical Center, and Chief, Pathology and Laboratory Medicine (acting), VISN 22
- Associate Chief of Staff, Primary Care Service
- Chief (interim), Medicine Service
- Physician, Infectious Disease
- Chief, Pathology and Laboratory Service
- Supervisory Clinical Laboratory Scientist, Specimen Acquisition and Send-Out
- Quality Assurance Manager, Pathology and Laboratory Medicine Service
- Manager (interim), Send-Out Lab
- Information Manager, Pathology and Laboratory Medicine Service
- Pharmacogenetics Coordinator, Send-Out Lab
- Clinical Laboratory Scientist, Send-Out Lab
- Medical Laboratory Technician, Send-Out Lab
- Staff, Microbiology Laboratory
- Chief, Organization Health and Experience
- Infection Prevention and Control Professional
- Patient Safety Manager, Quality and Patient Safety Department
- Risk Manager, Quality and Patient Safety Department
- Chief, Health Information Management Service

We conducted an exit briefing on October 23, 2025, with the following VISN 22 and Phoenix leadership:

- Network Director (interim), VISN 22
- Chief Medical Officer, VISN 22
- Quality Management Officer, VISN 22
- Deputy Medical Center Director

- Deputy Chief of Staff
- Associate Director, Operations
- Associate Director, Resources
- Deputy Associate Director for Patient Care Services
- Chief (interim), Quality and Patient Safety Department
- Health Systems Specialist, Chief of Staff Office
- Health Systems Specialist, Associate Director of Operations Office
- Administrative Officer, Quality and Patient Safety Department.

V. Background, Findings, Conclusions, and Recommendations

Allegation 1

For approximately the past 2½ [two and a half] years, the Send Out Lab has not verified as complete in VistA [Veterans Health Information Systems and Technology Architecture] hundreds of specimens sent to outside labs [laboratories] for testing or analysis, including Pharmacogenetics panels, Germline Genetics tests, Post Vasectomy analyses, Semen analyses, and Special Send Out tests.

Background

VA Send-Out Labs provide laboratory services for specimens that cannot be tested at the VA medical facility and must be sent to an outside commercial, specialized laboratory, or another VA laboratory. A reference laboratory is a laboratory that performs specialized testing not usually performed in a hospital laboratory or any laboratory that receives specimens from another laboratory for analysis.

Pharmacogenomics testing “...focuses on maximizing medication benefits and minimizing medication side effects by using a patient's genetic makeup to prescribe the most appropriate dose and medication with less trial-and-error.”⁴

Germline testing focuses on identifying inherited mutations in DNA that could cause increases in risk of specific diseases or cancers.

Semen testing may be completed for post-vasectomy or fertility analysis.

Per Phoenix Referral 1003, Ordering and Processing of Send Out Specimens, version 2.1, dated February 28, 2025, “*Special send-out testing is an orderable test only*

⁴ VHA Pharmacogenomic Testing, undated. Available at: <https://dvagov.sharepoint.com/sites/vhapgx>, last accessed January 30, 2026. **Note:** This is an internal VA website that is not available to the public.

*available for laboratory personnel.*⁵ It is used when providers contact the Send-Out Lab for special testing they are unable to order through the electronic health record (EHR) and allows laboratory staff to order tests that are not built in Veterans Health Information Systems and Technology Architecture (VistA).⁶

Phoenix Referral 1004, Verifying LEDI and Manual Entry Send Out Specimen Results, version 1.1, dated May 22, 2022, describes the process to verify results as complete in VistA. For all send-out tests, the Send-Out Lab staff must verify patient demographics are accurate and that the results have been uploaded into VistA. Next, they verify the send-out result as complete in VistA, and then the result is available to the ordering provider in the patient's EHR. The exception to this process is testing sent to the Long Beach VA medical facility and the Tucson VA medical facility, which are verified automatically.⁷

Test Result Management

VHA Directive 1106, Pathology and Laboratory Medicine Service, dated January 24, 2024, defines the Laboratory Information System (LIS) as *“a software system that records, manages and stores data for VA medical facility laboratories. LIS sends laboratory test orders to laboratory instruments, tracks those orders and records the results to a searchable database.*⁸ The VistA laboratory package is the LIS currently used at Phoenix. *“VistA Imaging has helped VA hospitals achieve an enterprise-wide paperless and filmless Electronic Health Record...The imaging system now captures clinical images, scanned documents, motion video and other non-text data, and makes them part of the patient's electronic medical record.”*⁹

VHA Directive 1106, section 8.c., Test Result Management, states:

“(1) There must be procedures to verify patient results are accurately transmitted from the point of data entry (interfaced instruments and manual input) to patient reports...

