AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

PREVENTING SEXUAL ASSAULTS AND SAFETY INCIDENTS AT U.S. DEPARTMENT OF VETERANS AFFAIRS FACILITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

JUNE 13, 2011

Serial No. 112–17

Printed for the use of the Committee on Veterans' Affairs

U.S. GOVERNMENT PRINTING OFFICE

67–192 WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

JEFF MILLER, Florida, *Chairman*

CLIFF STEARNS, Florida
DOUG LAMBORN, Colorado
GUS M. BILIRAKIS, Florida
DAVID P. ROE, Tennessee
MARLIN A. STUTZMAN, Indiana
BILL FLORES, Texas
BILL JOHNSON, Ohio
JEFF DENHAM, California
JON RUNYAN, New Jersey
DAN BENISHEK, Michigan
ANN MARIE BUERKLE, New York
TIM HUELSKAMP, Kansas
Vacancy
Vacancy

BOB FILNER, California, *Ranking*
CORRINE BROWN, Florida
SILVESTRE REYES, Texas
MICHAEL H. MICHAUD, Maine
LINDA T. SÁNCHEZ, California
BRUCE L. BRALEY, Iowa
JERRY MCNERNEY, California
JOE DONNELLY, Indiana
TIMOTHY J. WALZ, Minnesota
JOHN BARROW, Georgia
RUSS CARNAHAN, Missouri

HELEN W. TOLAR, *Staff Director and Chief Counsel*

SUBCOMMITTEE ON HEALTH

ANN MARIE BUERKLE, New York, *Chairwoman*

CLIFF STEARNS, Florida
GUS M. BILIRAKIS, Florida
DAVID P. ROE, Tennessee
DAN BENISHEK, Michigan
JEFF DENHAM, California
JON RUNYAN, New Jersey

MICHAEL H. MICHAUD, Maine, *Ranking*
CORRINE BROWN, Florida
SILVESTRE REYES, Texas
RUSS CARNAHAN, Missouri
JOE DONNELLY, Indiana

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

June 13, 2011

Page

Preventing Sexual Assaults and Safety Incidents at U.S. Department of Veterans Affairs Facilities 1

OPENING STATEMENTS

Chairwoman Ann Marie Buerkle 1
Prepared statement of Chairwoman Buerkle 34
Hon. Michael H. Michaud, Ranking Democratic Member 3
Prepared statement of Congressman Michaud 34
Hon. Jeff Miller 2
Prepared statement of Congressman Miller 35

WITNESSES

U.S. Government Accountability Office, Randall B. Williamson, Director, Health Care 5
Prepared statement of Mr. Williamson 36
U.S. Department of Veterans Affairs:
Joseph G. Sullivan, Jr., Deputy Assistant Inspector General for Investigations, Office of Investigations, Office of Inspector General 7
Prepared statement of Mr. Sullivan 52
William Schoenhard, FACHE, Deputy Under Secretary for Health for Operations and Management, Veterans Health Administration 8
Prepared statement of Mr. Schoenhard 55

American Legion, Verna Jones, Director, National Veterans Affairs and Rehabilitation Commission 23
Prepared statement of Ms. Jones 58
Disabled American Veterans, Joy J. Ilem, Deputy National Legislative Director 25
Prepared statement of Ms. Ilem 61
Veterans of Foreign Wars of the United States, Marlene Roll, Member, National Women Veterans Committee 26
Prepared statement of Ms. Roll 63
Vietnam Veterans of America, Richard F. Weidman, Executive Director for Policy and Government Affairs 27
Prepared statement of Mr. Weidman 65

SUBMISSION FOR THE RECORD

Carnahan, Hon. Russ, a Representative in Congress from the State of Missouri, statement 66

MATERIAL SUBMITTED FOR THE RECORD

Dean Stoline, Deputy Director, National Legislative Commission, The American Legion, to Diane Kirkland, Printing Clerk, Committee on Veterans' Affairs, follow-up letter dated September 12, 2011 67

PREVENTING SEXUAL ASSAULTS AND SAFETY INCIDENTS AT U.S. DEPARTMENT OF VETERANS AFFAIRS FACILITIES

MONDAY, JUNE 13, 2011

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 3:58 p.m., in Room 334, Cannon House Office Building, Hon. Anne Marie Buerkle [Chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle, Bilirakis, Roe, Benishek, Runyan, and Michaud.

