[redacted]

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AFMOA/CV
[redacted]
JBSA Lackland, TX 78236-1025

8/23/15

Hello [redacted]

I appreciate you responding to my letter. While it is admirable that you have acknowledged the multiple failures regarding my son's blatant substandard care resulting in his death; it seems as though you are trying to placate me! What you deem is unacceptable for a member of your family is an expectation for other service members and their families. This is evident by the failure of the Department of Defense (DOD) to address this issue in the manner that it deserves! Please refer to item 1 in the letter below for clarification.

I would like to bring a few items to your attention.

1. The following investigations were conducted into the death of my son:
    1) Joint Commission Investigation (Sentinel Event)
    2) Standards of Care Review
    3) A Surgeon General Incident Investigative Team was flown over

[redacted] at the Misawa Air Base informed me that the base was planning to implement the recommendations of all 3 investigations in an effort to prevent events like my sons from recurring. Recently, I was contacted by another mother of yet another "casualty" of the Misawa Air Base team. She informed me that "your son's doctor tried 3 times to place an airway into my son before he lost all oxygen to the brain!" I could not believe what I was hearing! An event that occurred several months before my son's death and yet the unqualified medical team was still allowed to practice medicine! Recently, Misawa Air Base put out an article giving praise to the same medical team after they were able to save a service member's life. So the same medical team is allowed to continue to practice medicine in spite of all of the investigations at the taxpayer's expense! This seems to be a common theme that I have found during my research of all of the cases that I have personally reviewed! Can you please explain this to me? Is this how the DOD is training our service members to learn medicine?

2. Provider's licensures- I am once again being denied copies of the licensures of the team that failed to provide care to my son. I have a special Power of Attorney over my son's medical records. It is an inherent right that the licensures of the medical team be disclosed to the patient and/or family members upon request. I am enclosing a copy of

my POA and will once again request that you provide me with copies of the licensures for the medical team of my son. It is up to you if you make them available or not. In nursing, there is well known saying "that if it is not documented, it is not done." If you refuse to provide copies of the licensures of those that failed to provide care to my son, I will assume that they don't exist!

3. Once again, I will reiterate that I have offered to partner up with the military in an effort to truly stop these types of events. However, the arrogance and condescending nature of the military only guarantees the continuation of the "medical disabilities" and "casualties" of our troops when seeking medical care during **NON-COMBAT**. I personally find it unconscionable that the military is willing to let another 400-800 (conservative rate as harm rate in events like my son is purported to be unknown by the military) service members to die or become medically disabled before addressing this issue (LaFraniere & Lehran, 2014)! There is a real solution for this issue that would resolve this matter. I would be willing to discuss this with you if you are interested.

4. Our active duty service *members signed to give their life in defense of our country.* They did not sign to become medically disabled and/or die at the hands of unqualified medical providers! I truly understand the sacrifice made by our active duty service members when defending our cherished freedoms. It is not my expectation nor should it be an expectation of the DOD that this be the accepted normal! The abuse of casualty provisions to justify the medical disabilities and/or deaths of our troops during NON-COMBAT at the hands of unqualified medical providers is going to stop!

In an effort to truly address this issue and help protect the **DEFENDERS OF MY FREEDOM,** I am starting up a non-profit.

STOP MILITARY MEDICAL NEGLIGENCE (SMMN)

MISSION: To raise public awareness regarding military medical negligence during NON-COMBAT

VISION: To ensure the **DEFENDERS OF OUR FREEDOMS** receive high quality medical care by board certified medical providers practicing within the scope of their practice during NON-COMBAT

I sincerely appreciate you taking the time to listen to my concerns and would appreciate a response to this letter. Please consider yourself educated in regards to military medical negligence. You are in the position to make a real and positive change in regards to this matter! Whether or not you choose to do the "right" thing is up to you!

Sincerely,

Phyllis Hardin

Phyllis Hardin Masters of Science Nursing (MSN), Board Certified (B.C.)
President: Stop Military Medical Negligence
International Published Author: Implications of Resource Constraint on Patient Satisfaction

REFERENCES

LaFraniere, S., & Lehran, A. (2014, June 28). *New York Times.* Retrieved from http://www.nytimes.com/2014/06/29/us/in-military-care-a-pattern-of-errors-but-not-scrutiny.html?_r=1