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United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510–6250

July 8, 2015

Ms. Linda Halliday
Deputy Inspector General
Office of the Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Ms. Halliday:

The Committee on Homeland Security and Governmental Affairs has been investigating the tragedies that occurred at the VA Medical Center in Tomah, Wisconsin (Tomah VAMC), including the health care inspection of the facility performed by the Department of Veterans Affairs Office of Inspector General (VA OIG). I was surprised to receive an unsolicited letter from Richard J. Griffin, former Deputy Inspector General of the VA OIG, dated June 4, 2015, and an accompanying "white paper" that purports to support the findings of the VA OIG's health care inspection.[1] The VA OIG prepared and transmitted the letter and white paper at that same time that it is withholding material in the face of a subpoena issued by the Committee on April 29, 2015.[2]

The VA OIG's entire course of conduct during its interactions with the Committee on this matter has been baffling. The OIG has gone to great lengths to hide its work from Congress and the American public. The most recent letter and white paper resort to *ad hominin* attacks, misleading statements, and victim-blaming to defend the work of the office. Rather than draft a lengthy defense of the inspection—which, at thirteen pages, is two pages longer than the inspection report itself—I would have preferred if Counselor to the Inspector General Maureen Regan and the rest of the VA OIG legal team had dedicated those efforts to properly informing the public and fully complying with the subpoena.

I am extremely disappointed by the posture of the VA OIG during the course of the Committee's oversight and investigation concerning the Tomah VAMC. As you know, one of VA OIG's chief duties is to keep Congress "*fully* and *currently informed* about problems and deficiencies relating to the administration of programs and operations and the necessity for and progress of corrective action."[3] The Committee's initial efforts to secure the VA OIG's cooperation, however, were unreciprocated. In the ensuing months, VA OIG staff questioned

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[1] Letter from Richard J. Griffin, Dep't of Vet. Affairs Off. of Inspector Gen., to Ron Johnson, S. Comm. on Homeland Sec & Governmental Affairs (June 4, 2015).
[2] *See* Subpoena issued to Richard J. Griffin, Dep't of Vet. Affairs Off. of Inspector Gen., by S. Comm. on Homeland Sec. & Governmental Affairs (Apr. 29, 2015).
[3] 5 app. U.S.C. §(2)(a)(3) (emphasis added).

my motives in conducting this investigation,[4] and implied that my criticism of the VA OIG is unfounded because I am not a "medical expert."[5] This resistance to my investigation is inappropriate, unnecessary, and counterproductive to the goal of improving the VA.

Most perplexing, on June 4, 2015, the VA OIG issued an unsolicited thirteen-page white paper purporting to defend the work of the VA OIG[6]—at the same time that the VA OIG was consciously withholding documents subpoenaed by the Committee. A copy of this white paper was sent to 38 separate Senators and Congressmen[7]—some with no involvement whatsoever in the Committee's investigation, or any connection to the Tomah VAMC—apparently with the hope that the document would be provided to the media. It was not. Undeterred, the VA OIG issued a press release on June 18 highlighting the white paper and followed the release with at least five separate tweets promoting the document.[8] From these actions, I can only assume that the white paper had the primary goal of attracting media attention by defaming many of the victims and Tomah whistleblowers.

Beyond this unusual behavior, the substance of the white paper highlights an unfortunate posture with respect to the Committee's investigation of the Tomah VAMC. I wish to address some particular examples in the white paper in which the VA OIG makes unprompted *ad hominem* attacks against victims and whistleblowers at the Tomah VAMC and provides misleading and incorrect information about the Committee's investigation.

a. The VA OIG's *ad hominem* attacks in its white paper against victims and whistleblowers of the Tomah VAMC are unacceptable.

