



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

STATEMENT OF INSPECTOR GENERAL MICHAEL J. MISSAL
DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS,
AND RELATED AGENCIES

COMMITTEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

HEARING ON

OFFICE OF ACCOUNTABILITY AND WHISTLEBLOWER PROTECTION'S FAILURES AT VA
NOVEMBER 14, 2019

Madam Chair, Judge Carter, and members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) report, *Failures Implementing the VA Accountability and Whistleblower Protection Act of 2017* (the Act).¹ In June 2018, one year after the Act's enactment, the OIG received requests from the then ranking member of the House Veterans' Affairs Committee and several senators raising concerns that VA was not properly implementing the Act. In addition, the OIG received complaints from VA employees and others relating to concerns about the Office of Accountability and Whistleblower Protection's (OAWP's) operations. In response, the OIG conducted a review focusing on the OAWP's operations from June 23, 2017, through December 31, 2018. During the review, additional allegations arose as new OAWP leaders began making changes, prompting further related work through August 2019.²

As detailed in the OIG's report and summarized here, the OIG identified significant deficiencies in the operations of the OAWP. The OIG recognizes that organizing the operations of any new office is challenging, but OAWP leaders made avoidable mistakes early in its development that created an office culture that was sometimes alienating to the very individuals it was meant to protect. Those leadership failures distracted the OAWP from its core mission and likely diminished the desired confidence of whistleblowers and other potential complainants in the operations of the office.

¹ Issued October 24, 2019; the law was signed on June 23, 2017 and became Public Law 115-41

² From June 23, 2017, until January 7, 2019, the OAWP operated without an assistant secretary—a position called for by the Act. It was led by Executive Director Peter O'Rourke from June 23, 2017, to February 28, 2018, followed by Executive Director Kirk Nicholas until January 7, 2019. The current Assistant Secretary for Accountability and Whistleblower Protection took office on January 7, 2019, and soon began implementing changes, some of which address matters identified throughout the review.

VA employees who identify serious misconduct must feel protected when coming forward with complaints. They are essential to helping VA spot and address significant problems that may otherwise go undetected and persist, which could increase veterans' risk of harm. This report highlights significant failings by OAWP's former leaders that have had a chilling effect on complainants still being felt today. These failings include the lack of relevant policies and procedures, fundamental misunderstandings of investigative scope, not holding individuals accountable, and inadequate protections for whistleblowers. As a result, the current Assistant Secretary for Accountability and Whistleblower Protection faces significant challenges in putting the OAWP on a path to meet its statutory mission, mandates, and goals.

BACKGROUND

The OAWP was established in 2017 to improve VA's ability to hold employees accountable for specified misconduct; prevent retaliation against whistleblowers and initiate action against supervisors who retaliate; and address senior executives' poor performance.³

In comments to the OIG's draft report, VA took issue with what it characterized as the OIG's conclusion that the Act was designed to target senior executives for discipline. VA noted that the Act included expanded disciplinary authorities that apply to all VA employees. That is an accurate summary of the statute but it misses the point. The report focused on the OAWP's operations and efforts to implement relevant sections of the Act. The expanded disciplinary authorities of the Secretary over VA employees generally, although part of the same legislation, are not directly relevant to OAWP's operations and, thus, the OIG report. The Act did expand the Secretary's disciplinary authority to all VA employees, but that authority applies without regard to any involvement or action by OAWP. Indeed, the Act provides no role for OAWP in the disciplinary process of employees other than its authority to recommend discipline based on its investigation of allegations of misconduct, poor performance, and retaliation involving certain senior executives (i.e., the defined categories of Covered Executives⁴) and allegations of retaliation on the part of supervisors.⁵ It is this authority of the OAWP with respect to disciplinary proceedings that are addressed in this report.

³ See Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017, P.L. 115-41, 131 Stat. 862 (June 23, 2017). The legislation codified the establishment of the OAWP following an executive order issued in April 2017 to create an entity to "improve accountability and whistleblower protection" at VA. Improving Accountability and Whistleblower Protection at the Department of Veterans Affairs, Exec. Order No. 13793, 82 Fed. Reg. 20539 (Apr. 27, 2017). See also Dep't of Veterans Affairs, News Release, "Secretary David Shulkin Announces Establishment of Office of Accountability and Whistleblower Protection and Names Peter O'Rourke as its Senior Advisor and Executive Director" (May 12, 2017).

