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# U.S. House of Representatives

## COMMITTEE ON VETERANS' AFFAIRS

ONE HUNDRED THIRTEENTH CONGRESS

335 CANNON HOUSE OFFICE BUILDING

WASHINGTON, DC 20515

<http://veterans.house.gov>

May 21, 2013

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

Dear Mr. President:

I am writing to bring to your attention an alarming pattern of serious and significant patient care issues at Department of Veterans Affairs Medical Centers (VAMCs) across the country. Recent events at the Atlanta, Georgia, VAMC provide a perfect illustration of the management failures, deception, and lack of accountability permeating VA's health care system. Because these issues are long-standing, systemic, and apparently immune to the current structure of accountability within VA, I believe your direct involvement and leadership is required.

On Monday, May 6, 2013, I spent the day in Atlanta, Georgia, with House and Senate Members of the Georgia Delegation, including Representative David Scott (D-GA-13), to address failures in management, leadership, and oversight at the Atlanta VAMC which the Department of Veterans Affairs Inspector General (IG) concluded contributed to the suicide of a veteran patient and the overdose deaths of two others.

Prior to this visit, several of these same Members of the Georgia Delegation, sent a letter seeking assurances that such lapses in care would never occur again, but a response never came from VA leadership.

From this visit, we learned that no one was fired or otherwise held accountable for the hospital's failure linked to the deaths of these veteran patients. Most disturbing, none of the facility leaders present came forth to inform us about another patient suicide that occurred at the facility in response to direct questioning about disclosing any other patient deaths that may have occurred. Just four days after our visit, the press exposed that an additional horrific veteran suicide had occurred at the facility.

The complacency and deceitfulness of VA leadership at both the local and central office levels cannot be tolerated when the health and safety of our veterans and their families are at stake.

May 21, 2013

The events that occurred at the Atlanta VAMC are unfortunately just the latest in a tragic series of recent incidents highlighting a culture of systemic complacency and failure to meet the health care needs of at-risk veterans through the VA health care system. For example:

- five patient deaths from a Legionella outbreak in the Pittsburgh VA Healthcare System;
- whistle-blower complaints, poor sterilization procedures, understaffing and missed diagnoses at the G.V. (Sonny) Montgomery VAMC in Jackson, MS; and,
- possible exposure of veteran patients to infectious diseases such as hepatitis and HIV at the VA Western New York Health Care System.

The single most important mission of VA is to provide the highest quality of care for the men and women who have served and support for their families.

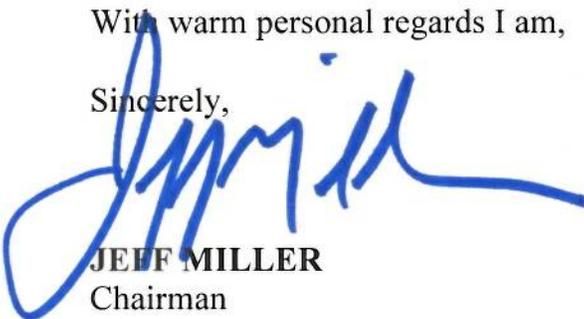
On behalf of the six million veterans who use VA for highest quality health care and all of those brave men and women who serve and sacrifice today, I respectfully request that you immediately address the management, oversight and leadership failures that are pervasive throughout the Department.

I look forward to hearing from you regarding what actions you intend to take and working with you to ensure the health of our nation's veterans is no longer compromised.

Thank you for your commitment to our veterans and prompt attention to this crucial matter.

With warm personal regards I am,

Sincerely,



**JEFF MILLER**  
Chairman

CJM/dd

cc: The Honorable Eric K. Shinseki, Secretary of Veterans Affairs