JERRY MORAN
KANSAS

521 DIRKSEN SENATE OFFICE BUILDING
WASHINGTON, DC 20510-1606
P: (202) 224-6521
F: (202) 228-6966

moran.senate.gov

United States Senate

COMMITTEES:
APPROPRIATIONS

BANKING, HOUSING, AND URBAN AFFAIRS

COMMERCE, SCIENCE, AND TRANSPORTATION

VETERANS' AFFAIRS

INDIAN AFFAIRS

September 2, 2016

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

Dear Secretary McDonald,

I am writing to call your attention to the tragic and disturbing allegations of abuse of veterans by a Physician Assistant in the VA Eastern Kansas Health Care System, Mark Wisner. As a result of veterans bravely coming forward with their experiences, Mr. Wisner faces two criminal cases in Leavenworth County that include charges of aggravated sexual battery, aggravated criminal sodomy and three misdemeanor charges of sexual battery. While the court proceedings for these cases are underway, Mr. Wisner also faces numerous lawsuits filed in federal court by the veterans who allege they were subjected to his abuse. Revelations regarding Mr. Wisner's criminal background and lewd behavior have surfaced in press reports, calling into question what the VA knew, or reasonably should have known, to protect veterans from a criminal who eventually abused them.

Recent reports and evidence of Mr. Wisner's medical credentials show that he admitted he was convicted of a crime when applying for his state licensure. It is unclear whether the VA investigated Mr. Wisner's criminal record as part of his application process and hiring by the VA. It is extremely troubling that a criminal can admit to having committed a crime and yet be hired for a position where veterans are under his or her care. Please explain the vetting process for hiring VA personnel and answer these specific questions:

1. What information is a medical provider applicant required to provide or answer as part of the VA hiring process?
2. Does the VA Central Office or a local medical center or facility oversee the hiring of medical provider applicants? Please describe the offices involved in and responsible for the hiring of medical providers.
3. Does the VA conduct a criminal background check on all applicants? Is there a different standard specifically for medical providers who seek a position in patient care? Please explain the criminal background check process for applicants to serve in the VA.
4. In the scenario of an applicant who has been convicted of a crime, what is the standard or threshold to determine if the applicant's crime is a disqualifying factor?
5. Is there any VA directive, guidance, regulation or rule that sets a standard or threshold to determine what type of crime is a disqualifying factor for an applicant? What office is responsible for making this determination?

HAYS OFFICE
1200 MAIN STREET
SUITE 402
HAYS, KS 67601

MANHATTAN OFFICE
923 WESTPORT PLACE
SUITE 210
MANHATTAN, KS 66502

OLATHE OFFICE
23600 COLLEGE BOULEVARD
SUITE 201
OLATHE, KS 66061

PITTSBURG OFFICE
306 N. BROADWAY STREET
SUITE 125
PITTSBURG, KS 66762

WICHITA OFFICE
3450 N. ROCK ROAD, BLDG 200
SUITE 209
WICHITA, KS 67226

When I first learned of this appalling situation in July of last year, I immediately reached out to VA Eastern Kansas leadership to fully understand how this could have happened. By that time, Mr. Wisner had been separated from the Dwight D. Eisenhower VA Medical Center in Leavenworth, Kansas, for nearly 13 months and criminal charges were pending. Court documents filed in Leavenworth County on July 6, 2015, and attached as an addendum to this letter reveal that on May 15, 2014, the Leavenworth VA police department contacted the VA Office of Inspector General (OIG) Criminal Investigative Division (CID) in Kansas City regarding a possible sexual assault involving Physician's Assistant Mark Wisner. A criminal history report conducted by the OIG on May 19, 2014, revealed a misdemeanor arrest for a solicited lewd act in 1987 and the OIG's database noted a 2012 sexual assault allegation that was not proven. On May 22, 2014, a Special Agent with the OIG interviewed Mr. Wisner in response to allegations involving sexual assault that occurred on May 15, 2014. During this interview, Mr. Wisner admitted to unnecessary and inappropriate behavior of a sexual nature with veteran patients and "opined that it is time for him to discontinue his practice as he has been 'letting his guard down' and needs to resolve his personal issues." He also added, "If I have to go to prison, I'll deal with that."

