Tragedy at Tomah:
Initial Findings

An Interim Majority Staff Report

Committee on Homeland Security and Governmental Affairs
United States Senate
Senator Ron Johnson, Chairman

June 25, 2015

I. Executive Summary

The Department of Veterans Affairs (VA) is charged with the challenging and rewarding duty of providing health care, benefits, and other services to the brave men and women who served in our nation's armed forces. As our soldiers return home from the battlefield, many veterans rely on the VA to deliver high-quality medical treatment. It is a small token of gratitude to the men and women in uniform who serve this great nation. These heroes and their families deserve a VA health care system that works efficiently and effectively.

In January 2015, Wisconsinites and all Americans were troubled to learn of the detailed reports of "doped up" and "zombified" veterans at the VA Medical Center in Tomah, Wisconsin (Tomah VAMC).[1] According to the reports, veterans and employees at the facility referred to the Tomah VAMC as "Candy Land" and nicknamed the facility's chief of staff, Dr. David Houlihan, the "Candy Man" because of his alleged reputation for dispensing drugs like candy.[2] Tragically, a 35-year old Marine Corps veteran and father of a young daughter, Jason Simcakoski, died at the facility on August 30, 2014.[3] Autopsy results showed that Mr. Simcakoski had a cocktail of over a dozen different drugs in his system when he died and the University of Wisconsin Hospital and Clinics identified the cause of death as "mixed drug toxicity."[4] Days after the initial news accounts, another veteran, Thomas Baer, died of neglect and delay at the Tomah VAMC urgent care center, after waiting hours to be seen.

The revelations also uncovered the existence of a nonpublic 11-page report by the VA Office of Inspector General (VA OIG) that documented the OIG's findings during a nearly three-year-long health care inspection of the Tomah VAMC.[5] The VA OIG's inspection began in 2011 and examined 32 separate allegations of misconduct, over-prescription of opioids, abuse of authority, potential drug diversion and more. While the VA OIG found that some prescribing practices were "at considerable variance compared with most opioid prescribers in [VISN 12][6] and the Tomah VAMC" that "raised potentially serious concerns,"[7] the VA OIG did not substantiate the allegations and administratively closed its Tomah VAMC inspection in March 2014, without making it public. Later, amid heavy public scrutiny and pressure from the Committee, the VA OIG finally published its Tomah VAMC inspection on February 6, 2015.

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[1] *See* Aaron Glantz, Opiates Handed Out Like Candy to 'Doped-Up' Veterans at Wisconsin VA, Reveal (Jan. 8, 2015), https://www revealnews.org/article-legacy/opiates-handed-out-like-candy-to-doped-up-veterans-at-wisconsin-va/.

[2] *Id.*

[3] *Id.*

[4] *Id.*

[5] U.S. Dep't of Veterans Affairs, Office of Inspector Gen., MCI No. 2011-04212-HI-0267, Administrative Closure: Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center (2014), *available at* https://www.documentcloud.org/documents/1384916-2014-va-oig-report html.

[6] VISN stands for Veterans Integrated Service Networks. The VA breaks down its medical centers into geographic regions called VISNs. In total, the VA has 21 separate VISNs. Wisconsin's VA facilities are all located in VISN 12, which is based in Westchester, IL. *See* U.S. Dep't of Veterans Affairs, Veterans Health Administration Locations, http://www.va.gov/directory/guide/division.asp?dnum=1 (last visited June 22, 2015).

[7] U.S. Dep't of Veterans Affairs, Office of Inspector General, *supra* note 5, at 9.

As one of his first acts as Chairman of Committee on Homeland Security and Governmental Affairs, Senator Ron Johnson launched an investigation into the allegations concerning the Tomah VAMC. In the ensuring five months, the Committee has received information from a number of sources, including:

- The Department of Veterans Affairs;
- The VA Office of Inspector General;
- The Drug Enforcement Administration (DEA);
- The Federal Bureau of Investigation (FBI);
- The United States Attorney's Office for the Western District of Wisconsin;
- The Merit Systems Protection Board (MSPB);
- The Government Accountability Office (GAO);
- The Tomah VAMC police department;
- The American Federation of Government Employees (AFGE) Local 007;
- Wisconsin state, county and local law-enforcement entities; and
- Dozens of whistleblowers who work, worked, or were treated at the facility.

To date, the Committee has received tens of thousands of pages from these sources. The Committee continues to receive and review additional material on an ongoing basis from the VA and other agencies. The VA OIG continues to defy a subpoena issued on April 29, 2015, for documents and communications relating to its work at the Tomah VAMC—knowingly withholding thousands of pages of documents highly relevant to the Committee's investigation. The material blatantly withheld by the VA OIG includes drafts of its Tomah VAMC health care inspection and internal communications about the inspection—material that bears directly on the Committee's inquiry into the Tomah VAMC.

On March 30, 2015, Chairman Johnson chaired a bicameral, bipartisan congressional field hearing in Tomah, Wisconsin, to gather testimony from whistleblowers, family members, and VA and VA OIG officials about the tragedies at the Tomah VAMC.[8] This interim report is designed to offer the family members, Wisconsinites, and the American public an update on the Committee's work since the March 30 field hearing. Transparency and accountability are vital for identifying and understanding the problems that led the tragedies at Tomah, and then to enacting meaningful reforms to prevent their reoccurrence. This interim report is merely the first step.

The information uncovered by the Committee and documented in this interim report suggests that problems at the Tomah VAMC extend far deeper and further back in time than currently known.

- The Committee has obtained evidence that employees were aware of the moniker "Candy Man" for Dr. David Houlihan as early as 2004.

[8] *See Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications: Hearing Before the S. Comm. on Homeland Security & Governmental Affairs*, 114th Congress (2015), *available at* http://www.hsgac.senate.gov/hearings/joint-field-hearing-tomah-vamc-examining-quality-access-and-a-culture-of-overreliance-on-high-risk-medications

- In 2009, the local AFGE chapter at the Tomah VAMC warned of "significant concerns" about patient safety at the facility, citing excessive prescriptions of narcotics, unexplained patient suicides, and a hostile work environment.
- Independent pharmacy consultants warned the OIG in 2012 and 2013 that the Tomah VAMC was in serious danger of losing its DEA controlled substance accreditation, describing the facility as "not safe."
- The DEA conducted at least three separate investigations concerning drug diversion at the Tomah VAMC since 2009, finding evidence that the facility's "culture of fear" prevented whistleblowers from speaking up.
- The VA did not examine the circumstances surrounding the termination and death of Dr. Christopher Kirkpatrick, although Dr. Kirkpatrick was terminated after raising concerns about overmedication.
- The VA Office of Inspector General told witnesses interviewed during the Tomah VAMC health care inspection to expect a public report on the results of the inspection by early 2013.

A theme running through the Committee's investigation thus far has been a fundamental lack of transparency from federal agencies involved in investigating the abuses at the Tomah VAMC. The VA OIG refuses to fully cooperate and is actively withholding documents that would show its work in arriving at its conclusions about the Tomah VAMC, despite Chairman Johnson's bipartisan subpoena for this information. A VA official even described the OIG inspection as having a strange "cone of silence," and calling the OIG's product a "secret report."[9] The VA OIG refused to publish its health care inspection or brief family members about the results of its work until pressured by Chairman Johnson and others. The DEA refuses to discuss its work in examining potential drug diversion at the facility. Wisconsin's veterans deserve better. They deserve answers to the many questions surrounding the Tomah VAMC.

