

Congress of the United States
Washington, DC 20515

June 13, 2014

The Honorable Jeff Miller
Chairman
House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Miller:

As your Committee continues exploring allegations of mismanagement, fraud, and criminal activity at VA facilities across the country, we write to ask that you include the serious questions surrounding the Miami VA Healthcare System in your investigation. From unacceptable wait time delays and their potentially criminal manipulation to security lapses at a drug rehabilitation center to doubts about the Chief of Staff's motives, decision making, and credentials; it is clear that all is not right at the Miami VA. As you continue your investigation, we seek your assistance in having the VA answer the following questions:

1. On June 1, 2013, Private Nicholas Todd Cutter, an Army Ranger and veteran of Operation Iraqi Freedom, died of a drug overdose while a patient at the Miami VA drug rehabilitation center. It was not until the release of a March 2014 VA Inspector General (IG) report that his mother learned how her son died.¹²
 - a. Why didn't officials inform Private Cutter's mother of his drug abuse?
 - b. Who informed Private Cutter's mother that he had choked to death and why?
 - c. Why did officials never follow up with Private Cutter's mother to inform of the details of his death?
 - d. Has the VA provided a headstone for Private Cutter's burial plot?
2. The IG found that the security surveillance camera at the Miami VA's drug rehabilitation center was not operational, staff had limited or no view of the center's entrance and exits, staff was not present in the center at all times as required, staff did search patients for contraband or monitor their whereabouts consistently as required, and one third of patients had failed toxicology tests.³

In response to the IG's report, the Miami VA defended its lack of a required operating surveillance camera by noting that "police and nursing staff had mechanisms in place including increased checks, and the use of sitters to monitor the area."⁴ However, the Miami VA goes on to concur with subsequent recommendations by the IG which

¹ "Miami veterans rehab clinic failed son who overdosed, his mother says," *Miami Herald*, April 26, 2014.

² "Miami VA hospital employee alleges crimes ignored," *Miami Herald*, May 23, 2014.

³ Report No. 13-03089-104, "Unexpected Patient Death in a Substance Abuse Residential Treatment Program," VA Office of Inspector General, Office of Healthcare Inspections, March 27, 2014.

⁴ *Ibid.*

- criticized the kind of checks and monitoring systems the VA claims to have had in place.
- a. How does the Miami VA reconcile its claim to have had checks in place while admitting in the very next breath that those checks were unacceptable?
 - b. What disciplinary actions, if any, were taken in response to the IG's report?
 - c. What is the current status of the IG's recommendations?
3. Miami VA Police Service Detective Thomas Fiore told CBS Miami in May that he reported the security lapses detailed in the IG report to Miami VA Chief of Staff Dr. Vincent DeGennaro two years ago. However, according to Detective Fiore, instead of being allowed to further investigate the discrepancies, Dr. DeGennaro told him to stop conducting investigations and was reassigned to a clerical department in retaliation.⁵
- a. Did Dr. DeGennaro block further investigations of the drug rehabilitation center's security lapses? If so, why?
 - b. Detective Fiore alleges that he informed Miami VA officials of the non-operating surveillance camera four years ago and despite the allocation of between \$2.5 million and \$3.5 million to improve the security situation, none of the funds were used to repair the camera.
 - i. When did the Miami VA know that the surveillance camera was not operating?
 - ii. If additional funds were allocated for the purpose of improving security, what happened to them?
 - c. Detective Fiore alleges that Private Cutter was known to abuse cocaine, smuggle it into the rehab center, and that he reported Private Cutter's behavior to his superiors.⁶
 - i. Did rehab center staff continue to give Private Cutter passes out of the facility? If so, why?
 - d. Detective Fiore alleges that rehab center staff did not immediately inform him about Private Cutter's death and although Private Cutter's room should have been treated as a crime scene, staff "bagged up the body and cleaned the room."⁷
 - i. When did rehab center staff inform the VA Police Service about Private Cutter's death and to whom did they report it to?
 - ii. Did rehab center staff remove Private Cutter's body and clean his room instead of informing the VA Police Service? If so, why?

⁵ "Miami VA Whistleblower Exposes Drug Dealing, Theft, Abuse," CBS Miami, May 20, 2014

⁶ Ibid.

⁷ Ibid.

- e. In response to Detective Fiore’s allegations that Miami VA officials refused to address rampant drug dealing, including drugs from the VA pharmacy, a Miami VA spokesman said that he wasn’t aware of “significant findings concerning illegal drugs at the Miami VA Healthcare System.”⁸
 - i. What is the extent of drug dealing at the Miami VA?
 - ii. If drug dealing is as pervasive as Detective Fiore alleges, how is it possible that VA officials are not aware of it?
 - f. Detective Fiore alleges that patient abuse is a problem at the Miami VA.
 - i. What is the extent of patient abuse at the Miami VA?
 - ii. Is administrative action appropriate in the case of patient abuse or should there be a law enforcement investigation?
 - g. Detective Fiore alleges that “theft is rampant” at the Miami VA.
 - i. What is the extent of theft at the Miami VA?
4. As you detailed during your Committee’s June 9, 2014 hearing, Dr. DeGennaro agreed to give up his medical license in New York after being disciplined in Florida because of his “failure to meet the standard of care for abdominal surgeries.”⁹ Philip Matovsky, the Assistant Deputy Under Secretary for Health for Administrative Operations, testified that “some appropriate action comparable to suspension” would be in order if the information about Dr. DeGennaro is “valid.”
- a. In response to questions about Dr. DeGennaro from the *Miami Herald*, the Miami VA wrote that the “Professional Standards Board (PSB) here at the Miami VA Healthcare System...found that this action had no bearing on his practice at the Miami VAHS.”
 - i. How is it possible that the Miami VA’s PSB can clear Dr. DeGennaro to practice yet he should also be subject to discipline “comparable to suspension?”
 - ii. What is the process that the PSB uses to clear physicians to practice at the Miami VA?
 - b. As Chief of Staff of a major regional VA medical facility, should Dr. DeGennaro be held to a higher standard?
 - c. Complaints about the quality of physicians available are common among veterans.

⁸ Ibid.

⁹ Chairman Jeff Miller, “Oversight Hearing on Data Manipulation and Access to VA Healthcare: Testimony from GAO, IG and VA,” House Committee on Veterans Affairs, June 9, 2014.

- i. Is it standard practice for the VA to overlook a revoked or surrendered medical license in one state where hiring that physician in another state?
- ii. What other negative marks does the VA overlook on a physician's record?
- iii. How can the VA improve the quality of its physicians?

Thank you for your assistance in having the VA provide answers to these critical questions.

Sincerely,



Ileana Ros-Lehtinen
Member of Congress



Mario Diaz-Balart
Member of Congress