

AMI BERA, M.D.
7TH DISTRICT, CALIFORNIA

COMMITTEE ON FOREIGN AFFAIRS

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ASIA AND THE PACIFIC

AFRICA, GLOBAL HEALTH, AND HUMAN RIGHTS

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Congress of the United States
House of Representatives

October 22, 2014

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The Honorable Robert McDonald
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary McDonald,

I am writing to request that the Office of the Inspector General at the Department of Veterans Affairs undertake a comprehensive review of the circumstances and subsequent actions surrounding an incident on October 17, 2014 at the Sacramento VA Medical Center.

I am deeply concerned about the reports of the death of Roland Mayo, a Vietnam veteran and former deputy sheriff after the incorrect placement of a do-not-resuscitate band. Initial reports from the medical center indicate that this error did not contribute to a delay in life-saving treatment. However, as a doctor, I know that every second counts in an emergency and no time can be wasted navigating uncertainties and systematic failures. I understand medicine isn't perfect, and unfortunately mistakes do happen. But true leadership fosters a culture of integrity, acknowledges tragic mistakes, and takes steps to ensure they don't happen again.

In addition to the public reports, late yesterday my office was forwarded an anonymous email from someone who appears to be an employee at the Sacramento VA Medical Center making allegations that raise potential serious concerns about the organizational culture and subsequent impact it has on patient care. I have enclosed a copy of the email.

In light of this recent event, I request further investigation of the incident including any contributing protocols and systems. Additionally, I ask for detailed recommendations for improvement to ensure similar errors are avoided in the future.

Our veterans have heroically served us and we now have a responsibility to provide them with the high quality health care they have earned. We must ensure issues that have led to this unfortunate mistake are immediately addressed and that the VA health care system is home to a culture of honesty, transparency and continuous improvement. Please keep me fully informed about the status of this problem and any resulting corrective actions. Thank you for your prompt attention to this request.

Sincerely,

A handwritten signature in blue ink, appearing to read "Ami Bera".

Ami Bera, M.D.
Member of Congress

Enclosure

cc: Richard J. Griffin, Acting Inspector General, Department of Veterans Affairs
David Stockwell, Director, VA Northern California Health Care System