

VETERANS SUFFER AT VA FACILITIES

*Veterans Dying at VA: Health Care Delays*¹

- According to CNN, at least 19 veterans have died because of delays in diagnosis and treatment at various VA hospitals. Delays were in simple medical screenings like colonoscopies or endoscopies.²
- According to CNN, these 19 veterans were part of 82 veterans who have died, are dying, or have suffered serious injuries as a result of delayed diagnosis or treatment for colonoscopies or endoscopies specifically.³
- As explained in the CNN article, Mr. Barry Coates was having excruciating pain and rectal bleeding in 2011. For a year the Army veteran went to several VA clinics and hospitals in South Carolina, trying to get help. But the VA's diagnosis was hemorrhoids, and aside from simple pain medication he was told he might need a colonoscopy. Coates waited months, even begging for an appointment to have his colonoscopy. But he only found himself on a growing list of veterans also waiting for appointments and procedures. He was finally told he could have a colonoscopy, many months later. The now 44-year-old veteran is undergoing chemotherapy in an effort to save his life.⁴

*Patient Died at New York VA Hospital: Hospital failed to notice alarm*⁵

- In January 2011, registered nurses at a Manhattan Veterans Affairs hospital failed to notice a patient had become disconnected from a cardiac monitor until after his heart had stopped and he could not be revived.⁶
- An October 2011 VA OIG investigated the death of the patient, who was in his 80s, at the Manhattan campus of the VA's New York Harbor Healthcare System. The man had undergone several heart procedures and needed to have his vital signs continuously monitored. On his fifth day at the hospital, monitor records show that an alarm indicated a problem with the device or the patient, but there is no evidence nurses were aware of the

¹ Scott Bronstein, Nelli Black, and Drew Griffin, "Veterans dying because of health care delays," CNN, January 30, 2014. <http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

² Scott Bronstein, Nelli Black, and Drew Griffin, "Veterans dying because of health care delays," CNN, January 30, 2014. <http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

³ Scott Bronstein, Nelli Black, and Drew Griffin, "Veterans dying because of health care delays," CNN, January 30, 2014. <http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

⁴ Scott Bronstein, Nelli Black, and Drew Griffin, "Veterans dying because of health care delays," CNN, January 30, 2014. <http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

⁵ Charles Ornstein and Tracy Weber, "Patient Died at New York VA Hospital After Alarm was Ignored," ProPublica, May 15, 2012; <http://www.propublica.org/article/patient-died-at-new-york-va-hospital-after-alarm-was-ignored>.

⁶ Charles Ornstein and Tracy Weber, "Patient Died at New York VA Hospital After Alarm was Ignored," ProPublica, May 15, 2012; <http://www.propublica.org/article/patient-died-at-new-york-va-hospital-after-alarm-was-ignored>.

alarm until the man was discovered unresponsive an hour and a half later. He was declared dead shortly afterward, according to the OIG report.⁷

- The death also prompted a broader review of skills and training of VA nurses. In an April 2012 VA OIG report, OIG found that only half of 29 VA facilities surveyed by the inspector general had adequately documented that their nurses had skills to perform their duties. According to the report, even though some nurses "did not demonstrate competency in one or more required skills," there was no evidence of retraining.

Gastrointestinal Consultation Backlog: VA-Private partnerships save veterans from VA

- In 2011 and 2012, 5,100 Augusta and Dublin, GA, VA beneficiaries who were in need of gastrointestinal procedures went without consultations.⁸
- Furthermore, VA HQ in Atlanta revealed a delay in 2,860 screenings, 1,300 surveillance and 340 diagnostic endoscopies.⁹
- According to an internal VA memo, reported on by The Augusta Chronicle, the Augusta VA sought assistance from "non-VA care partner facilities" in September 2012 for help in reducing consult delays—by January 2014, the VA was able to resolve all delayed consultations through utilizing options which existed within the Augusta community.¹⁰

Equipment Collapses, Killing Patient¹¹

- A 66 year-old veteran was undergoing a procedure using a gamma camera at the James J. Peters VA Medical Center in New York City when the apparatus collapsed and crushed him.¹²
- The diagnostic equipment was installed in 2006 and was maintained by its manufacturer. The equipment in the incident was a camera, Infinia Hawkeye 4 model, and can weigh more than 5,000 pounds.¹³

⁷ Charles Ornstein and Tracy Weber, "Patient Died at New York VA Hospital After Alarm was Ignored," ProPublica, May 15, 2012; <http://www.propublica.org/article/patient-died-at-new-york-va-hospital-after-alarm-was-ignored>.