⁴ "Covered Executives" refers to VA personnel holding statutorily enumerated senior-level positions as defined in 38 U.S.C. §§ 323(c)(1)(H)(i) and (ii).

⁵ 38 U.S.C. § 323(c)(1)(H). The OAWP may also recommend appropriate discipline for employees based on investigations carried out by other entities such as the OIG, the Office of the Medical Inspector, and the Office of Special Counsel. 38 U.S.C. § 323(c)(1)(I).

FAILURES IMPLEMENTING ASPECTS OF THE VA ACCOUNTABILITY AND WHISTLEBLOWER PROTECTION ACT OF 2017

The OIG's review focused on answering the following questions that emerged from complaints and allegations to the OIG from various sources:

1. Whether the OAWP was exercising its authority in accordance with the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 and other applicable laws
2. Whether the OAWP conducted adequate, thorough, and procedurally fair investigations of matters it investigated
3. Whether VA employees were held accountable by making appropriate use of the authorities provided in the Act
4. Whether the OAWP was adequately protecting whistleblowers from retaliation as required by the Act and other applicable laws
5. Whether VA complied with other requirements of the Act, including making timely and accurate reports to Congress

A summary of findings related to each of the review questions follows. The OIG made 22 recommendations to address the six findings.

Finding 1: The OAWP Misinterpreted Its Statutory Mandate, Resulting in Failures to Act Within Its Investigative Authority

The OAWP misconstrued its statutory investigative mandate both by accepting matters that it should not have and declining matters the Act requires it to investigate. The OAWP also investigated individuals outside the OAWP's scope of authority under the Act, which in some instances introduced an appearance of bias. This included investigating one of its own directors for allegations relating to the director's earlier position at another VA office, which was not within the OAWP's statutory authority to investigate. At the same time, it was too narrowly interpreting the scope of *what* the office should investigate. The OAWP inappropriately excluded investigations of misconduct and poor performance of covered individuals if the person making the allegations did not meet the statutory definition of whistleblower. The OAWP is not limited to investigating allegations made only by whistleblowers—defined as employees and applicants for employment—but rather can investigate allegations from other complainants as well.

In addition to misinterpreting its statutory investigative mandate, the OAWP also failed to refer matters for investigation to other more appropriate investigative entities. Pursuant to regulation, VA employees must, for example, refer to the OIG matters that may be serious violations of criminal law related to VA. The OAWP investigated criminal matters involving possible felonies that it was required to refer to the OIG. Allegations of discrimination similarly should have been referred to VA's designated equal

employment opportunity (EEO) office, the Office of Resolution Management (ORM), unless they fell within the OAWP's authority to investigate. Although the law does not require that the OAWP refer such matters to the ORM, filing with the ORM is the only way for employees to preserve their EEO rights and it has more expertise to handle investigations of discrimination.

A fundamental flaw identified by the OIG was OAWP's misunderstanding of its statutory authority. The lack of clear and consistent guidance contributed to many of the other deficiencies identified in the report. The OIG made four recommendations related to Finding 1. They focus on actions by the Assistant Secretary for Accountability and Whistleblower Protection to ensure that the office is acting within its statutory authority and develop policies and procedures for working with VA's Office of General Counsel (OGC), ORM, OIG, and the Office of the Medical Inspector to establish criteria and procedures for the referral of matters to these entities. A complete listing of all the report's recommendations are in Appendix A of this statement.

Finding 2: The OAWP Did Not Consistently Conduct Procedurally Sound, Accurate, Thorough, and Unbiased Investigations and Related Activities

Written policies and procedures are crucial to effective operations. During the tenures of former Executive Directors Peter O'Rourke and Kurt Nicholas, the OAWP did not adopt comprehensive written policies and procedures on any topic. As of July 2019, it still lacked OAWP-specific written policies and procedures.⁶ The failure to put in place key systems and quality controls has resulted in OAWP conducting investigations that were not always thorough, objective, and unbiased—undermining OAWP's credibility among some VA employees.

