

To: The President of the United States and Congress

From: [REDACTED]

Supervisor Retired Phoenix, VAMC
Pathology & Medical Laboratory Services
Specimen Acquisition and Send Outs

Date: June 5, 2026

Ref: OSC File No. DI-25-001991

Subj: Whistleblower Comments

I. Background

- a. I was employed as a Supervisor in the Specimen Acquisition and Send Out section of the Pathology and Medical Laboratory Services (P&LMS) department at the Phoenix, VAMC.
- b. During my tenure, I was detailed under false accusations for over 2 ½ years because I tried to hold accountable a union member who refused to draw blood because of DEI policy on morning rounds as a phlebotomist and was accusing me of racism.
- c. When I was finally allowed to return, it was in a reduced capacity to the Send Out section only, which prevented me from enforcing EO 14151 and EO 14173 ending previous DEI policy and establishing Merit Based Opportunity. I ran an Incomplete Report in the Send Out section for the previous 60 days and discovered that all of the Pharmacogenetic tests and many other tests had not been reported in VISTA. When I asked the Send Out Lead Tech why these had not been verified, she replied that none of the Pharmacogenetics had been verified while I had been detailed out of the lab in the last 2 ½ years because “no one cared about them”. She also was no longer running the Incomplete Reports because the Quality Assurance (QA) Coordinator stopped requiring their reporting after I left. The Send Out section had not even been inspected by the Joint Commission on the last two biannual inspections. She then became very angry that I continued to investigate this “non-problem”.
- d. As I continued my investigation of this “non-problem”, the Lead Tech of Send Outs requested a formal meeting with me. She and another tech as a witness again requested that I drop my investigation and became very hostile toward me when I refused to do so.
- e. Fearing retaliation after this meeting, I made a protected disclosure of what I had found to the OSC and also alerted the laboratory and hospital leadership of the

problems. The next day I was removed as a supervisor by the Lab Manager and detailed to Logistics to prevent me from continuing my investigation.

- f. I did not report to Logistics but continued my investigation from another location at work for over a week while receiving AWOL for no pay. It was there that I was able to run an Incomplete Report going back for 2 ½ years and found potential harm on two patients.
- g. Had I not made a thorough evaluation of the section after I returned and reported what I found, I believe that I would have been held accountable for the Send Out sections poor management and removed from service.

II. Causes of Personnel Shortages

- a. **Management knew of the problems that existed but chose to ignore them because no one was being held accountable and VISN 22 would not approve additional personnel needed to address them.**
 - i. Previous high standards maintained under the College of American Pathologists (CAP) were no longer being enforced.
 - 1. CAP inspects each lab with a Pathologist lead team of 3 or more people depending on the size and complexity of the lab
 - 2. Each member of the team has specialized expertise and inspects for a 1-3 day period in their assigned area of the lab.
 - 3. Each CAP inspector focuses on one area such as Send Out testing and has the time to look at enough details to discover systematic problems if they exist.
 - ii. **The Phoenix VA Lab changed accreditation from CAP to The Joint Commission (TJC) in September 2020.**
 - 1. Only one TJC inspector with generalized expertise inspected the lab over the same 21-3 days.
 - 2. Standard Operating Procedures (SOP's) had not even been reviewed before the previous inspection (2024 and the lab was not cited for this.
 - 3. The Send Out sections Quality Assurance plan which required running incomplete reports and reporting delays to QA was not being followed and the lab was not cited for this as well.
- b. The Phoenix VA laboratory was not given the personnel needed to adequately manage the department when it **consolidated under VISN 22 in 2018/19.**
 - i. The Phoenix VA Lab is consistently in the top 5 VA labs nationally for efficiency (amount of work done/assigned personnel).
 - ii. Efficiency sounds good from a business perspective but can be bad if it results in staff burnout and patient safety errors.
 - iii. Phoenix Laboratory Services experienced high turnover rates of personnel and burnout as a result.