This interim report represents the Committee's commitment to bring transparency and clarity to the situation at Tomah VAMC. The Committee's investigation is far from over. Serious questions remain unanswered:

- How far back does the "Candy Land" culture and fear of retaliation at the Tomah VAMC extend?
- Why had the problems at the Tomah VAMC gone unchecked for so long?
- Who is accountable for patient deaths at the Tomah VAMC?
- Why did the VA OIG administratively close its health care inspection of the facility in March 2014?
- Why did the VA's March 205 review arrive at a starkly different conclusion about the Tomah VAMC than the VA OIG's March 2014 report?
- Was senior VA leadership aware of the substantial issues at the Tomah VAMC?
- Why did VA OIG investigators promise that the report would be made public in 2013, and what prevented the VA OIG from following through on these promises?

In order to adequately fix a problem, policymakers must first define it—this is the process the Committee is currently undertaking. The Committee will continue to gather

[9] Telephone Interview (April 28, 2014).

evidence through documents and testimony from VA employees and patients. As the Committee continues its work, the Tomah community and veterans nationwide deserve to know the facts about what occurred at the Tomah Veterans Affairs Medical Center.

II. Preliminary Findings

Based on information gathered and reviewed thus far, the Majority Staff of the Committee presents the following preliminary findings relating to the tragedies at the Tomah VAMC:

- As early as 2004, employees at the Tomah VAMC referred a certain provider at the facility as the "Candy Man";

- VA pharmacists who did not work at the Tomah VAMC found that prescribing practices at the Tomah VAMC placed the facility in danger of losing its DEA controlled substance accreditation in 2013;

- The DEA has conducted at least three separate inquiries regarding potential drug diversion at the Tomah VAMC;

- The VA did not conduct any investigation into the firing and suicide of former Tomah VAMC employee, Dr. Christopher Kirkpatrick;

- The potential diversion of VA prescription medications extends beyond the Tomah VAMC to Sheboygan County, Wisconsin; and

- The VA Office of Inspector General told witnesses interviewed during the Tomah VAMC health care inspection to expect a public report on the results of the inspection by early 2013.

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IV. The Committee's Investigation Thus Far

Over the past five months, the Committee has begun an extensive inquiry into allegations of misconduct, mismanagement, and wrongdoing at the Tomah VAMC. To date, the Committee has sent a total of eighteen letters concerning the Tomah VAMC, including seven letters to VA Deputy Inspector General Richard Griffin; five letters to VA Secretary Robert McDonald; two letters to the MSPB; and two letters to the DEA. The Committee's Majority Staff has also spoken with more than 30 current and former employees and patients at the Tomah VAMC.

Some agencies have recognized and supported the Committee's authority and responsibility to uncover wrongdoing at the Tomah VAMC, and have produced documents relevant to the Committee's inquiries in a timely fashion. However, others have been less than forthcoming to the Committee and have only partially complied with the Chairman's requests or, in some cases, have ignored specific document requests altogether. The DEA, for instance, has refused to provide specific information to the Committee about its closed investigations into drug diversion at the Tomah VAMC.[10] Similarly, the Justice Department has declined to provide information about the involvement of federal prosecutors in reviewing allegations of public corruption and drug diversion at the Tomah VAMC.[11]

Most disappointingly, the VA Office of Inspector General has declined to cooperate voluntarily with the Committee's oversight. After multiple requests for information, on April 29, 2015, the Committee was forced to take the unusual step of issuing a subpoena to Deputy Inspector General Griffin for material about the Tomah VAMC. The VA OIG's noncooperation with the Committee's oversight and investigatory efforts are particularly troubling given the fact that the OIG is statutorily mandated to work with Congress.[12] To date, the VA OIG continues to obstruct the Committee's investigation by withholding vital information about its inspection of the Tomah VAMC, and has indicated that it no longer intends to produce any additional documentation pursuant to the subpoena.[13]

V. The VA Office of Inspector General Lacks Transparency and Accountability

At the outset of the Committee's investigation, the Committee reached out to the VA OIG to seek its assistance in understanding the allegations concerning the Tomah VAMC.

[10] *See* Letter from Eric J. Akers, Deputy Chief, Office of Cong. & Pub. Affairs, Drug Enforcement Admin., U.S. Dep't of Justice, to Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs (Mar. 17, 2015) (on file with Comm.).

[11] Telephone call between Comm. staff and Kenneth Kellner, Dep't of Justice (May 27, 2015).

[12] *See* Inspector General Act of 1978, 5 U.S.C. app. § 4(a)(5) (1978) ("It shall be the duty and responsibility of each Inspector General … to keep the head of such establishment and the Congress fully and currently informed…concerning fraud and other serious problems, abuses, and deficiencies relating to administration of programs and operations …and to report on the progress made in implementing such corrective action.")

[13] E-mail from Roy Fredrikson, Deputy Counselor, U.S. Dep't of Veterans Affairs, Office of Inspector Gen., to Comm. staff (May 27, 2015).

Committee staff received a briefing from the VA OIG employees who conducted the health care inspection on February 4, 2015, about the VA OIG's work in Tomah. Since that initial briefing, as the Committee has become more familiar with the matter and investigated the allegations more closely, the VA OIG has become increasingly confrontational and non-cooperative. The VA OIG's refusal to aid the Committee's investigation led to the highly unusual—and reluctant—issuance of a subpoena to Deputy Inspector General Richard J. Griffin for documents relating its inspection. The VA OIG's posture has not changed since the issuance of the subpoena. The VA OIG continues to withhold documents from the Committee and continues to take an increasingly hostile and defensive tone in its interactions with the Committee.

1. The VA OIG's posture toward the Committee's investigation is disturbing

The VA OIG's posture towards the Committee since February 4, 2015, is troubling. This is especially so given Congress's Constitutional right to documents from the Executive Branch and the VA OIG's statutory mandate to provide *all* supporting material. The Supreme Court has long recognized that Congress's power of inquiry and the processes to enforce it is "an essential and appropriate auxiliary of the legislative function."[14] The Court has further held that "[t]he scope of [Congress's] power of inquiry . . . is as penetrating and far-reaching as the potential power to enact and appropriate under the Constitution."[15]

Congress's investigatory power is at its peak when the subject of the congressional inquiry is potential waste, fraud, abuse, or maladministration within a government department.[16] In *Watkins v. United States*, the Court held that the congressional investigatory power "encompasses inquiries concerning the administration of existing laws as well as proposed or possibly needed statutes."[17] Further, the *Watkins* Court clearly articulated Congress's authority to "inquire into and publicize corruption, maladministration or inefficiency in agencies of the Government."[18] Given the fact that the VA OIG failed to publish the findings of its Tomah inquiry and the serious issues at the facility, the Committee is well within its constitutional powers to conduct an independent and unbiased investigation into what happened at the Tomah VAMC.