The OIG identified deficiencies in the following areas:

- The OAWP lacks comprehensive policies and procedures suitable for its personnel. This is particularly important given that individuals' reputations are at stake, whistleblowers' identities must be protected, and the issues on which the OAWP is reporting affect veterans' lives in tremendously significant ways. Staff were either missing guidance or were piecing together direction largely based on the mandates of a prior office that was not entirely aligned with OAWP's legislative scope. The results were felt across OAWP divisions:
 1. The Triage Division's procedures blurred the scope of OAWP authority and called for acceptances or referrals of cases that were not consistent with the OAWP's statutory authority.
 2. Operational procedures were incomplete and outdated, leaving staff without clear guidance.

⁶ OAWP staff reported during the review that written policies and procedures were being drafted.

3. The Investigations Division used selective portions of preexisting VA procedures that provided insufficient guidance and led to questionable results.

- The absence of OAWP quality control measures is particularly troubling given the hodgepodge of policies and procedures. OAWP’s Advisory and Assistance (A&A) Division identified issues with the thoroughness of investigations. In some cases, investigators failed to seek testimonial evidence from key witnesses, including in at least one instance from the subject of the investigation. VA’s OGC also identified deficiencies in the work of the A&A Division and Investigations Division. Although some investigatory inadequacies were detected by disciplinary officials and VA’s OGC, this de facto oversight was not an effective or sustainable solution.
- The OAWP has failed to provide the staffing and training necessary to ensure it has the expertise, experience, and commitment that yield objective and thorough investigations critical to OAWP’s success. Staff within OAWP that conducted investigations were not given the training and access to expertise needed to perform at the level expected of that office. While the Investigations Division has broadened its staffing strategy to include more than Human Resource specialists, it still lacked a coordinated strategy for training specific to investigations.
- The OAWP has fallen short of its commitment to conduct “timely, thorough, and unbiased investigations” in all cases within its investigative jurisdiction. VA employees and other complainants must be assured that OAWP investigations are conducted with the highest ethical standards, which does not yet appear to have been achieved. A contributing factor to both lack of thoroughness and appearance of bias was the OAWP’s practice of investigating to the “substantial evidence” standard. That is, OAWP investigators did not conduct investigations designed to ensure that all known or obviously relevant evidence was obtained.⁷ Rather, in many instances, they focused only on finding evidence sufficient to substantiate the allegations without attempting to find potentially exculpatory or contradictory evidence. One disciplinary official described OAWP investigations as “a [disciplinary] action in search of evidence.” This standard and its application contributed to limited and unbalanced investigations.

The OAWP has statutory authority to investigate matters that overlap with the authority granted to several other investigative bodies, which means more than one entity can potentially investigate the same matter. The OIG identified instances in which the OAWP’s

⁷ For example, the Council of Inspectors General on Integrity and Efficiency, Quality Standards for Investigations (November 15, 2011) provide that all known or obviously relevant evidence should be obtained during an investigation. While OAWP is not governed by these standards, they provide relevant guidance for conducting thorough and objective investigations in a similar context.

objectivity was impaired by at least the appearance of bias.⁸ In these instances, the OAWP should have referred the matters elsewhere or implemented measures sufficient to avoid the appearance of impropriety.⁹ Key to this process is having an effective apparatus for triaging which issues should remain within the OAWP. Written guidance and training for employing that judgment would help ensure consistency and enhance the integrity of the office. The report cites two examples related to OAWP investigations of political appointees that had the appearance of bias.¹⁰

The OIG received numerous complaints from whistleblowers who felt that their submissions to the OAWP were not being handled in a timely manner, and that they were not even sure that the OAWP had accepted their allegations for investigation. Lengthy processing times can discourage whistleblowers from making further reports.¹¹ The OIG recognizes, however, that investigations must be afforded adequate time to ensure accurate results. Still, the OIG evaluated the time taken by the OAWP to resolve matters that were received by the OAWP Triage Division and referred for administrative investigation and found many took a year or more to close.¹²

Dr. Bonzanto told OIG investigators that she prioritized the need for prompt resolution of matters due in part to impacts on the subjects of investigations. She also stated that she was introducing standardized “touchpoints” with whistleblowers to improve communication about case statuses. She told OIG investigators that she instituted new expectations relating to timeliness of investigations. Her stated goal is to reduce to 90 days the time it takes from the receipt of a submission to the end of the A&A Division’s involvement. Dr. Bonzanto explained

⁸ As discussed in Finding 1, the OAWP decided to investigate one of its directors in a case outside its statutory scope. The appearance of bias in that case was exacerbated by the slow progress of the matter at the discipline stage. Some OAWP staff familiar with the investigation questioned whether OAWP leaders were protecting a senior staff member.

