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July 24, 2024

The Honorable Shereef Elnahal, M.D.
Under Secretary for Health, Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20420

Dear Dr. Elnahal,

I write with deep concern regarding today's Department of Veteran's Affairs (VA), Office of Inspector General (OIG) report *Care Concerns and Deficiencies in Facility Leaders' and Staff's Responses Following a Medical Emergency at the Carl T. Hayden VA Medical Center in Phoenix, Arizona*. As an elected representative of Arizona's veterans, and as a combat veteran who has received care at the VA myself, I was appalled to learn of the inexcusable failures that led to the death of a veteran, and of the apparent lack of accountability at the Phoenix VA Medical Center in my district.

As you are likely aware, a veteran receiving care at the Carl T Hayden VA Medical Center in Phoenix died following a medical emergency. The patient, who had just left a urology appointment, had a medically documented history of congestive heart failure. Despite this, he did not have his vitals taken during his appointment, something that any person who has seen a doctor would assume is basic standard procedure.

Upon leaving his appointment, the veteran became unconscious. The veteran's family member returned him to the Ambulatory Care Clinic where he waited for local authorities to arrive and provide basic life saving measures. During that time, an unnamed – and to this day unknown – operator failed to connect the VA hospitality employee who placed the emergency call with either the Rapid Response team or the Veterans Affairs Police. Because of this error, it took emergency personnel 11 minutes to arrive and begin life saving measures – as opposed to the estimated two minutes that it would have taken had this error not taken place. After being taken to the hospital, the veteran died two days later.

As is so often the case, it was not a single failure, but multiple failures to take simple actions and implement commonsense procedures which led to this tragedy. Additionally, the failure to properly document the incident in the Joint Patient Safety Reporting System may be just as egregious. Because the incident was not properly recorded and investigated as soon as it occurred, the same deadly vulnerabilities remained, and this tragic incident had the potential to repeat itself. The decision not to seek to correct issues that potentially led to the death of veteran **over a year ago** while thousands of veterans continue to receive care, is inexcusable.

Today's OIG report outlined three main areas of concern, the Delayed Response, Quality of Care issues, and Deficiencies in Facility Leaders' and Staff's Response to a Medical Emergency. However, there is another area of concern which was not included in the report– the failure to hold those responsible accountable. This includes the failures to ensure that a public automated external defibrillator (AED) was available, to properly connect the emergency call with the proper emergency authorities, to properly log the emergency call, including the identity of the operator in question, and to hold those responsible for approving the flawed procedures that led to this veteran's death.

To that end, I demand answers to the following questions:

1. How many total veterans received care at the Carl T. Hayden VA Medical Center between the death of this veteran last year and the publishing of today's OIG report?
2. Why was an AED not in a highly trafficked area until after this event?
3. For which VA personnel is CPR training mandatory, and are there requirements or policies to have CPR trained personnel in patient settings?
4. Why did the operator not automatically connect callers with the VA Police during a medical or other emergency?
5. Is it a requirement for all emergency calls to be properly logged, including the identity of the operator?
6. If a call is improperly logged or is not logged at all, either accidentally or purposefully, what is the VA's policy? Is there a formal investigation? Would such an investigation include federal, state, or local law enforcement?
7. Is it VA policy to check vitals before every medical appointment? If not, what is the policy? If so, why did the patient's care plan not include this seemingly basic protocol?
8. Is it required procedure to file an incident report in cases like this, and, if so, why does it appear that no incident report was filed?
9. Has anybody been held accountable for the death of this veteran, and, if so, how?
10. What is the timeline for implementing the recommendations of the OIG report, and what are you doing to ensure these recommendations are followed?

In addition, a request a meeting with my staff, local leadership at the Phoenix Medical Center and VISN 22, and yourself or the appropriate members of your staff. I also request regular briefings on the full implementation of the OIG's recommendations.

It is our duty to care for our veterans, and they deserve far better than what today's report indicates. Thank you for your attention to this matter and I look forward to your response.

Sincerely,

Ruben Gallego
MEMBER OF CONGRESS