Moreover, as an inspector general, the VA OIG has a statutory mandate to work with Congress. Congress created inspectors general to act as "independent and objective units" that "provide a means for keeping the head of the establishment and the Congress fully and currently informed about problems and deficiencies relating to the administration of [Executive Branch agencies] and the necessity for and progress of corrective action."[19] Because OIGs are a creation of Congress, the Inspector General Act clearly states that nothing in the Act "shall be construed

[14] *McGrain v. Daugherty*, 273 U.S. 135, 174 (1927).
[15] *Eastland v. U.S. Servicemen's Fund*, 421 U.S. 491, 504, n. 15 (1975) (quoting *Barenblatt v. United States*, 360 U.S. 109, 111 (1959)).
[16] Morton Rosenberg, The Constitution Project, When Congress Comes Calling: A Primer on the Principles, Practices, and Pragmatics of Legislative Inquiry 7 (2009), *available at* http://www.constitutionproject.org/wp-content/uploads/2009/07/WhenCongressComesCalling.pdf.
[17] *Watkins v. United States*, 354 U.S. 178, 187 (1957).
[18] *Id*. at 200 n. 33.
[19] 5 U.S.C. app. § 2 (3) (1978).

to authorize or permit the withholding of information from Congress, or from any committee or subcommittee thereof."[20]

In light of these Constitutional and statutory foundations, the VA OIG's posture toward the Committee is highly unusual for an inspector general and counterproductive to Congress's efforts to identify and remedy the problems. In the months prior to the subpoena, the Committee took great pains to secure the VA OIG's voluntary cooperation with the Committee's inquiry. Between January 15, 2015, and April 29, 2015—the date of the subpoena—the Committee sent five separate letters to Deputy Inspector General Griffin requesting documents and all nonpublic healthcare inspections.[21] Committee staff held multiple in-person and telephonic meetings with VA OIG staff in an attempt to facilitate the production of VA OIG documents pertaining to the Committee's investigation. Chairman Johnson also met personally with Deputy Inspector General Griffin and his aide, Catherine Gromek, on March 2 to try to reach an accommodation on the production of documents.[22]

The Committee made great efforts to understand and accommodate the VA OIG's particularized concerns about specific documents. Chairman Johnson has made clear throughout the investigation that the Committee is not seeking veteran-specific medical information.[23] The Committee offered to accommodate the VA OIG by accepting rolling productions, limited redactions of sensitive veterans' health information, and other means to address the VA OIG's specific concerns.[24] The VA OIG, however, refused to articulate any particularized concerns about specific documents, instead asserting broad and generalized concerns about the documents as a whole. The VA OIG continuously reiterated its perceived barriers to compliance with the Committee's requests without proposing any path toward accommodation.[25] In fact, during one conference call between committee staff and VA OIG staff, Counselor to the Inspector General, Maureen Reagan, best summarized the VA OIG's contempt for the Committee's investigation,

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[20] 5 U.S.C. app § 5(e)(3) (1978).

[21] *See* Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs, to Hon. Richard J. Griffin, Deputy Inspector Gen., Office of Inspector Gen., U.S. Dep't of Veterans Affairs (Jan. 14, 2015) [hereinafter Jan. 14 Letter] (on file with Comm.); Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs, to Hon. Richard J. Griffin, Deputy Inspector Gen., Office of Inspector Gen., U.S. Dep't of Veterans Affairs (Feb. 25, 2015) [hereinafter Feb. 25 Letter] (on file with Comm.); Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs, to Hon. Richard J. Griffin, Deputy Inspector Gen., Office of Inspector Gen., U.S. Dep't of Veterans Affairs (Mar. 11, 2015)[hereinafter Mar. 11 Letter] (on file with Comm.) ; Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs, to Hon. Richard J. Griffin, Deputy Inspector Gen., Office of Inspector Gen., U.S. Dep't of Veterans Affairs (Apr. 20, 2015) [hereinafter Apr. 20 Letter] (on file with Comm.)

[22] Meeting between Sen. Ron Johnson, S. Comm. on Homeland Sec. & Governmental Affairs, & Hon. Richard J. Griffin, Deputy Inspector Gen., Office of Inspector Gen. U.S. Dep't of Veterans Affairs, (Mar. 2, 2015).

[23] *See* Feb. 25 Letter; *See also* Mar. 11 Letter; *See also* Letter from Sen. Ron Johnson, Chairman, & Sen. Thomas R. Carper, Ranking Member, S. Comm. on Homeland Security & Governmental Affairs, to Hon. Richard J. Griffin, Deputy Inspector Gen., Office of Inspector Gen., U.S. Dep't of Veterans Affairs (Apr. 29, 2011) (on file with Comm.)

[24] *See* Mar. 11 Letter.

[25] *See* Letter from Hon. Richard J. Griffin, Deputy Inspector Gen., Office of Inspector Gen., U.S. Dep't of Veterans Affairs, to Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs (Feb. 27, 2011) (on file with Comm.)

stating: "Technically [the VA OIG] doesn't have to do anything [in response] to a Chairman's letter."[26]

The Committee's efforts to procure the VA OIG's voluntary production of all documents relating to its Tomah VAMC inspection proved unsuccessful. The Committee had no choice but to subpoena the VA OIG for all relevant documents about the VA OIG's work at the Tomah VAMC. Chairman Johnson issued the subpoena, as chairman of the Committee, with the approval of Ranking Member Carper.[27]

2. The VA OIG has not complied with the Committee's Subpoena

Even in the face of a congressional subpoena, the VA OIG continues to stonewall the Committee's investigation by making inappropriate redactions to material produced and by outright refusing to produce certain documents. On May 27, 2015, Roy Fredrikson, the VA OIG's Deputy Counselor, certified that the VA OIG had completed the production of all documents responsive to the Committee's subpoena.[28] In the same communication, Fredrickson acknowledged—despite his certification—that the VA OIG has redacted information broader than agreed to by the Committee and has consciously withheld at least 1,812 pages of subpoenaed material.[29]

The Committee's subpoena compelled the production of "all documents and communications obtained, received, reviewed, created, or relied upon" by the VA OIG during its health care inspection of the Tomah VAMC or in preparation for its report of the investigation.[30] The subpoena further compelled the production of communications among VA OIG personnel regarding its Tomah VAMC health care inspection.[31]

The VA OIG has applied excessive and improper redactions to the documents it produced to the Committee. Although the Committee agreed to accept limited redactions of patient-specific medical information,[32] the VA OIG redacted information that goes well beyond patient-specific information. For example, the VA OIG redacted content of publicly available news articles,[33] names of Tomah VAMC employees that the VA OIG interviewed during its

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[26] Telephone meeting between Comm. staff & U.S. Dep't of Veteran's Affairs Office of Inspector Gen. staff (March 24, 2015) .

[27] *See* Letter from Sen. Ron Johnson, Chairman, & Sen. Thomas R. Carper, Ranking Member, Comm. on Homeland Security & Governmental Affairs, to Hon. Richard J. Griffin, Deputy Inspector Gen., Office of Inspector Gen., U.S. Dep't of Veterans Affairs (Apr. 29, 2011) (on file with Comm.)

[28] E-Mail from Fredrikson, *supra* note 13.

[29] *Id.*

[30] *See* Subpoena from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs, to Hon. Richard J. Griffin, Deputy Inspector Gen., Office of Inspector Gen., U.S. Dep't of Veterans Affairs, Schedule § A (1) (Apr. 29, 2011) (on file with Comm.)

[31] *See id.* at § A (4).

[32] *See id.* at § A.

[33] *See* VA OIG production, bates number 1409-1434. The VA OIG attached a number to identify each page it produced to the Committee pursuant to the Committee's April 29 subpoena. Any citations to documents produced pursuant to the subpoena will be referred to by the bates number on the document.

investigation, and even entire pages of interview transcripts.[34] These redactions are not based in statute, nor has the VA OIG claimed any lawful privilege on this material.

Further, the VA OIG has outright refused to produce subpoenaed material—including drafts of its Tomah VAMC health care report, and communications between VA OIG personnel about the report. In defense of its action, the VA OIG has asserted common-law privileges that have no bearing on congressional oversight conducted pursuant to authority derived from the Constitution. To explain these issues to the VA OIG, the Committee has attempted to schedule a meeting with VA OIG staff over the past several weeks.[35] This meeting has not yet occurred.

