On behalf of our parents and entire family, we would like to thank the U.S. Senate Committee on Homeland Security and Governmental Affairs for holding this hearing titled "Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers."

It is our honor to speak today for our brother, Dr. Christopher Kirkpatrick, who was a psychologist and whistleblower at the Tomah VA Medical Center from September 14, 2008 – July 14, 2009. Chris was fired because he raised questions about the large amounts of narcotics ordered and given to the patients in the PTSD and Substance Abuse Programs. Later that same day, he committed suicide.

Through Chris's own words and written documentation provided by his Union Representative, Lin Ellinghuysen, are we now able to speak on his behalf today.

Chris relocated to Wisconsin in 2008 to accept a temporary position as a graduate psychologist at the Tomah VA Medical Center. He was required to obtain a minimum number of supervisory approved clinical hours, take the State Boards and become licensed within the first two years of his appointment. He was trained in treating Post Traumatic Stress Disorder (PTSD), substance abuse and chronic pain.

In an application for a psychology internship, Chris wrote: "Experiences have taught me to be grateful for being able to choose my own professional path. In reflecting on my life and finding myself closer to finally realizing my goal of becoming a clinical psychologist I am confident that I have chosen a path with heart, grateful that I have the ability to pursue a career that I find interesting and rewarding. I am interested in applying my energies in ways that will improve the lives of people, research with utility that will inform social policy, especially the effects of trauma on the brain and behavior."

He wrote: "I would very much like to make a career out of serving the men and women who have served our country. All of my previous clinical, educational and research experiences provide me with a unique skill set to serve this population."

Chris was passionate about his chosen profession and especially interested in the use of innovative treatments for PTSD. During an internship, he began a program for veterans using Yoga Nidra and held weekly classes which the veterans used to support their sleep. He also offered training to the medical residents and staff. In addition, Chris was also trained in and incorporated Integrative Restoration (iRest), Eye Movement Desensitization and Reprocessing therapy (EMDR) and meditation.

While at the Tomah VA Medical Center, Chris told us that he was concerned about the overmedication of many of his veteran patients and raised questions – therapy sessions that he was facilitating were not effective, because the veterans were not alert, lethargic/too impaired and drugged due to the overmedication side effects so he could not help them.

On April 21, 2009, he telephoned the Union Office expressing concern that he could "be in trouble" with the Chief of Staff (Dr. David Houlihan). Two days later, April 23, 2009, in an email to his Union Representative he wrote that he was told of an accusation made by a Physician Assistant (PA) that he "…was inappropriate somehow in discussing medications that patients [who] we both see are prescribed…" He noted that he did have conversations with this PA "...about medications and possible side effect/adverse reactions they [veterans] were experiencing…these situations put me into an ethical dilemma." He continued: "Based on what others have told me, I have every reason to be very afraid of Dr. Houlihan [Chief of Staff]. I have sacrificed a lot to move up here and do the kind of work I excel at and help people in. I need help."

On April 30, 2009, Chris received a Written Counseling from his immediate supervisor based on information received from the Chief of Staff, noting that he "…criticized the PA for doing psychotherapy, as well as for what medications the PA was prescribing for the veterans in the program." Chris was told he "...should not be 'educating' patients about what medications they are on." He was "…advised to focus on his own work, and counseled that he should avoid advising on medications as it is not in his scope of practice."

May 4, 2009, in an email to his Union Representative, "I'm still really concerned about things but will keep my head down and hope for the best. Thanks again for your help and encouragement!"

May 13, 2009, Chris wrote to his immediate supervisor responding to the April 30th Written Counseling "…soon after our PA had joined the team, I and several other staff had asked questions about medications after noticing changes in demeanor in our patients. I do not presume to prescribe medications but think it is important there be a dialogue between providers so as to best serve our patients. Patients have occasionally asked questions about their medications for

which I refer them to their physician or other provider. Though neuropsychology and neuropharmacology are areas I am trained in and very basic information about how drugs work is covered in classes I teach at the Victor Center I only address the most basic of these questions and defer more detailed questions to the veteran's provider."

