

**Statement by Nicklas Family Before The House Committee on Veteran Affairs
Oversight Filed Hearing**

**“A Matter of Life and Death: Examining Preventable Deaths, Patient-Safety Issues
and Bonuses for VA Execs Who Oversaw Them”**

September 9, 2013

Before I begin, I would like to take this opportunity to thank the committee for arranging this field hearing in Pittsburgh. Our family is very grateful to so many of the congressmen for your support in pursuing the answers our family, and those families of the other victims of the Legionella outbreak in Pittsburgh, deserve. Without the support of the Chairman of the House Veterans Affairs Committee, Jeff Miller, Congressmen Tim Murphy, Keith Rothfus and Mike Doyle, Senator Bob Casey, and all of those who are here today and were with us at the Congressional hearing in February, we may never know the truth. With your support, however, we hope that we will have answers and accountability, not only for our loved ones but for all veterans who deserve better.

Thank you for the opportunity to share information about our father, William Nicklas, and our experiences with VA Pittsburgh Hospital System. Our father was not only, a devoted husband, father and grandfather but was a proud, loyal veteran who often spoke of the service he gave to his country. As a young man, he worked hard to gain the weight necessary for him to enter the military, and once accepted in the Navy, he worked just as hard, not only fulfilling his duties, but also providing the best service he could to his country, the Navy and his fellow servicemen. Upon leaving the service, my father met and married our mother and, subsequently, had three boys. While raising his family, he began his own auto body business where he worked until he retired. Being an extremely active man, he continued to keep himself busy by helping two of his sons begin their own business as contractors. In 2008, at the age of 84, he helped my brother construct a memorial to the WW II veterans in his community. He was known for his practical jokes, his love of sports, his ability to be the first and the last on the dance floor, and his undeniable dedication to family. He was, no doubt, the patriarch of our family who was there whenever he was needed. There was one other issue my father felt a deep sense of passion for...our country and its military personnel. Everyday, at our home, my father flew the American flag in his front yard as a symbol of his belief in this country. It was not often when we would see our father shed a tear, but each year on Thanksgiving Day as we sat around the table at my house, individually thanking God for the greatest things in our lives, it was always dad who, fighting back tears, would mention the soldiers who were away from home, fighting the war for this great country. He believed that those men and women deserved the utmost respect and to never be forgotten.

On November 1, my father entered the VAPHS due to nausea, which he believed stemmed from a new medication. This was the very day after the CDC advised Dr. Muder, Chief of Infectious Disease at VAPHS, that genetic testing confirmed two VAPHS patients contracted Legionnaires from the hospital. When my brother and father arrived at VAPHS, my father told my brother, "Go ahead. I'll be fine. They will probably just run some tests and release me." Again, my father's dedication to and belief in the VA led him to VAPHS. While he and my mother had private health insurance and could have accessed any hospital in the Pittsburgh area, he opted to go VAPHS because he believed that was where a veteran would get the best care. Or so we would have thought. Ironically, the very day my father entered the hospital, the CDC was already on site working on an ongoing problem with a deadly Legionella bacteria outbreak. Another significant event took place on the day that my father was admitted to the fifth floor of VAPHS - Dr. Muder, VAPHS Chief of Infectious Disease, reached out to several experts trying to locate someone who could do genetic testing and environmental Legionella sampling. Unable to find anyone, UPMC's Director of Clinical Microbiology Labs, William Pasculle suggested that VAPHS contact Janet Stout, former VA employee. Dr. Muder responded to that suggestion by saying "I would love to have Janet do it but that's not possible due to her association with a certain person, the administration would go ballistic when they saw the invoice." This disappointing political decision was the first of many unconscionable, devastating decisions resulting in my father contracting the disease, which ultimately caused his death.