⁸ Wesley Brown "Gastrointestinal consultation backlog reported at second east Georgia VA hospital" Stars & Stripes/The Augusta Chronicle, January 29, 2014.

<http://www.stripes.com/news/us/gastrointestinal-consultation-backlog-reported-at-second-east-georgia-va-hospital-1.264549>

⁹ Wesley Brown "Gastrointestinal consultation backlog reported at second east Georgia VA hospital" Stars & Stripes/The Augusta Chronicle, January 29, 2014.

<http://www.stripes.com/news/us/gastrointestinal-consultation-backlog-reported-at-second-east-georgia-va-hospital-1.264549>

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<http://www.stripes.com/news/us/gastrointestinal-consultation-backlog-reported-at-second-east-georgia-va-hospital-1.264549>

¹¹ Tamer El-Ghobashy, Christopher Weaver, "Equipment Collapses, Killing Patient," The Wall Street Journal, June 7, 2013; <http://online.wsj.com/news/articles/SB10001424127887324798904578529103419237828>.

¹² Tamer El-Ghobashy, Christopher Weaver, "Equipment Collapses, Killing Patient," The Wall Street Journal, June 7, 2013; <http://online.wsj.com/news/articles/SB10001424127887324798904578529103419237828>.

Recalled Medical Device Killed a Vet at Seattle’s VA Hospital: Eddie Creed died because of recalled device Infusomat¹⁴

- In 2012, Eddie Creed, who served in the Army in the 1950s went on to play piano for Seattle’s Chamber Jazz Quartet in civilian life. On April 19, 2012, Eddie died at the Veterans Affairs hospital on Beacon Hill—his death certificate said throat cancer had killed him.¹⁵
- According to A KUOW (a Puget Sound, Western Washington, and Southern British Columbia radio station) investigation, on Creed's second night at the VA, Eddie was hooked up to an Infusomat device—which was under a Class I recall—when it malfunctioned and drained all of its morphine into Eddie while he was asleep. Around 11 p.m. that night, a nurse discovered that during the malfunction Creed had received about 10 times the dose he was prescribed, and Eddie was pronounced dead shortly thereafter.¹⁶

Veteran Suicides at VA: Veterans Enrolled in the VA suffered three times suicide rate of Active Duty Troops

- “Veterans aged 18-24 in the VA's health program killed themselves at a rate of 46-per-100,000 in 2009 and nearly 80-per-100,000 in 2011, the latest year of data available. Non-veterans of the same age had a suicide rate during 2009 and 2010, of about 20-per-100,000. Up-to-date statistics for both vets and non-vets are not yet available.”¹⁷

Air Force Veteran Left with Horrific Injuries: Doctors IGNORED her symptoms because of her PTSD¹⁸

- According to the Daily Mail, Ms Temple had an ovariectomy in January 2007 which she claims was performed by a VA OBGYN surgeon. However, her surgeon removed piece of her colon was removed instead.
- For 15 months, she traveled several hundred miles to reach the hospital from her home in Maine to attend follow-up appointments because the pain continued.¹⁹

¹³ Tamer El-Ghobashy, Christopher Weaver, “Equipment Collapses, Killing Patient,” The Wall Street Journal, June 7, 2013; <http://online.wsj.com/news/articles/SB10001424127887324798904578529103419237828>.

¹⁴ John Ryan, “How a Recalled Medical Device Killed a Vet at Seattle’s VA Hospital,” KUOW, December 5, 2013; <http://kuow.org/post/how-recalled-medical-device-killed-vet-seattles-va-hospital>.

