United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

WASHINGTON, DC 20510–6250

September 9, 2016

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

Dear Mr. Secretary:

I write today about a tragic unfolding situation involving the Department of Veterans Affairs Medical Center in Tomah, Wisconsin (Tomah VAMC). On September 8, the body of U.S. Army veteran Brian Rossell was found in Wausau, Wisconsin; he had apparently committed suicide.[1] According to Mr. Rossell's mother, he suffered from Post-Traumatic Stress Disorder (PTSD), depression, and anxiety.[2] His mother told local media that Mr. Rossell had sought treatment from the Tomah VAMC's Mental Health Clinic but was turned away.[3] I request the VA's unfettered cooperation in providing a complete accounting of Mr. Rossell's interactions with the Tomah VAMC.

Immediately after learning the news that Mr. Rossell was missing and of his apparent effort to seek treatment at the Tomah VAMC, my staff spoke with Mr. Rossell's mother. On the same day, my staff contacted the facility seeking more information. Despite the Tomah VAMC's previous interaction with my staff in the course of my oversight over the previous failures of the facility, the Tomah VAMC's public affairs officer refused to provide information to my staff without a formal letter from me to you. Such formality is not only unnecessary, but it also delays the process of getting answers on behalf of my constituents.

My committee has conducted an extensive, bipartisan investigation into prescription practices, a culture of fear, and veterans' deaths at the Tomah VAMC. I released a 359-page staff report detailing the systemic failures and preventable tragedies at the facility.[4] At the Committee's field hearing in Tomah in May 2016, Deputy Secretary Sloan Gibson vowed to

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[1] *See* Zach Hagenbucher, *Rossell's Body Found in Lake Wausau,* WSAU.com, Sept. 8, 2016. http://wsau.com/news/articles/2016/sep/08/rossells-body-found-in-lake-wausau/

[2] *See* Alexandra Burnley, *Mother of missing Wausau veteran says Tomah VA denied him help*, WAOW.com, Sept. 7, 2016. http://www.waow.com/story/33043650/2016/09/07/mother-of-missing-wausau-veteran-says-tomah-va-denied-him-help.

[3] *Id.*

[4] *See* S. Comm. on Homeland Security & Governmental Affairs, The Systemic Failures and Preventable Tragedies at the Tomah VA Medical Center (May 31, 2016) (majority staff report)

improve patient care at the facility, telling the community that "at the end of the day . . . VA leadership owns this."[5]

While I appreciated Mr. Gibson's sentiments on behalf of VA leadership, the apparent suicide of Mr. Rossell underscores concerns that the VA has yet to take full ownership of the systemic failures of the Tomah VAMC. In August 2016, a whistleblower contacted my staff to disclose staffing shortages at the facility's Mental Health Clinic. The whistleblower told my staff that he had already raised these issues internally within the VA and that the VA's regional office, Veterans Integrated Service Network (VISN 12), should have been aware of the shortages. My staff notified the Office of Inspector General (OIG) in August and yesterday I asked Inspector General Missal to conduct a full and independent review of this matter.

I expect the VA's full cooperation with my staff as well as the VA OIG as we examine any interaction that Mr. Rossell may have had with employees at the Tomah VAMC. To this end, I ask that you produce all documents and communications referring or relating to Mr. Rossell. In addition, I request that VA employees provide a staff-level briefing about the circumstances leading up to this tragedy. Please provide these documents by September 23, 2016, and arrange for this briefing to occur no later than September 16, 2016.

If you have any questions about this request, please ask your staff to contact Brian Downey or Kyle Brosnan of my committee staff at (202) 224-4751. Thank you for your prompt attention to this important 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

Ms. Victoria P. Brahm
Acting Director
Tomah Veterans Affairs Medical Center
U.S. Department of Veterans Affairs

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[5] *"Tomah VAMC: Examining Patient Care and Abuse of Authority": Hearing of the S. Comm. on Homeland Security & Governmental Affairs*, 114th Cong. (2016) (testimony of Deputy Secretary Sloan Gibson).