3. During its investigation, VA OIG investigators told witnesses that the Tomah VAMC inspection would be made public in early 2013

According to the VA OIG, its Tomah VAMC health care inspection was administratively closed in March 2014. The report was not made public then, nor was its findings immediately disclosed to Congress. Catherine Gromek, a VA OIG spokesperson, defended the VA OIG's administrative, nonpublic closure "[b]ecause the inspection found that the prescription practices in question were within the standard of care . . . . Accordingly, a published report was deemed to be unnecessary."[36] The Majority Staff of the Committee has uncovered information suggesting that during its inspection, VA OIG investigators told witnesses otherwise—that the report would be made public by early 2013.

The Majority Staff has learned that VA OIG investigators appear to have conducted the inquiry with the intent of publishing their findings. VA OIG investigators told one interview subject, who asked about what the VA OIG would do with its findings: "[T]ypically after we do an investigation we do submit a report which is published on our website."[37] In another interview, from August 2012, Dr. Alan Mallinger, a Senior Physician with VA OIG conducting the inspection, told a witness: "[Y]eah, our findings will be summarized in a report that will actually, it goes to VA and to Congress." In the same interview, Dr. Mallinger promised the witness that the report would be public, stating: "[S]o [the report] will be available on our website to anyone who wants to read it. So if you check out our website from time to time, we'll have that report online. It will probably be six months down the road."[38] Likewise, in an interview with Mario DeSanctis, the then-Director of the Tomah VAMC, in September 2012, Dr. Mallinger once again put a timeframe on the report, saying: "we're hoping to have a report within about six weeks or so."[39]

[34] The VA OIG redacted the identities of nearly every person it interviewed as part of its Tomah inspection. For an example, see the documents marked with bates numbers 5317-5473.
[35] E-mail from Comm. staff to Roy Fredrikson (June 8, 2015).
[36] Donovan Slack, *Tomah: A Trail of Secrecy, Missed Opportunities*, Wausau Daily Herald, Mar. 17, 2015, http://www.wausaudailyherald.com/story/news/investigations/2015/02/24/tomah-veterans-affairs-secrecy-missed-opportunities/23901367/ .
[37] *See* interview between VA OIG staff and an unidentified subject, bates number 5472.
[38] *See* interview between VA OIG and staff an unidentified subject, bates number 5458
[39] *See* interview between VA OIG and Mario DeSanctis, bates number 6095.

It appears from this information that the investigators on the ground in Tomah conducting the inquiry intended to complete their investigation by early 2013 and make their findings public. Obviously, the report was not released until March 2014—and it was not made public until February 2015, after significant pressure from Congress. The VA OIG has refused thus far to produce communications among VA OIG personnel about the timeframe for publication, or draft inspection reports. These withheld documents may contain key information that will shed light on this open question of why VA OIG investigators told witnesses to expect a prompt and public report when neither occurred.

4. The VA OIG seems to lack clear standards for substantiating allegations

In addition to open questions about why the VA OIG promised witnesses a prompt and public report, the Majority Staff of the Committee has concerns about the VA OIG's standards for substantiating allegations. Chairman Johnson articulated these concerns at the Committee's joint field hearing in Tomah, when questioning Dr. John D. Daigh, the Assistant IG for Healthcare Inspections. Noting witness testimony about the culture of fear in the Tomah VAMC pharmacy, he asked Dr. Daigh: "[W]hat does it take to substantiate claims of retaliation and intimidation? What would be the standard for substantiation if that's not it? If everybody in the pharmacy is basically saying there's retaliation and there's a climate of fear?"[40] Dr. Daigh replied that the VA OIG required "clear evidence" in documentary form to substantiate a claim of retaliation. "[S]o we were looking at evidence beyond a story," he testified. "Something we could use to support the story."[41]

The Chairman's investigation since the field hearing has shown additional indications that the VA OIG lacks clear standards for substantiating allegations brought to their attention. In defending its failure to substantiate allegations of a "culture of fear" at the Tomah VAMC—an allegation the VA substantiated in March 2015[42]—the VA OIG claims it had no witnesses with "any direct negative personal experiences with Dr. Houlihan."[43] Yet, the VA OIG goes on to contradict itself, citing firsthand evidence it received about "negative" personal experiences with Dr. Houlihan:

> During her interview, Ms. [Noelle] Johnson related interactions between her and Dr. Houlihan in which she stated that he yelled and used profanity toward her. No other witnesses related any similar conduct on the part of Dr. Houlihan. One witness indicated that Dr. Houlihan would raise his voice and yell, but did not tell us that Dr. Houlihan used profanity. Another witness interviewed in 2012 described one meeting in which Dr. Houlihan yelled but also stated that he had calmed down a lot.[44]

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[40] *Id.*
[41] *Id*. at 22.
[42] *See* Memorandum from Carolyn M. Clancy, Interim Under Secretary for Health, Dep't of Veterans Affairs (Mar. 10, 2015), *available at* http://www.va.gov/opa/docs/MEMO_Summary_of_Phase_One_Clinical_Review_Findings_Tomah_WI.pdf.
[43] White Paper from the Dep't of Veterans Affairs Office of Inspector Gen. (June 4, 2015) (on file with Comm).
[44] *Id.*

It is hard to understand how evidence that Dr. Houlihan yelled and raised his voice cannot be considered evidence of a "negative" personal experience. Despite this information, the VA OIG cited contrary evidence, which it apparently weighted more heavily than the negative evidence in finding that it could not substantiate the allegation.

Similarly, in the VA OIG's review of the death of veteran Thomas Baer at the Tomah VAMC, it concluded that it could substantiate a majority of the allegations.[45] However, the VA OIG seems to rely on a literal standard requiring absolute confirmation to substantiate each allegation. For instances, the VA OIG did not substantiate an allegation that the Tomah VAMC's CT scan machine was "broken" because it determined that the machine was unavailable due to "routine maintenance" and not because it had failed spontaneously. Either way, the CT scan machine was not operational—but the VA OIG could not substantiate that it was "broken." Similarly, the VA OIG did not substantiate an allegation that the patient waited to be seen for "3 hours" because it determined the patient waited 2 hours and 16 minutes at most—another overly literalistic interpretation of a serious allegation. When asked by Committee staff about the VA OIG's standards for substantiation, the VA OIG staff offered no coherent explanation for how it weighs competing evidence.

VI. Preliminary Findings

Although the Committee's investigation is ongoing and the Committee continues to receive relevant information and materials, the Committee has already obtained information in the course of the investigation that sheds light and allows for some preliminary observations. This section briefly summarizes the preliminary findings of the Committee's Majority Staff since the Tomah field hearing on March 30, 2015. Despite the inquiry not being complete, the Majority Staff presents this information in the interest of keeping family members, Wisconsinites, and all veterans informed about the Committee's work and what it is learning.

