

United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

WASHINGTON, DC 20510-6250

KEITH B. ASHDOWN, STAFF DIRECTOR
GABRIELLE A. BATKIN, MINORITY STAFF DIRECTOR

April 20, 2015

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

Dear Secretary McDonald:

The Committee on Homeland Security and Governmental Affairs has been investigating the tragedies that have occurred at the Department of Veterans Affairs Medical Center in Tomah, Wisconsin (Tomah VAMC). During the course of its investigation, the Committee has learned that a former employee at the facility, Dr. Christopher Kirkpatrick, committed suicide on July 14, 2009—the same day he was terminated from the Tomah VAMC. There are many questions surrounding Dr. Kirkpatrick’s termination from the Tomah VAMC and death. Accordingly, I write to request information about Dr. Kirkpatrick’s termination from the Tomah VAMC and death.

Given the numerous reports of whistleblower retaliation at the Tomah VAMC, the timeline of events surrounding Dr. Kirkpatrick’s termination at the Tomah VAMC is disturbing. On April 30, 2009, Dr. Kirkpatrick received a “written counseling” from his immediate supervisor alleging that Dr. Kirkpatrick “criticized” a physician’s assistant (PA) and raised questions about medications that veterans were prescribed.¹ The written counseling “cautioned [Dr. Kirkpatrick] about engaging in any future criticisms of the PA and . . . cautioned that he should avoid advising on medications as it is not in the scope of his practice.”² The allegations in the written counseling were made to Dr. Kirkpatrick’s supervisor by the Tomah VAMC’s Chief of Staff, Dr. David Houlihan.³

Dr. Kirkpatrick wrote his immediate supervisor on May 13, 2009, responding to the April 30 written counseling. Dr. Kirkpatrick explained that he questioned the PA on medications because he and several other staff members at the Tomah VAMC “notic[ed] changes in demeanor in our patients.”⁴ He added that he believed “it is important there be a dialogue between providers [regarding medication] so as to best serve our patients.”⁵

In addition, Dr. Kirkpatrick contacted his union’s leadership to discuss the accusations brought against him. Dr. Kirkpatrick informed the union president that the PA alleged that Dr.

¹ Memorandum from Dr. Gary J. Loethen to Chris M. Kirkpatrick, Apr. 30, 2009.

² *Id.*

³ *Id.*

⁴ Letter from Chris Kirkpatrick to Dr. Gary J. Loethen, May 13, 2009.

⁵ *Id.*

Kirkpatrick was “inappropriate somehow in discussing medications that patients [both Dr. Kirkpatrick and the PA] see are prescribed.”⁶ He added that his conversations with the PA about medications occurred months before the written counseling was issued. Dr. Kirkpatrick wrote that the situation he encountered put him in “an ethical dilemma” and said that the fact that he questioned the medication protocols of Dr. Houlihan’s patients became an issue months after those conversations occurred was “open to interpretation.”⁷ He concluded 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.⁸

Dr. Kirkpatrick’s termination appears to be based almost entirely on pretext as he was fired for committing minor, mundane infractions. The July 14, 2014 memorandum informing Dr. Kirkpatrick of his termination stated that Dr. Kirkpatrick was fired due to “performance issues.”⁹ The memo gave no further explanation of the reasons for Dr. Kirkpatrick’s termination and was neither signed by Dr. Kirkpatrick nor his union representation. According to union documents, the meeting where Dr. Kirkpatrick was fired was “gruesome” and it was “apparent [that] the COS [Dr. Houlihan] was behind the termination.”¹⁰

During the meeting, Dr. Kirkpatrick reportedly said, “I know why this is happening, it’s because of the note I put in [a veteran’s] chart. He was difficult and violent. He didn’t belong in the program. He stood at my office door and told me he intended to do harm to me and my dog.”¹¹ Members of Dr. Kirkpatrick’s family have told Committee staff that a veteran threatened Dr. Kirkpatrick and his dog. Apparently the veteran who made these threats was supposed to be discharged from the Tomah VAMC, but never was.