Also Present: Representative Miller.

OPENING STATEMENT OF CHAIRWOMAN BUERKLE

Ms. BUERKLE. Good afternoon. This hearing will come to order.

I ask unanimous consent that all Members be allowed to sit on the dais and ask questions of our witnesses today.

Without objection, so ordered. Today the House Veterans' Affairs Subcommittee on Health will address a very serious issue, the vulnerability and the underreporting of sexual assaults and other safety instances at the U.S. Department of Veterans Affairs (VA) residential and inpatient psychiatric treatment facilities.

As a registered nurse and a woman who has been involved in and a counselor for domestic violence, I have seen firsthand the pervasive and damaging effects sexual assault can have on the lives of those who experience it. Last week, the GAO, the U.S. Government Accountability Office, released a deeply troubling report entitled "VA Health Care: Actions Needed to Prevent Sexual Assaults and Other Safety Incidents."

GAO found that between January 2007 and July 2010, nearly 300 sexual assault incidents, including 67 alleged rapes, were reported to the VA Police. Many of these alleged crimes were not reported to VA leadership officials or the VA Office of the Inspector General (OIG), in direct violation of VA policy and Federal regulations.

The findings of the GAO are disturbing for many reasons. Foremost, they represent a betrayal of trust by a system that was designed to treat our veterans at their most vulnerable. The gross failure of VA leadership to protect the safety and security of our veterans and VA staff, and systematically report and respond to

sexual assault and safety instances is a contempt of justice that also requires immediate action.

This is not the way to run a health care system, and it is certainly no way to treat the men and women who sacrificed so much on behalf of our Nation. Abuse like the kind the GAO references in their report is repugnant and inexcusable. But for it to occur in what should be an environment of healing for our wounded warriors is an affront to the VA's very mission.

So disturbed was I upon reading an early draft of the GAO's report that I, along with Chairman Miller, introduced legislation to ensure a safer and more secure VA medical facility. Our bill, H.R. 2074, the "Veterans Sexual Assault Prevention Act," would address the Department's safety vulnerabilities, security problems, and oversight failures, and create a fundamentally safer environment for our veterans and our VA employees.

Never should a warrior in need take the brave step of getting help and be met with anything less than safe, supportive, and high quality care in an atmosphere of hope, health, and healing. Let me assure each of you that I and the other Members of this Committee will remain committed to righting the many wrongs uncovered by the GAO. I am honored that our esteemed Chairman of the Veterans' Affairs Committee has joined us today, Mr. Jeff Miller, to participate in this hearing.

And I yield to you, Mr. Chairman, for any comments you may have.

[The prepared statement of Chairwoman Buerkle appears on p. 34.]

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you, Madam Chairwoman, for yielding and giving me the opportunity to speak here today. I, like I think all Members of this Committee, were sickened by what we read in the GAO report. The prevalence of sexual assault incidents at VA facilities, the lack of accountability from VA and its leadership, and the lack of safeguards in place for the victims. As a co-requester of the investigation, along with the Ranking Member, Bob Filner, I contacted Secretary Shinseki and urged him to provide an immediate response to the GAO report and to make it public so that we could have this hearing today. I appreciate the Secretary working diligently to do that so that we could move forward.

We found these findings so egregious that Ms. Buerkle and I decided to act immediately by introducing what you have just talked about, H.R. 2074. We intend to move this legislation expeditiously so that veterans are not undermined by the very system which is supposed to be protecting them.

In the past week, some have dismissed these allegations, comparing the size of the VA system and the number of allegations to the private sector. Let me be very clear: there is no comparison. Just one assault of this nature, one sexual predator, one veteran's rights being violated within the VA is one too many, and is absolutely unacceptable. If we need to do more as a Committee to protect our veterans and employees at VA, we will.

I understand that rape in particular has always been a difficult charge to prosecute. And though we have made strides in getting

victims to speak out, we know that for every rape that is reported, many more go unreported. Therefore, we need to know how many victims have not spoken out and how we can reach out to them so that not only is justice done, but so that we can provide them with the proper care and support.

