UNITED STATES SENATE **SELECT COMMITTEE ON ETHICS**

The Complaint of

REPUBLICAN PARTY OF WISCONSIN
JOE FADNESS

Complainants,

Against COMPLAINT

TAMMY BALDWIN

Respondent.

The Republican Party of Wisconsin, by and through its representative, Joe Fadness, brings this complaint against Tammy Baldwin and alleges as follows:

1. Tammy Baldwin, the junior United States Senator from Wisconsin, was sworn into office on January 3, 2013.

2. Baldwin previously served as the United States Representative from Wisconsin's 2nd Congressional District from 1999 to 2013.

3. According to a report published in the *Wisconsin State Journal*, in March 2014, Baldwin first became aware of issues of abuse and neglect by staff at the Veterans Affairs Medical Center in Tomah, Wisconsin, which ultimately led to a fatal overdose later in the year. *See* the *Wisconsin State Journal* report attached hereto as Exhibit A. (Baldwin, T. "U.S. Sen. Tammy Baldwin: We can do better for wisconsin's veterans". Wisconsin State Journal. 1/26/2015. Retrieved from http://host.madison.com/news/opinion/column/guest/u-s-sen-tammy-baldwin-we-can-do-better-for/article_06cb6b4b-6b86-526d-9e30-5947a8bd1d29.html#ixzz3RNHI17WH Accessed on 2/10/2015.)

4. Despite this, a report from *The Tomah Journal* notes that Baldwin visited the Tomah VA Medical Center facility on July 1st, 2014 and must have forgotten about alerts received on issues of abuse and neglect as Baldwin stated that the facility received "strong and positive reviews." *See* the *The Tomah Journal* report attached hereto as Exhibit B. (Rundio S. "Baldwin visits Tomah VAMC". The Tomah Journal. 7/2/2014. Retrieved from http://lacrossetribune.com/tomahjournal/news/local/baldwin-visits-tomah-vamc/article_2e45d876-c790-5acb-bbf6-beaec28af109.html. Accessed on 2/10/2015.)

5. A *Green Bay Press Gazette* article reported that Baldwin's office failed to act and later was the only member of Congress who received an inspection report from the Department of Veterans Affairs Office of Inspector General on August 29, 2014, which detailed unusual prescription practices by Tomah VA Medical Center caretakers. *See* the *Green Bay Press Gazette* article attached hereto as Exhibit C. (Slack, D. "Baldwin fires aide over Tomah VA report". Green Bay Press

Gazette. 1/27/2015. Retrieved from http://www.greenbaypressgazette.com/story/news/politics/2015/01/26/wisconsin-sen-tammy-baldwin-fires-aide-over-tomah-va-report/22349889/. Accessed on 2/10/2015.)

6. Baldwin did not pursue any action after reviewing the inspection report's detailed outline of problems existing at the Tomah VA Medical Center, as reported by the *Milwaukee Journal Sentinel*. *See* the report from the *Milwaukee Journal Sentinel* article attached hereto as Exhibit D. (Bice, D. "State investigating doctor, two others in Tomah VA Case. Journal Sentinel. 1/31/2015. Retrieved from http://www.jsonline.com/watchdog/noquarter/state-investigating-doctor-two-others-in-tomah-va-case-b99436610z1-290457851.html. Accessed on 2/10/2015.)

7. Ryan Honl – a former Tomah VA Medical Center employee – repeatedly contacted Baldwin's office for help, providing information that detailed abuse and neglect at the Tomah VA facility in November and December 2014. *Id.*

8. Marquette Baylor – Baldwin's former United States Senate Deputy State Director – served as the main point-of-contact for Honl while communicating with Baldwin's U.S. Senate Office. *See* the *Milwaukee Journal Sentinel* article attached hereto as Exhibit E. (Bice, D. "Sen. Tammy Baldwin ousts aide over VA controversy". Journal Sentinel. 1/26/2015. Retrieved from http://www.jsonline.com/watchdog/noquarter/sen-tammy-baldwin-ousts-aide-over-va-controversy-b99431970z1-289737031.html. Accessed on 2/10/2015.)

