

Congress of the United States
Washington, DC 20515

December 14, 2016

The Honorable Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20410

Dear Secretary McDonald:

We are writing in regards to recent media reports which have alleged the troubling actions of several employees at the Bay Pines VA Healthcare System. The reports indicate that in February of this year, hospice staff did not follow VA's procedures for the post-mortem care and proper transportation of a deceased veteran's body. The media reports cite an April 1, 2016 Administrative Investigation Board (AIB) memo, which stated that hospice staff left the deceased veteran's body in a hallway of the hospice unit and then later moved the body to an shower room where the body was left unattended for nine hours. The AIB found that some hospital staff had "demonstrated a lack of concern, attention and respect" for the deceased veteran and that their actions led to an "increased risk of decomposition" of the body. What is worse, is that the AIB also found that when confronted about their actions, a hospice staff member tried to cover up what had happened and was found to have "falsely and inaccurately document[ed] the post-mortem care."¹

Mr. Secretary, like you, we are horrified by these reports and the results of the AIB which show these employees' ignorance of VA's policies, their total lack of empathy for veterans and just plain human decency. While media reports now indicate that two individuals have been fired as a result of this incident,² we remain concerned about the lack of transparency that VA officials have shown in this case. Therefore, please provide the following information to the Committee:

- The completed April 1, 2016 memo from Administrative Investigation Board #16-01;
- The names, job titles, and pay grades of the AIB members;
- Any internal VA police reports or other investigations into the incident;
- The names, job titles, and pay grades of any of the employees who were involved in this incident and who were involved in this deceased veteran's hospice care;

¹ <http://www.tampabay.com/news/military/veterans/report-va-staff-left-veterans-body-in-shower-for-nine-hours-tried-to-hide/2305694>

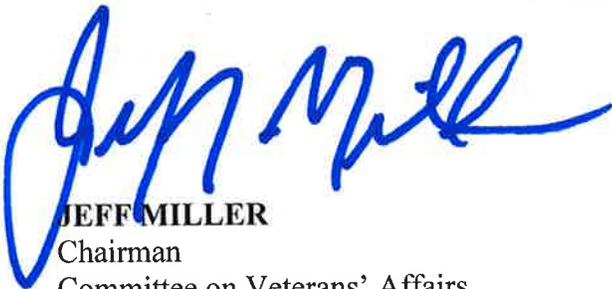
² <http://www.tampabay.com/news/military/veterans/va-now-says-it-fired-two-after-veterans-body-was-left-in-shower-nine-hours/2306150>

- Written copies of all proposed and final disciplinary actions for all employees involved in this incident. If proposed disciplinary actions were reduced, please provide a written justification for their reductions;
- The names, job titles, and pay grades of the proposing and deciding officials in this case;
- A written summary of the actions that VA has taken to inform the deceased veteran's next of kin of this incident; and
- A summary of the training that has been provided to hospice staff to ensure a tragedy like this never occurs again.

Pursuant to the Committee's oversight role of the Department, please provide the requested information and documents no later than close of business on December 22, 2016. When providing the requested information, do not alter the responsive documents in any way, including applying redactions or a water mark. Do not produce them in a way that disables printing. Note that the deliverables opened by this request will not be closed until the Committee is sufficiently satisfied with the responses provided.

We thank you for your assistance in this matter and if you have any questions please contact Jon Clark with the Subcommittee on Economic Opportunity at (202) 225-3527.

Sincerely,



JEFF MILLER
Chairman
Committee on Veterans' Affairs



GUS BILIRAKIS
Vice-Chairman
Committee on Veterans' Affairs

CJM/jc

Cc: The Honorable Mark Takano, Acting Ranking Member
The Honorable David P. Roe