2007. I thank my colleague, Mr. GIANFORTE from Montana, for bringing this bill before us so we may all pay tribute to a selfless public servant.

Travis was born on December 9, 1975, to parents Jack and Elaine. Growing up in Bozeman, Montana, he was an active outdoorsman, spending most of his time fishing, hunting, and snowmobiling. After high school, he worked as a painting and concrete contractor but soon felt called to serve.

On November 9, 2000, 24-year-old Travis joined the Army. He deployed to Kuwait with the 101st Airborne Division in March of 2003 and was an infantry team leader during the invasion of Iraq later that month.

After that deployment, he decided to pursue college and was honorably discharged in December of 2003. But as his father put it, the civilian life just didn't do it for him, and he rejoined the Army in December of 2005 as part of the 10th Mountain Division and was again deployed to Iraq.

Mr. Speaker, on June 1, 2007, during a route clearance in a town outside of Baghdad, Atkins' unit noticed two men trying to cross a road that they were securing. Atkins asked the men to stop. When trying to search one of the men, a fight broke out. Realizing the man was wearing a suicide vest, he fought to keep him from finding the trigger. Eventually, he did. Without hesitating, Staff Sergeant Atkins bear-hugged the insurgent, threw him to the ground and pinned him there, shielding his fellow soldiers only a few feet away. Staff Sergeant Atkins saved three men that day.

In every account of his character from his battle buddies, the word most used to describe him was a ''leader,'' and a fine leader he was, right up until his final moments.

Surviving Sergeant Atkins are his parents and his son, Trevor. Trevor said that he wants his father to be remembered as the best dad and the best soldier that anyone could ask for. At the White House, on March 27, 2019, Trevor accepted his father's Medal of Honor.

The legacy of Staff Sergeant Atkins—of loyalty, of dedication, of leadership—must never be forgotten. As the citizens he protected, we honor him by trying to live by his example to care deeply and lead well.

While we will never be able to fully convey the depth of our gratitude to the Atkins family, I hope that this bill, the naming of the clinic in his hometown, will offer some fraction of that comfort.

Mr. Speaker, I wholeheartedly support this bill and I urge my colleagues to do the same.

Mr. Speaker, I reserve the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of S. 900, as amended, a bill to name the Department of Veterans Affairs community-based outpatient clinic in Bozeman, Montana, the Travis W. Atkins Department of Veterans Affairs Clinic.

Staff Sergeant Travis Atkins was a Montana native and Army veteran. He was killed in action in Iraq in 2007 during an encounter with two enemy insurgents when he put himself between a suicide bomber and his fellow soldiers.

Staff Sergeant Atkins' quick and selfless actions saved the lives of those three soldiers and led to him being posthumously awarded the Medal of Honor. By naming the VA clinic in Bozeman after him today, we will further ensure that his life and legacy is forever remembered.

This bill was sponsored in the Senate by Senator STEVE DAINES and in the House by my friend and colleague Congressman GREG GIANFORTE, who will be the Governor of Montana very soon. It is also strongly supported by the other member of Montana's congressional delegation, the ranking member of the Senate Veterans' Affairs Committee and another good friend of mine, Senator JON TESTER.

I am grateful to Senator DAINES, Congressman GIANFORTE, Ranking Member TESTER, and the many Montana veteran service organizations that sent in letters of support for this bill, for their efforts to honor Staff Sergeant Atkins' service and sacrifice through this legislation. These are the true heroes, Mr. Speaker. I know you know that.

Staff Sergeant Atkins was just 32 years old when he died. He left behind many loved ones, including his then 11-year-old son, Trevor. I send my prayers to Trevor and to all of Staff Sergeant Atkins' friends and family members who, I know, are still grieving his loss today.

I hope that it is a small comfort to them to know that, with the passage of this bill, Mr. Speaker, Staff Sergeant Atkins' memory will live on and serve as an inspiration to all the veterans who seek hope and healing in the clinic that will now bear his name.

