U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED FIFTEENTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

July 28, 2017

The Honorable David J. Shulkin
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Secretary Shulkin,

We are writing to request a meeting with you at the earliest opportunity to discuss troubling allegations of personnel mismanagement impacting patient care at the Marion, Illinois VA Medical Center. We appreciate your prompt attention to this matter.

According to a memorandum dated May 31, 2017, written by the VA National Center for Patient Safety (NCPS) program manager, the Marion VAMC has experienced significant declines in patient safety culture metrics and employee morale since these areas were last assessed in 2014. Specifically, the memo describes a 2015 visit by NCPS to investigate employee complaints pertaining to worsening organizational and patient safety culture at the facility. Employees also alleged that senior leadership retaliated against them for reporting such problems. NCPS recommended that appropriate VISN personnel intervene to ensure that the Marion VAMC employees' complaints were fully investigated, but this does not appear to have happened. In 2016, a VA patient safety culture survey scored the Marion VAMC below average in all category measures. These scores may validate earlier employee complaints. More troubling is that VA internal documents demonstrate a strong need for the Central Office to investigate and take action to address the safety concerns.

We request that VA inform the Committee as to the plans and timeline to address these issues, and provide answers to the following questions:

1. The NCPS memo highlighted that VAMC employees were communicating patient safety and environmental concerns to their leadership but these reports "have either disappeared or were not appropriately submitted to [the] new Director by leadership staff." Why were these reports not submitted to the director? Who on the leadership team was responsible for the reports? Why is this process not conducted electronically?
2. Why has the VISN director failed to address the complaints and concerns about the Marion VAMC that have been communicated up over the years?
3. When will the VISN conduct an assessment of the Administrative Investigation Board process's effectiveness at Marion? Provide a copy of such assessment and its recommendations.

4. Several sources have contacted the Committee to relay safety concerns about the community living center. The NCPS memo includes an employee complaint that since October 2016, 15 veterans have died during or shortly after discharge from the CLC. In one incident, a veteran's sister contacted the Committee to report that her brother was mistreated while assigned to the CLC; he died within this timeframe. Please review all deaths in the CLC and reported deaths after discharge from the CLC from October 2016 to present, and provide the results of the review. Please confirm whether the reported number of deaths is accurate and determine whether any resulted from inadequate care.
5. The NCPS memo includes reports of retaliation, unprofessional conduct, and bullying toward employees by Marion leadership. Please investigate these allegations and report on your findings. Please also provide copies of any and all internal and external employee surveys conducted within the last three years.
6. Allegedly, Mr. Mel Gutierrez inappropriately appointed his wife to be the administrative officer for the surgery department at Marion. Reportedly, he also fails to hold his staff accountable for inappropriate behavior and exhibits an alarming lack of transparency. Please review the circumstances of Mr. Gutierrez's wife's hiring and promotion to surgery department administrative officer.

Please provide answers to these questions and the requested documents by Friday, **September 1, 2017**. Do not alter the documents in any way, including but not limited to application of redactions or a water mark. Further, the documents must not be provided in a format that disables printing. The deliverables opened by this request will not be closed until the Committee is sufficiently satisfied with the responses provided. If you have any questions, please do not hesitate to have your staff contact Jon Hodnette, Majority Staff Director of the Subcommittee on Oversight & Investigations, at (202) 225-3569.

Sincerely,

JACK BERGMAN
Chairman
Subcommittee on Oversight & Investigations

MIKE BOST
Member
Subcommittee on Oversight & Investigations

JB/tb

Attachment