⁹ The OAWP has statutory authority to refer whistleblower disclosures to other investigative entities, including the OIG. 38 U.S.C. § 323(c)(1)(D).

¹⁰ See examples 11 and 12 of the report.

¹¹ GAO, Office of Special Counsel: *Actions Needed to Improve Processing of Prohibited Personnel Practice and Whistleblower Disclosure Cases*, GAO-18-400, (June 2018) 16, 21, <https://www.gao.gov/assets/700/692545.pdf> (discussing importance of timeliness in resolving whistleblower claims).

¹² The data shows that from June 23, 2017, through December 31, 2018, the OAWP opened 628 matters for investigation and inherited 131 matters that had been pending with the OAR. Of the 628 OAWP matters, 299 were closed by the end of 2018, but 20 took more than a year to resolve. Of the 329 matters still pending at the end of 2018, 52 had been open more than a year. According to VA’s *Administrative Investigations: Resource Guidebook* (June 2004), “[a]n administrative investigation is an impartial inquiry, authorized by a facility director or higher level manager, to be conducted at any time deemed necessary, to determine facts and collect evidence in connection with a matter in which the VA is or may be a part in interest.” Directive 0700 also provides, “The term ‘administrative investigation’ refers to a systematic process for determining facts and documenting evidence about matters of significant interest to VA.”

that she is instituting check-in points to ensure that the staff of the Investigations Division are keeping up with their workload.

The OIG made four recommendations related to this finding. Three were to the Assistant Secretary for Accountability and Whistleblower Protection related to creating standard operating procedures, creating a quality assurance program, and providing training to OAWP staff. The other recommendation was to the OGC to review and update as needed VA Directive 0700 and VA Handbook 0700 and clarify how they apply to OAWP, if at all.

Finding 3: VA Has Struggled with Implementing the Act's Enhanced Authority to Hold Covered Executives Accountable

A critical purpose of the Act was to facilitate holding Covered Executives accountable for misconduct and poor performance. However, as of May 22, 2019, VA had removed only one Covered Executive from federal service pursuant to the authority provided by the Act. The OIG found that officials tasked with proposing and deciding disciplinary action had insufficient direction for how to determine the appropriate level of discipline that would ensure consistency and fairness for specific acts of misconduct and poor performance. In many cases, a disciplinary official mitigated the discipline recommended by OAWP as too severe or based on advice from the VA's Office of General Counsel. In part, this was because of the absence of clear guidance and the OAWP's practice of not always including relevant exculpatory evidence, which would emerge later in the process at the disciplinary stage.

The A&A Division adopted a practice of culling OAWP's investigative files to prepare an evidence file that it provided to the OGC and the proposing official. The A&A Division focused on including material in the evidence file that supported the proposed disciplinary action, rather than compiling all relevant evidence. According to the A&A Director, the content of the evidence file was determined by the A&A specialist and contained only the evidence that the specialist believed supported the charges.

The A&A Division would provide additional information from the investigative file if requested by the OGC. The OIG determined that this practice was problematic because OGC attorneys might not know what information to request. As one OGC attorney explained, neither the OGC attorney nor the disciplinary officials know what other information is in the investigative file until the subject responds, and even the subject might not know what is in the investigative file.¹³

Under a pilot initiative implemented by Dr. Bonzanto, OGC attorneys are now routinely provided access to the entire investigative file. The results of that pilot were not yet available.

¹³ This problem is exacerbated by the Act's timelines, which provide only seven business days for the subject to respond and an additional eight business days for the deciding official to process and review new information before rendering a decision. An evidence file provided by the proposing official to the deciding official with all relevant information would reduce the information the subject must collect and the deciding official must review.