Tragically, it appears that Dr. Kirkpatrick may have been foreshadowing his suicide during and after his termination meeting. During the meeting, Dr. Kirkpatrick reportedly told human resources representatives, “you are killing me!”¹² After the meeting, Dr. Kirkpatrick reportedly told his union’s leadership, “this is going to kill me.”¹³ He repeated his concern to the union leadership over the reported threat he received from the veteran saying, “I can’t even begin to tell you what the [veteran] said [they were] going to do to me and my dog.”¹⁴ In the parking lot, Dr. Kirkpatrick reportedly asked the union to “try and get a support system so that no one else has to go through what I did.”¹⁵ Tragically, Dr. Kirkpatrick was found dead his apartment that evening of a self-inflicted gunshot wound.

⁶ E-mail from Chris Kirkpatrick to AFGE Local 7 Leadership, Apr. 23, 2009.

⁷ *Id.*

⁸ *Id.*

⁹ Memorandum from Wayne Davis, Manager, Great Lakes Human Resources Management Service, to Chris Kirkpatrick, Jul. 14, 2009.

¹⁰ Juneau County Sheriff’s Department, *CAD Operations Report*, Call No. 09-13258, Jul. 15, 2009, at 34.

¹¹ *Id.* at 35.

¹² *Id.* at 37

¹³ *Id.* at 38

¹⁴ *Id.*

¹⁵ *Id.* at 39.

It appears that the VA Office of Inspector General (OIG) was aware of allegations surrounding Dr. Kirkpatrick's suicide during its healthcare inspection of the Tomah VAMC. Specifically, according to the VA OIG's administratively closed healthcare inspection report, the VA OIG staff reviewed documents "related to the suicide of a Tomah VAMC mental health professional immediately following termination of employment."¹⁶ However, the suicide is not mentioned again in the 11-page inspection.

In order to gain a better understanding of the events surrounding Dr. Kirkpatrick's termination and subsequent suicide, I ask that you please provide the following information and material:

1. Please explain the VA's protocols for investigating the suicides of employees or recently-terminated employees.
2. Did the VA conduct an investigation into Dr. Kirkpatrick's termination and suicide? If so, please provide all documents and communications referring or relating to the VA's investigation of Dr. Kirkpatrick's termination and suicide. If not, why not?
3. Did the VA communicate with any law-enforcement agency about Dr. Kirkpatrick's termination and suicide? If so, please provide all documents and communications referring or relating to the VA's communications with law-enforcement about Dr. Kirkpatrick's termination and suicide.
4. On multiple occasions prior to his death, Dr. Kirkpatrick discussed a threat he received from a veteran. He mentioned that he marked the threat in that veteran's chart and asked his supervisors that the veteran be removed from the Tomah VAMC:
 - a. What are the VA's protocols for addressing threats patients make against staff? Were they followed in the case of Dr. Kirkpatrick?
 - b. Was the veteran who threatened Dr. Kirkpatrick removed from the Tomah VAMC? If so, when? If not, why not?
5. Please provide Dr. Kirkpatrick's employee file.
6. Please provide all documents and communications between or among VA employees referring or relating to Dr. Kirkpatrick's termination.
7. Please provide all documents and communications between or among VA employees referring or relating to Dr. Kirkpatrick's suicide.
8. Please provide all documents and communications between VA employees and the VA Office of Inspector General referring or relating to Dr. Kirkpatrick's termination

¹⁶ VA Office of Inspector General, *Administrative Closure Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority Tomah VA Medical Center, Tomah, WI*, MCI# 2011-04212-HI-0267

or suicide.

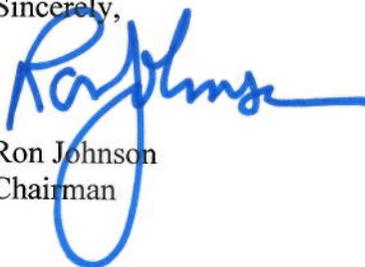
9. Please provide all documents and communications between VA employees and representatives from the American Federation of Government Employees union referring or relating to Dr. Kirkpatrick's termination or suicide.

Please provide this material as soon as possible but no later than 5:00 p.m. on May 4, 2015.

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."¹⁷ Additionally, 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"¹⁸ For purposes of responding to this request, please refer to the definitions and instructions in the enclosure.

If you have any questions about this request, please contact Kyle Brosnan of the Committee staff at (202) 224-4751. Thank you for your attention to this important matter.

Sincerely,



Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Member

Enclosure

¹⁷ S. Rule XXV(k); *see also* S. Res. 445, 108th Cong. (2004).

¹⁸ S. Res. 73 § 12, 114th Cong. (2015).