(4) There must be a quality control process to ensure test results manually entered into LIS are accurate and complete.

(5) Laboratory tests ordered by a VA health care provider or contract health care provider for use in providing patient care and tested by a VA medical facility laboratory, VA-contracted laboratory ([for example], reference laboratories) or agent of the VA laboratory must be entered into LIS.

5 Phoenix Referral 1003, Ordering and Processing of Send Out Specimens, version 2.1 dated February 28, 2025.

Note: *This is an internal VA document that is not available to the public.*

6 Ibid.

7 Phoenix Referral 1004, Verifying LEDI and Manual Entry Send Out Specimen Results, version 1.1, dated May 2, 2022. **Note:** *This is an internal VA document that is not available to the public.*

8 VHA Directive 1106, Pathology and Laboratory Medicine Service, dated January 24, 2024.

9 VA | VHA VistA Imaging, dated July 13, 2023. Available at: <https://www.va.gov/health/imaging/>, last accessed January 30, 2026.

(a) For reports captured outside of LIS, the test must be accessioned [laboratory receives the specimen and staff enter an order number in the laboratory package] into LIS and the location of the imaged document entered in the comment section of the results following EHR procedures.”¹⁰

VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated July 11, 2023, states “*Test results are the outcomes of patient testing and include the results of laboratory and pathology testing, diagnostic imaging and other diagnostic procedures.*”¹¹ VHA Directive 1088(1) states:

“...with listed exceptions, test results requiring action must be communicated to patients within 7 calendar days from the date on which the results are available to the Department of Veterans Affairs (VA) medical facility ordering provider or designee and 14 days for those that do not require any action. Depending on the clinical context, the VA medical facility ordering provider or designee may need to review and communicate test results in shorter timeframes.”¹²

Per PVAHCS Medical Center Policy (MCP) 11-102, Communicating Test Results to Providers and Patients, dated June 10, 2021, test results are to be “*...communicated to the provider within a time frame that allows appropriate clinical action to be taken. The provider communicates test results to patients so that they may participate in health care decisions.*”¹³ In addition, PVAHCS MCP 11-102 states “*For test results that require no action, results must be communicated by the ordering provider, or designee, to patients no later than 14 calendar days from the date on that the results are available to the ordering practitioner or designee.*”¹⁴

Quality Assurance

Phoenix Referral 1001, Send Out Quality Assurance Plan, version 1.1, dated May 2, 2022, establishes “*A procedural guideline for printing and resolving incompletes [accessions that remain on the Incomplete Report until verified as complete in the laboratory package by laboratory personnel] and for monitoring the timely resulting of send-out specimens.*”¹⁵ Send-out specimens are sent to contracted reference laboratories for analysis when in-house testing is not available. Phoenix Referral 1001 states “*Most of these results are automatically uploaded in vista [VistA] for daily verification by the send out section.*”¹⁶

Per Phoenix Referral 1001, “*Send out testing orders and results are available via LEDI [Laboratory Electronic Data Interchange] and manual order via referral lab [laboratory]*

¹⁰ Ibid.

¹¹ VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated July 11, 2023.

¹² Ibid.

¹³ PVAHCS MCP 11-102, Communicating Test Results to Providers and Patients, dated June 10, 2021. **Note:** This is an internal VA document that is not available to the public.

¹⁴ Ibid.

¹⁵ Phoenix Referral 1001, Send Out Quality Assurance Plan, version 1.1, dated May 2, 2022. **Note:** This is an internal VA document that is not available to the public.

¹⁶ Ibid.

