WASHINGTON (April 9, 2014) -- The American Legion’s national commander, Daniel M. Dellinger, told Congress at a hearing today that Department of Veterans Affairs (VA) leaders must be held accountable for mistakes that result in needless deaths at its medical facilities.

“Patient deaths are tragic -- preventable deaths are unacceptable,” Dellinger told the House Committee on Veterans’ Affairs. “But failure to disclose safety information -- or worse -- to cover up mistakes, is unforgivable, and The American Legion will not sit quietly by while some VA employees cover up the truth – and the VA shouldn’t, either.”

Dellinger recalled the deaths of six patients from an outbreak of Legionella bacteria at the Pittsburgh VA medical center. When a team from the Legion’s System Worth Saving (SWS) Task Force visited the facility last November, administrators claimed the outbreak was caused by equipment failure. E-mails and internal memos indicate human error, however.

At the Atlanta VA Medical Center, Dellinger testified, “two veterans died of an overdose, and one committed suicide, that was attributed to mismanagement and an inability to get the mental health care they needed in a timely manner.

“Veteran suicides continue to plague our nation at 22 per day, with no clear strategy from VA on addressing suicides proactively.”

“We all need to continue to ask the hard questions,” Dellinger told the committee. “What is VA doing to fix these problems, and are they concerned about keeping me informed? How is VA holding their leaders accountable for these errors?

“The American Legion will not stop asking the hard questions, and we hope you won’t, either.”

Reports issued by the Legion’s System Worth Saving Task Force on VA medical centers nationwide are available online at www.legion.org.

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