U.S. House of Representatives
Washington, DC 20515

July 29, 2024

Mr. Bryan C. Matthews
Director
Phoenix VA Health Care System
Carl T. Hayden Veterans' Administration Medical Center
650 East Indian School Road
Phoenix, AZ 85012

RE: July 2024 VA OIG Report 23-02958-203 titled, "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."

Director Matthews:

We write in grave concern of the findings of the Department of Veterans Affairs (VA) Office of Inspector General (OIG) recent report titled, "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."[1] Tragically, a veteran failed to receive necessary care at the medical center and later died at a non-VA hospital.

The OIG determined the medical center's policies were inconsistent with those required by the Veterans Health Administration (VHA), non-clinical staff were not trained in cardiopulmonary resuscitation (CPR), and there was a shocking lack of automated external defibrillators (AEDs) available. Upon reading the report, we discovered the patient was already at the VA for an urology appointment when he experienced complications. Despite the patient's long and well-documented history of congestive heart failure, high blood pressure, high cholesterol, and high prostate-specific antigen levels, vital signs were never taken at this appointment.

When the patient was unresponsive outside the Ambulatory Care Clinic entrance, staff was unable to perform basic life support. In addition, the medical center's policy states that the Rapid Response Team (RRT) should only respond to incidents inside the building, despite the veteran being unresponsive in the facility's parking lot. Worse, the report revealed the rapid response operations could not provide a reason why they did not mobilize to save the veteran's life.

The report offers ten recommendations to correct the gross mismanagement within the medical center, including offering CPR training, assess compliance with basic life care and documentation, implementing public access of AEDs, and ensure reports are completed in the required time frame.

[1] "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." U.S. Department of Veterans Affairs Office of Inspector General. 24 July 2024. 23-02958-203. (Report)

We respectfully request the following information:

1. With an extensive medical history of cardiovascular issues, why was an order never placed for the patient to receive a wearable cardioverter defibrillator, despite its inclusion in the patient's plan of care in early 2023?
2. Would you still consider the cardiology physician assistant's assessment of the patient as "overall asymptomatic" to be accurate?
3. Please provide a timeline for implementation and completion of the 10 recommendations outlined on pages 31 and 32 of the report.
4. Did the patient safety manager face any repercussions for submitting the patient safety report after the required timeframe?
5. Can we expect the Cardiopulmonary Resuscitation Committee (CRC) to revise facility policy to allow the RRT to mobilize for emergencies anywhere on the medical center campus?
6. Please provide a copy of the CRC's revised Rapid Response Policy 11-101 within 30 days of its presentation to the medical center's Governing Council.

Since 2014, the Phoenix VA has been the subject of scandal and subsequent OIG for extensive wait times, emergency room deaths, delays and lapses in follow-up care, and more. This is not a series of coincidental errors within the medical center. Rather, this is a pattern of fatal negligence. One veteran lost is one too many. Please provide a response to these questions within 60 days of receipt of this letter. We look forward to receiving this additional information and action from the Phoenix VA Health Care System.

Sincerely,

Paul A. Gosar, D.D.S.
Member of Congress

Eli Crane
Member of Congress

Debbie Lesko
Member of Congress

Andy Biggs
Member of Congress

Juan Ciscomani
Member of Congress

David Schweikert
Member of Congress