In attempting to defend its work, the VA OIG criticizes and demeans the very individuals its health care inspection failed to protect in the first place—the victims and whistleblowers of the Tomah VAMC. The paper impugns their motives, assassinates their character, and offers irrelevant information to discredit their accounts. These arguments are remarkable—and unfortunate—from an office whose duty it is to work with the Office of Special Counsel and other entities in *protecting* whistleblowers.[9] In light of the VA OIG's treatment of the victims and whistleblowers at the Tomah VAMC, it should not come as a surprise that VA whistleblowers and others would rather seek assistance from nonpartisan good-government

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[4] Telephone call between Comm. staff and Dep't of Vet. Affairs Off. of Inspector Gen. staff (Mar. 24, 2015).
[5] Donovan Slack, *Tomah probe finds no wrongdoing in death*, APPLETON POST CRESCENT, June 18, 2015 (quoting VA OIG spokeswoman Catherine Gromek).
[6] DEP'T OF VET. AFFAIRS OFF. OF INSPECTOR GEN., ANALYSIS OF THE EVIDENCE SUPPORTING THE FINDINGS OF THE VA OFFICE OF INSPECTOR GENERAL, OFFICE OF HEALTHCARE INSPECTIONS ADMINISTRATIVE CLOSURE OF ITS INSPECTION OF COMPLAINTS REGARDING THE TOMAH, WISCONSIN, VA MEDICAL CENTER (June 4, 2015) [hereinafter "VA OIG white paper"].
[7] The white paper was copied to Senators McConnell, Reid, and Carper; Representatives Miller, Brown, Abraham, Duffy, Kind, Pocan, and Walz; and the entire memberships of the Senate Committee on Homeland Security and Governmental Affairs and the Senate Committee on Veterans' Affairs.
[8] Dep't of Vet. Affairs Off. of Inspector Gen., OIG Releases White Paper on Evidence Supporting Administrative Closure of 2014 Tomah, WI, VA Medical Center Inspection on Opioid Prescription Practices (June 18, 2015).
[9] *See generally* Whistleblower Protection Act, Pub. L. 101-12, 103 Stat. 16; P.L. 103-424, 108 Stat. 4361 (codified, as amended, in various sections of Title 5 U.S.C.).

groups—like the Project on Government Oversight—than the VA OIG.[10] I wish to address the particular treatment of Dr. Noelle Johnson, Dr. Christopher Kirkpatrick, the Simcakoski family, the Baer family, and Mr. Ryan Honl.

1. Dr. Noelle Johnson

Dr. Noelle Johnson, a former pharmacist at the Tomah VAMC, offered important testimony at the Committee's field hearing about her firsthand experiences working at the Tomah VAMC.[11] Dr. Johnson testified—under oath—that she raised concerns about opioid prescription practices and was terminated for her actions.[12] The white paper implies that Dr. Johnson had "no personal knowledge of the facts and circumstances as they existed during [the OIG's] inspection."[13] This argument is curious given that the VA OIG investigators interviewed Dr. Johnson during the inspection—meaning that they presumably thought that she had personal knowledge about the facility. It is difficult to understand how the VA OIG can discount her testimony to the Committee because she has "no personal knowledge" when VA OIG investigators took her testimony as part of the VA OIG inspection.

In fact, the VA OIG's administrative closure report appears to include information obtained from Dr. Johnson. The VA OIG report stated:

> We substantiated the allegation that at least five outpatient pharmacy staff left the facility in recent years. . . . One pharmacist, a new employee, was not retained by the facility at the conclusion of his/her initial employment period. This individual reported that on three occasions he/she had refused to fill prescriptions for controlled substances due to concerns about patient safety and/or drug diversion.[14]

This pharmacist—"a new employee"—appears to be Dr. Noelle Johnson. The fact that the administrative closure included information relating to Dr. Johnson strongly suggests that the inspection covered the timeframe during which Dr. Johnson was employed at the facility. If, as the VA OIG alleged in the white paper, Dr. Johnson had no personal knowledge of the facts and circumstances surrounding the Tomah VAMC, I am at a loss as to why the VA OIG would interview her, draw conclusions from her interview, and include that material in the final product.

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[10] *"Addressing Continued Whistleblower Retaliation": Hearing before the Subcomm. on Oversight & Investigations of the H. Comm. on Veterans' Affairs*, 114th Cong. (2015) (Statement for the Record by the Project on Government Oversight), http://www.pogo.org/our-work/testimony/2015/pogo-provides-statement-for-house-hearing-on-va-whistleblowers.html?referrer=https://www.google.com/.

[11] *See "Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications": J. Hearing before the S. Comm. on Homeland Security & Governmental Affairs & the H. Comm. on Veterans' Affairs*, 114th Cong. (2015) [hereinafter "Tomah field hearing"].

[12] *Id.*

[13] *See* VA OIG white paper, *supra* note 6, at 3.