¹⁵ John Ryan, “How a Recalled Medical Device Killed a Vet at Seattle’s VA Hospital,” KUOW, December 5, 2013; <http://kuow.org/post/how-recalled-medical-device-killed-vet-seattles-va-hospital>.

¹⁶ John Ryan, “How a Recalled Medical Device Killed a Vet at Seattle’s VA Hospital,” KUOW, December 5, 2013; <http://kuow.org/post/how-recalled-medical-device-killed-vet-seattles-va-hospital>.

¹⁷ <http://www.observertoday.com/page/content.detail/id/593569/Data-reveals-dark-side-to--military-service.html?nav=5046>

¹⁸ Daily Mail, “Tragedy of female Air Force veteran left with horrific injuries following botched surgery because 'doctors IGNORED her symptoms because she suffers from PTSD” November 13, 2013, <http://www.dailymail.co.uk/news/article-2506751/Veteran-Robin-Temple-left-horrific-injuries-IGNORED-doctors.html>

- For three days, Ms Temple claims she was told by the doctor's office that because she has PTSD, her pain following the surgery 'was all in [her] head'.²⁰
- Later, Ms. Temple discovered she was suffering from two massive hernias and while undergoing an MRI scan to investigate, and also found that her ovaries had not been removed.²¹
- By this time the tumors had spread to her lymph nodes in her groin, she had bladder sheaths implanted which cut her bladder in half and were recalled, and her left kidney began to fail due to the amount of medication she required and ongoing infections.²²
- Due to these procedures Ms. Temple ended up losing half of her left kidney.²³

U.S. Vets Exposed to Contaminated Cadaver Parts: *Awaiting Disaster*²⁴

- According to Bloomberg, the U.S. Department of Veterans Affairs ordered \$241 million of cadaver tissue and other material derived from human and animal bodies in the last three years, some of it from vendors **warned by federal regulators about contamination** in their supply chain.²⁵
- According to federal contracting data compiled by Bloomberg, the VA ordered human tissue from the two suppliers despite previously being warned by the U.S. Food and Drug Administration for safety deficiencies -- RTI for contaminated products and processing facilities, and Musculoskeletal Transplant for distributing tissue from tainted donor bodies.
- **A Minnesota man died in 2001** after a knee surgery in which he was given contaminated cadaver bone; according to written testimony his parents gave the U.S. Senate Committee on Governmental Affairs in 2003.

¹⁹ Daily Mail, "Tragedy of female Air Force veteran left with horrific injuries following botched surgery because 'doctors IGNORED her symptoms because she suffers from PTSD" November 13, 2013, <http://www.dailymail.co.uk/news/article-2506751/Veteran-Robin-Temple-left-horrific-injuries-IGNORED-doctors.html>

²⁰ Daily Mail, "Tragedy of female Air Force veteran left with horrific injuries following botched surgery because 'doctors IGNORED her symptoms because she suffers from PTSD" November 13, 2013, <http://www.dailymail.co.uk/news/article-2506751/Veteran-Robin-Temple-left-horrific-injuries-IGNORED-doctors.html>

²¹ Daily Mail, "Tragedy of female Air Force veteran left with horrific injuries following botched surgery because 'doctors IGNORED her symptoms because she suffers from PTSD" November 13, 2013, <http://www.dailymail.co.uk/news/article-2506751/Veteran-Robin-Temple-left-horrific-injuries-IGNORED-doctors.html>

²² Daily Mail, "Tragedy of female Air Force veteran left with horrific injuries following botched surgery because 'doctors IGNORED her symptoms because she suffers from PTSD" November 13, 2013, <http://www.dailymail.co.uk/news/article-2506751/Veteran-Robin-Temple-left-horrific-injuries-IGNORED-doctors.html>

²³ Daily Mail, "Tragedy of female Air Force veteran left with horrific injuries following botched surgery because 'doctors IGNORED her symptoms because she suffers from PTSD" November 13, 2013, <http://www.dailymail.co.uk/news/article-2506751/Veteran-Robin-Temple-left-horrific-injuries-IGNORED-doctors.html>

²⁴ Kathleen Miller, "U.S. Vets Exposed to Cadaver Parts From Contaminated Lab," Bloomberg, January 24, 2014; <http://www.bloomberg.com/news/2014-01-24/u-s-vets-exposed-to-contaminated-cadaver-parts-from-labs.html>.

