



U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

October 22, 2026

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-25-001991

Dear Mr. President:

I am forwarding to you the report transmitted to the Office of Special Counsel (OSC) by the Department of Veterans Affairs (VA), in response to the Special Counsel's referral of a disclosure of wrongdoing at the Carl T. Hayden VA Medical Center (VAMC), Phoenix, Arizona. OSC has reviewed the disclosure, agency report, and whistleblower comments and, in accordance with 5 U.S.C. § 1213(e), I have determined that the report contains the information required by statute and the findings appear reasonable.¹ A summary of those findings and the whistleblower's comments follows.

██████████, who consented to the release of his name, alleged that for approximately two and a half years, the VAMC's Send-Out Lab (Phoenix Send-Out Lab) had not verified as complete in the Veterans Health Information Systems and Technology Architecture (Vista)² hundreds of specimens sent to outside labs for testing or analysis, including pharmacogenetics panels and germline genetics tests. ██████████ also alleged that two patients died because send-out test results were not timely verified as complete in Vista. ██████████ further alleged the Phoenix Send-Out Lab did not have updated Standard Operating Procedures (SOPs) that included new processes. The VA substantiated the first allegation and implemented corrective action but did not substantiate the second or third allegations.

VA Send-Out Labs provide laboratory services by sending specimens that cannot be tested in-house to outside commercial, specialized laboratories, or other VA laboratories, for testing. The report explains that VA laboratory test orders and results are tracked and maintained in Vista's laboratory information system.³ Agency investigators discovered that in

¹ OSC referred the allegations to Secretary Douglas A. Collins for investigation pursuant to 5 U.S.C. § 1213(c) and (d) on August 25, 2025. The VA Office of the Medical Inspector conducted the investigation and Secretary Collins reviewed and signed the agency report.

² Vista is the VA's electronic health record system. Its laboratory package tracks orders, results, and verification status. Vista Imaging is the component that stores scanned documents, images, and other non-text data as part of the electronic record.

³ See Veterans Health Administration Directive 1106, *Pathology and Laboratory Medicine Service* (2024) at § 8.c.

fiscal years 2023, 2024, and 2025 the Phoenix Send-Out Lab transmitted a total of 56,784, 63,366, and 62,803 tests, respectively, to commercial or other VA labs for specialized testing. Generally, send-out lab test results are automatically uploaded to the patient's Electronic Health Record (EHR) in VistA unless the results have a lengthy report, which requires manual entry by VA staff; lab personnel then verify that test results and patients' demographic information are in VistA and finalize the results as complete. Agency investigators noted that the presence of a test on the incomplete list does not necessarily mean the result was unavailable to the ordering provider. For pharmacogenomics testing, the National Pharmacogenomics Program documented results in patients' EHRs, designated ordering providers as cosigners, and mailed hard copies to patients. Providers also routinely contacted the laboratory directly for results when needed. In addition, some tests (such as post-vasectomy analyses) remain on the incomplete list by design for weeks while patients obtain and return the specimen.

The investigation substantiated that for approximately two and a half years, the Phoenix Send-Out Lab did not timely verify as complete in VistA hundreds of specimens it sent for testing and stated that VAMC Pathology and Laboratory Medicine Service (PALMS) leadership did not provide sufficient oversight because they were unaware of this backlog until July 2025. As of July 2025, the Phoenix Send-Out Lab had a backlog of approximately 2,224⁴ send-out test results that were over 100 days old and had not been finalized as complete in VistA. Investigators determined that a staffing shortage in the Phoenix Send-Out Lab caused the backlog, explaining that while three full-time employees work in the lab, from 2023 to 2025, at least one and sometimes two employees were on details away from the lab. The report also stated that lab staff spend most of their time processing and preparing specimens for send-out testing. In July 2025, PALMS leadership approved overtime for lab staff and hired temporary contract staff to address this backlog.