9. Honl spoke with Baylor about gross misconduct by members of the Tomah VA Medical Center staff and provided first-hand accounts of ongoing negligence. *Id.*

10. It is reported that, during one conversation in November, Baylor discouraged Honl from going public with this information for fear of losing employment or embarrassing Baldwin. *Id.*

11. Only after the *Center for Investigative Reporting* published details on January 9, 2015 regarding the August 2014 federal inspection report did Baldwin call for an independent investigation of the Tomah VA Medical Center. *See* the *Green Bay Press Gazette* report attached hereto as Exhibit F. (Slack, D. "Sen. Baldwin had Tomah VA report for months". Green Bay Press Gazette. 1/27/2015. Retrieved from http://www.greenbaypressgazette.com/story/news/local/2015/01/19/sen-baldwin-had-tomah-va-report-for-months/22025759/. Accessed on 2/10/2015.)

12. Baylor took the blame for Baldwin's inaction and poor leadership and Baldwin abruptly terminated Baylor from Federal Government payroll on January 22, 2015 effective immediately. *See* Exhibit E.

13. Despite Baylor's negligence, Baldwin offered her a severance package that allegedly included a nearly six-figure cash payout. *Id.*

14. Upon information and belief, in an effort to conceal this information and to prevent the leak of additional details on this situation, Baldwin allegedly required Baylor to sign a non-disclosure agreement regarding the Tomah VA Medical Center and the alleged cover-up by Baldwin's U.S. Senate Office in order to receive this severance package. *Id.*

15. Pursuant to 31 U.S.C. 1301(a), "Appropriations shall be applied only to the objects for which the appropriations were made except as otherwise provided by law."

16. Upon information and belief, given the reasons of termination, Baylor was not eligible for the severance payment extended by Baldwin.

17. Through the offer of a severance package that includes a cash payout of taxpayer dollars to Marquette Baylor, who is not expected to perform any United States Senate official duties, Tammy Baldwin has acted in direct violation of 31 U.S.C. 1301(a) since appropriated funds are being misused.

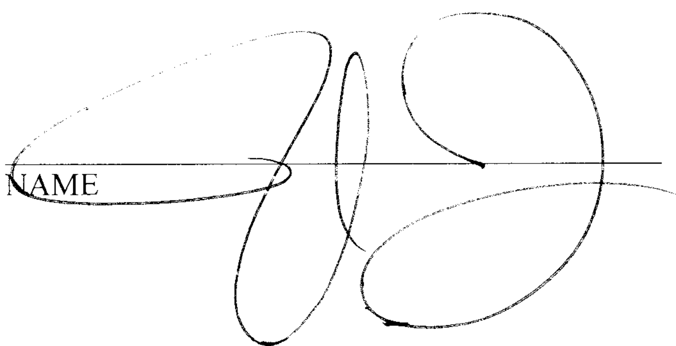
18. Further, pursuant to 18 U.S.C. 1001, it is illegal for any member of Congress to knowingly make any materially false, fictitious, or fraudulent statement or representation on behalf of the Government of the United States.

19. Through her actions to propose an agreement that improperly utilized appropriated funds, Baldwin is in direct violation of 18 U.S.C. 1001 by fraudulently advancing an improper contract to Baylor.

The above-referenced activity by Tammy Baldwin violates federal law. To wit: As part of a massive cover-up, Tammy Baldwin wrongly appropriated taxpayer funds to compensate a Senate employee who would not have performed official government duties while also fraudulently offering a contract to silence a former employee in order to save Baldwin's own political career, in violation of 31 U.S.C. 1301(a) and 18 U.S.C. 1001.

WHEREFORE, Complainants pray that the United States Senate Select Committee on Ethics commence an investigation into the actions of Respondents in regard to their activities; commence an action in civil court with respect to any civil violations; refer any criminal violations to the appropriate prosecutorial authorities; and render such other relief that the United States Senate Select Committee on Ethics may deem just and equitable.

Dated this 18th day of February 2015, at Madison, Wisconsin.