[14] DEP'T OF VET. AFFAIRS OFF. OF INSPECTOR GEN., ALLEGED INAPPROPRIATE PRESCRIBING OF CONTROLLED SUBSTANCES AND ALLEGED ABUSE OF AUTHORITY, TOMAH VA MEDICAL CENTER 5 (Mar. 12, 2014) [hereinafter "VA OIG administrative closure"].

Moreover, the white paper attempted to discredit Dr. Johnson's whistleblower retaliation claim by negatively characterizing the circumstances of her termination from the Tomah VAMC. In the white paper, the VA OIG quotes from Dr. Johnson's first and second line supervisors to justify her removal from the Tomah VAMC, claiming that Dr. Johnson had "poor interpersonal skills," "repeated negative interactions," and an "unsatisfactory" performance.[15] The VA OIG also attempted to discredit Dr. Johnson by implying that her perception of the retaliation was tainted because she was "only a probationary employee" who "had just completed her training and this was her first position as a pharmacist."[16] The VA OIG, however, failed to document in the white paper the entire account of Dr. Johnson's termination from the Tomah VAMC.

The Committee has obtained the Merit Systems Protections Board (MSPB) case file for Dr. Johnson's claim against the VA for wrongful termination. The file contains twelve letters of support from Tomah VAMC employees who interacted with Dr. Johnson during her tenure at the Tomah VAMC.[17] It also provides evidence that Dr. Johnson's support service line manager rated her as a "fully successful" employee in metrics of clinical functions, program management, customer service & value-added service, communications, and core competencies.[18] In 2010, Ms. Johnson and the VA settled her claim before the MSPB, resulting in her full reinstatement as an employee of the VA.[19] In fact, Ms. Johnson is currently employed at another VA facility. In spite of this positive information about Dr. Johnson's service, the VA OIG only focused on the comments and reviews that paint Dr. Johnson in a negative light.

2. Dr. Christopher Kirkpatrick

In the white paper, the VA OIG also needlessly attacked Dr. Christopher Kirkpatrick, a former Tomah VAMC doctor who tragically committed suicide on the same day in 2009 that he was terminated from the facility. The VA OIG acknowledged that Dr. Kirkpatrick's death was the "only specific death brought to [the VA OIG's] attention during the inspection."[20] The VA OIG's administrative closure alluded to his death, noting that VA OIG investigators reviewed documents concerning the death.[21] The closure, however, made no findings about Dr. Kirkpatrick's death, and it was not until the white paper that the VA OIG discussed the death in any detail.[22]

In the white paper, the VA OIG "strongly" recommended that readers undertake a "thorough" review of the Juneau County Sheriff's report about Dr. Kirkpatrick's death.[23] The VA OIG specifically pointed out "the voluminous amounts and types of marijuana and what

[15] *See* VA OIG white paper, *supra* note 6, at 9-10.
[16] *Id.* at 10.
[17] Noelle A. Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Exhibits T1-T12 [hereinafter "Noelle Johnson MSPB File"].
[18] Noelle Johnson MSPB File, Attachment N4
[19] *Id.*, Tab 16
[20] VA OIG white paper, *supra* note 6, at 8.
[21] VA OIG administrative closure, *supra* note 14, at 2
[22] *Id.*
[23] VA OIG white paper, *supra* note 6, at 8.

appears [*sic*] to be other illegal substances found in Dr. Kirkpatrick's residence."[24] The VA OIG concluded:

> The evidence indicates that Dr. Kirkpatrick was likely not only to have been using but also distributing the marijuana and other illegal substances. The Sheriff's report also lists large amounts of various prescription drugs found onsite, some of which were lying around loose with no indication whether they were prescribed for Dr. Kirkpatrick and, if so, when and by what provider.[25]

I do not understand why the VA OIG would cite this information in its white paper—information that is irrelevant and vastly out of context to the Dr. Kirkpatrick's criticism of the Tomah VAMC prescribing practices and his death—except in a desperate attempt to discredit Dr. Kirkpatrick by implying he was a drug dealer.

