WisGOP: Tammy Baldwin hiding from her role in the Tomah VA scandal

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Contact: Alec Zimmerman
(608) 257-4765

[Madison, WI] — Senator Tammy Baldwin is going to extreme lengths to cover up her disastrous role at the Tomah VA. Baldwin was the only Senator to receive an official government report showing the over-prescription of opioids at the Tomah VA, yet she failed to act on it. After it was discovered that she had the report, Baldwin did everything she could to cover the story up to save her political career.

Listen to the full story from 1130 WISN here or read more about it below:

The Terrible Truth About Tammy Baldwin and The Tomah VA

WISN
Dan O'Donnell
September 19, 2018

In September of 2011, Congressman Ron Kind received an anonymous letter detailing concerns about the over-prescription of opiate and opioid painkillers at the VA facility in Tomah. Almost immediately, Kind's office forwarded the letter to the Department of Veterans Affairs Inspector General's Office, which launched an investigation.

For three years, the Inspector General's office looked into prescription practices and eventually concluded that three different practitioners in Tomah ranked in the Top 10 in the region for most opiate prescriptions written. Even though the Tomah facility was tiny compared with much larger facilities in the Midwest–including those

in Milwaukee and Chicago–doctors there were prescribing opiate and opioid painkillers at a much higher rate.

Still, Dr. John Daigh, the Assistant Inspector General for Health Care Inspections, did not find conclusive evidence of criminal activity or illegal practices, so he closed the investigation in March of 2014 without releasing a public report. He did, however, release an "administrative closure" report to and briefed officials from the VA facilities in both Tomah and Chicago on his findings, which sounded the alarm about rampant over-prescription and unchecked drug-seeking behavior of patients.

At around the same time, a constituent contacted Senator Tammy Baldwin with concerns over prescription rates at the Tomah facility. On April 7th, Baldwin wrote to its medical director, Dr. Mario DeSanctis. He responded that everything was fine, but five months later, the VA Inspector General forwarded a copy of its damning report on the facility to Senator Baldwin's office.

The very next day, August 30th, 2014, a 35 year-old Marine Corps veteran named Jason Simcakoski died from an opiate overdose.

"There isn't a day that goes by when I don't relive that morning," Jason's father Marvin Simcakoski said at a hearing the next year. "I regret leaving my son in his room that morning, only to get a call hours later that he stopped breathing. I can't get that thought out of my head. I wish I would have been there for him. I loved Jason and still do with all my heart and miss him every day."

Jason's death also devastated a Tomah VA employee; a combat veteran (and former VA patient) named Ryan Honl, who had just started working as a secretary at the facility two weeks earlier. In the days after Simcakoski's death, Honl says his coworkers told him about major problems with over-prescription…and that the VA was covering them up.

"It hit me hard," he told WISN 12 News. "Just knowing that if the VA hadn't swept that under the rug, Jason would be alive today."

https://youtu.be/gr6fb5ZG5_o

A month later, Honl decided to blow the whistle on what he had seen and heard at the facility and contacted then-VA Secretary Robert McDonald as well as Wisconsin

Congressman Ron Kind and Senators Ron Johnson and Tammy Baldwin. Johnson's office opened a case file on the matter, but neither Kind nor Baldwin ever acted on the tip, with Kind saying it wasn't properly entered on his website and no one from his staff ever received the message.

Honl was furious and, after he quit working for the VA in disgust in mid-October, made it his mission to expose the problems there.

"If they're hiding reports and not giving upper leadership the full picture of the gravity of things–not just at Tomah but across the board–then what's going to happen is nothing," he later recalled.

And nothing did happen. But Honl was persistent and continued sending email after email hoping for an answer. Coincidentally, on Veteran's Day 2014, he learned from a friend that back in August Baldwin's office was sent a copy of the Inspector General report that he felt the VA was trying to hide. After persuading his friend to give him a copy of that report, Honl grew enraged by what he read.

He kept sending emails, but when they too went unanswered, he went public, sharing the Inspector General report with the Center for Investigative Reporting.

"The report verified everything people had been talking to me about since I blew the whistle," Honl said. "Excessive prescribing of narcotics, drug diversion, people not using their narcotics, a physician in 2009–Dr. Chris Kirkpatrick–who raised concerns about [Tomah VA Chief of Staff Dr. David] Houlihan's prescribing practices, was terminated, and went home and committed suicide."

https://youtu.be/Xq7aBKCqH6M

Eleven days after the Center for Investigative Reporting broke the story, USA TODAY revealed that Baldwin had obtained a copy of the IG report in August but had done nothing, even after a flood of emails from Honl.

"It is very disconcerting that a United States Senator would have been able to read the report and yet government still has allowed the Tomah leadership to ruin lives and run good doctors and physicians out of the facility," he wrote on Nov. 24.

The next day, he forwarded an article from Georgia about a vet hooked on

morphine saying: “This thing is going to hit home pretty soon in Tomah. Just making you aware.”