1. More than a decade ago, employees at the Tomah VAMC referred to a certain provider at the facility as "Candy Man"

On January 8, 2015, news reports brought to the forefront serious problems with the Tomah VAMC, highlighting that veterans referred to the facility as "Candy Land" and to one doctor in particular, Dr. David Houlihan, as the "Candy Man." The VA OIG's eleven-page healthcare inspection never used the words "Candy Land" or "Candy Man" to describe the operations or culture of the Tomah VAMC. During the congressional field hearing in Tomah on March 30th, Chairman Johnson presented information that the Tomah patients used the term "Candy Man" as far back as 2009.[46] Since the field hearing, the Majority Staff of the Committee

[45] *See* Office of Healthcare Inspections, Office of Inspector Gen., U.S. Dep't of Veterans Affairs, Report No. 15-02456-396, Care of an Urgent Care Clinic Patient Tomah VA Medical Center (2015).
[46] *See Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications: Hearing Before the S. Comm. on Homeland Security & Governmental Affairs*, 114th Congress (2015), (opening statement of Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs) *available at*

has uncovered additional information that suggests that the use of the term "Candy Man" originated much earlier than 2009.

a. A whistleblower account suggests that the "Candy Man" moniker dates back to 2004

Following the March 30 field hearing, a whistleblower who worked at the Tomah VAMC for many years contacted Chairman Johnson's Committee staff.[47] This whistleblower worked in a number of different programs at the Tomah VAMC and was employed at the facility both before and after Dr. Houlihan was hired.[48] In a discussion with Committee staff, the individual told Committee staff that Dr. Houlihan had "an interest in PTSD" and assigned himself to a program that allowed him to interact closely with veterans suffering from PTSD.[49]

The whistleblower informed Committee Majority Staff that the term "Candy Man came up in 2004."[50] Veterans reportedly referred to Dr. Houlihan as the "Candy Man" to other health care professionals at the facility in 2004. Health care professionals at the facility spoke with each other about the nickname and its troubling connotations. Dr. Houlihan reportedly became aware of the "Candy Man" nickname and was "furious." The whistleblower told the staff that Dr. Houlihan reportedly filed a reprimand against the employee that he believed perpetuated the nickname.[51] When asked about the evolution of prescription practices at the Tomah VAMC during the whistleblower's tenure working at the facility, the whistleblower said that he noticed that Dr. Houlihan was "being so free with [prescribing] 'benzos' [benzodiazepines]."[52]

Majority Staff asked how day-to-day operations changed after Dr. Houlihan was hired. The whistleblower stated, "when Dr. Houlihan came in, he started to prescribe meds very freely to the veterans."[53] The staff at Tomah apparently found this prescribing method disturbing as this individual described how "staff raised questions and Dr. Houlihan took the criticism very defensively."[54]

While this whistleblower account is just one data point about how far back in time the "Candy Man" moniker extends, it is an illuminating piece of evidence that suggests the problems with "Candy Land" were entrenched in the culture of the Tomah VAMC. It is unclear whether the VA or the VA OIG uncovered this information in the course of their reviews of the Tomah VAMC.

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http://www.hsgac.senate.gov/hearings/joint-field-hearing-tomah-vamc-examining-quality-access-and-a-culture-of-overreliance-on-high-risk-medications

[47] Telephone Interview (May 18, 2015).
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.*

b. The AFGE Local 007 Union raised concerns about the "Candy Man" in 2009

Another indication that Dr. Houlihan was widely known as "Candy Man," respectively, is a document from 2009 that was provided to the Committee. This document, a letter from local AFGE representatives to another union official, describes a number of issues at the Tomah VAMC—including that many employees had "significant concerns" about patient safety, among other issues, at the facility.[55]

The letter articulated a serious concern "that many of the Veterans served at this facility are **prescribed large quantities of narcotics**."[56] The letter detailed how Tomah VAMC providers and registered pharmacists refused to prescribe or fill large quantities of narcotic prescriptions.[57] It cited an example of a pharmacist who refused to fill an order for 1,000-plus narcotic tablets for a 30-day supply for a patient of Dr. Houlihan.[58] The letter alleged that this pharmacist received a "verbal thrashing" from Dr. Houlihan and that "many providers have left because of the harassment."[59]

This letter confirms that in the spring of 2009, the local chapter of AFGE was well-aware of the moniker "Candy Man."[60] The letter explains:

> Many of the patients call Dr. Houlihan "The Candy Man" because of the easy access to narcotic drugs/medications at the facility.
>
> There have been several unexplained deaths at this Medical Center. In 2008, there were three (3) suicides of veterans while sitting in parked vehicles on the Medical Center grounds. These patients were counseled by Psychiatrist/Chief of Staff Dr. David Houlihan.[61]

The letter closes: "Please know we have many concerns for our Veterans and for the Employees. I have taken the liberty to attempt to explain two (2) of the most significant concerns at this time."[62]

According to the local AFGE leadership, this letter most likely was provided to the VA OIG in 2009 as well. However, it is unknown whether the VA OIG took any action regarding the serious allegations in this letter about apparent employee retaliation and patient care at that time. It is also unclear whether the VA took any action to remedy concerns about patient safety connected with Dr. Houlihan's reputation as the "Candy Man" in 2009.

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[55] Letter from Am. Fed'n of Gov't Emps. Local 1882 AFL-CIO to Ben Balkum, President, AFGE Local 1882, VA Medical Center (Apr. 17, 2009) , available at Reproduction of VA OIG documents bates 5846-48
[56] *Id.* (emphasis in original).
[57] *Id.*
[58] *Id.* at 2.
[59] *Id.*
[60] *Id.*
[61] *Id*. at 2-3.
[62] *Id*. at 3.

c. Former Tomah VAMC employee heard the term "Candy Man" in 2009

Dr. Noelle Johnson, a former Tomah VAMC pharmacist who testified at the Committee's field hearing, raised concerns about veterans at the facility "appearing overmedicated" and the problem of "overprescribing of narcotic medications" during her time at Tomah.[63] Dr. Johnson, who was employed at the Tomah facility from 2008 to 2009, testified during the filed hearing:

> The 'Candy Man' statement the [news articles] reference is not made up, it is absolutely true. I heard more than one veteran reference Dr. Houlihan as this. I heard a particular [Tomah] patient in the hallway say "my primary care doctor took me off my narcotics, you need to see Dr. Houlihan because he will put you back on them just like he did me."[64]

This evidence, from several different sources with different viewpoints and experiences at the Tomah VAMC, suggests that the facility had a reputation for easy opioid prescription practices that dates back years. The term "Candy Man" and the culture of opioid abuse it represents appear to have been well-known and well-understood by Tomah employees and patients as far back as 2004.

2. Outside pharmacy consultants noted that the Tomah VAMC was at risk of losing its DEA controlled substance accreditation

Since the Committee's field hearing in March 2015, the Committee has learned that the VA OIG selected three VA pharmacists from outside of the Tomah VAMC to act as consultants in the OIG's inspection. These pharmacists assisted the VA OIG in its evaluation of the clinical and administrative aspects of Dr. Houlihan's interactions with pharmacy staff and the pharmacy staff's roles in protecting patient safety through the appropriate dispensing of controlled substances.[65] These consultants identified serious concerns with prescribing practices and management at the Tomah VAMC.[66]

After conducting an independent evaluation of the Tomah VAMC pharmacy, one consultant found "several concerns" that present "a significant risk" to the facility. The concerns identified were as follows:

1. The Tomah VAMC pharmacy was at risk of having its DEA controlled substance license either revoked or suspended "due to the lack of sufficient effort to decrease the potential for diversion, abuse, and overdose after several red flags were raised";
2. The Tomah VAMC pharmacy was at risk of having its Joint Commission Accreditation revoked or changed to partial accreditation; and

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[63] Statement of Concern of Noelle Johnson 3 (on file with Comm.).
[64] *See id*. at 4.
[65] *See*, U.S. Dep't of Veterans Affairs, Office of Inspector Gen., MCI No. 2011-04212-HI-0267, *supra* note 5 at 2.
[66] *See* memorandum from [VA Pharmacist-Consultant] to VA OIG Review Team, July 12, 2012, bates number 1943. *See also, OIG Consultation, Veterans Affairs Medical Center, Tomah, WI*, bates number 1547-48. The Committee has not provided the names of the pharmacy consultants to respect their privacy.