I am proud to support this bill, Mr. Speaker, and I yield back the balance of my time.

Mrs. LURIA. Mr. Speaker, I ask my colleagues to join me in passing S. 900, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Virginia (Mrs. LURIA) that the House suspend the rules and pass the bill, S. 900, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

IMPROVING SAFETY AND SECURITY FOR VETERANS ACT OF 2019

Mrs. LURIA. Mr. Speaker, I move to suspend the rules and pass the bill (S. 3147) to require the Secretary of Veterans Affairs to submit to Congress reports on patient safety and quality of care at medical centers of the Department of Veterans Affairs, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

S. 3147

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Improving Safety and Security for Veterans Act of 2019''.

SEC. 2. DEPARTMENT OF VETERANS AFFAIRS REPORTS ON PATIENT SAFETY AND QUALITY OF CARE.

(a) REPORT ON PATIENT SAFETY AND QUALITY OF CARE.—

(1) IN GENERAL.—Not later than 30 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report regarding the policies and procedures of the Department relating to patient safety and quality of care and the steps that the Department has taken to make improvements in patient safety and quality of care at medical centers of the Department.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A description of the policies and procedures of the Department and improvements made by the Department with respect to the following:

(i) How often the Department reviews or inspects patient safety at medical centers of the Department.

(ii) What triggers the aggregated review process at medical centers of the Department.

(iii) What controls the Department has in place for controlled and other high-risk substances, including the following:

(I) Access to such substances by staff.

(II) What medications are dispensed via automation.

(III) What systems are in place to ensure proper matching of the correct medication to the correct patient.

(IV) Controls of items such as medication carts and pill bottles and vials.

(V) Monitoring of the dispensing of medication within medical centers of the Department, including monitoring of unauthorized dispensing.

(iv) How the Department monitors contact between patients and employees of the Department, including how employees are monitored and tracked at medical centers of the Department when entering and exiting the room of a patient.

(v) How comprehensively the Department uses video monitoring systems in medical centers of the Department to enhance patient safety, security, and quality of care.

(vi) How the Department tracks and reports deaths at medical centers of the Department at the local level, Veterans Integrated Service Network level, and national level.

(vii) The procedures of the Department to alert local, regional, and Department-wide leadership when there is a statistically abnormal number of deaths at a medical center of the Department, including—

(I) the manner and frequency in which such alerts are made; and

(II) what is included in such an alert, such as the nature of death and where within the medical center the death occurred.

(viii) The use of root cause analyses with respect to patient deaths in medical centers of the Department, including—

(I) what threshold triggers a root cause analysis for a patient death;

(II) who conducts the root cause analysis; and

(III) how root cause analyses determine whether a patient death is suspicious or not.

(ix) What triggers a patient safety alert, including how many suspicious deaths cause a patient safety alert to be triggered.

(x) The situations in which an autopsy report is ordered for deaths at hospitals of the Department, including an identification of—

(I) when the medical examiner is called to review a patient death; and

(II) the official or officials that decide such a review is necessary.

(xi) The method for family members of a patient who died at a medical center of the Department to request an investigation into that death.

(xii) The opportunities that exist for family members of a patient who died at a medical center of the Department to request an autopsy for that death.

(xiii) The methods in place for employees of the Department to report suspicious deaths at medical centers of the Department.

(xiv) The steps taken by the Department if an employee of the Department is suspected to be implicated in a suspicious death at a medical center of the Department, including—

(I) actions to remove or suspend that individual from patient care or temporarily reassign that individual and the speed at which that action occurs; and

(II) steps taken to ensure that other medical centers of the Department and other non-Department medical centers are aware of the suspected role of the individual in a suspicious death.

(xv) In the case of the suspicious death of an individual while under care at a medical center of the Department, the methods used by the Department to inform the family members of that individual.

(xvi) The policy of the Department for communicating to the public when a suspicious death occurs at a medical center of the Department.