From November 1 through November 10, my father was allowed to shower and drink the hospital water. Never was anyone in our family ever advised that there was an ongoing CDC investigation and an Epi Aid investigation due to a Legionella outbreak being conducted at the very same hospital at the very same time. On Sunday, November 11, we received a call in the morning alerting us that they had moved my father to the 4th floor ICU due to elevated potassium levels. We were advised that he was fine, alert and otherwise OK and that there was no need to rush in. On November 12 or 13, we were advised that my father had an infection and a low-grade fever. When questioned about the source, the ICU staff was not certain but assured us that they were running the proper tests to determine the cause. As the next few days unfolded, we were told by the ICU staff that they believed the source of the low grade fever was a urinary tract infection which was also causing issues with my father's kidneys. Several days went by without any definitive cause of infection. You cannot imagine the shock and anxiety we experienced when, on Friday, November 16, as my wife and I listened to the local news on TV, we learned that the VAPHS announced a Legionella outbreak. Our disappointment mounted knowing that my father had already been in the hospital for 16 days.

On November 17, when we visited dad, we noticed that there were signs in the lobby water fountains, which read, DUE TO WATER LINE PROBLEMS, THIS FOUNTAIN IS OUT OF ORDER. As we entered his room in ICU, we saw a sign in the sink, which read, DUE TO WATER LINE PROBLEMS, DO NOT USE. There was no mention of Legionella or Legionnaires. We also noticed during our visit that dad was telling stories that did not make sense. When my wife mentioned it to the ICU nursing staff, she was told that it was a condition known as "ICU psychosis", a term used when patients show signs of delirium due to a prolonged stay in one room. We were assured that this would "clear up". At the same time, we were told that my father's kidney and liver were stressed but despite it all, the doctors assured us that he would be home by Thanksgiving.

Over the next few days, dad's condition deteriorated and his doctor began oral antibiotics, even though dad was suffering from bouts of diarrhea. On November 19, his doctor ordered the first culture for Legionella bacteria via a urine antigen test...nineteen days after dad entered the hospital, weeks after symptoms attributable to Legionnaires appeared, and with knowledge that they had an outbreak of Legionella. VAPHS further delayed the testing of this sample when the lab "lost" or "misplaced" my father's first sample. Once again, another sample had to be taken and on November 21, our family requested a meeting with dad's doctor due to the contradictory reports we were receiving from the ICU nurses and doctors when we phoned in to check on dad's condition. Our meeting was scheduled for 6:30 on Wednesday evening, November 21. Shortly before leaving our home to attend this meeting, my wife called ICU to check on dad and was told by the attending physician that they had just received confirmation that he tested positive for Legionella bacteria. When asked if this meant that he had Legionnaires, my wife was told by the attending physician, "we cannot say that right now". Stunned and disappointed, we arrived at the hospital for our meeting. We were told that they were treating dad with antibiotics and we subsequently learned that they had switched him from oral antibiotics to IV antibiotics. At this meeting, we were told numerous times by his doctor that she had expected him to make a full recovery prior to the diagnosis of Legionnaires. The doctor told us that even if the disease would clear, the repercussions of the Legionnaires were long lasting. The doctor suggested that we tell dad and once she did, his response was "just what I need".

That night began the slow, painful decline of my father. A man, who still, despite all that he was going through, wanted to reach out and protect his family, most importantly, his wife. He told us stories of people coming to get him...that they were trying to poison him and that we had to get out of there before they poisoned us, too. Over the course of the next 2 days, we watched my dad's mental state deteriorate further and further. He was obsessed with picking at his blanket. When we asked why, he told us "I have to get the poison off of me". My mom was called to the hospital on Friday, November 23, 2012, to try to help settle my dad who seemed extremely agitated. He was scared, he was worried, he was anxious, unsettled, still concerned that they were going to poison us.

In fact, as I sat there that night, holding his hand, he tried to "pick the poison" off of the back of my hand. He drew blood as he pinched my skin over and over and over again. We said our good nights, told him that we loved him and that we would see him the next day. That would never be. We drove my mom home and were planning to leave for the airport to pick up my brother, Ken. As we entered the house, the phone was ringing. My son answered the phone - it was the doctor advising us that dad had passed. My brother did not get here in time to see my father. Having to deliver that news to him as we stood outside of the airport was the toughest thing I have ever had to do. And why - why did this happen? Why were we not warned that the CDC was on site? Why wasn't something done after the 1st person died? the 2nd? the 3rd? the 4th? Why was the antigen testing not done sooner on my father, especially since they knew there was a problem? Who lost or misplaced my father's first sample? Why did the VAPHS not accept the help that they were offered by consultants such as Enrich or Liquitech? The questions go on and on and on.