²⁵ Kathleen Miller, "U.S. Vets Exposed to Cadaver Parts From Contaminated Lab," Bloomberg, January 24, 2014; <http://www.bloomberg.com/news/2014-01-24/u-s-vets-exposed-to-contaminated-cadaver-parts-from-labs.html>

- **The VA continued to purchase from RTI after the FDA warning letter**, according to online federal contracting data. The post-warning orders included a \$3,375 Achilles-tendon order in April 2013 and a \$3,355 skin-graft order in September 2013, according to the data.
- The agency’s letter told RTI that it found fungus in tissue-processing and packaging areas, bacteria in its water systems, and had failed to recognize environmental-monitoring data “indicative of contamination throughout your facility.”

Veterans’ Malpractice Claims On the Rise

According to The Atlanta Journal-Constitution and Cox Media Group, VA malpractice settlements and court judgments have cost taxpayers \$845 million since 2003 and reached a high of \$98 million in 2012.²⁶ Furthermore, the VA doesn't directly pay for damages; the money comes out of the Treasury.²⁷

- A 20-year Marine Corps veteran paralyzed after a routine tooth extraction;
- An Air Force veteran who died after a surgeon accidentally punctured his heart;
- An Army veteran who died after doctors repeatedly failed to diagnose signs of lung cancer.
- Bill Boritz, a Decatur resident who flew B-52s during the Vietnam War, trusted his doctors at the Atlanta VA Medical Center. In April 2010, doctors using laser surgery to fix a flutter in his heart accidentally burned a hole in it, said his wife, Veronica Boritz.
- Chuck Pennington died at the Dayton Veterans Affairs Medical Center of internal hemorrhage. Pennington had received too much blood thinner, and had not been regularly checked by the nurses at the hospital. Pennington’s wife was not the only one who received payments from the Dayton VA Medical Center for errors made between 2005 and 2008.
- According a Dayton Daily News investigation²⁸, other survivors of patients who received malpractice includes veterans who have:
 - Died after receiving an incorrect chemotherapy dose;
 - Killed by a post-hip surgery infection,
 - Died as a result of in-hospital injuries after allegedly being attacked by another patient

²⁶ Craig Schneider, “Veterans’ Malpractice Claims On the Rise” Military.com, November 13, 2013. <http://www.military.com/daily-news/2013/11/13/veterans-malpractice-claims-on-the-rise.html>

²⁷ Craig Schneider, “Veterans’ Malpractice Claims On the Rise” Military.com, November 13, 2013. <http://www.military.com/daily-news/2013/11/13/veterans-malpractice-claims-on-the-rise.html>

²⁸ Ben Sutherly, “VA Paid 8 Families in Death Lawsuits,” Dayton Daily News, March 10, 2012; <http://www.daytondailynews.com/news/news/local/va-paid-8-families-in-death-lawsuits-1/nMzKm/>.

Army Veteran Received Malpractice at VA Medical Center: Lost his leg and suffered severe brain damage²⁹