A week later, he emailed again recounting a conversation he had had with another member of Baldwin’s staff who he said told him to be patient and to let the senator’s staff “take your time doing something about it because there is a ‘process’ that must be followed.” Honl said Monday the aide also told him not to talk to the press.

That, it would seem, was an interesting request. Was there already an effort to keep the matter quiet since it was clear that Baldwin herself and her senior staff were not responding to the messages they had been receiving for a month?

“My question is, how long do veterans who are addicted to opiates at the Tomah VA, that are also flooding the streets of Tomah, have to wait to receive proper treatment,” he wrote Dec. 2. “When will Senator Baldwin say ‘enough is enough’ and push for better treatment of veterans and a better culture free of intimidation and retaliation in Tomah and VA wide for those who whistle-blow?

“Is it really going to take the media to shame Senator Baldwin and the VA to finally give veterans the proper care they deserve and employees a safe place to question leadership about unethical practices?”

On Dec. 4, Honl forwarded another article, this one about lawmakers in Minnesota calling for an investigation of a veterans’ facility there. “Do you think Senator Baldwin could step up and do what (they) did in Minnesota?” he wrote. On Dec. 21, he asked Helbick again to please make the senator aware of his suggestions.

When she still had not taken public action in December, Honl sent a message to her staffer with the subject line: “Final plea for Help from Senator Baldwin.”

“All we ask is that our senator publicly support our desire to have an open forum rather than remain silent publicly, which is what the VA does in hiding reports from the public,” Honl wrote.

Baldwin did not respond to any media inquiries after the story revealed her inaction, but in private, she was in panic mode. Her Chief of Staff, Bill Murat, flew in from Washington to try to quell the growing controversy and met with Honl in an effort to

placate him.

The blame, Murat explained, lay not with Senator Baldwin, but with her top aide in Wisconsin, a longtime Democratic Party operative named Marquette Baylor. She, not Baldwin, failed to respond to Honl's emails. She, not Baldwin, failed to act on the IG report.

And she, not Baldwin, should take the blame.

Baldwin's office fired Baylor on January 22nd and offered her a severance package in exchange for her silence. Two days later, Baldwin met with the family of Jason Simcakoski, the Marine who died a day after her office received the IG report.

"She said (she's) so sorry for our loss, and that she takes very serious those things, but not, 'Sorry for not reading the report,'" Simcakoski's widow Heather told USA TODAY.

On February 18th, as the controversy over her inaction continued to swirl, Baldwin hired attorney Marc Elias–a well-known Washington "fixer" who worked extensively with Hillary Clinton–to help with her crisis management.

Only after he was hired did she finally speak publicly about the scandal for the first time on February 25th…more than a month after her involvement was revealed.

https://youtu.be/LQXQnMs1G-Y

On March 13th, Baldwin released a report from Elias indicating that "mistakes were made" and punished two of her top aides, including Murat. As The Milwaukee Journal Sentinel reported:

Bill Murat, her veteran chief of staff, will take a one-time cut of more than $14,000 this year. He earns $169,000 annually.

In addition, Doug Hill will lose his job as Baldwin's state director to become her outreach boss. Hill's salary will be sliced from $131,300 annually to $80,800 a year — a cut of more than $50,000.

Earlier, Baldwin fired her deputy state director and bumped another staffer from

handling veterans issues for the Wisconsin Democrat. His pay was not reduced.

Baldwin hoped that this would be the last word on the matter, but the following month, Marquette Baylor filed an ethics complaint against her, alleging that Baldwin had used her as a scapegoat for her own inaction.

According to that complaint, Baylor and her staff in Baldwin's Milwaukee office acted on the IG report as soon as it came in on August 29th.

At my direction, a caseworker elevated the VA misconduct issue directly to the State Director, Doug Hill, and the Legislative Director, Daniel McCarthy. Months passed without critical guidance. Later, in November of 2014, I was informed of the VA OIG report regarding the over-prescription practices at the Tomah VA Medical Center. My staff and I immediately developed an action plan and sought approval from Hill, the State Director, and Murat, the Chief of Staff. Despite repeated requests for approval of the proposed action plan, our efforts were rejected by Murat. My staff and I eventually prepared memorandums directed to the Senator herself. These memorandums were either ignored by the Senator or were withheld from her by Murat.

Baylor was furious, alleging that "Senator Baldwin and her staff have disparaged the truth in order to cover up Murat's actions and to protect her political career.

"Had Murat, as the Chief of Staff, allowed me and other individuals to properly perform our roles, the issues surrounding the Tomah VA Medical Center would have been identified and addressed long ago," she wrote. "By attempting to place the blame at my feet, Senator Baldwin has concealed the truth, made false statements, and mischaracterized my service as the Deputy State Director.

"Her actions to cover up Murat's willful misconduct are unbecoming of a United States Senator. She has acted unethically."

Baylor responded directly to allegations in Elias' report that her team had failed to relay the IG report on to senior Baldwin staff.