*websites and requisitions.*¹⁷ Laboratory accessions will remain on the Incomplete Report until verified as complete in the laboratory package by laboratory personnel. Results that are not electronically uploaded into VistA by LEDI require laboratory personnel to find and manually enter the results into VistA. Phoenix Referral 1001 states, *“Ideally incomplete reports should be run twice a week on Mon [Monday] and Thurs [Thursday] unless there is a holiday with Tue [Tuesday] and Fri [Friday] being alternate days. This allows time to research and verify results still pending.”*¹⁸

To calculate and report quality assurance (QA) monitors for average time to report manually verified send-out tests, laboratory staff are expected to:

- Periodically pull ten manual reports each of the three external laboratories used by Phoenix and input into the Manual Send-Out Lab Audit Spreadsheet in a local drive and forward to the QA manager for monitoring.
- Periodically report, from the incomplete list for both VA and non-VA laboratories and forward to the QA manager for monitoring, the number of send-out tests greater than 15 days and 30 days old.
- Report to the Automated Data Processing Application Coordinator any LEDI specimens that are no longer automatically uploading from the external laboratories and need to be investigated and resolved.¹⁹

Findings

Phoenix’s Pathology and Laboratory Medicine Service (PALMS) reports to the VISN 22 Chief of PALMS. VISN 22 is in the process of deconsolidating the facilities’ PALMSs and aligning them with their respective facility leadership. VISN 22 has a goal to reorganize by January 2026.

In the absence of a facility-specific standard operating procedure, we visited the Send-Out Lab to observe their operations and obtain staff descriptions of the send-out process, from specimen acquisition through documentation and result reporting. We determined that the Send-Out Lab’s process starts when a VA provider orders a laboratory test that is not processed at their facility. The specimen is collected at the VA facility and then sent to the external laboratory for testing. Once the external laboratory has completed the test, the results are sent back to the VA (automated system or manual entry) and entered into the Veteran’s EHR. The VA provider is responsible for communicating the test results to the Veteran.

The details of the general Send-Out Lab process vary depending on the type of test and the receiving laboratory conducting the testing. For some tests, generally those with lengthy reports that cannot be directly entered into VistA, the Health Information Management and Health Records Service or Send-Out Lab staff uploads the results in a

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Ibid.

portable document format (PDF) into VistA Imaging. For all send-out tests, except tests sent to the Long Beach VA medical facility and the Tucson VA medical facility, which are auto-verified, the Send-Out Lab staff must verify that the patient demographics are accurate and that the results have been uploaded into VistA, then verify the send-out test result as complete in the laboratory package in VistA, after which the result is available in the EHR to the ordering provider. The whistleblower is concerned that if the verification in VistA by the Send-Out Lab staff is delayed, the provider may not be able to timely notify the patient of their results.

Two points require clarification regarding the whistleblower's concerns. First, it is generally expected that the turn-around time for results related to Pharmacogenomics, Germline testing, Post Vasectomy, and Semen Analysis would be longer than the expected turn-around time for other laboratory tests such as those performed at the on-site laboratory, for example general chemistry or hematology. Second, the inclusion of an accession number or test on the incomplete list does not inherently indicate that the result was not received by the provider and communicated to the patient. For instance, the National Pharmacogenomics Program (NPP) documented receipt of test results in patients' EHRs, designated the ordering providers as cosigners on the associated clinical notes, and mailed hard copies of the results directly to the patients. The NPP paused this practice in August 2025, and plan to resume it later in calendar year 2026. The NPP reported distributing 1,188 results in the second quarter through fourth quarter of fiscal year (FY) 2023, 1,105 results in FY 2024, and 501 results in FY 2025. In addition, providers regularly contact the laboratory to obtain specific test results when such information is not readily accessible within the patient's EHR.

We reviewed Phoenix laboratory workload data and determined that Phoenix send-out tests, to contracted laboratories and other VA medical facilities, totaled 56,784 in FY 2023, 63,366 in FY 2024, and 62,803 in FY 2025. Table 1 shows the distribution of the send-out tests referenced in the allegation.