NAME

WISCONSIN STATE JOURNAL

Exhibit A

GUEST COLUMN

U.S. Sen. Tammy Baldwin: We can do better for Wisconsin's veterans

JANUARY 26, 2015 11:45 AM • U.S. SEN. TAMMY BALDWIN

Our men and women in uniform have made incredible sacrifices on our behalf. We all have a shared responsibility to ensure that when they return home, our veterans and their families are provided the care and support they need.

Problems at the Veterans Administration Medical Center in Tomah have been in the news recently, so I wanted to let people know about my efforts to address the problems and put solutions in place for our Wisconsin veterans.

When my office was first contacted by a constituent last March with concerns about the Tomah VA, we immediately brought those concerns to the Tomah VA and then to the U.S. Department of Veterans Affairs headquarters in Washington D.C., and the VA Office of Inspector General (OIG).

I am very upset that when we brought forward our constituent's concerns, the Tomah VA, its regional parent organization, the VA Great Lakes Health Care System, and the U.S. Department of Veterans Affairs were not forthcoming that an OIG investigation was initiated by others in 2011. It is also extremely troubling that they did not let us know the OIG report had been concluded last March.

In fact, we were not provided a copy until the end of August, five months after our initial inquiries and five months after the report was concluded in March.

Since the OIG failed to release the report publicly, our office had to initiate a Freedom of Information Act request to obtain a copy. When we finally received a copy of the report at the end of August, we immediately took action to provide it to the constituent who had brought concerns to us. As a result of taking this action, the report was then shared with other whistleblowers and the media.

Not only were we very disturbed with the OIG's findings, but we were also concerned that the report concluded there was no wrongdoing at the medical facility.

In the fall, as we weighed next steps and additional concerns about problems at the Tomah VA were brought to our attention, we should have done a better job listening to and communicating with another constituent with whom we were working on problems at

the VA. I take full responsibility for any mistakes we made because I not only share his belief that the report's conclusion fell short, but I also share his commitment to exposing problems at the VA and working on solutions.

That is precisely why I have worked on this issue over the last year and why I am pleased that several weeks ago, the OIG report we shared with a constituent became the subject of an investigative media report which also revealed larger issues at the Tomah VA that were not addressed in the March OIG report.

In response to the larger issues exposed in that media report, concerns brought to my attention by constituents and whistleblowers, and the fact that the March OIG report was limited in focus and was not a thorough investigation, I called for VA Secretary Robert McDonald to take immediate action to conduct a new, comprehensive investigation into the operation of the Tomah VA.

After speaking with Secretary McDonald, I am pleased that the VA has announced a new investigation into Tomah VA prescribing practices and abuse of administrative authority. While I wish this action had been taken much sooner, the U.S. Department of Veterans Affairs is now actively reviewing allegations of retaliatory behavior and over-medication at the Tomah VA. The chief of staff of the Tomah VA has also been temporarily reassigned and will not be seeing patients or prescribing medication.

These are important steps in the right direction that are a direct result of the people I work for in Wisconsin taking action, bringing their concerns to my office, and letting their voices be heard.

I can assure you that I will closely monitor the investigation's progress and work to ensure that its scope and resulting actions will achieve and maintain the goal of providing the timely, highest-quality care to our Wisconsin veterans.

In addition, I just called on the Senate Committee on Veterans' Affairs to hold a hearing to address the failure of the Department of Veterans Affairs to stop improper opioid prescribing practices and associated abuse of administrative authority at the Tomah VA Medical Center.

As your United States senator, I am committed to working hard every day to keep our promise to our veterans and their families. That is why I look forward to continuing my work on solutions to the many problems the VA faces here in Wisconsin and across America, getting the job done to make sure our veterans receive the quality care they have earned and deserve.

Exhibit B

THE TOMAH JOURNAL

Baldwin visits Tomah VAMC

July 02, 2014 2:56 pm • Steve Rundio steve.rundio@lee.net

Wisconsin U.S. Sen. Tammy Baldwin, D- Madison, said shifting population patterns is no excuse for the long wait times at some Veterans Administration hospitals.

Baldwin visited the Tomah VA hospital Tuesday and said the Tomah hospital is granting appointments in a timely manner. However, she said the VA still must address the problem of wait times nationwide and allegations that paperwork was forged to conceal the situation.