3. The Tomah VAMC showed a high potential risk of litigation by former or current employees.[67]

This independent review found that Dr. Houlihan condoned questionable prescription practices and stifled pharmacy questioning and opposition to his narcotic prescription practices. In particular, the consultant noted that (1) veterans were prescribed excessive doses of controlled substances; (2) veterans were prescribed an excessive amount of short-acting narcotics with no long-acting agents; and (3) providers exhibited a lack of due diligence when issues were raised about patients who demonstrated behaviors of abuse or diversion of medications.[68]

The same consultant noted that "more than one" individual at the Tomah VAMC told him that Dr. Houlihan was nicknamed "Candy Man" by the patients "due to the ease in which [Dr. Houlihan] prescribed controlled substances."[69] The consultant further noted "concerns that were raised by local police officers" and "more than one" overdose that occurred in the parking lot of the Tomah VAMC.[70] For each of these points, the consultant noted that "[i]t appears that there was no action taken by senior leadership to address these concerns."[71]

Another independent consultation that occurred in the summer of 2012 described the prescriptions written by the Chief of Staff, Dr. Houlihan, as "extreme in quantity and dose."[72] This consultant noted that "safety would be a concern of mine as well" with respect to the Tomah VAMC pharmacy.[73] Alarmingly, the consultant described the Tomah VAMC pharmacy as "not safe."[74] The consultant believed that the "Chief of Staff at Tomah was the reason for the hostile environment at the pharmacy."[75]

Although the VA OIG apparently solicited and obtained these independent analyses of the Tomah VAMC pharmacy, the OIG's eleven-page administratively closure did not mention this material. At this point, it is unclear why the OIG did not refer to these independent consultations in its report. Nonetheless, these candid assessments of the risks at the Tomah VAMC paint a startling picture of the problems with opioid over-prescription at the Tomah VAMC.

3. The DEA has conducted at least three separate inquiries regarding potential drug diversion at the Tomah VAMC since 2009

According to information obtained by the Committee, DEA agents interviewed employees of the Tomah VAMC on three separate occasions as part of potential criminal investigations in 2009, 2011, 2012, and 2015. Despite the fact that the inquiries are closed, the

[67] *See, OIG Consultation, Veterans Affairs Medical Center, Tomah, WI*, bates number 1547-48
[68] *Id.*
[69] *Id.* at 1548.
[70] *Id.*
[71] *Id.*
[72] Memorandum from [VA Pharmacist-Consultant] to VA OIG Review Team, July 12, 2012, bates number 1943.
[73] *Id.*
[74] *Id.*
[75] *Id.*

DEA has refused to provide any documentation or specific information to the Committee on its Tomah investigations, citing an ongoing criminal investigation.[76] The Majority Staff's preliminary finding is based on documentation collected from sources other than the DEA. Because of the DEA's non-cooperation with the Committee's investigation, it is unclear what the DEA found in its closed investigations or the status of its ongoing investigation.

The earliest DEA examination of potential drug diversion at the Tomah VAMC known to the Committee occurred in 2009. Dr. Noelle Johnson, then a pharmacist at the Tomah VAMC, was reportedly interviewed by DEA investigator Thomas Hill on June 19, 2009.[77] During the interview, Dr. Johnson reportedly showed Mr. Hill approximately ten examples of patients under Dr. Houlihan's care that received narcotic prescriptions that in her opinion were either too high a dosage or too long in length.[78] Dr. Johnson reportedly told Mr. Hill about three "unexplained suicides" of Dr. Houlihan's patients at the Tomah VAMC during her employment.[79] At the conclusion of the two-hour interview, Mr. Hill informed Dr. Johnson that federal prosecutors would be in touch with her and he advised her not to fill any prescriptions she felt were unsafe.[80]

Subsequently, according to information made available to the Committee, the DEA conducted a drug diversion investigation in concert with the VA OIG's health care inspection of the Tomah VAMC in 2011 and 2012.[81] VA OIG documents indicate that as of August 2011, DEA drug diversion investigators in Milwaukee had initiated an investigation based on anonymous complaints that Dr. Houlihan and another medical professional at the Tomah VAMC were "excessively prescribing opiate medications to patients with PTSD."[82] On April 13, 2012, VA OIG criminal investigator Greg Porter met with the DEA drug diversion investigators. At the meeting, the DEA investigators confirmed to Mr. Porter that "they had initiated a diversion investigation in regards to the Tomah VAMC and local area veterans in Tomah, and that they would cooperate with the VA OIG investigation."[83] On April 25, 2012, DEA investigators, along with criminal investigators from the VA OIG and a Tomah police detective, interviewed a Tomah VAMC employee.[84] The employee told law enforcement that "Houlihan and [another medical professional] are the root of drug diversion/pill-selling by veterans at the Tomah VAMC and they have created a culture of fear within the Tomah VAMC, to which employees are afraid

[76] *See* Letter from Eric J. Akers, Deputy Chief, Office of Cong. & Pub. Affairs, Drug Enforcement Admin., U.S. Dep't of Justice, to Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs (Mar. 17, 2015) (on file with Comm.).
[77] Noelle A. Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Tab 1 at 6. Dr. Johnson also confirmed that she was interviewed by the DEA in 2009 in her written testimony for the Committee's Field Hearing in Tomah on March 30, 2015. http://www.hsgac.senate.gov/hearings/joint-field-hearing-tomah-vamc-examining-quality-access-and-a-culture-of-overreliance-on-high-risk-medications
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] *See* U.S. Dep't of Veterans Affairs, Office of Inspector Gen., MCI No. 2011-04212-HI-0267, Administrative Closure: Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center (2014), *available at* https://www.documentcloud.org/documents/1384916-2014-va-oig-report html.
[82] See *MCI Search Results MCI# 2011-04212-DC-0252*, bates number 1392.
[83] *Id.*
[84] See *MCI Search Results MCI# 2011-04212-DC-0252*, bates number 1393; *See also* interview between Greg Porter, et. al and "Anonymous Tomah VAMC Employee, Apr. 25, 2012, bates numbers 1475-76.

to step forward and/or speak their minds."[85] The employee also said that particular patients of Dr. Houlihan frequently requested early refills in conjunction with their high prescription rates of narcotics.[86]

In addition to the documents showing coordination between the VA OIG and DEA in investigating potential drug diversion, whistleblowers have confirmed to the Committee that they were interviewed by the DEA in the 2011 and 2012 timeframe. The DEA has refused to provide any information to the Committee about these investigations.[87]

From information obtained by the Committee, it appears that the DEA is continuing to investigate drug diversion at the Tomah VAMC. The DEA has confirmed to the Committee that it is currently performing an investigation involving the Tomah VAMC.[88] Whistleblowers have told the Committee that DEA investigators have been present on Tomah VAMC grounds over the course of several months in 2015. While the DEA has thus far refused to provide any specific information to the Committee regarding its investigations of the Tomah VAMC, the DEA provided a limited briefing to Committee staff on March 27, 2015, in which a DEA employee discussed general policies and procedures that the DEA uses when conducting diversion investigations but refused to answer any questions about the DEA's work at the Tomah VAMC. [89]

Without cooperation from the DEA, the Committee is unable to determine what the DEA found in its investigations. However, the mere fact that the DEA has conducted several investigations involving potential drug diversion at the Tomah VAMC since 2009 strongly suggests the presence of an ongoing, sustained problem with illicit drug diversion that should have been addressed—whether by the DEA, the VA, the VA OIG, or other law-enforcement agencies.

