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July 15, 2016

The Honorable Michael J. Missal
Inspector General
U.S. Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Mr. Missal:

I write to you today with increased concern for the mental health care treatment and subsequent recovery coordination provided to our veterans through the Department of Veterans Affairs (VA). Although the VA recently released figures indicating that veteran suicides are down from 22 per day to 20 per day as of 2014, I remain concerned and disheartened that progress is not being made quickly enough.

On June 24, 2015, I wrote to the Interim Undersecretary for Health, Dr. Carolyn Clancy expressing great concern over the death of Richard Miles, an Iraq War veteran who was found dead at Water Works Park in Des Moines, Iowa. Mr. Miles had not received adequate mental health care from the VA. Immediately following Mr. Miles' death, I requested that your office investigate the VA Central Iowa Health Care System's mental health program, and I instructed my staff to monitor and assist in the investigation as necessary.

Yet again, however, it appears the VA's mental health care services have failed another Iowa veteran. Mr. Brandon Ketchum, a combat veteran who served in both the Marine Corps and Army National Guard, recently drove over an hour to the Iowa City VA Medical Center seeking mental health care from a psychiatrist who had been treating him for over a year. Mr. Ketchum had reportedly been flagged for suicide risk in the past, and I am deeply troubled by media reports and correspondence from family and friends to my office indicating that the VA denied Mr. Ketchum the mental health services he urgently needed and requested.

Today I write to both you and Dr. David J. Shulkin, the Under Secretary for Health of the Department of Veterans Affairs, to request an immediate and thorough investigation of the Iowa City VA Medical Center's apparent failure or refusal to properly treat Mr. Ketchum.

Expanding recovery and coordination activities for patients with Post-Traumatic Stress Disorder (PTSD), as well as improving care management service, is something I fear is not happening quickly enough in Iowa's VA system. I am deeply concerned that too little is being done to hold Veterans Integrated Service Network Directors accountable for providing comprehensive case management in accord with Veterans Health Administration (VHA) policy.

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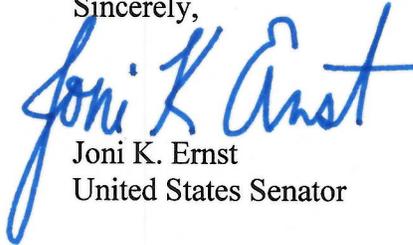
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I remain committed to working together to end the epidemic of veteran suicide. I urge you to work to improve veterans' services at the VHA, throughout Iowa but also nationwide. In addition to the results of your thorough investigation, I expect a written response from your office detailing concrete steps that will be taken to prevent tragedies such as Mr. Ketchum's from ever happening again. I speak for all Iowans when I say that our veterans deserve better.

If you have any questions concerning this request, please contact my staff via Katherina Dimenstein at (202) 224 -3254 or katherina_dimenstein@ernst.senate.gov.

Sincerely,

A handwritten signature in blue ink that reads "Joni K. Ernst". The signature is written in a cursive style with a large, stylized "J" and "E".

Joni K. Ernst
United States Senator