Curiously, although the VA OIG recommended a "thorough" review of the Sheriff's file, it omits other information in the file—information that has a direct relationship to the circumstances at the Tomah VAMC and the VA OIG's health care inspection. The file contains an April 2009 counseling memorandum that Dr. Kirkpatrick received from his immediate supervisor because Dr. Kirkpatrick "criticized" a physician's assistant and raised questions about medications that veterans were prescribed.[26] The allegations in the written counseling were made to Dr. Kirkpatrick's supervisor by Dr. Houlihan.[27] The file also contains Dr. Kirkpatrick's response to the counseling memorandum in which he explained that he questioned the physician's assistant on medications because he and several other staff members at the Tomah VAMC "notic[ed] changes in demeanor in our patients."[28] He added that he believed "it is important there be a dialogue between providers [regarding medication] so as to best serve our patients."

Also within the Juneau County Sheriff's file are union documents that describe concerns with opioid over-prescription at the Tomah VAMC. One document from the spring of 2009 specifically references Dr. Houlihan's nickname as the "Candy Man" and concerns that "[v]eterans served at this facility are prescribed large quantities of narcotics."[29] Communications between the union and Dr. Kirkpatrick indicate that he was perplexed by the allegations that it was "inappropriate somehow in discussing medications that patients [both Dr. Kirkpatrick and the physician's assistant] see are prescribed."[30] He added that the situation placed him in an "ethical dilemma" and the fact that his discipline came months after he questioned the prescription protocols of Dr. Houlihan was "open to interpretation."[31] Dr. Kirkpatrick concluded

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[24] *Id.* at 8-9.
[25] *Id.* at 9.
[26] Memorandum from Dr. Gary J. Loethen to Christopher M. Kirkpatrick, Apr. 30, 2009.
[27] *Id.*
[28] Letter from Christopher Kirkpatrick to Dr. Gary J. Loethen, May 13, 2009.
[29] Letter from Am. Fed'n of Gov't Emps Local 1882 AFL-CIO to Ben Balkum, Apr. 17, 2009.
[30] E-mail from Christopher Kirkpatrick to Am. Fed'n of Gov't Emps. Local 7 Leadership, Apr. 23, 2009.
[31] *Id.*

that, based on what fellow employees of the Tomah VAMC told him, he had "every reason to be afraid of Dr. Houlihan" and he asked the union for help.[32]

It is beyond belief that the VA OIG could perform a "thorough" review of the Sheriff's investigative file, seemingly ignore the evidence with any actual merit to the subject of its inspection, and instead focus solely on information to attempt to discredit a deceased witness. Both the administrative closure and the white paper acknowledged the fact that the VA OIG reviewed material relating to Dr. Kirkpatrick's death during the health care inspection at the Tomah VAMC. However, the only analysis of this information, which the VA OIG offers with scant evidence, appears to consist of blaming Dr. Kirkpatrick and implying that drug use contributed to his death. Nowhere does the VA OIG discuss the actual evidence in the Juneau County Sheriff's file relevant to the subject matter of its inspection of the Tomah VAMC.

3. The Simcakoski Family

The VA OIG's white paper also attempted to discount the testimony of the family of Jason Simcakoski, a Marine veteran who died of "mixed drug toxicity" at the Tomah VAMC.[33] In the white paper, the VA OIG states that "testimony of the family of Jason Simcakoski was limited to their knowledge of his care, not the care of veterans in general at the Tomah VA medical center."[34] I do not understand why the VA OIG would believe that information about Jason Simcakoski's treatment at the Tomah VAMC has no relevance to "the care of veterans in general." I can think of no better source of information on the treatment of veterans at the Tomah VAMC than the veterans themselves and their family members who have firsthand experience of treatment at the facility.

In addition, both Marvin Simcakoski and Heather Simcakoski testified that their observance of Jason's care occurred *during* the period of the VA OIG's health care inspection. Marvin Simcakoski, who played a large role in helping his son navigate the struggles of post-traumatic stress disorder and addiction, testified that he had "argued with Jason's doctors for the last four years about them overmedicating him."[35] He recounted an instance in which VA doctors "sent [Jason] a three-month supply of lorazepam and [Jason] took them all in four days and almost died."[36] Jason's widow, Heather Simcakoski, testified that in 2013—during the VA OIG's health care inspection—Jason communicated with the Federal Bureau of Investigation, the Tomah VAMC police, and the Tomah municipal police about veterans at the Tomah VAMC selling their prescription medications.[37] The white paper fails to note any of this information.