FY	Pharmaco-genetics	Germlines	Post-Vasectomy Analysis	Semen Analysis	Special Send-Out tests	Total in Allegation	Total Send-Out tests
2023	1,313	79	111	64	342	1,909	56,784
2024	943	106	94	88	387	1,618	63,366
2025	594	98	125	138	438	1,393	62,803

Table 1 Distribution of send-out tests referenced in the allegation for FY 2023, FY 2024, and FY 2025.

A Phoenix Send-Out Lab staff member acknowledges the allegation as true. We reviewed Phoenix's Send-Out Lab data, from January 1, 2023, through July 1, 2025, (allegation references approximately two and a half years) and confirmed a backlog of

hundreds of send-out tests not verified as complete in VistA. Specifically, we ran a historical query for three of the send-out tests mentioned in the allegation to review the number of specimens collected from January 1, 2023, through September 30, 2025, that took greater than 100 days from laboratory accession to laboratory verification. The data for the three tests showed 1,848 for Pharmacogenomics Panel, 260 for Special send-out testing, and 116 for Germline Genetic Test. A total of 2,224 send-out tests that took over 100 days to verify as complete confirms that hundreds of send-out tests were not verified timely and is consistent with a large backlog and staff testimony.

We ran a second query for the same three send-out tests to review the current state of specimens collected from July 1, 2025, through October 20, 2025, that took greater than 100 days from laboratory accession to laboratory verification. The data for the three tests showed 17 for Pharmacogenomics Panel, 15 for Special send-out testing, and 7 for Germline Genetic Test. The data showed 7 Special send-out testing accessions were greater than 100 days. Of the remaining tests, 24 were less than 30 days and 8 were between 25 to 48 days. PALMS leadership stated they were not aware of the backlog of incompletes in the Send-Out Lab until approximately July 2025 when it was brought to their attention through emails and a Joint Patient Safety Reporting (JPSR) system entry. PALMS leadership immediately addressed the backlog by approving overtime pay and temporary contracted staff. They stated that a staffing shortage was the primary reason for the backlog and further explained that a large portion of the Send-Out Lab staff's time is spent processing blood tubes and other specimens in preparation for send-out testing.

The Send-Out Lab has three positions, including a 1.0 full-time equivalent (FTE) Supervisory Clinical Laboratory Scientist, a 1.0 FTE Clinical Laboratory Scientist (CLS), and a 1.0 FTE Medical Laboratory Technician (MLT), but often during the timeframe referenced in the allegation, two or fewer staff were working in the Send-Out Lab. The laboratory manager authorized details of the supervisory CLS and the CLS. The supervisory CLS was detailed from approximately February 2023, except for late April 2025 through mid-July 2025. The CLS was detailed to manage Phlebotomy from approximately February 2023 until returning to the Send-Out Lab full time in late August 2024. The CLS helped in the Send-Out Lab when possible while she was detailed to Phlebotomy. Phoenix has a part-time contract MLT who spends part of his time in the Send-Out Lab, and a 1.0 FTE contract MLT entered on duty in the Send-Out Lab on October 27, 2025. The Send-Out Lab currently has 3.0 FTE staff. Send-Out Lab staff, with the help of the CLS returning to the laboratory full time, has since made a dedicated effort to reduce the backlog.

The OSC referral references an Incomplete Report generated on July 26, 2025, using the query "incomplete test for the past 14 to 1,000 days." The report identified the following incomplete tests in VistA: 1,399 Pharmacogenetics panels; 102 Germline Genetics tests; 30 Post-Vasectomy analyses; 16 Semen analyses; and 272 Special send-out tests. For comparison purposes, at 2 pm on October 21, 2025, we generated a report of all Send-Out Lab incompletes on the list for 1 day or longer (all incomplete tests). The result indicated 13 Pharmacogenetics tests, 7 Germline Genetics tests, 39 Post-Vasectomy analyses, 19 Semen analyses, 18 Special send-out tests, and 21

additional tests, for a total of 117 incomplete tests. These results represent a significant improvement compared to July 26, 2025, and reflect that in an active laboratory, there will always be some results in incomplete status due to ongoing laboratory operations.

