Congress of the United States
Washington, DC 20515

October 1, 2014

The Honorable Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Secretary McDonald:

We write you concerning an issue that touches upon two of your stated goals for the U.S. Department of Veterans Affairs: accountability and service to our nation's veterans. In your recent remarks to the American Legion's 96th Annual Convention, you distilled these goals down to the simple truth that "'VA is a customer-service organization. We serve Veterans.' If we fail at serving Veterans, we fail."

As elected Members of Congress who serve as advocates for our local veterans, we could not agree more with your sentiments. We contact you today to bring a matter to your attention where the VA has failed your standard for our veterans and their families.

This November will mark a somber anniversary for the VA Pittsburgh Healthcare System (VAPHS). It was nearly two years ago that the Centers for Disease Control and Prevention deployed an emergency response team to VAPHS to address an outbreak of legionella in the water supply of the University Drive facility.

Investigations later determined that the outbreak had been occurring since early 2011. At least six of our nation's heroes were killed by the legionella bacteria, and more than twenty-one others became ill.

In April 2013, the VA Office of Inspector General (OIG) concluded that systemic failures at VAPHS resulted in these tragic and preventable deaths. Since that time, we have been working on behalf of the families for accountability for those failures. Enclosed is a timeline of our efforts to convince the VA administration to deliver the accountability our veterans and their families deserve. **To date, there has been none.**

To the contrary, in the intervening months troubling information has come to light that senior executives who oversaw VAPHS during the legionella outbreak were actually praised in their performance reviews and awarded significant monetary bonuses. Notably, Terry Gerigk Wolf, the Director and CEO of VAPHS, received a $12,924 bonus in 2011. Even more outrageous, Michael Moreland, the Director for VISN 4, received the Presidential Distinguished Rank Award, the government's highest award for civil servants, and a nearly $63,000 bonus only days after the OIG released its damning report.

PRINTED ON RECYCLED PAPER

These taxpayer-funded bonuses were inappropriate, deeply offensive to the victims of the outbreak and their families, and ultimately should be returned. We also believe that it is long past time for the VA to take appropriate disciplinary action and disclose it to the public.

All too often, the VA has been loud and enthusiastic in promoting its successes and awards but silent about addressing its failures and challenges. The VA must begin taking responsibility and holding employees to account, during both the good times and the bad.

To that end, in November 2013, we requested that the VA provide Congress with specific information about what administrative actions, if any, the agency would implement to address the failures that led to the 2011-2012 outbreak. Unfortunately, the only responses that we have received have been cursory and lacking of the transparency that is deserved.

Notably, in a letter dated July 24, 2014, Interim Under Secretary for Health Carolyn Clancy stated that the VA initiated administrative actions against five individuals related to the legionella outbreak, three of which were then completed. The Under Secretary's letter provided no detail or accountability.

To clear up these deficiencies, on August 1, 2014, several of us responded to the Under Secretary's letter seeking additional information. To date we have received no response to that letter.

Specifically, we requested that the VA provide the following answers:

1. Names and/or positions of the three individuals identified in the Under Secretary's letter against whom the VHA initiated and completed administrative actions;

2. An explanation of the scope of the investigations that the VHA conducted regarding these individuals, including any findings or conclusions reached by the VHA and the roles that these individuals played in the legionella outbreak;

3. All disciplinary administrative actions that the VHA has taken to date as a result of the investigations;

4. Whether any of these individuals received positive performance reviews and/or bonuses in connection, directly or indirectly, with their work during the relevant time period; and

5. What recommendations and reforms have been put in place to ensure this does not happen again.

We also requested that should the Under Secretary determine that statutory protections or administrative guidelines absolutely prevent the VA from providing any or all of this information that a detailed justification for the decision be provided including citations to relevant statutes or rules on which it is based.

The lack of responsiveness and bureaucratic stonewalling is unacceptable, and we believe this now deserves your immediate and personal attention. As we have stated before, veterans deserve a full and open accounting of this matter. It is long past time for the investigations to be completed, disciplinary actions taken, and the results shared with veterans and their representatives in Congress.

In your welcome message to VA employees following your confirmation, you stated that "trust is essential in everything we do." This simple truism is also reflected in the VA's core values to act with integrity and "maintain the trust and confidence of all with whom I engage."

Again, we certainly appreciate your efforts to date to begin rebuilding that trust with veterans, their families, and the American people. But we would strongly urge you that it is only through increased transparency and accountability, as deserved here, that the VA will ever achieve that goal.

Please know that we stand ready to work with you on this matter and to ensure that our veterans receive the respect, support, and care they have earned and rightly expect.

Thank you for your prompt attention. Should you have any questions, please do not hesitate to contact our offices.

Sincerely,

Keith J. Rothfus
Member of Congress

Tim Murphy
Member of Congress

Mike Kelly
Member of Congress

Pat Toomey
United States Senator

Jeff Miller
Chairman
House Committee on Veterans' Affairs

Mike Coffman
Chairman
House Committee on Veterans' Affairs,
Subcommittee on Oversight and
Investigations

KR/br
Encl.

