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Congress of the United States
House of Representatives

July 29, 2015

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

Dear Secretary McDonald,

I commend the Office of the Inspector General (OIG) on their responsive and thorough investigation into the circumstances and subsequent actions surrounding the death of a local veteran at the Sacramento VA Medical Center on October 17, 2014. The numerous mistakes and systematic failures that contributed to his death are inexcusable. I am encouraged to see that several corrective actions to prevent future incidents have already been implemented at the facility and look forward to ongoing updates as the remaining recommendations are completed.

After reviewing the report and meeting with OIG staff, I remain concerned about the adequacy of Veterans Health Affairs (VHA) systems and processes to disseminate best practices across all Veterans Integrated Service Networks (VISN).

In light of findings in the report that suggest several contributing factors may have been larger institutional problems, not isolated facility incidents, I request further clarification on VHA procedures to implement appropriate corrective actions.

How does the VHA identify best practices and disseminate findings from OIG reports across all 23 VISN? More specifically, what are the plans to implement corrective actions related to redesigned wristbands and to ensure ongoing monitoring and verification of patient information and code status across VHA facilities? What barriers prevent implementation of uniform best practices?

This tragic death was preventable. We must ensure that similar systematic failures are immediately addressed and that appropriate steps are taken to prevent future potentially lethal errors. I look forward to working together to guarantee that all veterans, no matter where they seek care, get the highest quality care. Thank you for your prompt attention to this request.

Sincerely,

Ami Bera, M.D.
Member of Congress

cc: Linda Halliday, Deputy Inspector General, Department of Veterans Affairs
David Stockwell, Director, VA Northern California Health Care System