In VistA, once laboratory staff accessions a specimen within the laboratory package, it appears on the incomplete list until results are verified and finalized. The timeframe for Send-Out Lab staff to complete testing varies depending on both specimen receipt and test type. For example, in Post-Vasectomy analysis, the specimen kit is provided to patients on the day of surgery, which also serves as the accession date. However, patients are instructed to wait for approximately 12 weeks before obtaining the specimen, and during this time the test remains on the incomplete list.

We learned that the VA National Pharmacogenomics Program enters a note with the pharmacogenetic test results into the patient's EHR, and the ordering provider is alerted to view and cosign the results and notify the patients. Thus, for the pharmacogenetics send-out test results, although the ordering providers do not have to rely on the facility's Send-Out Lab to verify and complete the results in VistA, the Send-Out Lab must verify the results in the VistA laboratory package to complete the test.

Although Phoenix has a QA Plan (Phoenix Referral 1001), it is subjective and does not include specific pull intervals for Send-Out Lab reporting. For example, it says, *"Periodically report the following items from the incomplete list for both VA and non-VA labs and forward to QA for monitoring..."* The Send-Out Lab QA manager is not currently monitoring any Send-Out Lab metrics.

Conclusions for Allegation 1

- We **substantiate** that during approximately the past two and a half years, the Send-Out Lab did not timely verify as complete in VistA hundreds of specimens Phoenix sent to outside labs for testing and analysis. Currently, staff have reduced the backlog and currently monitor and address the incomplete reports on business days.
- The incompletes backlog developed primarily due to short staffing in the Send-Out Lab and the prioritization of the time-consuming process of preparing send-out specimens.
- PALMS leadership did not provide sufficient oversight of the Send-Out Lab as they were not aware of the incompletes backlog issue until July 2025.
- Phoenix Referral 1001 is vague and subjective, and the Send-Out Lab QA manager does not monitor Send-Out Lab metrics.

Recommendations to Phoenix

4. Conduct a workflow optimization project for the Send-Out Lab from specimen processing through result verification.

5. Establish a plan for continued sufficient staff coverage for the Send-Out Lab.
6. Strengthen Phoenix Referral 1001 and develop QA monitoring with specific pull intervals for reporting Send-Out Lab incompletes. Require monthly reporting to a higher-level committee, such as the QA Committee, and PALMS leadership.

Allegation 2

Per OSC, any related allegations of wrongdoing discovered during the investigation of the foregoing allegations.

Findings

The whistleblower alleged when [REDACTED] reviewed the Incomplete Report, [REDACTED] “discovered the death of at least one patient whose provider ordered a send-out test for infectious organisms, including [REDACTED], but did not receive the test results given the incomplete status of the test.” The whistleblower submitted a JPSR system report that “two patients died as a result of [REDACTED] results that were send-out tests for infectious organisms not verified in over a month for one patient and not at all for the second patient.” In addition to the Phoenix Chief of PALMS review, who did not agree with the allegation in the JPSR system report, we recommended that VISN 22 have a clinical provider, preferably an Infectious Disease physician, outside of Phoenix, review the two patients referenced in the JPSR system report (hereinafter Patient A and Patient B), to include an opinion on whether the verification process for send-out tests contributed to the death of these patients. The outcome of those reviews is as follows:

- Patient A: *“While there was indeed a delay in the return of the West Nile CSF [cerebrospinal fluid] testing in this case, I do not believe it ultimately impacted the care of this patient in an appreciable way or contributed to his demise. The diagnosis of [REDACTED] was known to [REDACTED] team at [a health care facility in the community] as of [REDACTED], 2023, and [REDACTED] had already received corticosteroids and IVIG [intravenous immunoglobulin] by then, both of which are potential treatments for [REDACTED] (though no treatment has proven efficacy). I do find it a little unusual that his [REDACTED] panel took five days to return, as it can usually be done in an hour if it is done in-house. I suspect it may be a send-out at the Phoenix VA, in which case, this turnaround time makes more sense.”*
- Patient B: *“I do not find any evidence that the failure to send the [REDACTED] antigen send-out test on the patient’s [REDACTED] played a significant role in the patient’s subsequent care or ultimate demise. The diagnosis of disseminated [REDACTED] had already been made, and [REDACTED] was already on appropriate treatment.”*

