PERKINSCOIE

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FROM: Marc E. Elias
Jonathan S. Berkon

RE: **Report on Senator Baldwin's Office Response to Tomah Whistleblower Complaints**

In 2014, Senator Baldwin's office received complaints from whistleblowers alleging wrongdoing at the Tomah VA. In the course of responding to these complaints, Senator Baldwin's office sought and obtained a report issued by the Office of Inspector General ("OIG") that evaluated earlier allegations of wrongdoing at Tomah. Following the publication of an investigative report by the Center for Investigative Reporting on January 8, 2015 there has been public scrutiny of how Senator Baldwin's handled this matter, with the Republican Party of Wisconsin even alleging that Senator Baldwin's office "covered up" the OIG report. As more facts have come to light, scrutiny has shifted to how congressional offices in both parties have handled this matter.

In response, Senator Baldwin asked us to conduct an external review of how her office handled this matter. In the course of our review, we looked at internal office communications and correspondence that Senator Baldwin's office had with constituents and federal agencies. We also spoke directly with several members of Senator Baldwin's staff. This external review found nothing unethical and no effort to suppress information, but it did find that mistakes were made. While some things were done right, there was more that could have been done by staff to address the problems at Tomah. Our findings are below.

1. **There was no cover-up or any similar effort to suppress the whistleblower allegations or the OIG report.**

Senator Baldwin's office did not cover-up or make any similar effort to suppress the whistleblower allegations or the OIG report. To the contrary, a caseworker in Senator Baldwin's Milwaukee office confronted the VA facilities about the allegations and prompted the OIG to turn over a previously unpublished report.

Upon receiving the first whistleblower complaint from a Tomah VA facility employee in March 2014, Senator Baldwin's office requested in April that the Director of the Tomah VA Medical Center conduct a "full review and investigation" of allegations that a large percentage of veterans being treated for substance abuse are for substances that were originally prescribed by the VA and that medical staff at the Tomah VA facility utilized prescribing practices that were inconsistent with national standards.

After the Director of the Tomah VA Medical Center denied these allegations in a May letter, the office contacted several agencies, including the U.S. Department of Veterans Affairs Congressional Liaison and the VA OIG, in June again calling for a "full review and

investigation" of these allegations. A caseworker from Senator Baldwin's office had a telephone conference with the OIG in July, during which the OIG revealed that it had had completed an investigation into similar allegations in March 2014. The caseworker followed up with a written request to the OIG asking for a copy of the report.

After receiving the report on August 29, 2014, the caseworker provided a copy to the first whistleblower in early September. As a result of taking this action to provide it to the whistleblower, our understanding is that it was then shared with other whistleblowers and concerned citizens, and then the media, which helped uncover the full extent of the problems and misconduct at the facility. Without the work of Senator Baldwin's office to uncover the report and share it with the first whistleblower, it might have taken longer for the problems at the Tomah VA facility to come to public light.

2. For too long, the constituent services team did not effectively communicate their work on these complaints to senior staff in Wisconsin and Washington D.C.

Unfortunately, the constituent services team in Milwaukee did not effectively communicate their important work to Senator Baldwin's Wisconsin State Director and Washington D.C. staff. On July 1, 2014, Senator Baldwin visited the Tomah VA facility. Senator Baldwin's Chief of Staff had been pressing the staff to identify problems at Wisconsin VA facilities that could be addressed in the reform legislation moving through Congress following the Phoenix VA scandal. Prior to Senator Baldwin's trip, staff convened a conference call to go over issues that Senator Baldwin should discuss with facility administrators while at Tomah. Although the Deputy State Director for Constituent Services (Casework Supervisor) was on the call, she inexplicably failed to inform other staff about the whistleblower complaint, the office's correspondence with the Director of the Tomah VA Medical Center, the U.S. Department of Veterans Affairs Congressional Liaison, the VA Great Lakes Health Care System, VISN 12, or its initial communications with the OIG. As a result, Senator Baldwin was not made aware of this crucial information in advance of her visit to the Tomah facility in July.

Likewise, the constituent services team did not consult with the Senator's State Director or Washington D.C. staff prior to submitting the written request for the OIG report. The constituent services team did include a blurb about the telephone conference with OIG in its weekly constituent services report dated August 8. The blurb noted that the office had received a whistleblower complaint and that the OIG report (which had yet to be received by the office at this time) had substantiated the whistleblower's concerns. However, the blurb failed to note what those concerns were – specifically, the abnormal prescribing practices for veterans at the VA facility. Neither the State Director nor the Washington D.C. staff followed up on this blurb and the constituent services team did not inform anyone else when it received the OIG report in late August. As noted above, the caseworker simply provided the copy to the first whistleblower and, after failing to receive any additional correspondence from the whistleblower, closed the case. The constituent services team did not share the OIG report with the State Director and Washington D.C. staff until mid-November.