A glaring defect in the report, however, is the inexplicable actions by Murat to prevent action on the VA issues identified in the November 24, 2015, December 12, 2015, and December 17, 2015 memorandums, including my persistent requests for

an action plan. Indeed, the report appears to excuse Murat for his obstructionism on the ground that the memorandums also touched on“broader VA-related issues.” Ultimately, the report states that “many” of our recommendations“never reached Senator Baldwin,” suggesting that the Senator did see at least some of our recommendations for action, yet did nothing.

In this, Baylor is correct. If some of the recommendations did reach Baldwin, as Elias’ report indicated, then why didn’t she act on them? Why did she do nothing even after receiving information that something was so amiss at the Tomah VA facility that her Milwaukee office was recommending action on it?

“Ultimately, it is telling that Elias and his firm never asked to interview me or submit questions about the circumstances and events surrounding the VA mistreatment issues,” Baylor added. “Their so-called ‘external’ review was bought and paid for by the Senator’s campaign, and the report they produced is a one-sided, incomplete, and misleading narrative of what occurred.”

Despite this firsthand account of Baldwin’s negligence, the Senate Ethics Committee dismissed Baylor’s complaint, finding that she did not “provide evidence of a violation of law.” With that high of a bar to clear for disciplinary action, it was unsurprising that Baldwin escaped punishment, but Baylor’s complaint painted a clear picture of a Senate office in disarray–far more concerned with image than action and desperately focused on self-preservation once threatened with the consequences of its inaction.

Just a day before that decision came down, memos obtained by USA TODAY showed that Baldwin’s inaction wasn’t the only inaction that allowed over-prescription in Tomah to continue:

Lin Ellinghuysen, president of the local chapter of the American Federation of Government Employees that represents Tomah employees, outlined the issues in an April 2009 memo that is marked as having been “hand-delivered” to Rep. Ron Kind, then-congressman Dave Obey and then-Sen. Russ Feingold.

“(M)any of the Veterans served at this facility are prescribed large quantities of narcotics,” she wrote, adding that it had become a “significant” and “serious” concern.

Ellinghuysen also said the center's chief of staff at the time, Dr. David Houlihan, was ordering as many as 1,000 narcotic tablets per month for a single patient, and that pharmacists who raised concerns were disciplined and fired."

Many of the patients call Dr. Houlihan 'The Candy Man' because of the easy access to narcotic drugs/medications at this facility," she wrote.

Like Baldwin years later, however, fellow Democrats Russ Feingold, Ron Kind, and Dave Obey did nothing, allowing the Candy Man to keep over-prescribing opiates until, eventually, over-prescription killed Jason Simcakoski.

Would he still be alive today had those Democrats acted on the report that had been hand-delivered to them? Could the over-prescriptions have been stopped had Senator Baldwin acted on the IG report as soon as her office had gotten it?

While those questions are likely to forever remain unanswered, Baldwin's negligent response to the scandal essentially ended with a fittingly quiet coda. In January of 2017, after the new Congress was sworn in and committee assignments were handed down, Baldwin quietly left the Senate Committee on Homeland Security and Governmental Affairs, which has direct oversight of the Tomah VA.

She didn't put out a press release or make a statement about why she was leaving; she simply abandoned her responsibility for oversight of the Tomah VA facility without any sort of an explanation.

It wasn't the first time she did so.

Then, while continuing to pay her "fixer" Marc Elias's firm, Perkins Coie, she went right back to damage control in preparation for her run for re-election. In early 2018, a pro-Baldwin Super PAC even started running ads touting her work on veterans and the VA.

https://youtu.be/BIVee9i40bM

Two months later, Baldwin herself sought to gain sympathy on the issue by talking for the first time about her late mother's opioid addiction.

https://youtu.be/L2EVKfn-pGk

Tellingly, Baldwin never mentioned the VA scandal during her discussions about her mother's addiction and none of the media outlets covering them pressed her on the issue and the obvious question it raised: Why, if Baldwin has such a deep, personal connection to opiate addiction did she turn a blind eye to opiate over-prescription in Tomah?

Her aide, Marquette Baylor, perhaps understanding this connection, said she worked tirelessly to get information about the IG report to Baldwin and to formulate an action plan. Why didn't Baldwin enact it even though the report she commissioned on the matter admitted that she had gotten at least some of Baylor's suggestions?

The answer appears to be painfully obvious. The discussion about her mother's addiction, like the Super PAC ads and Marc Elias's scapegoating of Baylor before them, were yet another attempt at deflecting blame for Baldwin's inaction.

The painful, terrible truth about Tammy Baldwin and the Tomah VA is that no matter the reason–whether indifference or negligence–Baldwin did nothing. She did nothing even though she was the only member of Congress who could have. She did nothing even though her office was the only one in Congress that knew everything in the damning IG report.

And an even more painful, more terrible truth about Tammy Baldwin and the Tomah VA is that she did nothing and then did everything she could to cover it up.