The whistleblower also alleged that there is no SOP for reporting communicable diseases and that reporting has not been done for several months. We determined that PVAHCS SOP 111-122, Reporting Communicable Diseases, dated March 29, 2021,

establishes procedures for the mandatory reporting of communicable diseases by Infection Prevention and Control Professionals and laboratory personnel who are required by law to report communicable diseases. In addition, Phoenix's PALMS Policy GEN-PG1048, Pathology [and] Laboratory Medicine Department Reporting Communicable Diseases, dated July 25, 2017, establishes the policy and procedures for reporting communicable diseases from PVAHCS to the Arizona Department of Health Services (ADHS). PALMS Policy GEN-PG1048 states that the Phlebotomy supervisor, or designee, will monitor all reportable reference laboratory sent out testing, on a periodic basis, to ensure compliance with ADHS reporting requirements and report any positive send-out tests to the Infection Control Coordinator. PALMS Policy GEN-PG1048 lists West Nile virus infection as 1 of the 14 reportable send-out tests.

Phoenix provided the Arizona Administrative Code § R9-6-204, Clinical Laboratory Director Reporting Requirements, effective June 2, 2025. The document outlines the requirements for clinical laboratory directors to report test results and specimens to the ADHS. We confirmed Phoenix reported from both the Provider and Laboratory Required Reporting lists to ADHS monthly between January 2025, through present, with a total of over 2,300 results.

Conclusions for Allegation 2

- We **do not substantiate** that two patients died as a result of [REDACTED] send-out test results for infectious organisms that were not verified in over a month for one patient and not at all for the second patient.
- We **do not substantiate** that there is no SOP for reporting reportable diseases and that reporting has not been done for several months.

Recommendations to Phoenix

None.

VI. Summary Statement

We developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel concerns that for two and a half years, the Phoenix Send-Out Lab has not verified as complete in VistA hundreds of specimens sent to outside laboratories resulting in the death of two patients, that there is no SOP for reporting reportable diseases, and reporting has not been done for several months. We reviewed the allegations and determined the merits of each. We found the Send-Out Lab did not timely verify as complete in VistA hundreds of specimens that Phoenix sent to outside laboratories for testing and analysis. However, we found no evidence that the delay in verifying laboratory results played a significant role in the care or death of the two identified patients. We also found that Phoenix has two guidance documents, one SOP and one service level policy, for reporting communicable diseases and has reported appropriately.

Attachment A

References

Arizona Administrative Code § R9-6-204, Clinical Laboratory Director Reporting Requirements, effective June 2, 2025.

Phoenix PALMS Policy GEN-PG1048, Pathology & Laboratory Medicine Department Reporting Communicable Diseases, dated July 25, 2017. **Note:** *This is an internal VA document that is not available to the public.*

Phoenix Referral 1001, Send Out Quality Assurance Plan, version 1.1, dated May 2, 2022. **Note:** *This is an internal VA document that is not available to the public.*

Phoenix Referral 1003, Ordering and Processing of Send Out Specimens, version 2.1 dated February 28, 2025. **Note:** *This is an internal VA document that is not available to the public.*

Phoenix Referral 1004, Verifying LEDI and Manual Entry Send Out Specimen Results, version 1.1, dated May 2, 2022. **Note:** *This is an internal VA document that is not available to the public.*

PVAHCS MCP 11-102, Communicating Test Results to Providers and Patients, dated June 10, 2021. **Note:** *This is an internal VA document that is not available to the public.*

PVAHCS PALMS Workload Statistics by Major Section Report, dated October 22, 2025. **Note:** *This is an internal VA report that is not available to the public.*

PVAHCS SOP 111-122, Reporting Communicable Diseases, dated March 29, 2021. **Note:** *This is an internal VA document that is not available to the public.*

VA | VHA VistA Imaging, dated July 13, 2023. Available at: <https://www.va.gov/health/imaging/>, last accessed January 30, 2026

VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated July 11, 2023.

VHA Directive 1106, Pathology and Laboratory Medicine Service, dated January 24, 2024.