3. The office gave too much weight to the representations by the Office of Inspector General that the problems at the Tomah VA facility were being adequately addressed.

The OIG report found no "conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies" and, as a result, "[t]his inspection was originally administratively closed in March 2014 because we could make no conclusive finding of inappropriate prescription practices." The OIG had found that the "inspection raised potentially serious concerns that should be brought to the attention of VISN 12 management [Veteran Integrated Services Network] for further review." Specifically, "the amounts of opioid equivalents prescribed by [the medical staff in question] … were at considerable variance compared with most opioid prescribers in the VISN, and that a Tomah VAMC was likewise prescribing an unusually high total opioid amount." However, the OIG concluded in the end that while "the[se] allegations dealing with general overuse of narcotics at the facility may have had some merit, they do not constitute proof of wrongdoing."

On the July telephone conference, the OIG told Senator Baldwin's caseworker that the VISN director was taking a series of actions to remedy some of these issues – including peer review and personnel changes – and that this process was ongoing. OIG warned the caseworker that further intervention might have unintended consequences of disrupting patient care. At the time, the caseworker took these representations at face value and did not press any further. When the constituent services team finally provided the OIG report to the State Director and Washington D.C. staff in November, the caseworker noted that because the issues raised by the whistleblower and the report "were being addressed by the IG and VISN 12 network director, I believed that no further action from our office was necessary."

Likewise, when reading the report, the State Director and Chief of Staff also focused on the topline conclusion – no proof of wrongdoing, no substantiation of the majority of allegations, and no conclusive evidence affirming criminal activity, gross clinical incompetence or negligence, or administrative practices that were illegal or violated personnel policies. Accordingly, they did not make it a priority to independently verify the OIG's representations that the concerns about prescription practices were being addressed. In retrospect, this was a mistake.

4. The senior staff took too long to formulate an effective response.

As summarized above, the allegations made by the first whistleblower were handled like a standard constituent case. They were assigned to a caseworker who contacted government agencies to substantiate the constituent's allegations and provided the whistleblower with the OIG report. Hearing nothing further from the whistleblower, he closed the case. Treating the whistleblower's complaint simply as a constituent services matter was an error. The whistleblower was alleging widespread misconduct at a government facility, not an isolated problem that could be solved simply with casework efforts. It would have been appropriate to assign the matter to the legislative team or other senior staff in Washington D.C. from the outset.

Nonetheless, when it was given an opportunity to manage the situation in November, the senior staff took too long to formulate an effective response. The Chief of Staff and the State Director were alarmed that they had not received a copy of the report in August. They were even more disturbed that they had not been made aware of the whistleblower's allegations or the office's correspondence with the Tomah VA Medical Center before Senator Baldwin's visit to Tomah in July. They had expressed concern earlier in the year to the Deputy State Director for Constituent Services (Casework Supervisor) regarding her failure to prepare a standard casework manual or properly monitor the VA cases logged in the casework database.

The lack of communication about Tomah, combined with these earlier concerns, caused the Chief of Staff and State Director to focus their attention on building a comprehensive list of all VA-related complaints that had come into the office, rather than focusing like a laser on Tomah. While staff circulated some recommendations, many of these never reached Senator Baldwin. Those that did were not received until the eve of holiday break in December and were either similar to the office's prior actions or suggested deferring action until 2015, when new Senate Veterans Affairs Committee members would be able to focus on issues affecting Wisconsin VA facilities. They also focused on broader VA-related issues, rather than on the specific problems at Tomah.

It was not until the publication of the Center for Investigative Reporting's article on January 8 that the office first learned about the deaths of two Wisconsin veterans who were treated at the Tomah facility and fully understood the severity of the issues there. At that point, the office formulated an effective policy response, which has since been implemented on many levels.

5. The second whistleblower was not treated properly by the constituent services team.

In late September, a second whistleblower sent a message to the Senate office through its website reporting "grave concerns at the Tomah Veterans Affairs Medical Center concerning patient health and safety." The email was initially assigned to a legislative correspondent in the Washington D.C. office, but was then reassigned to the same caseworker who had handled the first whistleblower's complaint. As a result, the second whistleblower and the caseworker did not connect until late October.

In mid-November, the second whistleblower informed the caseworker that he had been made aware of the OIG report and wanted a copy. The second whistleblower reiterated that request two weeks later in an email to Senator Baldwin's caseworker and a staffer from Senator Johnson's office. It does not appear that the second whistleblower was ever provided with a copy of the report. This was inexplicable; there was no good reason to provide the report to one whistleblower but not the other. Moreover, the Deputy State Director for Constituent Services (Casework Supervisor) told the caseworker not to communicate with the second whistleblower and even suggested at one point that the office block his emails (thankfully, this did not happen). It was wrong to treat a constituent in this way.

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The bottom line is this: Senator Baldwin's staff took some important steps to investigate the abuses at Tomah VA, but then missed numerous chances to follow up and press for action.