United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

WASHINGTON, DC 20510–6250

February 25, 2015

The Honorable Richard J. Griffin
Deputy Inspector General
Office of the Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Deputy Inspector General Griffin:

I write to express concerns about the operations and effectiveness of the Department of Veterans Affairs Office of the Inspector General (VA OIG). The Committee on Homeland Security and Governmental Affairs has been examining the tragedies that have occurred at the VA Medical Center (VAMC) in Tomah, Wisconsin. I am troubled that the VA OIG has refused to cooperate with the Committee's oversight of the Tomah VAMC, especially in light of the OIG's nonpublic review of the facility completed in 2014. I ask that you direct your office to cooperate with the Committee's ongoing oversight work.

Yesterday, the Committee heard testimony from four inspectors general who take seriously their obligations to oversee the executive branch and identify waste, fraud, and abuse.[1] These IGs effectively partner with congressional oversight committees to ensure that federal programs are run responsibly and taxpayer dollars are spent wisely. Moreover, they have a shared view of their duties as the independent watchdogs of their respective agencies.

The contrast between these IGs and your office is stark. In March 2014, your office completed a three-year healthcare inspection of opioid prescription habits and the work environment at the Tomah VAMC.[2] The VA OIG did not publicly release the eleven-page administrative closure at the time of its completion and it delayed reporting its findings to Congress. Amid calls for increased transparency on the Tomah VAMC investigation earlier this year, VA OIG finally publically released the March 2014 inspection on February 6, 2015.

Following the public release of this report, Committee staff sought to better understand the nature and scope of the VA OIG's review. On February 4, 2015, Committee investigators met with Dr. John Daigh, the Assistant Inspector General for Healthcare Inspections, and Dr.

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[1] *"Improving the Efficiency, Effectiveness, and Independence of Inspectors General": Hearing before the S. Comm. on Homeland Sec. & Gov't Affairs*, 114th Cong. (2015).

[2] U.S. Department of Veterans Affairs, Office of Inspector General, Administrative Closure, Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority at the Tomah Medical Center, MCI# 2011-04212-HI-0267.

Alan Mallinger, Senior Physician in the Office of Healthcare Inspections.[3] During this meeting, Committee staff learned that the VA OIG compiled and still possesses a comprehensive investigative file gathered during its almost three-year investigation of the Tomah VAMC. Committee staff requested that the VA OIG produce the investigative file to the Committee to assist with the Committee's oversight work. Catherine Gromek, VA OIG's Congressional Relations Officer, indicated that the VA OIG would review the material and make it available to the Committee.

On February 11, 2015, after a phone call with Committee staff about the status of the documents, Ms. Gromek wrote to Committee staff: "We are going through the documents – of which there are many (we tend to gather a lot of information) – so let me discuss with our Release of Information Office staff about what a reasonable timeline could be for getting you the documents."[4] On February 13, 2015, Ms. Gromek e-mailed Committee staff requesting a meeting between the Committee and VA OIG attorneys about the documents.[5] Committee staff agreed to the meeting in an effort to facilitate the production of the investigative file.[6]

On February 18, 2015, two weeks after the Committee requested the VA OIG's investigative file pertaining to the Tomah VAMC, Committee staff met with VA OIG attorneys, including Maureen T. Regan, the Counselor to the Inspector General and Privacy Officer for the VA OIG.[7] During this meeting, Ms. Regan refused to cooperate with the Committee's oversight, questioning the Committee's authority and even the Committee's purpose for reviewing the work performed by the VA OIG. Ms. Regan stated that the VA OIG had no obligation to report to Congress outside of its semi-annual report. Ms. Regan implied that the VA OIG would not comply with the Committee's request and suggested that the VA OIG would need to seek the approval of the VA before producing certain material to the Committee.

When Committee staff asked Ms. Regan to discuss the types of documents contained in the investigative file to better understand the VA OIG's position, Ms. Regan refused to discuss the categories of documents. She refused to provide Committee investigators with a list of contents of the Tomah VAMC investigative file that she possessed during the meeting and to which she regularly referred. When asked whether the VA OIG's distribution of the March 2014 Healthcare Inspection of the Tomah VAMC was appropriate, she said she believed that the VA OIG was "transparent" in its release of the report.

The noncooperation of the VA OIG in the Committee's examination of the Tomah VAMC – as particularly exemplified by your chief counsel, Ms. Regan – is troubling. The Inspector General Act established inspectors general to assist Congress in its oversight duties by keeping "Congress fully and currently informed by means of [semi-annual reports] and *otherwise*" of "fraud and other serious problems, abuses, and deficiencies . . . ."[8] The refusal of

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[3] Meeting between Comm. staff & John Daigh & Alan Mallinger (Feb. 4, 2015).
[4] E-mail from Catherine Gromek to Comm. staff (Feb. 11, 2015).
[5] E-mail from Catherine Gromek to Comm. staff (Feb. 13, 2015).
[6] E-mail from Comm. staff to Catherine Gromek (Feb. 13, 2015).
[7] Meeting between Comm. staff & Catherine Gromek, Maureen T. Regan, & Darryl Joe (Feb. 18, 2015).
[8] 5 app. U.S.C. § 4 (emphasis added).

your office to comply fully and promptly with the Committee's oversight needlessly narrows and delays the Committee's examination of the tragedies that occurred at the Tomah VAMC.

Accordingly, I ask that you cooperate fully with the Committee's oversight of the Tomah VAMC. I request that you produce the VA OIG's entire investigative file pertaining to the Tomah VAMC no later than 5:00 p.m. on February 27, 2015. Because your staff has already acknowledged that it still possesses the entirety of the investigative file, I believe you could produce the material to the Committee without delay.

The Committee on Homeland Security and Governmental Affairs is authorized by Rule XXV of the Standing Rules of the Senate to investigate "the efficiency and economy of operations of all branches of the Government."[9] Additionally, S. Res. 253 (114th Congress) and S. Res. 73 (114th Congress) authorize the Committee to examine "the efficiency and economy of all branches of the Government including the possible existence of fraud, misfeasance, malfeasance, collusion, mismanagement, incompetence, corruption, or unethical practices . . . ."[10] For purposes of responding to this request, please refer to the definitions and instructions in the enclosure. Thank you for your attention to this important matter.

Sincerely,

Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Minority Member

The Honorable Robert A. McDonald
Secretary
U.S. Department of Veterans Affairs

Enclosure

[9] S. Rule XXV(k); *see also* S. Res. 445, 108th Cong. (2004).
[10] S. Res. 253 § 12, 113th Cong. (2013).