4. The VA did not conduct any investigation into the firing and suicide of former Tomah VAMC employee, Dr. Christopher Kirkpatrick

Dr. Christopher Kirkpatrick was a clinical psychologist at the Tomah VAMC who was fired, according to documents obtained by the Committee, for expressing his belief that his patients were overmedicated. On the same day of his termination from the Tomah VAMC, Dr. Kirkpatrick took his own life. Despite the tragedy of his firing and death—and in the face of reports of broader overmedication and employee retaliation at the facility—the Committee has learned that the VA did not examine the circumstances that led to Dr. Kirkpatrick's termination.

[85] Interview between Greg Porter, et. al and "Anonymous Tomah VAMC Employee, Apr. 25, 2012, bates number 1476.
[86] See *MCI Search Results MCI# 2011-04212-DC-0252*, bates number 1393
[87] *See* Akers, *supra* note 76; *see also* email from Matthew J. Strait, Acting Section Chief, DEA Congressional Affairs Section to Comm. staff (June 8, 2015).
[88] *See* Akers, *supra* note 76. ("DEA has an ongoing investigation regarding the VAMC-Tomah facility.")
[89] DEA Briefing with Comm. staff (March 27, 2015).

On April 20, 2015, Chairman Johnson wrote to VA Secretary McDonald asking whether the VA conducted any investigation into Dr. Kirkpatrick's termination and suicide.[90] The letter noted the particularly alarming circumstances surrounding Dr. Kirkpatrick's termination and death in light of the numerous reports of whistleblower retaliation at the Tomah VAMC.

According to documents obtained by the Committee, Dr. Kirkpatrick reportedly expressed concerns to his supervisors and his union representation that the patients he was seeing appeared to be overmedicated.[91] On July 14, 2009, Dr. Kirkpatrick was terminated from his employment at the Tomah VAMC for "performance issues."[92] The local chapter of the AFGE union, which represented Dr. Kirkpatrick during the firing, described the termination meeting as "gruesome" and that "management would not listen to any rationale [*sic*] argument."[93] Tragically, Dr. Kirkpatrick was found dead in his apartment that evening from a self-inflicted gunshot wound.

The Committee has found that the VA did not conduct any investigation into Dr. Kirkpatrick's suicide. In a May 29, 2015 letter to Chairman Johnson, VA Deputy Secretary Sloan Gibson confirmed that the "VA did not conduct an investigation into Dr. Kirkpatrick's termination and suicide."[94] Deputy Secretary Gibson elaborated:

> Tomah VAMC management did not investigate [Dr. Kirkpatrick's] suicide because during the July 14, 2009, meeting where Dr. Kirkpatrick was notified that his temporary appointment would be terminated effective July 28, 2009, he indicated his intention to resign prior to the termination effective date. Tomah VAMC management did not receive a resignation letter from Dr. Kirkpatrick prior to his death.[95]

It is unclear why the VA chose not to investigate the suicide of a current employee—Dr. Kirkpatrick had not yet tendered his resignation—who came forward with concerns of overmedication. The VA appears to have been aware at the time of allegations of overmedication and over-prescription. According to information presented to the Committee, the DEA interviewed at least one Tomah VAMC pharmacist during the summer of 2009.[96] Why the VA ignored Dr. Kirkpatrick's death remains a mystery still today.

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[90] *See* Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs, to Hon. Robert A. McDonald, Secretary, U.S. Dep't of Veterans Affairs (Apr. 20, 2015) (on file with Comm.). *Also available at http://www.hsgac.senate.gov/library.*

[91] Juneau County Sherriff's Department, *CAD Operations Report,* Call No. 09-13258, Jul. 15, 2009 (VA OIG bates number 5795-5851).

[92] Letter from Wayne Davis, Manager, Great Lakes Human Resources Management Service, to Chris Kirkpatrick (July 14, 2009) (VA OIG bates number 5845).

[93] AFGE (American Federation of Government Employees) Union, Representation with Dr. Chris M. Kirkpatrick (on file with Comm. staff).

[94] Letter from Sloan Gibson, Deputy Sec'y, U.S. Dep't of Veterans Affairs, to Sen. Ron. Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs (May 29, 2015) (on file with Comm.).

[95] *Id.*

[96] *See supra* Section VI.3.

5. The potential diversion of VA prescription medications extends beyond Tomah

The Chairman's investigation has uncovered that the Tomah VAMC was potentially used to fuel the local drug trade in central Wisconsin—an issue that DEA apparently has been examining since 2009.[97] During the investigation, the Committee has become aware of another VA prescription drug diversion investigation with a nexus to Wisconsin. The reports of alleged drug diversion at the Tomah VAMC led a district attorney in another part of Wisconsin—Sheboygan County—to suspect that diversion may be a systemic problem at the VA.[98] He documented to Chairman Johnson his own experience with diverted VA prescription drugs.

In March 2015, Chairman Johnson received a letter from Sheboygan County District Attorney Joe DeCecco.[99] District Attorney DeCecco described an investigation in which law-enforcement intercepted a shipment from Santa Cruz, California, to Sheboygan County, Wisconsin, containing 458 "commercially produced oxycodone pills."[100] After investigation, law-enforcement learned that the supplier of the pills was a veteran receiving treatment at the VA Palo Alto California Health Care system.[101] It was determined that this veteran was prescribed 600 oxycodone pills per month,[102] which District Attorney DeCecco noted is "a ridiculous amount of this opiate drug."[103] This veteran was convicted of possession of controlled substances.[104]

In response to the concerns raised by District Attorney DeCecco, Chairman Johnson wrote to VA Secretary Robert McDonald about the potential of a larger problem of drug diversion at the VA.[105] In response, the VA downplayed systemic issues of drug diversion, writing that "reports of internal diversion of prescription medications by VA staff *appear to be random events and are not indicative of a widespread problem in the VA network*."[106] The VA forwarded the Chairman's letter to the VA OIG—without the Committee's consent or knowledge—and the VA OIG submitted information on the VA's behalf.[107] The VA OIG notified the Committee that since 2008, it has opened four diversion investigations in Wisconsin,

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[97] *See* Letter from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs to Hon. Robert A. McDonald, Sec'y, U.S. Dep't of Veterans Affairs (Feb. 4, 2015) (on file with Comm.)
[98] *See* Letter from Joe DeCecco, Office of the Dist. Att'y, Sheboygan County to Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs (Mar. 11, 2015) (on file with Comm.).
[99] *Id.*
[100] *Id.*
[101] Letter from Carolyn M. Clancy, Interim Under Secretary for Health, Dep't of Veterans Affairs, to Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs (May 27, 2015) (on file with Comm).
[102] *See* DeCecco, *supra* note 98.
[103] *Id.*
[104] *See* Letter from Hon. Richard J. Griffin, Deputy Inspector Gen., Office of Inspector Gen., U.S. Dep't of Veterans Affairs, to Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs (May 8, 2015) (on file with Comm.).
[105] *See* Letter from from Sen. Ron Johnson, Chairman, S. Comm. on Homeland Security & Governmental Affairs to Hon. Robert A. McDonald, Sec'y, U.S. Dep't of Veterans Affairs (Mar. 27, 2015) (on file with Comm.).
[106] *See* Clancy, *supra* note 101 (emphasis added).
[107] The Committee notes the irony in the fact that the VA OIG responded to a congressional inquiry that was not addressed to it while refusing to respond appropriately to the Chairman's requests for information to the VA OIG.

but maintained that none of the investigations involved the Tomah VAMC.[108] This assertion appears to contradict documents produced by the VA OIG, which show that the VA OIG worked with the DEA to examine allegations of drug diversion at the Tomah VAMC and even interviewed Tomah VAMC employees in 2011 and 2012.[109] The VA still has not responded to the remaining questions in the Chairman's letter about its awareness of potential drug diversion in Wisconsin.