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[32] *Id.*
[33] *Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications": J. Hearing before the S. Comm. on Homeland Security & Governmental Affairs & the H. Comm. on Veterans' Affairs*, 114th Cong. (2015).
[34] VA OIG white paper, *supra* note 6, at 3.
[35] Tomah field hearing, *supra* note 11 (testimony of Marvin Simcakoski).
[36] *Id.*
[37] *Id.* (testimony of Heather Simcakoski).

It is beyond disappointing that the VA OIG has gone to such lengths in its attempt to discredit and downplay the firsthand experiences of the Simcakoski family. Jason's widow and father lived the nightmare of watching Jason battle the demons of addiction. It is insulting that the VA OIG would conclude that they have no "personal knowledge of the facts and circumstances" of the Tomah VAMC.

4. The Baer Family

The VA OIG in the white paper attempted to discount the critical testimony of Candace Delis, the daughter of Thomas Baer, by stating that "Mr. Baer had not been seen or treated at the Tomah VAMC for over 30 years."[38] I am unclear why the VA OIG believes that Mr. Baer's infrequent treatment at the Tomah VAMC disqualifies his family from testifying about his treatment at the facility on January 12, 2015. Ms. Delis accompanied Mr. Baer to the Tomah VAMC and was present during his treatment. The thirty-year gap between his visits to the facility is simply irrelevant. Even a patient on his or her first visit to the Tomah VAMC is an authority for evaluating the treatment he or she received; it does not take multiple or frequent visits to develop a basis for an opinion about the treatment and the VA facility.

5. Ryan Honl

In the white paper, the VA OIG further attempted to discredit former Tomah VAMC employee Ryan Honl by stating that he had no personal knowledge of narcotic over-prescription.[39] The VA OIG neglects to mention Honl's testimony about a culture of fear at the facility. Indeed, Honl testified that his initial complaints to the VA OIG were "centered on a hostile work environment that tolerated fraud and abuse."[40] He continued: "There is a culture in the VA where cronyism runs rampant leaving incompetence in charge at all levels that tolerates unethical practices."[41] Certainly, from Honl's tenure working at the Tomah VAMC, he has firsthand experience about the culture of fear and abuse of authority—an apparent focus of the VA OIG's inspection. To discount Honl's testimony on such narrow grounds indicates a tainted and slanted perspective within the VA OIG. Even the VA, after only a month of investigation, confirmed that a culture of fear existed within the Tomah VAMC.[42]

b. The VA OIG's white paper includes misleading statements about the Committee's involvement concerning the Tomah VAMC.

The VA OIG also resorted to attacking the Committee and me in particular. It asserts that "although Senator Johnson and his staff have publically criticized our findings, neither he nor any other Member of this Committee has requested to be personally briefed regarding the

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[38] VA OIG white paper, *supra* note 6, at 3.
[39] *Id.*
[40] Tomah field hearing, *supra* note 11 (testimony of Ryan Honl).
[41] *Id.*
[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.

allegations, our inspection, our findings, and supporting evidence."[43] This statement is extraordinarily misleading in several regards.

First, in early February 2015, my staff requested and received a detailed briefing from Dr. John Daigh, Dr. Alan Mallinger, and Catherine Gromek about the VA OIG's inspection of the Tomah VAMC, its findings, and the supporting evidence.[44] In fact, it was during this meeting that the Committee first learned of the existence of supporting material gathered by VA OIG investigators in the course of conducting the inspection. My staff had another meeting with VA OIG staff, including Maureen Regan, on February 18, specifically to discuss the inspection and the supporting evidence.[45] It was at this meeting that VA OIG staff alluded to the Committee that the VA OIG would not voluntarily produce the supporting evidence.

Second, I met personally on March 2, 2015, with the former Deputy Inspector General Griffin.[46] I expected at this meeting to discuss the work of the VA OIG in its Tomah VAMC inspection. However when we met, he offered no information about the allegations at the Tomah VAMC, the inspection, findings, or the supporting evidence. Instead, Mr. Griffin used the meeting to question the Committee's reasons for examining the Tomah VAMC, to complain about my staff, and to attempt to persuade me to give up the inquiry. In short, I gave him an opportunity to personally brief me on the inspection, and he declined to do so.