(B) A description of any additional authorities or resources needed from Congress to implement any of the actions, changes to policy, or other matters included in the report required under paragraph (1)

(b) REPORT ON DEATHS AT LOUIS A. JOHNSON MEDICAL CENTER.—

(1) IN GENERAL.—Not later than 60 days after the date on which the Attorney General indicates that any investigation or trial related to the suspicious deaths of veterans at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, (in this subsection referred to as the ''Facility'') that occurred during 2017 and 2018 has sufficiently concluded, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report describing—

(A) the events that occurred during that period related to those suspicious deaths; and

(B) actions taken at the Facility and throughout the Department of Veterans Affairs to prevent any similar reoccurrence of the issues that contributed to those suspicious deaths.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A timeline of events that occurred at the Facility relating to the suspicious deaths described in paragraph (1) beginning the moment those deaths were first determined to be suspicious, including any notifications to—

(i) leadership of the Facility;

(ii) leadership of the Veterans Integrated Service Network in which the Facility is located;

(iii) leadership at the central office of the Department; and

(iv) the Office of the Inspector General of the Department of Veterans Affairs.

(B) A description of the actions taken by leadership of the Facility, the Veterans Integrated Service Network in which the Facility is located, and the central office of the Department in response to the suspicious deaths, including responses to notifications under subparagraph (A).

(C) A description of the actions, including root cause analyses, autopsies, or other activities that were conducted after each of the suspicious deaths.

(D) A description of the changes made by the Department since the suspicious deaths to procedures to control access within medical centers of the Department to controlled and non-controlled substances to prevent harm to patients.

(E) A description of the changes made by the Department to its nationwide controlled substance and non-controlled substance policies as a result of the suspicious deaths.

(F) A description of the changes planned or made by the Department to its video surveillance at medical centers of the Department to improve patient safety and quality of care in response to the suspicious deaths.

(G) An analysis of the review of sentinel events conducted at the Facility in response to the suspicious deaths and whether that review was conducted consistent with policies and procedures of the Department.

(H) A description of the steps the Department has taken or will take to improve the monitoring of the credentials of employees of the Department to ensure the validity of those credentials, including all employees that interact with patients in the provision of medical care.

(I) A description of the steps the Department has taken or will take to monitor and mitigate the behavior of employee bad actors, including those who attempt to conceal their mistreatment of veteran patients.

(J) A description of the steps the Department has taken or will take to enhance or create new monitoring systems that—

(i) automatically collect and analyze data from medical centers of the Department and monitor for warnings signs or unusual health patterns that may indicate a health safety or quality problem at a particular medical center; and

(ii) automatically share those warnings with other medical centers of the Department, relevant Veterans Integrated Service Networks, and officials of the central office of the Department.

(K) A description of the accountability actions that have been taken at the Facility to remove or discipline employees who significantly participated in the actions that contributed to the suspicious deaths.

(L) A description of the system-wide reporting process that the Department will or has implemented to ensure that relevant employees are properly reported, when applicable, to the National Practitioner Data Bank of the Department of Health and Human Services, the applicable State licensing boards, the Drug Enforcement Administration, and other relevant entities.

(M) A description of any additional authorities or resources needed from Congress to implement any of the recommendations or findings included in the report required under paragraph (1).

(N) Such other matters as the Secretary considers necessary.

The SPEAKER pro tempore. Pursuant to the rule, the gentlewoman from Virginia (Mrs. LURIA) and the gentleman from Florida (Mr. BILIRAKIS) each will control 20 minutes.

The Chair recognizes the gentlewoman from Virginia.

GENERAL LEAVE

Mrs. LURIA. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and to insert extraneous materials on S. 3147.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from Virginia?

There was no objection.

Mrs. LURIA. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of S. 3147, the Improving Safety and Security for Veterans Act, introduced by Senator MANCHIN and Senator CAPITO of West Virginia. Representative MCKINLEY introduced a companion measure, H.R. 5616, here in the House.

