United States Senate
WASHINGTON, DC 20510

May 26, 2017

The Honorable Michael J. Missal
Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Inspector General Missal:

We are writing to you regarding several allegations recently brought to our attention regarding quality of patient care and safety and mismanagement at Marion Veterans Affairs (VA) Medical Center in Illinois. We urge you to initiate an independent Department of Veterans Affairs Office of the Inspector General (OIG) investigation into patient care and management at Marion VA Medical Center.

Our offices were recently contacted by staff at Marion VA Medical Center who shared troubling allegations about mismanagement at Marion VA Medical Center throughout the past few years. Citing examples of nepotism and intimidation, they described a workplace environment that has resulted in resignations of desperately needed medical professionals and a shortage of clinical staff. In addition, these staffers highlighted a disturbing pattern of retaliation against whistleblowers and a lack of appropriate oversight by both Marion VA Medical Center and Veterans Integrated Service Network (VISN) 15 leadership to address employee concerns, including those identified in annual VA All Employee Surveys.

Most troubling is the allegations that such mismanagement has had and could have on the quality of health and safety of patients at Marion VA Medical Center. In addition to sharing examples of clinical errors, falsifications in patient records, and even potential secret waitlists, these staffers expressed alarm over specific cases that may have resulted in patient deaths. Moreover, there are allegations that recommendations for improvements to patient care and safety by the VA National Center for Patient Safety have been ignored by leadership.

We understand some of these concerns may have been communicated to the OIG by Marion VA Medical Center staff or patients. We also recognize that any complaints to the OIG Hotline are typically referred to VISN 15 or even Marion VA Medical Center directly. However, given the seriousness of these allegations as well as the fact that some of the concerns pertain to VISN 15 and Marion VA Medical Center leadership, any review by VISN 15 or by Marion VA Medical Center leadership may not have the necessary transparency or impartiality. We urge you to include in your investigation a review of whether VISN 15 has provided appropriate oversight in addressing concerns at Marion VA Medical Center. In addition, we urge you to examine the VA All Employee Surveys from Marion VA Medical Center between 2014 and 2016, and ensure that any interviews with employees take place without the presence of supervisory or management staff.

An immediate and thorough investigation by the OIG will help ensure that the brave men and women who have served our country will receive the level of care and services they deserve in VA facilities such a Marion VA Medical Center.

Thank you for your prompt attention to this matter.

Sincerely,

Richard J. Durbin
United States Senator

Tammy Duckworth
United States Senator

CC: The Honorable David J. Shulkin, Secretary, Department of Veterans Affairs