- iv. Funding needed for additional personnel was transferred to and controlled by VISN 22. Additional personnel needed to address staff burnout and additional growth was not approved by VISN 22 which contributed to two suicides.
 - v. **The Phoenix VA Lab will never be able to begin to address personnel shortages unless it is deconsolidated away from VISN 22 and returned to local management.**
- c. Those who did try to request the personnel needed and to hold federal workers accountable for refusing to do their jobs **were retaliated against by upper management and detailed away from the lab which only compounded the personnel shortage problems.**
- i. This retaliation included both myself and our former Service Chief who was detailed out of the Lab for more than a year until he left federal service.
 - ii. Those who caused the retaliation continue to remain in federal service and perpetuate the cycle of abuse and retaliation.
 - iii. Everyone at the Phoenix VA Medical Center, not just the lab, is afraid to report serious patient safety errors and abuse because no one is ever held accountable for retaliation. There is no fear of consequences by upper management.
 - iv. The most a whistleblower can ever expect is to keep or get their job and legal expenses back after spending tens of thousands of dollars on lawyers and lost wages. Few people have the resources to do that. Even if they do win their case, it is likely that no one will be held accountable for the harm they caused.

III. Investigation Shortfalls

a. Review process is inadequate.

i. Assumptions not challenged

1. **Error was due to personnel shortage and not systemic problems.** Lack of oversight by management, Quality Assurance, and regulatory agencies were the biggest cause of this problem. Procedures were also inadequate and required software for pharmacogenetics had not been installed.
2. **Personnel shortage was temporary and not chronic.** This is absolutely not true. Temporary shifting of personnel from one section of the Lab to another has only caused problems in those sections in the past.
3. **Only the ordering provider for Pharmacogenetics testing needed to know that results were available and where to find those results.** For each patient, this is a once in a lifetime test and patient providers change frequently. Mailing results to the ordering provider does not solve this problem. Results need to be verified in VISTA with comments of where to find scanned documents so that ANY provider looking for the results can access them.

4. **Patients can understand the results of Pharmacogenetics testing mailed to them.** It takes a trained medical provider to be able to interpret the results of pharmacogenetics testing. The only benefit to mailing results to patients is so that they can share them with a new provider who cannot find them.
5. **No harm was done to patients A and B because they were adequately treated before they died.** There was no discussion on delays in treatment for Patient B or the overmedication of Patient A that resulted from lab results being delayed or not available.

ii. Reported facts not checked-

1. **Phoenix VA Lab has deconsolidated as of January 2026 and returned to local control.** A one minute Google search revealed this to not be true and confirmed by a document dated 3/11/26 that listed the Phoenix, VA P&LMS as part of VISN 22.
2. **The NPP paused the practice of mailing pharmacogenetics testing results to ordering providers and patients in August 2025 and planned to resume this later in 2026.**
 - a. Several month earlier providers started ordering duplicate testing when they could not find the results in VISTA and were no longer receiving mailed results.
 - b. The Reference Lab started contacting me the first week of July 2025 to inquire why we were sending them multiple duplicate orders on patients who had previously been tested since this test is only needed one time in a patient's lifetime.
 - c. The resumption of mailing results for pharmacogenetics testing needs to be confirmed and followed up on.

b. Whistleblowers are not allowed to participate in the investigation process to prevent the inclusion in the final report of:

- i. False assumptions
- ii. False facts
- iii. Necessary questions remaining unanswered Inadequate recommendations in the final report.

c. Key information excluded from final report to minimize existing problems.

- i. Patient A was given Antifungal, Antibiotic, and Antiviral medication when results for West Nile Virus were available but not verified. This information was reported by me but excluded from the final report nor was this even mentioned by the independent outside provider who investigated this case. How much and for how long did Patient A receive unnecessary medications and was this a contributing factor in his demise? This question was not even addressed.
- ii. Patient B was diagnosed with disseminated Cocci and adequately treated before his demise. When was this diagnosis made and treatment started

and was there a delay in treatment because lab results were not immediately reported? There was no attempt to address this question even though it was believed that a delay had occurred in treatment when it was reported.

- iii. The Phoenix, VA Lab had not installed the software needed to download comments from Pharmacogenetics Panels into VISTA. I was not aware that this software existed until I was asked about it by the National Laboratory Information Manager when she questioned me about it. Again, this information never made it into the final report.

d. No process included for checking for similar problems in other areas/facilities.

- i. Do similar backlogs exist for Send Out sections of other VISN 22 Labs or other VISN labs nationally?
- ii. Did other VA labs fail to install the software needed to migrate the comments for Pharmacogenetics Panels into VISTA?
- iii. Did the Joint Commission fail to adequately inspect other areas of the Phoenix, VA Lab?
- iv. Did the Joint Commission fail to adequately inspect other VA Labs in general?