Since then, the focus of the Committee's investigation has been precisely what the white paper accuses me of neglecting—a search for the evidence supporting the allegations, inspection, and findings. The VA OIG has refused to produce the evidence supporting the inspection. It is a curious position to take—to criticize me on the one hand for allegedly not examining the VA OIG inspection and the evidence supporting it, while on the other hand refusing to produce the very same supporting evidence requested and subpoenaed by the Committee.

Finally, in its white paper, the VA OIG implied I was personally aware of the allegations surrounding the Tomah VAMC as early as 2011.[47] In support of this accusation, the VA OIG cited to testimony and a letter from an unnamed individual,[48] but the VA OIG has no real evidence—other than rumor and innuendo—that my office received the complaint in 2011. As I have stated before, this assertion is untrue. When I did first learn of the tragedies at the Tomah VAMC in January 2015, I directed my staff to immediately begin an investigation. I can only assume that the motivation of the VA OIG in making this accusation against me is to deflect criticism from the OIG. Similar to how the VA OIG shamelessly attacked whistleblowers and family members of the victims of the Tomah VAMC, the VA OIG appears to be attacking me in an attempt to discredit my committee's investigation.

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[43] VA OIG white paper, *supra* note 6, at 1.
[44] Meeting between Comm. staff and Dep't of Vet. Affairs Off. of Inspector Gen. staff (Feb. 4, 2015).
[45] Meeting between Comm. staff and Dep't of Vet. Affairs Off. of Inspector Gen. staff (Feb. 18, 2015).
[46] Meeting between Ron Johnson, S. Comm. on Homeland Sec. & Governmental Affairs, & Richard J. Griffin, Dep't of Vet. Affairs Off. of Inspector Gen. (Mar. 2, 2015).
[47] VA OIG white paper, *supra* note 6, at 2.
[48] *Id.*

c. The VA OIG's white paper artificially narrows the scope of the Committee's investigation, thereby raising serious concerns about the VA OIG's inspection.

The white paper artificially and erroneously narrows the scope of the Committee's investigation to argue that the VA OIG has fully complied with the Committee's oversight. The VA OIG's entire white paper purports to be a "summary of the evidence as it relates to what Senator Johnson has articulated to be the scope of his investigation in this matter."[49] In reality, the white paper consists of a flimsy defense by cherry-picking statements that I have made about the Tomah VAMC. As I have explained to Mr. Griffin in writing several times previously, the Committee is conducting a broad investigation of circumstances relating to the Tomah VAMC, including allegations of veterans deaths, retaliation against whistleblowers, a culture of fear among employees, opioid over-prescription, abuse of authority, and the VA OIG's health care inspection.

However, even among the issues that the VA OIG defines as the scope of the Committee's investigation, there are several areas of concern that demand the Committee's oversight of the VA OIG and the Tomah VAMC.

1. Who Knew What and When

The VA OIG claims that the Committee's investigation is limited to "who knew what and when." I am certainly interested in better understanding how far back the problems extend at the Tomah VAMC and why no serious actions had been taken by officials—in the VA and the VA OIG—to address them. But from the VA OIG's white paper, I am concerned that the VA OIG does not share this goal. In particular, the white paper states that it was "not necessary" during the VA OIG's inspection to determine who knew what and when.[50] This statement suggests a fundamental weakness and a lack of rigor with the VA OIG's inspection.

The white paper acknowledged that the VA OIG received allegations of misconduct at the Tomah VAMC in March 2011.[51] The VA OIG received these allegations from a Marine Corps veteran who worked at the Tomah VAMC.[52] In three separate communications, the veteran relayed serious allegations including overdose deaths, drug diversion, and Dr. Houlihan's prescribing practices, specifically referencing the mixture of opioids, benzodiazepines and amphetamines.[53] The veteran included news articles that outlined veteran deaths and arrests for alleged drug diversion dating back to 2009.[54] Both the VA OIG's criminal and health care inspection divisions declined to review the case,[55] and the allegations were ultimately investigated by VA's regional Veterans Integrated Service Network 12 (VISN 12).[56]

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[49] *Id.* at 1.
[50] *Id.* at 2
[51] *Id.*
[52] Dep't of Vet. Affairs Off. of Inspector Gen. production of pursuant to S. Comm. on Homeland Security and Governmental Affairs subpoena (Apr. 29, 2015) at bates number 1511 [herein after "subpoenaed documents"].
[53] *See id.* at 1402, 1405-08, 1511.
[54] *Id.* at 1419-1433.
[55] *Id.* at 1377.
[56] *Id.* at 1438.