TIMELINE: Actions taken by the Western Pennsylvania Congressional Delegation to increase Transparency and hold accountable those Individuals who are responsible for the 2011-2012 Legionella Outbreak at the VA Pittsburgh Healthcare System (VAPHS)

- **February 5, 2013**: Congressmen Keith Rothfus, Tim Murphy, and Mike Doyle participated in a House Veterans' Affairs Committee (HVAC), Subcommittee on Oversight and Investigations (O&I), hearing entitled "Analyzing VA's Actions to Prevent Legionnaire's Disease in Pittsburgh." Witnesses included Dr. Robert Jesse, Principal Deputy Under Secretary for Health, and Dr. Lauri Hicks, Medical Epidemiologist, National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention.

- **April 3, 2013**: Congressman Rothfus, HVAC Chairman Jeff Miller, and O&I Subcommittee Chairman Mike Coffman sent a letter to President Obama and then-Secretary Eric Shinseki expressing grave concern about the VA's lack of responsiveness to committee requests for documents and emails relating to the outbreak.

- **April 25, 2013**: Congressmen Rothfus, Murphy, and Doyle conducted a closed-door meeting with Michael Moreland, then-Director of VISN 4, and Terry Gerigk Wolf, then-Director and Chief Executive Officer of VAPHS, to address the serious and systemic failures identified by the VA Office of the Inspector General (OIG) that led to the legionella outbreak. The OIG's report, No. 13-00994-180, was issued on April 23, 2013. In addition to calling for accountability for those who were responsible for the outbreak, the delegation also urged VAPHS to institute new written guidelines outlining duties and responsibilities for infection control.

- **May 3, 2013**: Congressmen Rothfus and Murphy sent a letter to then-Secretary Shinseki calling for the rescission of the Presidential Distinguished Rank Award and a $62,895 bonus paid to then-VISN 4 Director Michael Moreland. The award was presented to Mr. Moreland on April 25, 2013, the same day as the closed-door meeting with members of the delegation and just days after the OIG released its report highlighting major failures at VAPHS that led to the outbreak. The letter also called upon the Secretary to meet with the victims' families and provide a copy of the nomination package and all relevant information about any bonus payments to senior leadership at VAPHS.

- **August 8, 2013**: Congressman Murphy sent a letter to then-Secretary Shinseki calling for accountability and requesting a reply whether there had been any suspensions, sanctions, or firings of individuals who contributed to the failures that led to the legionella outbreak. The letter also reiterated prior calls for the Secretary to rescind bonuses that went to the leadership at VAPHS.

- **September 9, 2013**: Congressmen Rothfus, Murphy, and Doyle joined Chairman Miller and Ranking Member Michael Michaud for a field hearing in Pittsburgh, PA to address failures at VAPHS and other VA facilities around the nation. The hearing was entitled, "A Matter of Life and Death: Examining Preventable Deaths, Patient-Safety Issues, and Bonuses for the VA Execs Who Oversaw Them."

At that hearing, then-Under Secretary for Health Dr. Robert Petzel defended then-VISN 4 Director Michael Moreland and stated that he would not call on Mr. Moreland to return the $62,895 bonus. Dr. Petzel also stated that the VA would consider administrative disciplinary action relating to the outbreak after the conclusion of an ongoing criminal investigation by the U.S. Attorney's Office for the Western District of Pennsylvania, the Federal Bureau of Investigation, and the OIG.

- **November 21-26, 2013**: Congressmen Rothfus, Murphy, and Senator Pat Toomey sent letters to then-Secretary Shinseki calling on the VA to hold accountable those individuals who are responsible for the outbreak and seeking additional information regarding what administrative disciplinary action the VA planned to take. The letters followed up on Dr. Petzel's statements at the September 9th hearing and was in response to U.S. Attorney David Hickton's decision not to pursue criminal charges in connection with the outbreak.

- **May 21, 2014**: Congressmen Rothfus, Murphy, and Mike Kelly, along with Senator Toomey, sent a letter to then-Secretary Shinseki following up on the Secretary's public promise to take "swift and appropriate action" when warranted following the results of an OIG investigation. The letter reminded the Secretary that six veterans died as a result of the legionella outbreak at VAPHS, which the OIG had determined more than a year before was preventable and caused by systemic failures. The letter also repeated a prior request for the Secretary to meet with the families of the veterans who tragically lost their lives as a result of the outbreak.

- **August 1, 2014**: Congressmen Rothfus, Murphy, and O&I Subcommittee Chairman Coffman sent a letter to Interim Under Secretary for Health Carolyn Clancy demanding a "full and open accounting" of any disciplinary or administrative actions taken against VA employees who have been found to be responsible for the legionella outbreak. The letter was in response to two correspondences from the VA:

  First, on June 13, 2014, the VA provided a statement to the members of the Western Pennsylvania Delegation that indicated that then-Director Terry Gerigk Wolf was being placed on administrative leave "pending the completion of administrative actions related to the Legionella outbreak." This one sentence long statement failed to provide any other details regarding the VA's reasoning or what those administrative actions were.

  Second, in a letter dated July 24, 2014, Interim Under Secretary for Health Carolyn Clancy stated that the VA had initiated administrative actions against five individuals related to the outbreak, three of which had been completed at that time. The letter failed to identify the names or positions of these individuals, however, and it failed to provide any other information regarding the findings and conclusions of the VA's investigations into the matter, the roles that these unnamed individuals played in the outbreak, or what disciplinary actions were taken as a result. Nor did the letter include any information concerning whether these individuals received positive performance reviews or bonuses in connection with their work during the relevant time period.