This bipartisan bill requires the Department of Veterans Affairs to submit to Congress two critical reports relating to patient safety and quality of care at its medical facilities.

This bill was introduced in the wake of a disturbingly tragic series of patient deaths that occurred in 2017 and 2018 at the Clarksburg, West Virginia, VA Medical Center.

This past July, a nursing assistant who worked at the Clarksburg VA Medical Center pleaded guilty to seven counts of second-degree murder and one count of assault to commit murder after unnecessarily injecting several veteran patients with insulin with the intent to cause death.

There are no words to adequately express the sorrow we feel for the families of veterans whose lives were tragically cut short in Clarksburg. There are countless questions about how this could have happened and what the Department of Veterans Affairs is doing to better protect veteran patients in the future, not only in Clarksburg, but in other VA facilities nationwide.

The first report outlined in this bill and mandated by S. 3147, which is due within 30 days of enactment, requires the VA to outline the Department's policies and procedures related to monitoring patient safety and suspicious deaths, ensuring proper storage and access controls for high-risk substances, trafficking employees' contact with veteran patients, and removing from patient care employees who are implicated in suspicious deaths.

□ 1715

The Improving Safety and Security for Veterans Act also requires the VA to submit to Congress an after-action report on the events that occurred in Clarksburg. Among other things, the report will detail the timeline of events at Clarksburg and the actions taken at the facility level and throughout the Department of Veterans Affairs in response to these tragic and suspicious deaths.

We can only hope that S. 3147, the Improving Safety and Security for Veterans Act, will serve as a first step toward better understanding what gaps in VA management existed and what actions the Department still needs to take to protect our veterans.

We also hope that this measure will serve as a foundation for helping to restore veterans' confidence in the safety, security, and quality of the care delivered at VA medical facilities.

Mr. Speaker, I reserve the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of S. 3147, the Improving Safety and Security for Veterans Act of 2019.

This bill was drafted in response to a tragic incident at the Department of Veterans Affairs Medical Center in Clarksburg, West Virginia, where a former VA nursing assistant killed at least seven veteran patients by injecting them with lethal doses of insulin while they were under her care.

As a member of the House Veterans' Affairs Committee, I personally grieved the loss of those veterans. I cannot fathom the pain that their loved ones must feel. My heart is with them, especially during this holiday season.

Congress must act to ensure that no other veteran, family, or community experiences such tragedy ever again.

Passing S. 3147 today will help us do that, Mr. Speaker. The bill would require VA to report to Congress on the Department's efforts to assess, monitor, and improve patient safety and quality of care throughout the VA healthcare system. It would also require the VA to report to Congress on the series of events surrounding the Clarksburg murders and the actions taken in Clarksburg and nationwide, for that matter.

We need to ensure that we learn from this tragedy and that it never, ever is repeated.

This bill is sponsored by Senator JOE MANCHIN from West Virginia and is the companion to a House bill in the House by my good friend, a great member of the Energy and Commerce Committee, and I know he supports veterans, DAVID MCKINLEY, who I will yield to in a second. DAVID is from West Virginia.

I appreciate Senator MANCHIN's and Congressman MCKINLEY's efforts to ensure that veterans in West Virginia and across the country receive care that is timely, safe, and of the very highest quality. Again, we have to thank them for their service to our country, and they are entitled to this quality of care, Mr. Speaker.

Every veteran deserves to feel confident that they will be well cared for when they walk through VA's doors. While nothing can bring back the veterans who were ruthlessly murdered in Clarksburg, I hope that the passage of this bill today will restore some of the trust that has been lost due to this heartbreaking chapter in VA's history and ease other veterans' fears that they may have about their own safety seeking care through the VA healthcare system.

Mr. Speaker, I urge every one of my colleagues to join me in supporting this bill today. I reserve the balance of my time.

Mrs. LURIA. Mr. Speaker, I reserve the balance of my time.