The VA OIG eventually conducted a review of the Tomah VAMC based on a Hotline complaint it received in August 2011. During this review of the facility, VA OIG inspectors examined events dating back to at least 2009. According to the administrative closure, the VA OIG reviewed the "OIG Master Case Index records of 19 cases at Tomah VAMC since 2009."[57]

Given that the VA OIG inspection of the Tomah VAMC examined events dating back to at least 2009, I am troubled by the statement that "because [the VA OIG] did not substantiate the Hotline allegations [from August 2011], it was not necessary for the inspectors to determine who knew what and when for the purpose of holding people accountable."[58] This conclusion begs the question—how do you substantiate allegations if you do not even attempt to construct a timeline of wrongdoing during an investigation? The examination of who knew what and when is a basic, crucial, part of any investigation. The Committee will continue this part of its investigation.

2. Allegations of drug diversion

The OIG's white paper states that "drug diversion was not identified as an issue being addressed in Senator Johnson's investigation."[59] To the contrary, my first letter to VA Secretary Robert McDonald, dated February 4, 2015, requested several categories of material about potential drug diversion at the Tomah VAMC.[60] In addition, the VA OIG provided an unsolicited response to another request I made to the VA about potential drug diversion.[61] In the white paper, however, the VA OIG stated that it investigated no cases of drug diversion involving the Tomah VAMC. This statement contradicts other documents obtained by the Committee.

According to documents obtained by 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.[62] These documents show that as of August 2011, DEA investigators 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."[63] In April 2012, a VA OIG criminal investigator met with the DEA investigators, during which the DEA confirmed that "they had initiated a diversion investigation in regards to the Tomah VAMC and local area veterans in Tomah, and that they would cooperate

[57] VA OIG administrative closure, *supra* note 14.
[58] VA OIG white paper, *supra* note 6, at 2
[59] *Id.* at 7.
[60] Letter from Ron Johnson, S. Comm. on Homeland Sec. & Governmental Affairs, to Robert McDonald, Dep't of Vet. Affairs (Feb. 4, 2015).
[61] Letter from Richard J. Griffin, Dep't of Vet. Affairs Off. of Inspector Gen., to Ron Johnson, S. Comm. on Homeland Sec. & Governmental Affairs (May 8, 2015).
[62] *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.
[63] See *MCI Search Results MCI# 2011-04212-DC-0252*, subpoenaed documents, *supra* note 52, at 1392.

with the VA OIG investigation."[64] Later, in April 2012, a VA OIG investigator, along with DEA investigators and a Tomah police detective, interviewed a Tomah VAMC employee.[65] The employee told them 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 to step forward and/or speak their minds."[66] The employee also said that particular patients of Dr. Houlihan frequently requested early refills in conjunction with their high prescription rates of narcotics.[67]

I hope you are as concerned as I am by the VA OIG's statement in the white paper that it investigated no cases of drug diversion concerning the Tomah VAMC when these documents show that a VA OIG investigator actively worked with other law-enforcement officials to investigate potential drug diversion at the facility.

3. Culture of fear at the Tomah VAMC

The VA OIG office attempted in the white paper to characterize the Committee's investigation as limited to the examination of "culture of fear" at the Tomah VAMC, and it explained that the VA OIG health care inspection did not address the issue. The VA OIG also noted, however, that while "some individuals expressed that they had some level of fear, . . . it was based primarily on gossip, rumor, and hearsay, not personal experiences or fact."[68] This statement, too, contradicts other information known to the Committee.

