

## **VFW Calls for Immediate Firings at VA**

May 28, 2014

KANSAS CITY, Mo., May 28, 2014 — A preliminary report released today by the Department of Veterans Affairs Office of the Inspector General confirms the existence and seemingly widespread use of a second patient waiting list by the Phoenix VA Health Care System. The interim report did not, however, indicate whether the delay in scheduling a primary care appointment resulted in a delay in diagnosis or treatment of those who allegedly died while on the waiting list. Those details are expected when the final report is published in August.

"We call on VA Secretary Eric Shinseki to immediately fire every employee and supervisor who knowingly gamed the reporting system," demanded William A. Thien, national commander of the Veterans of Foreign Wars of the United States. "The VA is entrusted with the care and treatment of our nation's heroes, and there are people in Phoenix and possibly elsewhere who failed miserably, and quite possibly, criminally," he said. "There are no second chances when you deal with people's lives, and that includes everyone in senior leadership who should have known but didn't, or knew but didn't care."

"Military veterans are used to waiting in lines, but no veteran should ever have to wait for timely access to care for their wounds, illnesses and injuries, said Thien. "In light of the interim report, I want to make it clear to Secretary Shinseki that he needs to move immediately to terminate the employment of those bearing any responsibility for this travesty. And if the final IG report confirms willful negligence, then those responsible need to be held accountable to the fullest extent of the law. Anything less will not be tolerated by the VFW."

The VFW continues to support calls for an independent review.

Read the interim IG report online athttp://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf.

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