STATEMENT FOR THE RECORD OF
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
FOR THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
"FACT CHECK: AN END OF YEAR REVIEW OF ACCOUNTABILITY AT THE DEPARTMENT OF VETERANS AFFAIRS"
DECEMBER 9, 2015

Mr. Chairman and Members of the Committee, thank you for the opportunity to provide a statement for the hearing record that will clarify the role of the Office of Inspector General (OIG) regarding VA's actions to hold VA staff accountable in general and specifically with respect to the OIG's recent report, *Administrative Investigation: Inappropriate Use of Position and Misuse of Relocation Program and Incentives in VBA*.

As the Committee knows the OIG conducts many types of reviews—audits, inspections, evaluations, and administrative and criminal investigations. While most of our reports include specific recommendations for VA to take in response to our findings, with regard to administrative investigations or any report that has findings that may require individual accountability, we use more general language so as not to interfere with the due process rights of employees who may be subject to administrative action. We reiterated this position in our statement for the Committee's October 21, 2015, "An Examination of the VA Office of Inspector General's Final Report on the Inappropriate Use of Position and the Misuse of the Relocation Program Incentives" hearing when we said:

> Our statements and comments will be limited in order to preclude any allegation that our testimony unduly influenced VA or the Department of Justice regarding potential administrative or criminal action.

We would like to clarify the role of the OIG with respect to the VA's responsibility to hold people accountable. The OIG's role is to provide oversight of VA's programs, operations, and people. Inspectors General have no authority or responsibility for program functions. It is a VA program function to take any type of action, be it writing a policy, educating and training staff, or taking disciplinary or performance based administrative actions.

We agree with VA's statement that it "cannot rely wholesale on an OIG report to impose discipline." Our reports are not evidence; rather they are a summary of the evidence obtained and reviewed by OIG staff. It is VA's obligation to request and review all documentation and other evidence that the OIG obtained relating to the report and to conduct additional work if necessary before taking administrative action. We fully recognize that the standards for administrative action require this as well as applying the evidence for a different purpose. However, we take exception to the inference that

we based the subject report on “unsworn hearsay conclusions.” All interviews conducted during the work on this report were sworn and taped interviews conducted by experienced senior OIG staff.

The Inspector General Act requires that OIG’s post issued reports on their websites within 3 days. We cannot control nor can we be influenced by what the media and others publicly state about the report. There is nothing in the OIG’s press statement for the subject report that was not published in the report. Further, it is the longstanding practice to include the names of senior officials and this report is no different from other reports on OIG administrative investigations.

We would also like to take this opportunity to clarify some information regarding the OIG’s investigations into scheduling and access data manipulations and differences in the number of investigative cases. We have been working diligently on finishing the investigations we opened on scheduling and wait time manipulations. We provided VA’s Office of Accountability Review with 77 reports related to 73 sites of care. However, in 52 of those 77 reports, we did substantiate some type of scheduling issue ranging from outright data manipulation to intentionally game the system to simply not following VA policies and procedures. We have 36 open investigations involving 33 sites of care remaining. These numbers in some cases reflect that the OIG opened more than one investigation at a particular Veteran Health Administration facility. Unrelated allegations pertaining to a unique site were worked under separate case numbers to ensure thorough tracking of each allegation and corresponding investigative work. Past experience has proven that rolling unrelated allegations into a single report is not only cumbersome and may delay the issuance of a report, it also unnecessarily creates Privacy Act concerns when the VA used evidence supporting reports of investigation to initiate multiple unrelated administrative actions.

In conclusion, different views on the weight of evidence are indicative that the OIG work was conducted independently and without influence by VA. Now that VA has corrected their administrative errors by making all evidence available to the individuals involved, we expect VA to take appropriate steps to protect the due process rights of these individuals as well as all employees as they move forward with appropriate accountability actions.