The VA OIG in the white paper claims that it found no witnesses with "any direct negative personal experiences with Dr. Houlihan" relating to a culture of fear.[69] Yet, the VA OIG then cited firsthand evidence 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.[70]

Thus, the testimony that the VA OIG cited to attack Ms. Johnson and undermine her credibility *directly supports her account*. I am perplexed by the VA OIG's use of these logical and

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[64] *Id.*
[65] See *MCI Search Results MCI# 2011-04212-DC-0252*, subpoenaed documents, *supra* note 52, at 1393; *See also* interview between Greg Porter, et al. and "Anonymous Tomah VAMC Employee, Apr. 25, 2012, subpoenaed documents, *supra* note 52, at 1475-76.
[66] Interview between Greg Porter, et al. and "Anonymous Tomah VAMC Employee, Apr. 25, 2012, subpoenaed documents at 1476.
[67] See *MCI Search Results MCI# 2011-04212-DC-0252*, subpoenaed documents, *supra* note 52, at 1393
[68] VA OIG white paper, *supra* note 6, at 10.
[69] *Id.* at 11.
[70] *Id.*

rhetorical summersaults. The white paper rejected this negative firsthand evidence by citing other evidence that Dr. Houlihan is "quite nice" and "not a rude person at all."[71] However, it failed to explain why it discredited the negative evidence suggesting a culture of fear—with at least three examples of yelling—in favor of contrary evidence. Notably, while the VA OIG's multi-year inspection did not "substantiate" a culture of fear, the VA's own month-long investigation substantiated the allegation in March 2015.[72] This discrepancy is of significant concern to me and necessitates continued oversight by the Committee.

4. The Committee's subpoena is not "significantly broader" than the records the Committee have been requesting for months.

Mr. Griffin's cover letter to me accompanying the white paper accused the Committee of "significantly" broadening the scope of its subpoena over previous requests.[73] However, my requests to the VA OIG have been consistent. In our interactions with the VA OIG, my staff and I have consistently asked for the entire VA OIG case file since February 4, 2015. The subpoena reflects the Committee's longstanding request for the VA OIG's entire case file relating to the Tomah VAMC health care inspection.

As the Committee has become aware of additional information pertaining to the Committee's investigation, I have requested that material as well. For that reason, when the Committee became aware of the existence of 140 previously-unreleased healthcare inspections, I asked the VA OIG to produce the reports to the Committee.[74] Those reports were not produced as requested— but instead were posted as redacted copies on the VA OIG website—and therefore I included an item in the subpoena requiring the VA OIG to produce all administratively closed reports.

The unprecedented attempts to artificially redefine the scope of the Committee's investigation are unnecessary and counterproductive. The congressional power of inquiry and the processes to enforce it is "an essential and appropriate auxiliary of the legislative function."[75] The Supreme Court has 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."[76] It is the prerogative of the Committee—and not the VA OIG—to define the scope its investigation into the circumstances surrounding the Tomah VAMC. While the VA OIG's three-year health care inspection is an important piece of the much-larger inquiry, it is by no means the entire scope of the Committee's review. However, based on the information

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[71] *Id.*
[72] *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.
[73] Letter from Richard J. Griffin, Dep't of Vet. Affairs Off. of Inspector Gen., to Ron Johnson, S. Comm. on Homeland Sec. & Governmental Affairs (June 4, 2015).
[74] Letter from Ron Johnson, S. Comm. on Homeland Security & Governmental Affairs, to Richard J. Griffin, Dep't of Vet. Affairs Office of Inspector Gen. (Mar. 17, 2015)
[75] *McGrain v. Daugherty*, 273 U.S. 135, 174 (1927).
[76] *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)).

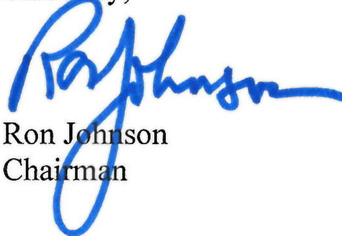
known at this time, the Committee has significant and growing concerns about the VA OIG's health care inspection of the Tomah VAMC.

d. Conclusion

The VA OIG's unsolicited white paper attacked the victims and whistleblowers of the Tomah VAMC, mischaracterized the Committee's investigation, and exhibited a serious disregard for Congressional oversight. The assertions in this white paper are inappropriate, counterproductive, and without merit. That this unusual document was created by an inspector general's office makes it all the more confounding. Even more troubling, the VA OIG prepared, transmitted, and publicized this white paper at the same time that it consciously had failed to comply fully with the Committee's subpoena.

As you assume your new duties leading the VA OIG, I hope that you will attempt to restore trust in the VA OIG. I urge you to reconsider the VA OIG's contemptuous posture with respect to the Committee's investigation, as shown in the VA OIG's white paper, and join me in working to bring transparency and accountability for our nation's veterans. Thank you for your attention to this important matter.

Sincerely,



Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Member