The report stated that the backlog was reduced as follows: seven special send-out test results over 100 days old needed to be finalized in VistA; and 32 test results less than 48 days old needed to be finalized. Investigators concluded that given the nature of laboratory operations, the Phoenix Send-Out Lab will always have some test results with an incomplete status in VistA. However, investigators also concluded that staff significantly improved the backlog as compared to 2025.

To continue improving Phoenix Send-Out Lab operations, the VAMC implemented several corrective actions. The Send-Out Lab filled the supervisor vacancy and hired a medical laboratory technician, which increased Send-Out Lab staff to four full-time equivalent employees (FTEEs). The staffing schedule states that the lab will maintain coverage at no fewer than two FTEEs each business day. The VAMC reissued *Phoenix SOP 1009, Send Out and Referral Department Duties and Responsibilities* and retrained Phoenix Send-Out Lab staff on the SOP. The VAMC also revised the Phoenix Send-Out Lab's quality assurance (QA) plan, *Phoenix*

⁴ This total breaks down as follows: 1,848 pharmacogenomics panel tests; 260 special send-out tests; and 116 germline genetic tests.

Referral 1001, Send Out Quality Assurance Plan (Referral 1001), by strengthening QA monitoring activity. This included: setting specific intervals to review the number of Send-Out Lab test results that are incomplete and not yet finalized in VistA; establishing key performance indicators for send-out testing; and implementing defined reporting requirements for pending send-out tests.⁵ Management ensured that lab staff know how to pull and review the incomplete specimen report. Monthly turnaround-time metrics for pending send-out tests are reported to the QA Committee and PALMS leadership, and the Send-Out Lab has presented quarterly reports to the Quality and Patient Safety Board and Clinical Executive Board. The lab's lead technician also attends daily huddles and bi-weekly administrative staff meetings. Finally, by December 2026, the VAMC intends to begin testing in-house, the high-volume tests that are currently sent to outside facilities.

The investigation did not substantiate that the delay in finalizing send-out lab results contributed to the deaths of two patients. The report acknowledged that [REDACTED] filed a Joint Patient Safety Report regarding the failure to timely finalize these patients' send-out test results in VistA. However, an independent clinician with Veterans Integrated Service Network-22 reviewed these patients' EHRs and concluded that the delayed verification did not contribute to either patient's death. The clinician determined that the teams providing care to these patients were aware of the respective diagnoses before the tests were verified as complete in VistA and the patients had been receiving appropriate treatment.

With respect to SOPs, specifically the failure to have an SOP for reporting communicable diseases, investigators confirmed the VAMC has a local procedure, Phoenix VA Health Care System SOP 111-122, *Reporting Communicable Diseases* (2021), that requires Infection Prevention and Control Professionals and laboratory personnel to report communicable diseases. The VAMC's Pathology and Laboratory Medicine Service Policy GEN-PG1048, *Pathology [and] Laboratory Medicine Department Reporting Communicable Diseases* (2017) also requires the Phlebotomy supervisor or their designee to monitor laboratory sent out tests for reportable communicable diseases and report any positive tests to the Infection Control Coordinator and Arizona Department of Health Services. Investigators confirmed the facility follows these reporting policies and procedures. Thus, the allegation was not substantiated.

In his comments, [REDACTED] disagreed with the findings and conclusions related to the unsubstantiated allegations. [REDACTED] also criticized VA leadership for not providing the Phoenix Send-Out Lab with adequate staff to manage the unit properly. Finally, he expressed disappointment with the investigative process generally and for not holding accountable the facility officials who mismanaged the Phoenix Send-Out Lab.

⁵ The revisions to Referral 1001 meet Federal, State, and local VA policies, and accreditation standards.

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I thank the whistleblower for bringing these important issues to OSC. In accordance with 5 U.S.C. § 1213(e) I have determined that the report contains the information required by statute and the findings appear reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of this letter, the agency report, and whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. OSC has also placed redacted copies of these documents and the redacted referral letter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

A handwritten signature in cursive script that reads "Charles N. Baldis".

Charles N. Baldis
Special Counsel

Enclosures