Congress of the United States
Washington, DC 20515

August 1, 2014

The Honorable Carolyn M. Clancy, MD
Interim Under Secretary for Health
U.S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Under Secretary Clancy,

We write you in response to your letter dated July 24, 2014 regarding the 2011-2012 Legionella outbreak at the VA Pittsburgh Healthcare System (VAPHS).

As you are aware, the VA Office of Inspector General (OIG) concluded in April 2013 that systemic failures at VAPHS resulted in the deaths of at least six veterans and sickened many more. In November 2013, upon the completion of a related criminal investigation by the United States Attorney's Office for the Western District of Pennsylvania, we requested that the VA provide Congress with information about what administrative actions would be implemented.

Your letter dated last week is the only response we have received to that request.

Regrettably, the update you provide is completely lacking of the transparency that the families of the victims of the outbreak and veterans who receive care at the VA deserve. In particular, you state that the Veterans Health Administration (VHA) has initiated administrative actions against five individuals related to the outbreak, three of which have been completed. You fail to identify the names or positions of these individuals, your findings or conclusions, the roles that these individuals played in the outbreak, and what disciplinary actions have been taken as a result. Nor did you include any information concerning whether these individuals received positive performance reviews or bonuses in connection with their work during the relevant time period.

Veterans deserve a full and open accounting of this matter. It is long past time for the investigations to be completed and the results shared with veterans and their representatives in Congress. To that end, we respectfully request that you provide the following information in writing to our offices within ten business days:

1. Names and/or positions of the three individuals identified in your 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;

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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.

Should you determine that statutory protections or administrative guidelines absolutely prevent you from providing any or all of this information, we request that you provide a detailed justification for your decision including specific citations to the relevant statutes or rules on which you base it.

Thank you for your prompt attention to these requests. 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 Coffman
Chairman
House Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations

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