Mr. BILIRAKIS. Mr. Speaker, I yield such time as he may consume to the gentleman from West Virginia (Mr. MCKINLEY).

Mr. MCKINLEY. Mr. Speaker, I rise in support of S. 3147, the Improving Safety and Security for Veterans Act of 2019.

The bill is indeed the companion to H.R. 5616, which I introduced in January of this year following the death of seven veterans at our Clarksburg VA Medical Center.

A former nursing assistant at the hospital has now pled guilty to murdering these veterans by intentionally and inappropriately injecting them with insulin. Her actions are beyond the pale. Congress must do everything it can to ensure that this never happens again.

This bill was just the first step toward that goal. It will, indeed, as you heard the chairman say, provide transparency and accountability at our VA medical facilities by requiring the VA to submit to Congress detailed reports on patient safety and quality of care at those hospitals.

It will also ensure that the public is well-informed as to what occurred in Clarksburg. The public was kept in the dark for far too long during the course of this investigation.

Our veterans have sacrificed so much for our country, and they deserve the best possible care and should feel safe when they come to one of our facilities.

Congress now has the opportunity to restore the public's confidence in our Veterans Affairs system and ensure that our veterans are receiving the care they deserve.

I join with the chairman, Mr. Speaker, in saying that I urge all of our colleagues to join unanimously in supporting this bill.

Mr. BILIRAKIS. Mr. Speaker, I yield back the balance of my time.

Mrs. LURIA. Mr. Speaker, I have no further speakers, and I am prepared to close. I yield myself such time as I may consume.

Mr. Speaker, I ask all of my colleagues to join me in passing S. 3147.

I want to thank Mr. MCKINLEY for introducing this bill in the House and Senator MANCHIN for working very diligently in the Senate to bring this legislation before us today because, as Mr. MCKINLEY said, we do need to provide assurance to our veterans about their safety in our VA health centers, both in Clarksburg and across the country.

I also want to thank Mr. BILIRAKIS, my colleague on the Veterans' Affairs Committee, for his work on this and all the bills that we have reviewed today.

Mr. Speaker, I urge my colleagues to join me in passing S. 3147, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from Virginia (Mrs. LURIA) that the House suspend the rules and pass the bill, S. 3147.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mrs. LURIA. Mr. Speaker, on that I demand the yeas and nays.

The SPEAKER pro tempore. Pursuant to section 3 of House Resolution 965, the yeas and nays are ordered.

Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair declares the House in recess until approximately 6:30 p.m. today.

Accordingly (at 5 o'clock and 23 minutes p.m.), the House stood in recess.

□ 1830

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. CUELLAR) at 6 o'clock and 30 minutes p.m.

WOUNDED VETERANS RECREATION ACT

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the unfinished business is the vote on the motion to suspend the rules and pass the bill (S. 327) to amend the Federal Lands Recreation Enhancement Act to provide for a lifetime National Recreational Pass for any veteran with a service-connected disability, on which the yeas and nays were ordered.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. HUFFMAN) that the House suspend the rules and pass the bill.

The vote was taken by electronic device, and there were—yeas 401, nays 0, not voting 28, as follows:

[Roll No. 219]

YEAS—401

Adams	Bera	Brown (MD)
Aguilar	Bergman	Brownley (CA)
Allen	Beyer	Buchanan
Allred	Biggs	Buck
Amash	Bilirakis	Bucshon
Armstrong	Bishop (GA)	Budd
Arrington	Bishop (NC)	Burchett
Axne	Bishop (UT)	Burgess
Babin	Blumenauer	Bustos
Bacon	Blunt Rochester	Butterfield
Baird	Bonamici	Byrne
Balderson	Bost	Carbajal
Banks	Boyle, Brendan F.	Cárdenas
Barr	Brady	Carson (IN)
Barragán	Brindisi	Carter (GA)
Bass	Brooks (AL)	Carter (TX)
Beatty		Cartwright