"The population changes should have been anticipated," Baldwin said. "Being in two wars of a decade in duration each is an indicator that you're going to have growth in demand for health care. We should have enough census data to know where populations are growing and where populations are shrinking."

Baldwin said she has consulted county veterans service officers to monitor care at VA hospitals in Wisconsin. She said the feedback was positive.

"Those who identified Tomah as the primary hospital where they refer patients had really positive things to say, and we didn't just ask about the wait times," Baldwin said. "It's a very veteran- and patient-centered model that's getting strong and positive reviews."

Baldwin voted for legislation that creates a two-year pilot program that would expand the use of private providers. She likes the pilot provision because it will give time for Congress "to see how it complements the VA system."

The bill, which also gives the VA greater authority to fire senior executives and adds new benefits for military members and their families, is estimated to cost $35 billion over the next 10 years. The House of Representatives and Senate passed different versions of the bill, and Baldwin said the price tag is an issue in negotiations between the houses.

Baldwin is skeptical of calls to privatize VA services.

"Any long-term decision should be based on facts and evidence and feedback from the veterans and not simply on the political ideology of members of Congress," she said.

Exhibit C

Baldwin fires aide over Tomah VA report

Donovan Slack, Gannett Wisconsin Media Washington bureau *10:44 a.m. CST January 27, 2015*

(Photo: File/Gannett Wisconsin Media)

WASHINGTON – Wisconsin Sen. Tammy Baldwin has fired a top aide as questions mount about what the senator knew and when about an inspection report highlighting potentially excessive prescribing of opiates to veterans at the Tomah Veterans Affairs Medical Center.

The Milwaukee Journal Sentinel (http://www.jsonline.com/watchdog/noquarter/sen-tammy-baldwin-ousts-aide-over-va-controversy-b99431970z1-289737031.html) reported Monday that the Madison Democrat fired Marquette Baylor, her deputy state director and head of her Milwaukee office, and offered a severance deal that requires her to keep quiet.

Baldwin's office declined Monday to confirm the report or explain what happened.

"We do not comment on personnel matters," her chief of staff, Bill Murat, said in a statement.

Ryan Honl, a whistleblower who met with Murat on Friday, said Murat told him he was dispatched from Washington to Wisconsin to deal with the burgeoning crisis following a USA TODAY report (/story/news/local/2015/01/19/sen-baldwin-had-tomah-va-report-for-months/22025759/) last Monday that revealed Baldwin's office received the inspection report in August and did not act on it for months, despite repeated pleas from Honl.

RELATED: Sen. Baldwin had Tomah VA report for months (/story/news/local/2015/01/19/sen-baldwin-had-tomah-va-report-for-months/22025759/)

For much of last week, the senator defended her actions and offered few answers (/story/news/politics/2015/01/21/baldwin-fire-inaction-tomah-report-offers-answers/22133469/) in statements to the media. On Friday, Baldwin suggested for the first time that she and her staff may have made a mistake.

RELATED: Baldwin offers few answers on VA drug report (/story/news/politics/2015/01/21/baldwin-fire-inaction-tomah-report-offers-answers/22133469)

"In the fall, as we weighed next steps and additional concerns about problems at the Tomah VA were brought to our attention, we should have done a better job listening to and communicating with another constituent with whom we were working on problems at the VA," she wrote in an op-ed column (/story/opinion/2015/01/23/tammy-baldwin-tomah-va-opiates-investigation/22230363/) titled, "We can do better for Wisconsin veterans."

"I take full responsibility for any mistakes we made because I not only share his belief that the report's conclusion fell short, but I also share his commitment to exposing problems at the VA and working on solutions."

RELATED: Tammy Baldwin: We can do better for Wisconsin veterans (/story/opinion/2015/01/23/tammy-baldwin-tomah-va-opiates-investigation/22230363/)

Baldwin's office still won't say whether the senator read the report, or respond to questions about what she knew when. In response, an aide provided a link to her op-ed column and a letter she wrote long before receiving the report. The Journal Sentinel report said Baylor's allies say she notified supervisors about the controversy and they did nothing. USA TODAY could not independently confirm that.