- In February 2009, 43 year old Army veteran, Dirk Askew, complained of chest pain and went on to receive a cardiac stent at the John Cochran VA Medical Center in St. Louis, Missouri. Unfortunately, Mr. Askew soon developed swelling and bleeding at the surgical site in his right upper thigh. After a week, he was readmitted to Cochran and had surgery to repair an artery at the wound site, which had become infected.³⁰
- According to Mr. Askew’s attorneys, Mr. Askew was unnecessarily delayed for multiple days before a corrective surgery was performed, and that surgeons improperly used infected tissue to patch the artery. Mr. Askew’s legal team also accuses Cochran VA of further negligence, which Mr. Askew claims led significant blood loss which caused his severe brain injury. Making matters worse, Askew’s infected right leg required amputation when it became infected with gangrene.³¹
- Askew, who is father of three, is now paralyzed and struggles to communicate.³²
- A nurse in Cochran’s intensive care unit was banned from treating patients after injecting one patient with a potentially lethal dose of the painkiller fentanyl and other “egregious acts resulting in death or near death of patients” in 2010.³³
- Mr. Askew’s case has not been the only claim of negligence at John Cochran VA, which has had years of problems relating to negligence with VA employees and in its sterilization safety.³⁴
 - A Florida man sued the hospital in February claiming he was unnecessarily treated with radiation and chemotherapy for months after a misdiagnosis of lymphoma. The case is ongoing.³⁵

²⁹ Blythe Bernhard, “St. Louis man wins \$8.3 million malpractice award against John Cochran VA hospital,” St. Louis Post-Dispatch, November 19, 2013; http://www.stltoday.com/news/local/crime-and-courts/st-louis-man-wins-million-malpractice-award-against-john-cochran/article_0ef9ea5d-1a4c-5ea0-abdc-a1a41b544670.html.

³⁰ Blythe Bernhard, “St. Louis man wins \$8.3 million malpractice award against John Cochran VA hospital,” St. Louis Post-Dispatch, November 19, 2013; http://www.stltoday.com/news/local/crime-and-courts/st-louis-man-wins-million-malpractice-award-against-john-cochran/article_0ef9ea5d-1a4c-5ea0-abdc-a1a41b544670.html.

³¹ Blythe Bernhard, “St. Louis man wins \$8.3 million malpractice award against John Cochran VA hospital,” St. Louis Post-Dispatch, November 19, 2013; http://www.stltoday.com/news/local/crime-and-courts/st-louis-man-wins-million-malpractice-award-against-john-cochran/article_0ef9ea5d-1a4c-5ea0-abdc-a1a41b544670.html.

³² Blythe Bernhard, “St. Louis man wins \$8.3 million malpractice award against John Cochran VA hospital,” St. Louis Post-Dispatch, November 19, 2013; http://www.stltoday.com/news/local/crime-and-courts/st-louis-man-wins-million-malpractice-award-against-john-cochran/article_0ef9ea5d-1a4c-5ea0-abdc-a1a41b544670.html.

³³ Blythe Bernhard, “St. Louis man wins \$8.3 million malpractice award against John Cochran VA hospital,” St. Louis Post-Dispatch, November 19, 2013; http://www.stltoday.com/news/local/crime-and-courts/st-louis-man-wins-million-malpractice-award-against-john-cochran/article_0ef9ea5d-1a4c-5ea0-abdc-a1a41b544670.html.

³⁴ Blythe Bernhard, “St. Louis man wins \$8.3 million malpractice award against John Cochran VA hospital,” St. Louis Post-Dispatch, November 19, 2013; http://www.stltoday.com/news/local/crime-and-courts/st-louis-man-wins-million-malpractice-award-against-john-cochran/article_0ef9ea5d-1a4c-5ea0-abdc-a1a41b544670.html.

³⁵ Blythe Bernhard, “St. Louis man wins \$8.3 million malpractice award against John Cochran VA hospital,” St. Louis Post-Dispatch, November 19, 2013; http://www.stltoday.com/news/local/crime-and-courts/st-louis-man-wins-million-malpractice-award-against-john-cochran/article_0ef9ea5d-1a4c-5ea0-abdc-a1a41b544670.html.

