United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

WASHINGTON, DC 20510–6250

July 26, 2016

The Honorable Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Mr. Secretary,

The Committee on Homeland Security and Governmental Affairs Committee is continuing its oversight of the Department of Veterans Affairs' (VA) medical facilities. Recent reports have highlighted security problems in the domiciliary unit of the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin.[1] In particular, it appears that veterans and visitors have been able to easily transport illegal drugs and other contraband into the domiciliary unit.[2] The free flow of illicit substances into the domiciliary has led to reports of multiple veterans overdosing on drugs while receiving treatment at the facility. After becoming aware of problems at the Zablocki VA, I immediately directed my staff to seek answers from the VA. Although the VA provided a telephone briefing on June 15, 2015, subsequent events suggest that the concerns remain unaddressed. Accordingly, I write to request more information and material on security procedures in the domiciliary unit of the Zablocki VA Medical Center.

On November 8, 2015, Cole Schuler, a veteran from Fox Valley, Wisconsin, died of a heroin overdose in the Zablocki VA's Residential Treatment Program. In a briefing with my staff on June 15, 2016, VA officials stated that in the wake of Mr. Schuler's passing, the Zablocki VA increased security checks and monitoring for contraband at the facility.[3] Even with the changes made in the wake of Mr. Schuler's death, the Zablock VA should work to ensure that other veterans do not have access to illegal drugs in the domiciliary unit.

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[1] Sarah Thomsen, *Target 2 Investigates: Drug overdose, suicide spark outrage, safety concerns at VA*, ABC 2, (July 14, 2016), http://wbay.com/2016/07/14/target-2-investigates-drug-overdose-suicide-spark-outrage-safety-concerns-at-va/

[2] *Id.*

[3] Briefing between VA staff and Comm. Staff (June 15, 2016).

After the death of Mr. Schuler, an Administrative Investigation Board (AIB) made 16 recommendations that were reportedly implemented; however, subsequently, another veteran was apparently able to obtain and overdose on heroin while receiving treatment at the facility.[4] Veterans with drug addiction should not fear for their health or safety due to the accessibility of illegal drugs while receiving care for their addiction. The recent overdose—after Mr. Schuler's death—raises questions about potentially larger problems at the Zablocki VA.

The tragedies of the Tomah VA Medical Center highlight the need for better accountability and transparency within the VA. In light of the allegations surrounding the Zablocki VA, I respectfully request the following information and material:

1. An AIB reportedly examined security procedures and the protocols at the Zablocki VA in October 2015 and made 16 recommendations to provide better safety and security for veterans at the facility.[5] What were the sixteen recommendations the AIB provided to the VA about the Zablocki facility? What is the status of the Zablocki VA's implementation of these recommendations?

2. What is the status of the VA's investigation into the overdose death of Cole Schuler? Please explain.

3. What policies is the VA implementing to prevent illegal drugs from entering VA medical facilities?

Please provide this information and material as soon as possible, but no later than 5:00 p.m. on August 19, 2016.

The Committee on Homeland Security and Governmental Affairs is authorized by Rule XXV of the Standing Rules of the Senate to investigate "the efficiency, economy, and effectiveness of all agencies and departments of the Government." Additionally, S. Res. 253 (113th Congress) authorizes the Committee to examine "the efficiency and economy of operations of all branches and functions of Government with particular references to (i) the effectiveness of present national security methods, staffing, and processes . . . ." For purposes of this request, please refer to the definitions and instructions in the enclosure.

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[4] Sarah Thomsen, Target 2 Investigates: Drug overdose, suicide spark outrage, safety concerns at VA, ABC 2, (July 14, 2016), http://wbay.com/2016/07/14/target-2-investigates-drug-overdose-suicide-spark-outrage-safety-concerns-at-va/

[5] Sarah Thomsen, *Target 2 Investigates: Local veteran dies of overdose in VA Treatment Center*, ABC 2, (May 2, 2016), http://wbay.com/2016/05/02/local-veterans-overdose-death-sparks-federal-investigation-of-va/

If you have any questions about this request, or concerns about the instructions or requirements in the enclosure, please contact Kyle Brosnan or Brian Downey at (202) 224-4751. Thank you for your prompt attention to this matter.

Sincerely,

Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Member

The Honorable Michael J. Missal
Inspector General
U.S. Department of Veterans Affairs

Enclosure