

BRIAN HIGGINS
27TH DISTRICT, NEW YORK

COMMITTEE ON HOMELAND SECURITY
SUBCOMMITTEE ON
BORDER AND MARITIME SECURITY
SUBCOMMITTEE ON COUNTERTERRORISM
AND INTELLIGENCE

COMMITTEE ON FOREIGN AFFAIRS
SUBCOMMITTEE ON THE
MIDDLE EAST AND SOUTH ASIA
SUBCOMMITTEE ON TERRORISM,
NONPROLIFERATION AND TRADE

REVITALIZING OLDER CITIES
TASK FORCE
Co-CHAIR

Congress of the United States
House of Representatives
Washington, DC 20515-3227

WASHINGTON OFFICE:
2459 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-3306
(202) 226-0347 (FAX)

WESTERN NEW YORK OFFICES:
LARKIN BUILDING
726 EXCHANGE STREET
SUITE 601
BUFFALO, NY 14210
(716) 852-3501
(716) 852-3929 (FAX)
FENTON BUILDING
2 EAST 2ND STREET
SUITE 300
JAMESTOWN, NY 14701
(716) 484-0729
(716) 484-1049 (FAX)
higgins.house.gov

January 15, 2013

George Opfer
Inspector General
Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Ave. NW
Washington D.C. 20420

Inspector General Opfer,

I write with grave concern over the recent disturbing revelations about the possible exposure to disease of over 700 veterans due to the negligent administration of medication at the Buffalo VA Medical Center. As the agency responsible for review of the actions at our VA facilities, I ask that you immediately commence an independent investigation into this egregious breach of patient safety and evaluate what action should be taken in connection with this negligent behavior.

The Department of Veterans Affairs notified my office of the possible exposure of 716 patients at the Buffalo VA Medical Center to Hepatitis A, Hepatitis B, and HIV. These patients were receiving care which involved the injection of insulin through medical pens that were meant for individual patient use but were instead reused on multiple patients. It would seem that flaws in the pharmacy regulations in place at the VA and/or common nursing practices at this facility may have possibly contributed to the egregious contamination of medical equipment potentially leaving a detrimental impact on the lives of hundreds of veterans in my community.

While the VA is attempting to contact those veterans that may have been exposed to these harmful pathogens there is much more work to be done. We must evaluate the root causes of this unthinkable error, identify who is responsible for this systematic failure, better understand if it is an isolated incident or representative of widespread problems and ensure it never happens again. I request that you perform an exhaustive assessment of the Buffalo VA Medical Facility to determine how this error was made, how it went unnoticed for over two years, and how it was not reported to patients for three months after it was discovered.

The health and wellness of our veterans should be one of our nation's highest priorities. The Office of Health Inspections within the Office of the Inspector General is tasked with evaluating individual health care issues while performing quality program assistance reviews of medical center operations along with evaluations of nationwide health care programs. I ask that you order a comprehensive review to identify the causes and recommend procedures that will prevent medical errors like these in the future.

The VA has a duty to ease the fears and health concerns of those who serve this nation, but this situation has done quite the opposite. The people of Western New York, especially our veterans, deserve much better from their government. Thank you for your sincere and swift attention to this critical matter. I look forward to hearing from you.

Sincerely,

A handwritten signature in blue ink, appearing to read "Brian Higgins", with a stylized flourish at the end.

BRIAN HIGGINS
Member of Congress