Over nine months ago, we began to ask questions about this unfathomable situation, which has devastated our family. Those questions have led us on a journey, full of more questions with no answers. We realize that the power, which Congress has, could make all the difference in giving the families the closure they deserve by providing us with answers and accountability. We are here today to urge Congress to help us to get answers and to, ultimately, hold those accountable for the decisions that were made that led to this travesty. In February of 2013, we attended the Congressional hearing in Washington DC where several panels presented information on the history of the water system at VAPHS, the closing of the world renowned lab at VAPHS in 2006 and the subsequent senseless destruction of thousands of Legionella samples, the years of support offered by consultants to help manage the copper silver ionization system after the closing of the VAPHS lab, and the lack of training provided to those employees now responsible for monitoring that same system. At that hearing, no one from the Pittsburgh VA Hospital administration attended and those VA representatives who did, were unable to answer specific questions. While several startling pieces of information were revealed during that hearing, no specific answers were provided.

Since the hearing in February, many stories have appeared in the local newspapers, on local television, on national news broadcast such as CNN and CBS national news, yet still no answers and no accountability. In April of 2013, the findings of a four month long federal investigation by the U.S. Office of the Inspector General were released.

What we learned were that the copper-silver ionization system was not managed thus allowing Legionella to flourish in the system; there was little documentation of the system being monitored; communication between the infectious disease team and facilities management staff was "poor"; those in charge of the system did not routinely flush faucets and showers with hot water as advised by the manufacturer of the system; when personnel did flush the system, they did not raise the temperature of the hot water enough thus violating the VA's own guidelines; and staff did not test all health care-associated pneumonia patients for Legionella as, again, VHA guidelines recommend. The Director of the VA responded to this report by saying, "they validated what we already knew" and that she and other officials were in "total agreement" with the findings. All of this they knew. What else did they know? Management also knew that the first person contracted the Legionnaires in February 2011, that the first death from the outbreak occurred in July 2011 and they knew that there were 6 more people who were infected in the fall of 2011. One would ask ... Why, then, were people still being infected and still dying in November of 2012? What do we know? We know that after several of those deaths, VAPHS advised the families of most of those infected that the bacteria must have been acquired outside of the hospital even though they knew they had ongoing issues with Legionella.

Our family's disappointment and outrage did not stop there. In late April of 2012, we learned that the Director of VAPHS, Terry Wolf, and the Regional Director, Michael Moreland, each received a performance bonus in the approximate amount of \$13,000 and \$16,000, respectively. Yet, again, on May 2, 2013, it was announced that Michael Moreland was awarded the Presidential Distinguished Rank Award, which was approved by VA Secretary, Eric Shinseki and the White House. This award is given to less than 1% of the federal government's senior executives...54 employees this year! The award includes a bonus equal to 35% of the employee's annual salary. For Michael Moreland that salary was \$179,700 making the bonus approximately \$63,000.

I ask all of you present today, to imagine what my family has been through. Now, remember these veterans who senselessly lost their lives through a long, painful process full of anxiety and struggle. I also ask everyone who is present today to reflect on this one question...What would have happened if you had performed your job in the same manner as the VAPHS administration? Would you still be employed? Would you still have your benefits? Would you be receiving bonuses?

My father, William E. Nicklas, was a man who served his country honorably and responsibly; a man who put himself in danger to protect his country and his comrades; a man who raised a family and instilled in that family that same sense of responsibility to themselves, their family, the community, and this country. He was also a man who held himself and his family accountable for their actions. We ask for nothing less for him and all of the other victims of this outbreak.

Again, we urge Congress and all veterans to join with us to demand answers and accountability. The same tax dollars paid by every citizen, including family members affected by this travesty, are the same tax dollars used to pay the salaries, the benefits, the bonuses and the budgets of the employees of VAPHS. We beg you to please help us to get the answers that these and possible other victims deserve!

William E. Nicklas
John Ciarolla
Clark Compston
John McChesney
Lloyd Wanstreet

Thank you for this opportunity to testify and I will be happy to answer your questions at this time.