Baldwin was the only member of Congress who had a copy of the inspection report, which found that two practitioners at the Tomah VA center were among the highest prescribers of opiates in a multistate region — at "considerable variance" with most opioid prescribers, raising "potentially serious concerns." Her office received a copy Aug. 29.

Honl learned in early November that Baldwin had the report and he repeatedly urged her to make it public and call for an investigation. But the senator didn't act until earlier this month, when the Center for Investigative Reporting revealed that a veteran had suffered a fatal overdose as an inpatient at the center.

According to an online biography, Baylor was responsible for "statewide constituent services and legislative and outreach" for Baldwin. Previously, she worked 10 years for Herb Kohl while the Democrat represented Wisconsin in the Senate.

Honl, who left the Tomah VA in October, has said Baylor called him in November and asked him not to speak with the press. In an email to her office recounting the conversation, he said she 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."

So far, it's unclear whether any "process" was taking place.

--- Contact dslack@usatoday.com (mailto:dslack@usatoday.com). Follow @donovanslack.

Read or Share this story: http://gbpg.net/1JPepmP

Exhibit D

State investigating doctor, two others in Tomah VA case

Jan. 31, 2015

The state has opened an investigation of a doctor dubbed the "Candy Man" and two other individuals tied to the death of a patient at the **Tomah VA Medical Center.**

An official confirmed that the state Department of Safety and Professional Services is investigating **David Houlihan,** chief of staff at the troubled Tomah facility.

Houlihan had been given the nickname "Candy Man" by some vets for his supposedly easy and widespread distribution of painkillers. He wrote at least some of the prescriptions for a 35-year-old Marine Corps vet who died at the medical center in August.

A nurse and pharmacist who worked with Houlihan are also under investigation by the state.

State officials have the authority to issue reprimands or suspend or strip the state licenses of medical professionals in Wisconsin. The state could also refer the matter for criminal prosecution.

"We do have investigations ongoing against them," said **Hannah Zillmer**, spokeswoman for the state agency.

"Because there is an alleged death, it is on an expedited process," Zillmer continued. "So we are currently investigating, but I can't give you a completion date."

Two individuals interviewed by a state investigator said the matter could be turned over to the Monroe County district attorney.

But Zillmer said that would not be done until after her agency completes its probe.

"We, of course, take these complaints very seriously," she said. "We're investigating as quickly as possible."

An inspection report from the Veterans Affairs Office of Inspector General found last year that officials at the Tomah medical center were prescribing high amounts of opiate pain pills to patients.

Veterans who relied on the facility for care had begun calling it "Candy Land."

Media reports last month disclosed that **Jason Simcakoski**, a 35-year-old Marine Corps veteran, died at the Tomah facility in August from "mixed drug toxicity."

As a result of the press coverage, members of the Wisconsin congressional delegation called for an investigation of the medical center.

Last week, the **Center for Investigative Reporting** disclosed that U.S. Secretary of Veterans Affairs **Robert McDonald**dispatched a team of investigators to the facility.

Those investigators, the center said, are looking into allegations of runaway painkiller prescriptions, drug overdoses and abuse of authority by Houlihan.

Ryan Honl, a former Tomah employee who has acted as a whistle-blower, called for an independent investigation of the facility. For months, Honl had tried to get three Wisconsin lawmakers — U.S. Sens. **Tammy Baldwin** and **Ron Johnson** and U.S. Rep. **Ron Kind** — to intervene.

The state investigation is separate from the federal probe.

Zillmer said Friday that her agency first received an anonymous complaint against Houlihan last fall accusing him of "alleged overprescribing of oxycodone." The investigation was opened Aug. 12.

That would have been a couple of weeks before Simcakoski died of a fatal overdose in the Tomah VA's psychiatric ward. **Gannett Wisconsin Media** reported that he went to the center for anxiety and an addiction to painkillers and was put on more than two dozen medications.

More recently, Zillmer said, her agency opened its own investigation of Houlihan on Jan. 20 in response to the media coverage of the Tomah facility. Officials are looking into allegations of "overprescribing with suspicions that this practice led to at least one patient's death."