IV. Recommendation Shortfalls

- a. Evaluate Phoenix VA Lab for adequate staffing and adjust as needed.
 - i. Growth in Phoenix VA has been disproportionately high. Specific positions have been added and taken away, yet the budget relative to other VA's has remained the same.
 - ii. Personnel increases need to be evaluated based on workload every 10 years for the same reasons that a census is conducted every 10 years.
 - iii. Increased staffing needs have been reduced or denied outright based on false promises of "staff saving improvements" that have not delivered the promised savings
 - 1. The track system-savings were greatly reduced by the increased maintenance required.
 - 2. Auto verification-savings were reduced by the increased personnel needed for the required validations.
- b. Deconsolidate the Phoenix, VA Pathology and Laboratory Medicine Services (P&LMS) as promised. VISN 22 did not fail to prevent the problems identified in this report, they are the cause of them because of reduced staffing and operational budgets needed to justify their existence. One person has described them as a "giant succubus" that sucks the life of its victims.
- c. Schedule a for cause inspection by CAP of the Phoenix, VA P&LMS. This is needed to evaluate what other areas are experiencing problems not identified by the Joint Commission.

- d. Hold the Lab Manager, Service Chief and HR representatives Accountable for the retaliation and mismanagement that has occurred under their watch. Make examples out of them as a deterrent to others that whistleblower retaliation is not tolerated. Zero tolerance is advertised but rarely enforced. Public servants should not have a “right to privacy” when they violate the law. The problems identified in this report occurred when I was retaliated against and removed under questionable investigations for 2 ½ years.
- e. Change the findings for patients A and B from do not substantiate to unable to substantiate. Patients A and B were affected by results not being reported or delayed as previously discussed but no one can say with any certainty how that affected their ultimate demise.
- f. Write a lab Standard Operating Procedure (SOP) on Scanned Documents and train all Send Out validation personnel on its use. Only one person was trained and responsible for scanning documents in the Phoenix, VA Lab for over three years. The two patients reported in the Joint Patient Safety Reporting (JPSR) system occurred when this person was on emergency FMLA. There needs to be an SOP written and all Send Out validation personnel trained in it to include:
 - i. The Validation Process
 - ii. What Scanned Documents **CAN NOT** be used for such as:
 - 1. Infectious Disease reports
 - 2. Critical Values
 - 3. Oncology Reports
 - iii. Expected Turn Around Time
 - iv. Necessary comments such as “the location of imaged documents” (VHA Directive 1106, section 8. C., Test Result Management (5) (a). Without these comments its like handing the provider an encyclopedia and stating that your patient’s results are in this book. If the patient gets a new provider and nothing is verified in VISTA, the new provider doesn’t even get the encyclopedia.

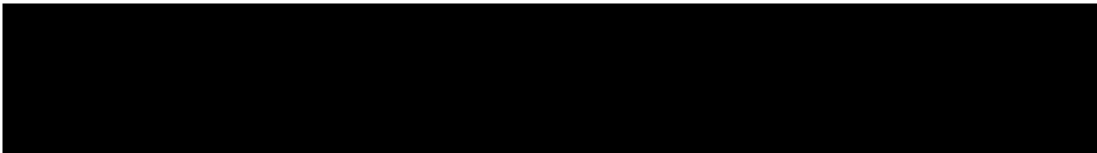
V. General Recommendations

- a. Include Whistleblowers in the investigation process as previously discussed.
- b. Return Whistleblowers to service as soon as preliminary investigation discovers that information disclosed is legitimate and retaliation likely. I remained on detail beyond when the inspectors were finished. All I wanted to do was fix the problems that were discovered and not allowed to repair. The OSC still has not removed the disparaging comments the Agency put on my final Retirement SF-50.
- c. Hold managers and senior administrators accountable for retaliation when it occurs.

- d. Change the current rule by Law or Executive Order which prevents the reporting of the names of people that are guilty of retaliation. Public servants who betray the trust given to them should not have a "Right to Privacy" This change alone will prevent future retaliation from occurring.
- e. Evaluate VA hospitals for adequate staffing and adjust as needed every 10 years. Interim budgets can be adjusted proportionately but systematic reevaluations need to be conducted every 10 years to adjust for demographic shifts and trends.
- f. Deconsolidate all of the VISN Labs. The only benefits to individual labs provided by the VISN's are bulk purchasing of equipment and coordination of shared testing. Both of these could easily be accomplished with Memorandums of Understanding (MOU's) without the cost prohibitive management layer of the VISN.

I declare under penalty of perjury that the foregoing is true and correct.

Date: 6/5/2026



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