For Finding 3, the OIG made 3 recommendations. Two were directed to the Secretary related to providing guidance and training on penalties for actions taken pursuant to the Act, as well as guidance and training for disciplinary officials to maintain compliance with mandatory adverse action criteria outlined in the Act. The third recommendation under this finding was to the Assistant Secretary for Accountability and Whistleblower Protection to make certain that all relevant evidence is provided to the VA Secretary, or the disciplinary officials designated to act on the Secretary's behalf, when OAWP recommends a disciplinary action.

Finding 4: The OAWP Failed to Fully Protect Whistleblowers from Retaliation

From June 2017 to May 2018, the OAWP referred 2,526 submissions to other VA program offices, facilities, or other components that were not all equipped to undertake such investigations and without adequate measures to track the referrals or sufficient safeguards to protect whistleblowers' identities.¹⁴ While referring other submissions to entities best positioned to address them is not inherently problematic, complainants were not always advised of these referrals. Of those referred, at least 51 involved allegations of whistleblower retaliation by a supervisor (and so properly fell within the investigative authority of the OAWP). The concerns raised by OAWP's referrals are primarily threefold:

1. The recipient agency must be competent to conduct the investigation of the type of matter being referred in a comprehensive, accurate, and balanced manner.
2. The OAWP must have tracking and monitoring processes to determine if the recipient entity has reasonably and appropriately handled the referral.
3. The OAWP must be transparent with complainants about the referral process and have procedures in place to ensure that complainants' identities will be protected—particularly from individuals in VA who are the subject of the allegations or are positioned to identify the complainant based on the nature of the submission or other released information.

Other concerns regarding protecting whistleblowers from retaliation include the following:

- The OAWP took the position that allegations of whistleblower retaliation could not be investigated unless the whistleblower was willing to disclose his or her identity. The consent to disclose allowed the OAWP to further disclose the whistleblower's identity to other VA components. This policy places OAWP's obligation to investigate whistleblower retaliation in conflict with its obligation to maintain confidentiality of whistleblowers' identities. An OAWP Senior Advisor told the OIG that the OAWP adopted this policy because of the belief that to "investigate retaliation, you have almost no choice but to disclose the individual's identity."

¹⁴ In April and May 2019, Dr. Bonzanto directed, as part of an effort to review all 539 investigations of whistleblower retaliation allegations received from June 23, 2017, through April 15, 2019, to determine if they were properly developed. A plan has been submitted for reviewing 42 disclosures determined to need further review.

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- In 2017, the OAWP established a whistleblower reintegration program, which was later renamed the Whistleblower Mentorship Program. The OIG received complaints that the program was being used inappropriately to target whistleblowers. The stated purpose of the program was to provide whistleblowers who had made complaints with transitional support resources if needed after the whistleblowing experience. OIG interviews indicate that the motivation for the program was also to break the perceived routine of whistleblowers to continue reporting.

Ultimately, in its approximately 18-month existence, the program served one whistleblower as a test case, which was described by OAWP staff as successful. Dr. Bonzanto placed the program on hold because her assessment revealed that it had not met with identifiable or measurable success sufficient to warrant devotion of the resources that would be required to expand the program to serve more individuals.

- The OAWP also failed to establish safeguards sufficient to protect whistleblowers from becoming the subject of retaliatory investigations. One troubling instance involved the OAWP initiating an investigation that could itself be considered retaliatory. At the request of a senior leader who had social ties to the OAWP Executive Director, the OAWP investigated a whistleblower who had a complaint pending against the senior leader. After a truncated investigation, the OAWP substantiated the senior leader's allegations without even interviewing the whistleblower.
- Former leaders of OAWP also directed funds for purposes unrelated to OAWP's core mission. There were \$2.6 million of OAWP's fiscal year 2018 budget of \$17.37 million (15 percent) obligated on two separate contracts for process improvement and leadership development services. Each contract had two subsequent option years which, if exercised, would have brought the potential total obligation to over \$6.8 million. The first contract related to process improvements. According to Dr. Bonzanto, shortly after she became Assistant Secretary, she learned about the existence of the process improvement contract. She told OIG investigators that the contractor "was supposed to be helping us with our directives and our workload," but she learned after inquiring further that "everything that they were doing, none of it was related to OAWP." She also told the OIG that she ordered then Deputy Director Todd Hunter to refocus the contractor to "come back and start doing work that's related to OAWP." According to Dr. Bonzanto, by March 2019 the contractor's work was redirected to assisting the OAWP with developing its processes and procedures.