Houlihan has been "temporarily reassigned" from his post as the medical center's chief of staff.

Also under investigation are **Deborah Frasher**, a nurse, and **Margaret Hyde**, a pharmacist. Zillmer said it is believed that the two worked with Houlihan at the Tomah center.

The complaints allege the two individuals "collaborated with physician in gross overprescribing," Zillmer said.

Frasher, 55, could not be reached at her home in Mauston. Hyde, 64, also was not available. A female hung up the phone at her residence in Sparta when a reporter asked to speak to Hyde.

Houlihan — a 50-year-old psychiatrist — did not return a call to his cellphone Saturday.

Zillmer said none of the three had been disciplined by the state in the past.

In 2003, a complaint was filed against Houlihan in Iowa, where he was also practicing, but the matter was dismissed, Zillmer said. Also, authorities found no grounds for pursuing a 2008 complaint against the psychiatrist for allegedly bullying staff and changing a patient's medication too abruptly.

Leading the state probe of the three medical professionals is **Matthew Wallock**, an attorney with the Department of Safety and Professional Services. He declined to comment last week.

Complicating the investigation is the fact that the Department of Veterans Affairs does not require those working at its hospitals to hold a state license. That limits what Wallock's agency can do in this matter.

"If there are no Wisconsin licenses, we do not have authority over those individuals," Zillmer said.

Even before any of the various probes have been completed, there has already been some fallout from the scandal.

Last month, Baldwin dismissed **Marquette Baylor**, the senator's deputy state director and chief of her Milwaukee office, supposedly over her handling of Honl's complaints, **No Quarter**reported last week.

Baldwin's office received the federal inspection report of the Tomah facility in August but didn't call for an investigation until the media reported on the problems there in January.

Baylor has been offered a cash payout as part of a severance package that includes a confidentiality agreement. Baylor had three weeks to sign the deal.

It is not known if she has done so.

Baylor has not returned calls. Baldwin's office has declined to discuss Baylor's dismissal.

Contact Daniel Bice at (414) 224-2135 or dbice@jrn.com. Follow him on Twitter @DanielBice or on Facebook at fb.me/daniel.bice.

Find this article at:
http://www.jsonline.com/watchdog/noquarter/state-investigating-doctor-two-others-in-tomah-va-case-b99436610z1-290457851.html

☐ Check the box to include the list of links referenced in the article.

Exhibit E

Sen. Tammy Baldwin ousts aide over VA controversy

Jan. 26, 2015

Under fire for her office's inaction over alleged overmedication at the Veterans Affairs Medical Center in Tomah, U.S. Sen. **Tammy Baldwin** abruptly ousted one of her top state staffers late last week.

Marquette Baylor — deputy state director for Baldwin and chief of her Milwaukee office — was let go on Thursday without explanation. Baylor has been offered a cash payout as part of a severance package if the former aide agrees to keep her lips zipped.

"It looks like they're trying to pin the blame on her," a source said of Baylor's dismissal by Baldwin.

But **Ryan Honl** — a former Tomah VA employee who has acted as a whistle-blower — said Sunday that Baylor is just one of several Baldwin staffers who mishandled the matter and should be let go.

He said he talked with Baylor for two hours in late November about the problems at the Tomah medical center and that the Baldwin aide discouraged him from going public with his concerns, saying that doing so might get her and others fired.

Honl said he was not happy that Baldwin was offering Baylor a severance deal.

"I get run out of my job and she gets a golden parachute for (expletive) veterans?" Honl asked incredulously.

Baylor's dismissal came as Baldwin tries to respond to the biggest controversy to hit her office since she was elected in 2012.

Bill Murat, chief of staff to Baldwin, traveled to Wisconsin late last week to try to deal with the burgeoning Tomah controversy.

Murat met with Honl for three hours on Friday, apologizing for how his office had handled the matter. Honl said it was clear, based on Murat's remarks, that Baylor was canned as a result. Murat was joined by Baldwin over the weekend in meeting with other whistle-blowers in the Tomah area, according to Honl.

