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ONE HUNDRED THIRTEENTH CONGRESS

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November 20, 2013

The Honorable Eric Shinseki
 Secretary
 U. S. Department of Veterans Affairs
 810 Vermont Ave. NW
 Washington, DC 20420

Dear Secretary Shinseki,

The Office of Inspector General (OIG) of the Department of Veterans Affairs (VA) recently issued a report (No. 13-00505-348) on October 23, 2013, documenting substandard care leading to three veteran deaths at the Emergency Department of the Memphis VA Medical Center. One patient died after a physician prescribed a medication for which the patient had a known allergy; another patient died after being administered multiple sedating drugs but without proper monitoring; and a third patient died after delays in treatment for high blood pressure.

According to the OIG, inadequate monitoring of patients in the Emergency Department was an issue identified in an earlier site visit last year. See OIG Report No. 11-04090-253, dated August 2012. Also troubling is the OIG's finding that implementation by the Memphis VAMC of root cause analysis action plans developed in response to previous adverse events was delayed and incomplete.

Given the patient deaths and the apparent inability of the VA to implement corrective actions at the Emergency Department in Memphis, I request the following information for purposes of an oversight investigation being conducted by this Committee:

- 1) The root cause analysis action plans related to the three patient deaths.
- 2) All peer reviews of the medical professionals involved in treating the patients who died.
- 3) All performance reviews for each of the medical professionals involved in the patient deaths from January 1, 2010 to the present, including those responsible for oversight of patient safety, such as the facility director and chief of staff.
- 4) All disciplinary actions, counseling, and/or reprimands for the individuals in item 3 from January 1, 2010 to the present. For all of individuals involved in the three deaths, please also indicate where in the VA they currently work and if any are no longer with VA, describe the circumstances of their departure.

Thank you for your attention to the matter. If you have any questions, please contact Mr. Eric Hannel, Staff Director, Subcommittee on Oversight and Investigations at (202) 225-3569.

Sincerely,

A handwritten signature in blue ink, appearing to read "Jeff Miller", with a long horizontal flourish extending to the right.

JEFF MILLER
Chairman

JM/hr