- According to a VA OI report, a nurse in Cochran’s intensive care unit was banned from treating patients after injecting one patient with a potentially lethal dose of the painkiller fentanyl and other “egregious acts resulting in death or near death of patients” in 2010.³⁶
- Another investigation into a 2010 death of a 58-year-old man found that a nurse did not recognize or report that the man receiving kidney dialysis had become unresponsive during a five-hour treatment session.³⁷
- More than 1,800 veterans were notified in 2010 that they might have been exposed to HIV, hepatitis or other viruses because of inadequate sterilization procedures in the dental clinic. No illnesses have been linked to the potential exposure.³⁸

Mistreatment at the Memphis Veterans Hospital: Patients claim VA Hospital discharged him with needle in arm³⁹

- Howard Hughes Senior- Went into the VA hospital for neck surgery, and came out with a severed nerve and paralyzed vocal chords.⁴⁰
- Samuel Rounds- Discharged from the VA hospital despite complaining of arm pain. Doctors later discovered a needle still in his arm; it had turned causing nerve damage into his hand.⁴¹

Navy Yard Shooter, Alex Alexis botched Diagnosis: Navy Yard Shooter Given Clean Mental Health Evaluation at VA⁴²

- Alex Alexis, who killed 12 people in the 2013 rampage at Washington's Navy Yard convinced VA doctors before the shootings that he had no mental health issues despite disturbing problems and encounters with police during the same period.⁴³

³⁶ Blythe Bernhard, “St. Louis man wins \$8.3 million malpractice award against John Cochran VA hospital,” St. Louis Post-Dispatch, November 19, 2013; http://www.stltoday.com/news/local/crime-and-courts/st-louis-man-wins-million-malpractice-award-against-john-cochran/article_0ef9ea5d-1a4c-5ea0-abdc-a1a41b544670.html.

³⁷ Blythe Bernhard, “St. Louis man wins \$8.3 million malpractice award against John Cochran VA hospital,” St. Louis Post-Dispatch, November 19, 2013; http://www.stltoday.com/news/local/crime-and-courts/st-louis-man-wins-million-malpractice-award-against-john-cochran/article_0ef9ea5d-1a4c-5ea0-abdc-a1a41b544670.html.

³⁸ Blythe Bernhard, “St. Louis man wins \$8.3 million malpractice award against John Cochran VA hospital,” St. Louis Post-Dispatch, November 19, 2013; http://www.stltoday.com/news/local/crime-and-courts/st-louis-man-wins-million-malpractice-award-against-john-cochran/article_0ef9ea5d-1a4c-5ea0-abdc-a1a41b544670.html.

³⁹ Shay Harris, “Second patient claims VA hospital discharged him with needle in arm,” WMCTV, January 15, 2014; <http://www.wmctv.com/story/24466449/second-patient-claims-va-hospital-discharged-him-with-needle-in-arm>.

⁴⁰ Nick Kenney, “Patient claims VA hospital discharged him with needle in arm,” WMCTV, January 8, 2014; <http://www.wmctv.com/story/24400304/patient-claims-va-hospital-discharged-him-with-needle-in-arm>.

⁴¹ Nick Kenney, “Patient claims VA hospital discharged him with needle in arm,” WMCTV, January 8, 2014; <http://www.wmctv.com/story/24400304/patient-claims-va-hospital-discharged-him-with-needle-in-arm>.

⁴² Kevin Freking, “Gunman’s doctor before rampage: No problem there,” AP, January 31, 2014, <http://bigstory.ap.org/article/gunmans-doctor-rampage-no-problem-there>

⁴³ Kevin Freking, “Gunman’s doctor before rampage: No problem there,” AP, January 31, 2014, <http://bigstory.ap.org/article/gunmans-doctor-rampage-no-problem-there>

- Alexis told a VA emergency room doctor in Providence that he couldn't sleep, the doctor wrote that his speech and thoughts seemed "clear and focused" and noted that he "denies flashbacks, denies recent stress."⁴⁴

Veterans Affairs Hospital Releases a Delusional Man: Doctors ignored evaluations by staff nurses⁴⁵