This alarming confirmation of Mr. Wisner's illicit acts should have warranted immediate action to protect veterans and remove him as an employee of the VA for his deplorable exploits, particularly if earlier concerns were expressed by veterans and were not fully investigated. Please provide a detailed explanation of internal VA and VA OIG actions and decisions regarding Mr. Wisner's misconduct. In addition, please answer the following specific questions:

1. In addition to the allegation reported on May 15, 2014, to the VA IOG, were any other allegations involving Mr. Wisner ever reported during his employment in the VA system? If so, what were the allegations and what was the VA response to those allegations?
2. Are VA employees, particularly medical providers in patient care, monitored and assessed periodically if any allegation of a serious nature is reported? Please explain the oversight of a VA employee suspected of misconduct.
3. Please explain the VA entities, such as VA police, VA OIG, local VA administrators or otherwise, that are involved when an allegation of this serious nature is reported and their coordination process.
4. In response to Mr. Wisner's misconduct of a sexual nature with veterans at the Leavenworth VA and his admittance, did the VA OIG Special Agent immediately notify VA leadership (local VA administrators, Veterans Integrate Service Network 15 or otherwise) and contact local law enforcement in Leavenworth, Kansas? If so, who and when?
5. Upon notification of Mr. Wisner's misconduct, did the VA immediately place Mr. Wisner on administrative leave and remove him from patient care with veterans? If so, when? If not, why not?
6. Upon notification of Mr. Wisner's misconduct, did the VA immediately contact the Kansas Board of Healing Arts? If so, when and what information was provided? If not, please explain why the Kansas Board of Healing Arts was not immediately notified.

7. Upon notification of Mr. Wisner's misconduct, did the VA initiate the process to terminate Mr. Wisner's employment with the VA? If so, when? If not, explain why termination was not initiated.
8. At least one veteran victim reported abuse that was confirmed by a witness on May 15, 2014, and Mr. Wisner admitted to his actions on May 22, 2014. Investigations by the VA OIG and law enforcement presumably proceeded as a result. What additional information, if any, is required to initiate termination of a VA employee under such circumstances?
9. Were any adverse actions of any kind proposed or carried out to hold Mr. Wisner accountable for his egregious misconduct and abuse of at least one known veteran at the time?
10. Please explain the difference between voluntary retirement and termination from the VA.
11. Please explain why Mr. Wisner received approval for voluntary retirement effective June 28, 2014, versus termination from the VA for his misconduct against veterans for which he admitted. Who is responsible for approving his request?
12. What administrative actions, privileges or benefits might a VA employee receive or be granted under voluntary retirement that an employee who is terminated would not?
13. Please provide any earnings and benefits afforded to Mr. Wisner as a result of his voluntary retirement despite his admittance of misconduct on May 22, 2014.

I am deeply concerned that Mr. Wisner may have abused and taken advantage of more Kansas veterans than previously stated. Initial information indicated that episodes of harassment and abuse were isolated to the Leavenworth VA, yet information I have received from veterans who have confidentially contacted my office suggests instances of abuse by Mr. Wisner at the Topeka VA as well. In addition, if the VA did not report Mr. Wisner's misconduct to the appropriate authorities, such as the Kansas Board of Healing Arts, it is possible that other Kansans were at great risk with Mr. Wisner being able to continue to practice medicine. Please answer the following questions:

1. Did Mr. Wisner also see veterans at the Topeka VA at any time during his employment with the VA?
2. If so, what efforts have been made to contact and support veterans who were seen by Mr. Wisner at the Topeka VA?
3. Veterans who have contacted my office are traumatized by their experiences and many are reluctant to return to the VA for care. What arrangements are being made to allow Mr. Wisner's patients the option to access care in the community?
4. After Mr. Wisner's voluntary retirement on June, 28, 2014, and prior to surrendering his medical license eight months later on February 10, 2015, what actions were taken by the VA to make certain Mr. Wisner was not a threat to veterans receiving care in the community and the general public in Kansas?

Nearly nine months after Mr. Wisner separated from the VA, the VA OIG Special Agent once again interviewed Mr. Wisner who "admitted that he crossed the professional line…" and "that he knew that what he was doing to these patients was wrong and that he had no self-control." It is clear that Mr. Wisner has not attempted to conceal his misconduct and readily admitted to his

abuse of veterans. I am curious as whether the VA intends to support veterans who experienced abuse and have sought legal retribution by filing lawsuits in federal court. Please verify whether the VA is providing documentation and information that would aid veterans who were subjected to Mr. Wisner's abuse and who are seeking legal recourse. My office has been made aware of concerns that the VA is interested in settling out of court, which has upset many veterans in Kansas, particularly those who are in the midst of dealing with the trauma they experienced.

The agency created to serve and take care of veterans employed a criminal who took advantage of veterans who sought his medical assistance. Veterans who put their lives on the line to return home safely and then experience abuse by a medical provider they trusted at their own VA, a place where they should be protected and honored, is an egregious injustice. Mr. Wisner violated the sacred promise of the VA's sole mission to care for those who served our nation, not to add to their wounds of war. The revelations of Mr. Wisner's background and the depth of his abuse must be fully investigated and I want to make certain the VA is taking every action possible to determine how such a horror could have happened and to prevent such a situation from ever happening again. I look forward to your prompt and informative response.

Sincerely,

Jerry Moran

Jerry Moran

CC: The Honorable Michael Missal, Inspector General of the Department of Veterans Affairs