The services to be acquired under the second contract related to leadership development and coaching, which former Executive Director Nicholas intended for VA generally, not just the OAWP. In response to the OIG's inquiry concerning the contracts, VA suspended performance on the contract for leadership development and coaching, which limited VA's cost to the \$88,000

already expended. The OIG did not find any evidence that VA leaders requested that Mr. Nicholas initiate either procurement or redirect OAWP funds to these contracts.

During its review, the OIG received several allegations from OAWP employees pertaining to personnel decisions and other exercises of discretion by OAWP management. These related to past practices as well as events occurring between January and June 2019. The investigation of individualized complaints of prohibited personnel practices was not within the scope of this review. Witnesses raising allegations of whistleblower retaliation or prohibited personnel practices were encouraged to file complaints with the Office of Special Counsel. Some of these allegations related to dissatisfaction with current OAWP management's decisions. Reviews of these types of allegations were declined when they amounted to reasonable policy differences that were not appropriate or ripe for OIG oversight. Nonetheless some of these allegations raised important issues that OAWP managers needed to address. Accordingly, the OIG deidentified the complaints and transmitted their general substance to OAWP in September 2019.

The OIG made three recommendations to the Assistant Secretary for Accountability and Whistleblower Protection regarding safeguards to maintaining confidentiality of employees making submissions; conducting an organizational assessment of OAWP employee concerns and developing an appropriate action plan; and developing a process and training for OAWP's Triage Division to identify and address potential retaliatory investigations.

Finding 5: VA Did Not Comply with Additional Requirements of the Act and Other Authorities

The OIG determined that VA failed to implement various requirements under the Act, including revising supervisors' performance plans and developing supervisors' training regarding whistleblower rights. VA also has not provided whistleblower protection training for all other employees. On numerous occasions, VA did not submit timely, responsive, and/or accurate reports to Congress on whistleblower investigations and related disciplinary actions as required by the Act. The causes of these lapses included

- OAWP's lack of an adequate database system to capture required information,
- OAWP leaders' failure to understand their responsibilities and deadlines under the Act and plan accordingly, and
- OAWP's inadequate procedures or processes to track the information requested by Congress.

In addition, VA has interpreted the requirement that it submit reports to Congress when the Secretary "does not take or initiate the recommended disciplinary action" within 60 days of receipt of a recommendation in such a way that VA disciplinary officials' mitigation or declination of OAWP's recommended actions are not reported to Congress.¹⁵ By failing to meet these statutory obligations, the

¹⁵ 38 U.S.C. § 323(f)(2).

OAWP has undermined Congress's intent to create greater transparency with respect to employee accountability and whistleblower protection within VA.

There are six recommendations related to Finding 5. Four recommendations are for the Assistant Secretary for Accountability and Whistleblower Protection of which two relate to training; one deals with performance plan requirements; and one addresses improvements to systems to be capable of tracking the data required by the Act. Two recommendations are for the VA Secretary and deal with ensuring supervisor training is implemented and that VA comply with the 60-day reporting requirements.

Finding 6: The OAWP Lacked Transparency in Its Information Management Practices

In the course of the OIG review, staff identified issues outside the initial scope regarding OAWP's information management practices. VA has obligations under the Privacy Act of 1974 to disclose its uses of information collected from individuals, and it has obligations under the Freedom of Information Act (FOIA) to provide timely and accurate responses to requests for information. The OAWP failed to publish notices required by the Privacy Act concerning the collection of information from individuals and VA's routine uses of that information. The OIG also found that the OAWP did not communicate appropriately with individuals who made submissions to the office, and that its responses to requests for information pursuant to FOIA have not met statutory deadlines and lag significantly behind other VA components.

The two recommendations associated with this finding are directed to the Assistant Secretary for Accountability and Whistleblower Protection. The first relates to publishing Systems of Record Notices for each OAWP system of records. The OIG also recommended training, staffing, and establishing procedures for the OAWP's FOIA Office in order to comply with governing requirements.