"What choice do they have?" Honl asked. "Her staff was completely and totally incompetent. But they understand the gravity now."

An inspection report from the Veterans Affairs Office of Inspector General found last year that officials at the Tomah VA Medical Center were prescribing high amounts of opiate pain pills to patients. Baldwin's office received a copy of the report in August.

But Baldwin did not call for an investigation into the Tomah facility until media reports disclosed just this month that a vet died at the Tomah facility from "mixed drug toxicity."

On Friday, Murat declined to discuss Baylor's dismissal or the proposed severance deal.

"We do not comment on personnel matters," Murat said.

Even, apparently, when it involved a Wisconsin staffer on the federal payroll.

Baylor could not be reached for comment. A receptionist at Baldwin's Milwaukee office said Friday of Baylor, "She is no longer with the staff." She declined to provide a number for Baylor because she is now a "private citizen."

Baylor has worked for Baldwin for a little more than a year, earning a little more than $66,000 a year. She previously spent more than 10 years as a Wisconsin staffer for then-U.S. Sen. **Herb Kohl**, a Milwaukee Democrat, and also was once a community relations coordinator for the **Milwaukee Brewers**.

She is a member of the city Equal Rights Commission, the head of the Milwaukee chapter of the **National Coalition of 100 Black Women** and a board member for **Jewish Family Services**.

Sources said Baldwin's office has offered a severance package to Baylor that includes a confidentiality agreement and a payment. It is not known how much money she would receive, but insiders said it would be less than six figures.

Baylor has several weeks to decide if she will accept the deal.

It is not known if the payout would involve the use of tax dollars.

Honl, a Gulf War vet and U.S. Military Academy graduate, began contacting Baldwin's staff in November after learning her office had received a copy of the inspection report months earlier.

In an email provided to **Gannett Wisconsin Media**, Honl contacted Baldwin aide **Mike Helbick** on Dec. 2 to complain about the matter. He said in the email that he had already talked to Baylor about the inspection report.

"When will Senator Baldwin say 'enough is enough' and push for better treatment of our veterans and a better culture free of intimidation and retaliation in Tomah and VA wide for those who whistleblow?" Honl asked Helbick in the email.

A source said Helbick, a constituent services rep for Baldwin, is expected to keep his job.

Honl said he couldn't understand why Helbick wasn't being ousted along with Baylor. Both seemed primarily interested in avoiding trouble, he said.

What's not clear, Honl said, is whether the pair raised the issue with Murat or even Baldwin.

Baylor allies maintain that she did bring the controversy to the attention of her supervisors, who then did nothing. But Murat gave the impression that he was unaware of the problems at the Tomah medical center, Honl said.

Last week, Republican state lawmakers chided Baldwin, a Madison Democrat, for failing to call for changes sooner based on the report. A Baldwin spokesman has defended her actions.

Honl noted that he also reached out to U.S. Sen. **Ron Johnson**, a Republican, and U.S. Rep. **Ron Kind**, a Democrat, but got little response until the media picked up on the issue in early January.

Since then, he said, federal lawmakers have been very responsive to his concerns.

"They were caught with their pants down," Honl said.

Chitchat

Conservative talk show host **Charlie Sykes** will join me this week in a live chat at **JSOnline** answering questions on all things political — including Gov. **Scott Walker's** Iowa speech, his upcoming budget address and the spring elections — and just about anything else of interest.

Sykes and I will start answering questions at 2 p.m. Wednesday. We also will, no doubt, respond to one another's responses — and to each other's counter-responses. Which should be the fun part.

The chat is scheduled to go an hour but will probably run a little bit longer. You may start submitting questions as early as Monday on the Journal Sentinel's website.

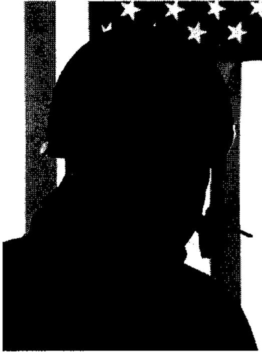
Find this article at:
http://www.jsonline.com/watchdog/noquarter/sen-tammy-baldwin-ousts-aide-over-va-controversy-b99431970z1-289737031.html

☐ Check the box to include the list of links referenced in the article.