On July 14, 2009, ten months after he was hired, Chris was directed to report to the human resources office. While speaking with his Union Representative that morning before the meeting, when the subject of a worst case scenario (termination) was mentioned, he stated, "Oh no, I can't survive that." Chris's employment at the Tomah VA Medical Center was terminated during this meeting, attended by the human resources representative, his two supervisors and Union Representative, effective two weeks later, July 28, 2009. Chris was told his services were no longer needed "due to performance issues." The following allegations were made:

1) it was stated that he left the hospital without requesting all of his vacation leave, to which Chris responded "You told me you did not have a bank of comp-time, but that I could keep track of the extra hours I worked beyond my regular tour and then, off the record, take the informal comp-time by doing what I did. I used vacation for 2:00-4:00 pm and left at 1:00 pm and told [Program Director]." He was told by several others that "this is what we do here," which his Union Representative indicated was a breach of Dept of Labor regulatory laws since he was a bargaining unit employee and should be paid or given legitimate comp-time for any time worked beyond his 8 hour day;
2) it was stated that one time he inaccurately wrote down his leave, which had to be corrected by the Secretary;
3) it was stated that when he brought his dog to work (prior permission received, possibly a Saturday) and his dog went to the bathroom, someone other than Chris cleaned it up;
4) it was stated that he was on vacation and sick leave more on Mondays and Fridays - Chris responded that this was the first time he was hearing that there was a "pattern" with his leave and if he was sick on Monday, he would still make sure he was there for group therapy Tuesdays, Wednesday & Thursdays.

Chris replied, "I've been in a bad way. I have been taking a few days off for self-preservation. I told you that I should not be taking on so many complex cases that I needed help. I don't have the emotional resources to cope with this stress. I've been dreaming; I wake up 2:00-4:00am, anxious. I'm imagining about patients all weekend. After what the guy [patient] said he was going to do to me and my dog, I had to take a day of vacation on Friday [July 10]. A person needs processing of this work; it's great stress. Having to handle this without support or debriefing is too much; but I won't abandon the guys who are genuinely here to be helped." Chris was dedicated to his patients. He continued, "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 this program. He stood at my [office] door and told me what he intended to do to harm me and my dog. I told you about this. The team decided this patient needed to be discharged and released

from the program. On Thursday [July 9] he was still here. I charted this." Please note, Chris took a vacation day on Friday, July 10th and used a sick day on Monday July 13th because that threatening patient was not discharged and still there. Chris was terminated that Tuesday, July 14th. It was reported that there was no response from Management to Chris's plea for help.

Chris continued, "I told all of you prior that due to the challenging cases that I should not be working with [patient] anymore due to his threats towards me. I have had no one to talk with about what this patient stated. It bothers me greatly when I hear what some of the veterans tell me. I am isolated and don't have anyone to talk with." He was a recent graduate psychologist, studying for his license, with a full patient load, facilitating the group therapies on his own, hearing in great detail about horrific events experienced by his patients but yet he had no guidance and support, despite going through the proper chain of command for assistance more than once.

Chris told his Union Representative that after he charted on Thursday, July 9th about the threatening patient and the team decided to discharge the patient, but the patient was not discharged, he was told, by the Program Director, "I wish you had not put that note in the chart." It was noted by the Union Representative that both of Chris's supervisors praised his professional clinical skills because there were no issues, but they continued with the mundane accusations.

"I would never leave the veterans without having coverage. I regret writing the note about the patient. Despite threats...he should not be in the program. I am so committed to this. I give 110%. Please – I have no one to talk with..."

When it was mentioned that he had been arriving late for groups, Chris replied: "Yes, that was an issue at that time where I would be coming to a point in psychotherapy where a traumatized patient was opening up and I couldn't break off the session until after processing…I have improved and within the past month I have not been late one time."

Chris stated towards the end of the meeting, "You are killing me! You are telling me I am getting fired for [nonsense] reasons when I know it's about what I charted last Thursday in the patient's chart." It is our understanding that clinical staff are instructed to document information about threatening behaviors for care planning and to forewarn other staff as a legal requirement and ethical professional practice.

Chris continued, "I gave up everything to come here. My girlfriend, my family, everything. This will devastate me." He was asked by human resources representative: "…what you meant when you said 'you are killing me?'" Chris replied: "Just a figure of speech."

Chris's Union Representative tried to get him two more months as a temporary employee but management would not comply. Chris knew it would be difficult to find new employment in his field after losing this job and without his license.

In Chris's office, as he was preparing to leave, he stated: "You just wouldn't believe some of the things I hear…it's awful…but, of course, I can't repeat it. Sometimes it really bothers me what I hear from the vets and what they have done; and, I can't tell anyone. I carry it with me – I wake up at 2am and I can't sleep. I can't even begin to tell you what the guy said he was going to do to me and my dog."

It was later that afternoon that my sister and I each received a call from the local sheriff's office to tell us that Chris was dead from a self-inflicted gunshot wound. We had to tell our father that Chris was gone and were there as he told our mother.

The Tomah VA Medical Center did not disclose the circumstances of Chris' termination as related in this testimony. We were told that he had "missed too many days."

His Union Representative has explained that since Chris was a temporary employee, he did not have a right to independent third party review of his termination or statutory appeal rights requiring management to show just cause for his removal. "Employees with temporary appointments and recent hires still on probationary status have very limited protections against retaliatory terminations, suspensions and other unwarranted personnel actions."