VA Comments to the OIG Report

VA concurred with all recommendations and provided action plans for implementation. However, some of the planned actions lacked sufficient clarity or specific steps to ensure corrective actions will adequately address the recommendations (see Appendix A for a listing of all recommendations). In particular the actions detailed in multiple responses (specifically to Recommendations 2, 3, 4, 7, 11, 12, 18, 19, and 20) were identified by VA as completed as of October based on the issuance of Directive 0500 on September 10, 2019, or other actions taken in recent months. The OIG has not received sufficient documentation to determine whether recent actions and attempts to implement Directive 0500 fully address the recommendations. The OIG notes that the planned actions for two recommendations (Recommendations 2 and 12) are not sufficient to address the findings and will require updated action plans. OIG staff recently met with OAWP leaders regarding their responses to the OIG report, and will continue to engage with them on planned actions to implement the recommendations effectively and ensure sustainability. In addition to discussing OAWP's current action plans, the meeting provided VA an opportunity to understand why the OIG has declined at this time to close certain recommendations for

which the OAWP believes sufficient remedial measures have already been taken. For example, VA views Directive 0500 (issued in September 2019) as fully resolving several of the recommendations. In the OIG's view, the directive is a start, but it does not address the operational procedures that the OAWP needs to govern its process, and it continued to expand the OAWP's investigative scope beyond that provided by statute without providing any legal justification for doing so. Similarly, the other organization changes implemented recently may lay the foundation for addressing some of the recommendations, however the OIG needs to fully assess the changes before it can close recommendations.

CONCLUSION

The OIG found that VA has failed to properly implement several key provisions of the VA Accountability and Whistleblower Protection Act of 2017, as well as other authorities. In particular, the OAWP's former leaders failed to understand the office's statutory mandates and investigative authority. They were also ineffective at establishing clear policies, procedures, and training sufficient to ensure that the OAWP and VA met their obligations to protect whistleblowers' identities and hold VA employees accountable. Although the OIG recognizes that there have been a series of improvements planned by the Assistant Secretary in 2019, there are significant steps that must be taken to restore the trust of whistleblowers and other complainants due to missteps and a culture set by former leaders who did not appear to value whistleblower contributions. The very office established to protect whistleblowers and enhance accountability lacked the basic structures needed to achieve its core mission. Recent communications to the OIG hotline indicate that some individuals continue to harbor a fear of OAWP retaliation or disciplinary action for reporting suspected wrongdoing. The OAWP leaders and staff who are committed to improving VA programs and operations face considerable challenges in overcoming the deficiencies identified in the OIG review.

Madam Chair, this concludes my statement and I would be happy to answer any questions that you or the other members of the Subcommittee may have.

**APPENDIX A: LISTING OF RECOMMENDATIONS FROM
FAILURES IMPLEMENTING ASPECTS OF THE VA ACCOUNTABILITY AND
WHISTLEBLOWER PROTECTION ACT OF 2017**

FINDING 1

1. The Assistant Secretary for Accountability and Whistleblower Protection directs a review of the Office of Accountability and Whistleblower Protection's compliance with the VA Accountability and Whistleblower Protection Act of 2017 requirements in order to ensure proper implementation and eliminate any activities not within its authorized scope.
2. The VA Secretary rescinds the February 2018 Delegation of Authority and consults with the Assistant Secretary for Accountability and Whistleblower Protection, the VA Office of General Counsel, and other appropriate parties to determine whether a revised delegation is necessary, and if so, ensures compliance with statutory requirements.
3. The Assistant Secretary for Accountability and Whistleblower Protection, in consultation with the Office of General Counsel, Office of Inspector General, Office of the Medical Inspector, and the Office of Resolution Management establishes comprehensive processes for evaluating and documenting whether allegations, in whole or in part, should be handled within the Office of Accountability and Whistleblower Protection or referred to other VA entities for potential action or referred to independent offices such as the Office of Inspector General.
4. The Assistant Secretary for Accountability and Whistleblower Protection makes certain that policies and processes are developed, in consultation with the VA Office of General Counsel and Office of Resolution Management, to consistently and promptly advise complainants of their right to bring allegations of discrimination through the Equal Employment Opportunity process.