While there are still open questions about the extent of drug diversion within the VA system and its effect on Wisconsin veterans, it is clear from information available to the Majority Staff of the Committee at present that this problem extends beyond the Tomah VAMC. The Committee will continue to examine the drug diversion problems at VA facilities across the country to determine if the VA, VA OIG, DEA and other law-enforcement entities are sufficiently focusing on this growing problem.

VII. Unanswered Questions and Next Steps

This interim report is intended to update the Tomah community and veterans across the nation on the progress of the Committee's investigation of the tragedies that occurred at the Tomah VAMC. The Committee's investigation is far from over. Identifying all of the facts and circumstances surrounding events at the Tomah VAMC, which date back over a decade, is a large task that requires careful and thorough analysis and the cooperation of several federal agencies.

Regrettably, the Committee's task has been more laborious by the noncooperation of entities created specifically to hold the VA accountable. The VA Office of Inspector General continues to defy a bipartisan subpoena from the Committee—withholding documents that include drafts of its Tomah inspection report and communications among VA OIG staff about its Tomah inspection. These documents are instrumental to the Committee's investigation of the Tomah VAMC. Moreover, although the Committee has agreed to allow limited redactions to protect patient-sensitive information, the VA OIG has abused the Committee's accommodation in order to withhold material unrelated to particular patients or even medical information.

The preliminary findings presented in this interim report are just a starting point. Serious questions remain unanswered. As the Committee continues its investigation, it will strive to ascertain how far back in time the culture of "Candy Land" and the fear of retaliation extend. The Committee will seek to understand why the problems at Tomah went so long without being fixed and who is accountable for the breakdowns leading to patient deaths. The Committee will also search for why the VA OIG decided to close its health care inspection in March 2014, and why the VA's own internal review in 2015 arrived at such a different conclusion. In addition, the Committee will seek to answer the open question about why the VA OIG promised witnesses that its report would be made public in early 2013 when it was not released until February 2015.

[108] *See* Griffin, *supra* note 104. (Further, for the VISN 12, there were six cases. Nationally, the VA OIG opened a total of 825 investigations.)
[109] *See* notes 85 and 86, *supra*.

It also unclear now whether senior VA leadership was aware of the issues facing the Tomah VAMC and what steps the VA took to remedy the problems. The Committee will work to answer these and other important questions to bring accountability to the Tomah VAMC.

Going forward, the Committee will continue to gather documents from all corners—federal agencies, private parties, and whistleblowers. The Committee will continue to press the DEA and other federal law-enforcement agencies for information. The Committee will continue to attempt to obtain all required information from the VA OIG that it necessary for the Committee's investigation. The Committee will take testimony from witnesses with firsthand experience and knowledge about the Tomah VAMC. Throughout this process, the Committee's highest priority will be to bring accountability and transparency to the Tomah VAMC and the VA system in general. Our veterans deserve nothing less.

VIII. Timeline of the Committee's Inquiry

Below is a timeline that shows the sequence of actions taken by the Committee in the course of the investigation to date:

January 14, 2015 Chairman Johnson sent a letter to the VA OIG, co-signed by Congressman Sean Duffy, requesting information about its health care inspection.

January 22, 2015 Chairman Johnson sent a letter to President Obama requesting the appointment of a permanent VA Inspector General.

January 28, 2015 Chairman Johnson sent a letter to the DEA requesting documents and briefing about the DEA's work at the Tomah VAMC.

February 4, 2015 Chairman Johnson sent a letter to the VA requesting documents about the opioid over-prescription and potential drug diversion at the Tomah VAMC.

February 4, 2015 Chairman Johnson sent a letter to the Veterans Health Administration requesting information about the death of Thomas Baer.

February 10, 2015 Chairman Johnson sent a letter to the Chairman and Ranking Member of the Senate Veterans Affairs Committee requesting language in Clay Hunt Committee Report to require annual third-party reviews of VA system-wide opioid prescription trends.

February 25, 2015 Chairman Johnson sent a letter to the VA OIG requesting the OIG's case file for its Tomah health care inspection.

March 3, 2015 After the DEA refused to provide information on its actions in Tomah, Chairman Johnson sent a second letter to the DEA reiterating his request for documents about the DEA's work at the Tomah VAMC.

March 11, 2015 Chairman Johnson sent a letter to the VA OIG reiterating his February 25, 2015 request for the OIG's case file for its Tomah health care inspection.

March 17, 2015 Chairman Johnson sent a letter to the VA OIG requesting that the VA OIG release its 140 unreleased health care inspection reports.

March 24, 2015 Chairman Johnson sent a letter to the VA requesting information and documents about tort or Equal Employment Opportunity complaints made against a Tomah VAMC official.

March 25, 2015 Chairman Johnson sent a letter to the Merit Systems Protection Board requesting its case file concerning Noelle Johnson's termination from the VA.

March 26, 2015	Chairman Johnson, along with Senator Baldwin, offered an amendment to the Fiscal Year 2016 Budget to improve the transparency of the VA OIG. The amendment was adopted by the Senate via unanimous consent.
March 27, 2015	Chairman Johnson sent a letter to the VA requesting that the VA release the findings of its interim report concerning the Tomah VAMC.
March 27, 2015	Chairman Johnson sent a letter to the VA requesting information about potential diversion of VA prescription drugs from a VA facility in California to Sheboygan, Wisconsin.
March 30, 2015	Chairman Johnson convened a bicameral, joint field hearing in Tomah, Wisconsin.
April 20, 2015	Chairman Johnson sent a letter to the VA requesting information and documents about the termination and death of former Tomah VAMC employee, Dr. Chris Kirkpatrick.
April 20, 2015	Chairman Johnson sent a letter to the VA OIG reiterating the Committee's request for OIG material concerning the VA OIG's Tomah health care inspection.
April 20, 2015	Chairman Johnson sent a letter to the Merit Systems Protection Board requesting its case file concerning the termination of a former Tomah VAMC employee, Ron Pelham, from the VA.
April 28, 2015	Chairman Johnson introduced S. 1117, the Ensuring Veteran Safety Through Accountability Act of 2015 to allow the VA to better discipline and dismiss poor performing employees or wrongdoers.
April 29, 2015	On behalf of the Committee, and with the support of Ranking Member Carper, Chairman Johnson issued a subpoena to VA Deputy Inspector General Richard Griffin for material relating to the VA OIG's Tomah health care inspection.
June 16, 2015	Chairman Johnson sent a letter to the VA OIG requesting that VA OIG provide briefings to family members about the OIG's investigation into their loved ones' deaths.
June 22, 2015	Chairman Johnson sent a letter to the United States Attorney for the Western District of Wisconsin about its prosecutorial opinion concerning the Tomah VAMC.
June 25, 2015	Majority staff issued an interim report with an update of the Committee's investigation and preliminary findings from its work.