Opening Statement of Senator Tammy Baldwin
"Tomah VAMC: Examining Patient Care and Abuse of Authority"

Tuesday, May 31, 2016

As submitted for the record:

Thank you, Chairman Johnson. I want to thank you for organizing this hearing today and I also want to add my words of appreciation to your staff, Senator Carper's staff and to my staff in terms of the undertaking that resulted this work product. It is a very significant investment on their part and we appreciate that.

I think the fact that we are both here again today sends an important message to this community that we share a bipartisan commitment to addressing problems at the Tomah VA and that we will continue to work across the partisan aisle in order to address the problems at the Tomah VA. In fact, I would describe it as, there is no aisle.

This weekend, I had the honor of attending a Memorial Day ceremony in Union Grove. Across Wisconsin and in communities across our nation, Americans joined together to pay tribute to everyday heroes who served and sacrificed to protect freedoms that we all cherish.

As Americans, we are united. We are united by an eternal bond with the families and friends of our fallen. We are also united by the sacred trust that we have with our veterans and their families.

I will say this, when you look into the eyes of our American patriots – our veterans, our service members or a family member who lost one to the ultimate sacrifice, you are reminded of the American values that hold us together. You are reminded of the values that define us as one nation united.

Today, as we hear the story of how that sacred trust with our veterans and their families has been broken, it's important for us to keep in mind what unites us.

One profound thing that I have learned about the tragic problems at the Tomah VA is that Veterans, their families and whistleblowers all want the same thing.

They want answers and accountability, but most importantly, they want solutions to the problems at the Tomah VA so that these tragedies never ever happen again.

What I am committed to is fixing what has been broken. What I am focused on is restoring the sacred trust we have with our veterans and their families.

The Committee's report makes clear much of what we have known for some time – the problems at the Tomah VA have had tragic and preventable consequences.

The report sheds light on the failures surrounding the deaths of Kraig Ferrington, Dr. Christopher Kirkpatrick, Jason Simcakoski and Thomas Baer. What this report can never do is repair the damage that their losses have had on their families, many of whom are here with us today.

The Committee's report also confirms the report released by the Department of Veterans Affairs Office of Inspector General last August that found the Tomah VA leadership and physicians entrusted with veterans care failed to keep their promise to a Wisconsin Marine and his family.

It's just as clear to me today, as it was a long time ago, that the VA prescribed Jason Simcakoski a deadly mix of drugs that led to his death. And those responsible at the Tomah VA for this tragic failure should have been held accountable long ago. In fact, they should have been held accountable before Jason's death.

The actions taken by the VA last September to replace Mario DeSanctis, the Director of the Tomah VA, were long overdue.

The actions taken by the VA last November to remove David Houlihan, the Tomah VA Chief of Staff, from federal employment and revoke his clinical privileges came tragically too late.

Both the VA and the VA Inspector General failed to do the job that we all expect them to do.

The result of this failure was a culture of abuse of authority, staff intimidation and retaliation by management of employees. The problem of improper prescribing practices, overmedication and high rates of dangerous drug combinations was simply not properly addressed as it should have been. The result of this failure was tragic.

The record is clear. For far too long, serious problems have existed at the Tomah VA and they were simply ignored or not taken as seriously as they should have been by the VA and the VA Inspector General.

My office was just one of many voices who were trying to expose the problems at the VA.

When my Senate office was first contacted in March 2014 with complaints about the Tomah VA, including prescribing practices, they came from an anonymous whistleblower, someone who still remains anonymous today.

We immediately brought those concerns to the Tomah VA and then to the VA Office of Inspector General, and then to the U.S. Department of Veterans Affairs headquarters in Washington D.C.

Four months prior to Jason's death, I called for a full review and investigation from the Tomah VA.

Two months prior to Jason's death, I called for a full review and investigation from the U.S. Department of Veterans Affairs and the VA Office of Inspector General.

On August 30, 2014, Jason tragically died at the Tomah VA as a result of what was medically deemed, “mixed drug toxicity.”

The Simcakoski family lost a son, a husband, a father, and we lost somebody who faithfully served his country.

If there is one thing that I want to come out of this hearing and one thing that comes from this report, I want it to be this.

I want everyone to hear the voice of Jason’s wife Heather, who has said, and I quote:

“*When I look back at the past, I want to know we made a difference. I want to believe we have leaders in our country who care. I want to inspire others to never give up because change is possible."*

Jason’s family, just like veterans and their families in this community and communities across Wisconsin, are not interested in finger pointing and a blame game. Neither am I.

That is why over the past year I have focused on solutions to problems at the VA.

I have worked across party lines to advance reforms that will improve transparency at the VA Office of Inspector General, to strengthen protections for whistleblowers and to provide stronger oversight of the VA’s prescribing practices.

I authored a reform that was recently signed into law which requires the VA Inspector General to submit reports to Congress and make them available to the public. That is the standard that must now be met.

More must be done to change the status quo at the VA. We must work to build a VA that embraces, rather than retaliates against, whistleblowers who want to improve the system. I have a tremendous amount of respect for the courage of whistleblowers that have come forward about problems at the VA.

Last year, I had the honor of working with Jason’s family to develop legislation to provide the VA with the tools it needs to help prevent this type of tragedy from occurring to other veterans and their families.

One year ago, I introduced this bipartisan legislation in Jason’s name that earned the support of many veterans service organizations and I’m so proud, Senator Johnson, to have you join in this effort.

I am pleased that House of Representatives recently passed a version of Jason’s bill and I am equally grateful to members of the Senate Committee on Veterans’ Affairs for their bipartisan support of Jason’s bill, the Jason Simcakoski Memorial Opioid Safety Act. It’s a critical reform and it continues to move forward. Families like Jason’s have a story to tell and it needs to be heard, and the movement of their legislation is strong evidence that their voice is being heard.

My goal is to put these reforms in place to prevent Jason's tragedy from ever happening to another veteran or any of our veterans' families.

Change is indeed possible. Heather's words have inspired me and it is my hope that they will inspire all of us to work together and prevent these problems and tragedies from ever happening again.

I thank you, Senator Johnson, for providing me with this opportunity to join you today. I look forward to continuing our work together.