It was not until we were contacted by whistleblower Ryan Honl last winter who put us in contact with Chris's Union Representative, Lin Ellinghuysen, did our family hear the actual circumstances of Chris's experience at the Tomah VA Medical Center as relayed in this testimony.

One thing that we want to make clear: the police report that was mailed to us in September 2009 contained 16 pages, page 17 and on, in the police report, documents a visit made to the sheriff's office late July 2009 by a Tomah VA Medical Center employee to report "known threats" against Chris along with documentation and detailed notes and emails provided by Lin Ellinghuysen, which has been summarized in this testimony. Since Chris's voice can be heard in these papers, we find it ironic then that the VA OIG white paper used this same report to try to discredit him.

The VA OIG white paper report released in June 2015 "strongly" recommended a "thorough review" of the police report filed for our brother's death, stating that the "evidence" indicates Chris was a drug dealer. This accusation was beyond offensive and disturbing for our family. How dare they! The haphazard attempt to discredit and slander Chris was absolutely outrageous to us when our brother was merely questioning opioid abuse and concerns that the veterans were not being cared for properly. He is not here to defend himself, so we will. We want Chris's good name and reputation cleared.

There was no investigation of his death. Our family would like to know why.

Our brother felt helpless and hopeless with the obstacles he encountered at the Tomah VA Medical Center. He wanted to improve the quality of care for our nation's veterans through holistic options and continuously questioned the overmedication practices which hindered his ability to treat his patients. He felt his personal safety disregarded when his life was threatened by a patient who was never dismissed from the medical center. Even after expressing concerns with his complex case load, it appears that no assistance was given, his concerns were disregarded. He had finally reached his goal of becoming a clinical psychologist, studying to obtain his license, then was fired as retaliation for speaking up for what was ethical and right. But... he was only a temporary employee...he had no rights….

Please listen carefully to our brother's final words to his Union Representative, before he got into his car and drove out of the parking lot at the Tomah VA Medical Center for the last time:

"Try to get a support system so that no one else has to go through what I did! Will you please do that?"

In Dr. Christopher Kirkpatrick's memory and in support of all VA employees who work in highly stressful positions providing medical and mental health care to Veterans, we offer the following recommendations for change:

1. We urge Congress to mandate the development of a comprehensive support system for VA medical and mental health care professionals, that provide needed consultation services with trained professionals as part of their employment, and not to be seen as private treatment. These support services and consultations must maintain strict confidentiality. Currently, all that is offered at the Tomah VA are one or two sessions with a VA provided counselor; after that, employees are left to manage these very intense job duties on their own without time to debrief, refresh or regroup. Particularly, psychotherapy with Veterans is difficult and draining; and, can take a great deal out of a clinician emotionally and physically.

2. If not licensed when hired, (graduate) Psychologists are required to be licensed within two (2) years. They are not given time to prepare for the exam. Mentors could ensure there is appropriate patient care assignments –and- time set-aside for study. NOTE: Prep for exam requires 20hours/week of study time for 3-6 months.

As a graduate Psychologist, Chris was expected to counsel Veterans with complex needs, facilitate group therapy; participate in Care Planning Team Meetings --- along with all of the required reporting and documentation.

3. Develop VHA protocols for investigation of suicides of employees and recently terminated employees. The Tomah VA management and Police did not investigate Chris's death.

4. Develop VHA protocols for addressing threats patients make against staff.

5. We also request that lawmakers investigate the pervasive use of extended temporary appointments within the VA health care workforce, and the abusive use of terminations and other personnel actions against temporary and probationary employees, and mandate additional protections, both statutory and administrative for these most vulnerable employees who pay the heaviest price when they question the current way of doing things.

6. We urge Congress to take steps to ensure greater accountability for VA front line managers, mid-level managers and upper management who engage in retaliation against Whistleblowers and other front line employees who speak up for Veterans' needs.

7. Additionally, we urge Congress to review the current reporting structure for the Chief of Police at VA Medical Centers. Currently, they report to the Medical Center Director, rather than a separate entity that can address mismanagement or staff concerns without interference, such as the alleged illegal drug activity at Tomah.

8. We are thankful the Senators and Congressmen are addressing and putting into place checks and balances that will ensure the safe ordering of opioids as well as the development of guidelines for the safe combining of opioids with other addictive drugs in an earnest effort to keep Veterans safe.

9. Lastly but immensely important to our family, is our request that Chris's Official Personnel File and all information be sent to Sean Kirkpatrick. It is also requested that any and all Tomah VA Supervisory Notes, Reports of Contacts, etc., related to Christopher Kirkpatrick be sent to Sean Kirkpatrick.