- In September 2012, a veteran in his 40s was admitted to a VA hospital in Puerto Rico for surgery possibly related to chronic liver disease. The veteran was hospitalized for 54 days, and was also treated for pneumonia and a urinary tract infection during his stay. He was then discharged by his doctors, against his nurses recommendations, despite still requiring treatment.⁴⁶
- VA OIG investigated this veteran's treatment in Puerto Rico and found that he was not treated well at the VA facility. VA OIG also found that the hospital left the veteran malnourished and dehydrated, and that he had lost 96.4 pounds during his stay. Furthermore, the veteran's skin was covered with ulcers and still suffered from his urinary tract infection.⁴⁷
- VA OIG reported that "Nursing notes indicated the patient remained confused and combative, had visual hallucinations, and required intermittent restraints during the remainder of his hospitalization. They also noted the patient was unable to stand, perform self-care, or feed himself,"⁴⁸

Veterans Administration Back Charges Triple Amputee Thousands of Dollars⁴⁹

- Senior Airman, Brian Kolfage Jr., the most severely wounded Airman in US history---a triple amputee---was informed recently by the Veterans Administration Debt Management Center that he would be back charged \$4825.00.
- On September 11, 2004, while serving his second deployment in support of Operation Iraqi Freedom, Brian Kolfage lost both his legs and an arm when a 107 mm rocket exploded three feet from the Airman, throwing him into a wall of sandbags.
- After an Arizona background check, the VA claimed that Brian was overpaid, each month, for several years. According to the VA, Brian's indebtedness---for this alleged overpayment

⁴⁴ Kevin Freking, "Gunman's doctor before rampage: No problem there," AP, January 31, 2014, <http://bigstory.ap.org/article/gunmans-doctor-rampage-no-problem-there>

⁴⁵ Phillip Swarts, "VA Hospital's release of delirious veteran latest in string of failures," The Washington Times, January 5, 2014; <http://www.washingtontimes.com/news/2014/jan/5/va-hospitals-request-of-delirious-veteran-latest-i/#ixzz2rp0cnDAI>.

⁴⁶ Phillip Swarts, "VA Hospital's release of delirious veteran latest in string of failures," The Washington Times, January 5, 2014; <http://www.washingtontimes.com/news/2014/jan/5/va-hospitals-request-of-delirious-veteran-latest-i/#ixzz2rp0cnDAI>.

⁴⁷ Phillip Swarts, "VA Hospital's release of delirious veteran latest in string of failures," The Washington Times, January 5, 2014; <http://www.washingtontimes.com/news/2014/jan/5/va-hospitals-request-of-delirious-veteran-latest-i/#ixzz2rp0cnDAI>.

⁴⁸ Phillip Swarts, "VA Hospital's release of delirious veteran latest in string of failures," The Washington Times, January 5, 2014; <http://www.washingtontimes.com/news/2014/jan/5/va-hospitals-request-of-delirious-veteran-latest-i/#ixzz2rp0cnDAI>.

⁴⁹ "Veterans Administration Back Charges Triple Amputee Brian Kolfage Thousands of Dollars," Freedom Outposts; <http://freedomoutpost.com/2013/11/veterans-administration-back-charges-triple-amputee-brian-kolfage-thousands-dollars/#vby4dsl07dKoWCO.99>.

of \$4825.00--would require monthly payments of \$105 to be taken out of his benefits account until the debt was satisfied.

VA's eBenefits site Data Breach⁵⁰

- On Jan. 15, the VA discovered its beneficiaries accounts on the VA's eBenefits website, its webpage to apply for VA benefits, were overlapped—meaning a veteran who was logged onto the eBenefits system could log off, log back on, and be routed to a different veterans account.⁵¹
- The VA assessed that this data breach may have compromised the personal data of 5,351 veterans.⁵²

⁵⁰ American Legion, "VA'S eBenefits suffers data breach" American Legion, January 21, 2014, <http://www.legion.org/veteransbenefits/218278/vas-ebenefits-suffers-data-breach>

⁵¹ American Legion, "VA'S eBenefits suffers data breach" American Legion, January 21, 2014, <http://www.legion.org/veteransbenefits/218278/vas-ebenefits-suffers-data-breach>

⁵² American Legion, "VA'S eBenefits suffers data breach" American Legion, January 21, 2014, <http://www.legion.org/veteransbenefits/218278/vas-ebenefits-suffers-data-breach>