VHA Office of Productivity, Efficiency, and Staffing, Facility Complexity Level Model Fact Sheet, undated. Available at: <https://dvagov.sharepoint.com/sites/VHAOPES/VHAOPESFY23FacilityComplexityModelFactSheet>, last accessed January 30, 2026. **Note:** *This is an internal VA website that is not available to the public.*

VHA Pharmacogenomic Testing, undated. Available at: <https://dvagov.sharepoint.com/sites/vhapgx>, last accessed January 30, 2026. **Note:** *This is an internal VA website that is not available to the public.*

VHA Support Service Center Trip Pack, Phoenix, dated January 29, 2026. Available at: <https://reports.vssc.med.va.gov/ReportServer/Viewer.aspx>, last accessed January 30, 2026. **Note:** *This is an internal VA website that is not available to the public.*

Other documents reviewed as part of this report.

Phoenix PALMS Workload Statistics by Major Section Report, date range January 1, 2023, through December 31, 2025. **Note:** *This is an internal VA report that is not available to the public.*

Attachment B
List of Acronyms

ADHS	Arizona Department of Health Services
CLS	Clinical Laboratory Scientist
CSF ²	cerebrospinal fluid
CY	calendar year
EHR	electronic health record
FTE	full-time equivalent
FY	fiscal year
IVIG ²	intravenous immunoglobulin
JPSR	Joint Patient Safety Reporting
LEDI ²	Laboratory Electronic Data Interchange
LIS	Laboratory Information System
MCP	medical center policy
MLT	medical laboratory technician
NPP	National Pharmacogenomics Program
OSC	Office of Special Counsel
PALMS	Pathology and Laboratory Medicine Service
PDF	portable document format
PVAHCS	Phoenix VA Health Care System
QA	quality assurance
SOP	standard operating procedure
VA	Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

VistA ¹	Veterans Health Information Systems and Technology Architecture
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¹ Note: Acronym first defined in allegation contained in this report.

² Note: Acronym first defined in direct quote contained in this report.

Table B-1 List of Acronyms

Index of Names

Key to Investigative Team Members

- [REDACTED] M.D., Senior Medical Investigator
- [REDACTED], MSN, FNP, FACHE, Clinical Program Manager
- [REDACTED], MLS (ASCP), VHA National Laboratory Information Manager, VHA Pathology and Laboratory Medicine Program Office
- [REDACTED], MLS (ASCP), Laboratory Information Manager National Coordinator, VHA Pathology and Laboratory Medicine Program Office
- [REDACTED], Human Resources Consultant, VHA Workforce Management and Consulting Office, Human Resources Center of Expertise

Key to Interviewees

- [REDACTED], M.D., Executive Director, VHA National Pharmacogenomics Program
- [REDACTED], M.D., Director of Operations, VHA Pharmacogenetics Program
- [REDACTED] M.D., Chief Medical Officer, VISN 22
- [REDACTED], M.D., Chief, Pathology and Laboratory Medicine Service, Loma Linda VA Medical Center, and Chief, Pathology and Laboratory Medicine (acting), VISN 22
- [REDACTED] M.D., Associate Chief of Staff, Primary Care Service
- [REDACTED], M.D., Chief (interim), Medicine Service
- [REDACTED], M.D., Infectious Disease
- [REDACTED], M.D., Chief, Pathology and Laboratory Service
- [REDACTED], Supervisory Clinical Laboratory Scientist, Specimen Acquisition and Send-Out
- [REDACTED], Quality Assurance Manager, Pathology and Laboratory Medicine Service
- [REDACTED], Manager (interim), Send-Out Lab

- [REDACTED], Information Manager, Pathology and Laboratory Medicine Service
- [REDACTED] Pharm.D., Pharmacogenetics Coordinator
- [REDACTED], Clinical Laboratory Scientist, Send-Out Lab
- [REDACTED], Medical Laboratory Technician, Send-Out Lab
- [REDACTED], Staff, Microbiology Laboratory
- [REDACTED], Psy.D., Chief, Organization Health and Experience
- [REDACTED], RN, Infection Prevention and Control Professional
- [REDACTED], RN, Risk Manager, Quality and Patient Safety Department
- [REDACTED], RN, Patient Safety Manager, Quality and Patient Safety Department
- [REDACTED], Chief, Health Information Management Service