Exhibit F

Sen. Baldwin had Tomah VA report for months

Donovan Slack, Gannett Wisconsin Media Washington bureau *10:42 a.m. CST January 27, 2015*



(Photo: Marko Marcello, Getty Images/iStockphoto)

WASHINGTON — Sen. Tammy Baldwin's office received an inspection report (http://wisinfo.biz/ic/PDFs/2014VAreport.pdf) last summer detailing high amounts of opiates prescribed at the Veterans Affairs Medical Center in Tomah, but there is no indication her office took action on the findings until last week, when she called for an investigation after a news report revealed a veteran died from an overdose at the facility.

The report by the VA inspector general, a copy of which was obtained by USA TODAY, noted that two practitioners at the center were among the highest prescribers of opiates in a multistate region — at "considerable variance" compared with most opioid prescribers. That, the report said, raised "potentially serious concerns."

A whistleblower who learned in November that Baldwin had had a copy for months and hadn't acted, repeatedly emailed her office asking that she do something to help the veterans at the center, according to copies of the emails obtained by USA TODAY.

PDF: Read the report (http://wisinfo.biz/ic/PDFs/2014VAreport.pdf)

In them the whistleblower — former Tomah VA employee Ryan Honl — asked that Baldwin call for an investigation, that she push colleagues on the Veterans Affairs committee to take action, and that she help bring the issues in the report to public attention. The report had not been made public, but Baldwin's office received a copy in August.

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."

Tammy Baldwin *(Photo: File)*

"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.

Honl, a Gulf War vet and West Point graduate who left the Tomah facility in October, said in an interview Monday he believes Baldwin's inaction after receiving the report is a "travesty."

Baldwin's office declined to explain what she did between receiving the report in August and last week, when she called for an investigation after the Center for Investigative Reporting published details of the inspection report outlining opiate prescription amounts at the center and recounting the overdose death in August of a 35-year-old Marine Corps veteran while he was an inpatient.

"We are pleased that the Department of Veterans Affairs is actively reviewing allegations of retaliatory behavior and over-medication at Tomah VA, and that the Chief of Staff has been temporarily reassigned and will not be seeing patients or prescribing medication," her office said in a statement Monday.

Baldwin aides forwarded letters she wrote in April and June in response to a constituent complaint about veterans being prescribed opiates at the VA center. She asked the director of the Tomah center and the VA inspector general to investigate. Baldwin's office was briefed on the earlier IG investigation in July and got a copy Aug. 29, and provided a copy to the constituent, according to correspondence forwarded by her office.

Aides to Baldwin did not respond to multiple messages asking what the senator did in response to the inspection report she received, or how she responded to the whistleblower's emails.

According to the emails provided to USA TODAY, on Nov. 12, Honl learned about the report's existence and that a copy had been given to Baldwin's office, and so he asked for a copy in an email to Baldwin aide Mike Helbick. Honl said he received no response. Two weeks later, he obtained his own copy of the report and began urging in emails to Helbick that the senator do something.

"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.

"Do you think that's proper that a nurse practitioner ... is ranked the number one prescriber of opiates out of 3,206 physicians in the (region)?"

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.

"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.

Honl said in the interview Monday that he heard nothing from her office for several weeks and was surprised when he read about her calling last week for an investigation.

The call came after the Center for Investigative Reporting reported Jan. 8 on the contents of the inspection report and that a 35-year-old former Marine, Jason Simcakoski, fatally overdosed in the Tomah VA psychiatric ward in August. He had gone to the center for help with severe anxiety and an addiction to pain killers. Doctors put him on 15 drugs, including the opioid tramadol, anti-psychotics, tranquilizers, and muscle relaxers. An autopsy report concluded the cause of death was "mixed drug toxicity," CIR reported.

"She's the only one that ever had this report," Honl said. "It is a travesty that you've got a United States senator and her staff sitting on this report."

Contact dslack@usatoday.com. Follow @donovanslack.

Read or Share this story: http://gbpg.net/1J4HJFz