FINDING 2

5. The Assistant Secretary for Accountability and Whistleblower Protection ensures that the divisions of the Office of Accountability and Whistleblower Protection adopt standard operating procedures and related detailed guidance to make certain they are fair, unbiased, thorough, and objective in their work.
6. The VA General Counsel updates VA Directive 0700 and VA Handbook 0700 with revisions clarifying the extent to which VA Directive 0700 and VA Handbook 0700 apply to the Office of Accountability and Whistleblower Protection, if at all.
7. The Assistant Secretary for Accountability and Whistleblower Protection assigns a quality assurance function to an entity positioned to review Office of Accountability and Whistleblower Protection divisions' work for accuracy, thoroughness, timeliness, fairness, and other improvement metrics.

8. The Assistant Secretary for Accountability and Whistleblower Protection directs the establishment of a training program for all relevant personnel on appropriate investigative techniques, case management, and disciplinary actions.

FINDING 3

9. The VA Secretary, in consultation with the VA Office of General Counsel, provides comprehensive guidance and training reasonably designed to instill consistency in penalties for actions taken pursuant to 38 U.S.C. §§ 713 and 714.

10. The VA Secretary ensures the provision of comprehensive guidance and training to relevant disciplinary officials to maintain compliance with the mandatory adverse action criteria outlined in 38 U.S.C. § 731.

11. The Assistant Secretary for Accountability and Whistleblower Protection makes certain that in any disciplinary action recommended by the Office of Accountability and Whistleblower Protection, all relevant evidence is provided to the VA Secretary (or the disciplinary officials designated to act on the Secretary's behalf).

FINDING 4

12. The Assistant Secretary for Accountability and Whistleblower Protection implements safeguards consistent with statutory mandates to maintain the confidentiality of employees that make submissions, including guidelines for communications with other VA components.

13. The Assistant Secretary for Accountability and Whistleblower Protection leverages available resources, such as VA's National Center for Organizational Development and the Office of Resolution Management, to conduct an organizational assessment of Office of Accountability and Whistleblower Protection employee concerns and develop an appropriate action plan to strengthen Office of Accountability and Whistleblower Protection workforce engagement and satisfaction.

14. The Assistant Secretary for Accountability and Whistleblower Protection develops a process and training for the Triage Division staff to identify and address potential retaliatory investigations.

FINDING 5

15. The Assistant Secretary for Accountability and Whistleblower Protection collaborates with the Assistant Secretary for Human Resources and Administration, and the VA Secretary to develop performance plan requirements as required by 38 U.S.C. § 732.

16. The Assistant Secretary for Accountability and Whistleblower Protection ensures the implementation of whistleblower disclosure training to all VA employees as required under 38 U.S.C. § 733.

17. The VA Secretary makes certain supervisors' training is implemented as required under § 209 of the VA Accountability and Whistleblower Protection Act of 2017.

18. The Assistant Secretary for Accountability and Whistleblower Protection confers with the VA Office of General Counsel to develop processes for collecting and tracking justification information related to proposed disciplinary action modifications consistent with 38 U.S.C. § 323(f)(2).

19. The VA Secretary in consultation with the Office of General Counsel and the Assistant Secretary for Accountability and Whistleblower Protection ensures compliance with the 60-day reporting requirement in 38 U.S.C. § 323(f)(2) consistent with congressional intent.

20. The Assistant Secretary for Accountability and Whistleblower Protection develops or enhances database systems to provide the capability to track all data required by the VA Accountability and Whistleblower Protection Act of 2017.

FINDING 6

21. In consultation with the VA Office of General Counsel, the Assistant Secretary for Accountability and Whistleblower Protection completes the publication of Systems of Records Notices for all systems of records maintained by the Office of Accountability and Whistleblower Protection, and adopts procedures reasonably designed to ensure that the Office of Accountability and Whistleblower Protection does not create additional systems of records without complying with the requirements of the Privacy Act of 1974.

22. The Assistant Secretary for Accountability and Whistleblower Protection consults with the VA Chief Freedom of Information Act Officer to ensure adequate training and staffing of the Office of Accountability and Whistleblower Protection's Freedom of Information Act Office, and establishes procedures to comply with FOIA requirements including timeliness.