Congress of the United States

Washington, DC 20515

July 25, 2024

The Honorable Denis McDonough
Secretary of Veterans Affairs
U.S. Department of Veterans Affairs
810 Vermont Ave, NW
Washington, D.C. 20420

Secretary McDonough:

This week, the Veterans Administration (VA) Office of Inspector General (OIG) issued a report,[1] which found that the tragic death of a veteran at a Phoenix VA facility—a facility with a troubling history of ongoing patient care issues—was due to poor care management and delayed emergency care. We request an immediate briefing from you on how the Phoenix VA will implement the OIG's recommended policy changes and training standards immediately, as well as ensure lifesaving equipment is available.

As you know, in March of 2023, a veteran lost consciousness in front of the Carl T. Hayden VA Medical Center following a routine appointment. A series of cascading mistakes—lack of an automated external defibrillator on site, an operator failing to connect with the Veterans Affairs Police, no staff from the facility performing CPR, and local emergency services taking 11 minutes to respond—resulted in this veteran failing to receive timely care and tragically passing away two days later.

Upon investigation, the OIG found unacceptable failures on the part of the Phoenix VA. The veteran's vitals were not taken during the routine appointment, despite the fact that he suffered from a chronic heart condition; and reporting issues hid the true risk about the patient's multiple previous emergencies. The report reads:

> "Despite having awareness of the delay in basic life support and the location of the patient's medical emergency, the patient safety manager did not incorporate that information into the patient safety report investigation or assign investigators with the expertise to examine clinical aspects of the patient's care; this resulted in an inaccurate harm assessment."

This incident is a part of a troubling pattern of inappropriate response by the Phoenix VA, whose procedures have contradicted and failed to meet Veterans Health Administration standards.

Our veterans put their lives on the line to protect our freedom, security, and future. They deserve our enduring gratitude—both during and after their service. It is our responsibility to ensure that

[1] https://www.vaoig.gov/sites/default/files/reports/2024-07/vaoig-23-02958-203.pdf

they return home to a nation that cares for them and their loved ones—and that includes receiving quality, timely health care.

We look forward to hearing from you promptly on this matter.

Sincerely,

Greg Stanton
Member of Congress

Mark Kelly
Member of Congress

Kyrsten Sinema
Member of Congress

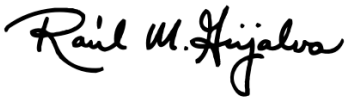
Elijah Crane
Member of Congress

Debbie Lesko
Member of Congress

Andy Biggs
Member of Congress

Ruben Gallego
Member of Congress

David Schweikert
Member of Congress



Raúl Grijalva
Member of Congress

Juan Ciscomani
Member of Congress