Today we expect to get answers to the following questions: How widespread are assaults at VA facilities due to the lack of reporting protocols at VA? How many cases have been prosecuted? How many are still pending? How many employees who allegedly perpetrated assaults are still working at VA? What has been done to protect patients from fellow patients? And, what is VA doing to ensure that this never, never happens again?

I was looking in some of the citations of the report, on page eight specifically, where it says criminal matters involving felonies must be immediately referred to the VA Office of Inspector General (OIG) Office of Investigations. VA management officials with information about possible criminal matters involving felonies are responsible for prompt referrals to the OIG. It goes on to talk about examples of the felonies. One of those is in fact rape.

Also, VA defines serious incidents as incidents including incidents on VA property that result in serious illness, bodily injury, including sexual assaults. Why were these not forwarded as appropriate?

The safety and security of our veterans is paramount. This Committee will demand answers to assure fellow veterans and the public that VA facilities are safe havens for our veterans and VA employees, and that nobody's rights are violated.

Madam Chairwoman, thank you for your interest in taking this issue so seriously and working on this piece of legislation. I appreciate the opportunity to be here today with you and my good friend, the Ranking Member, Mr. Michaud, and I yield back.

[The prepared statement of Congressman Miller appears on p. 35.]

Ms. BUERKLE. Thank you, Mr. Chairman.

And thank you for joining us this afternoon.

I will now recognize the Ranking Member, Mr. Mike Michaud.

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you very much, Madam Chair, and good afternoon.

I first of all would like to thank everyone for attending this extremely important hearing this afternoon. The purpose of today's hearing is to examine how changes in patient demographics present unique challenges for VA in providing safe environments for all veterans treated at VA facilities. In 2008, I requested the GAO report on women's veterans services, such as research on unique physical and mental health treatment needs of female veterans, how VA was addressing the needs of women veterans, what health care services offered by VA are tailored to women veterans, and barriers that may prevent women veterans from accessing VA health care services.

In July of 2009, this Subcommittee held a hearing on the findings of that report. During the conduct of this report, GAO was made aware of safety issues involving women veterans and sexual

assaults in some VA facilities. Subsequent to that report, then the full Chairman, Mr. Filner, submitted a request for GAO to look further into sexual assault incidents.

We know that the wars in Afghanistan and Iraq have been an unprecedented call upon our National Guard and Reserve components. Today, women serve in the Guard and Reserves at a rate over 17 percent, which is 3 percent higher than that of active-duty military. VA recently reported that within 10 years, women are expected to become 10 percent of VA's patient population. However, the VA health care system was built to accommodate the war-related illnesses and injuries of male veterans.

As women are serving in combat conditions alongside their male counterparts, it is important for the Department to embrace and recognize the needs of all veterans, both men and women alike. In the 110th and 111th Congresses, this Committee held a series of hearings to examine the needs of women veterans. The veterans who testified shared their stories of feeling unwelcome, alienated, and disrespected in some VA medical centers, so that they are now reluctant to pursue the benefits and services that they have earned with their service to our country.

Women veterans should not have to worry about being subject to cat calls upon entering a facility. And they should certainly not have to worry about falling victim to sexual assault while receiving care.

While sexual assault is often considered an issue only affecting women, in fact, both men and women have suffered sexual assaults. Further, victims may be assaulted by predators of the same or the opposite sex. Like other types of trauma, sexual trauma can leave lasting scars upon the physical and mental health of its victims.

The GAO has recently uncovered many of the nearly 300 sexual assault incidents reported to the VA Police since 2007 that were not reported to the VA leadership. Incidents like this simply should not happen and need not happen. When policies and procedures are not in place or, worse, not followed, we fall short of our national commitment to provide the utmost level of care possible.

I want to thank our panelists today for appearing today. I am committed to working with you and the Chairwoman of this Subcommittee to ensure that the safeguards are in place so that no veterans, male or female, fall victim to sexual assault under the VA care.

With that, I yield back, Madam Chair.

[The prepared statement of Congressman Michaud appears on p. 34.]

Ms. BUERKLE. Thank you, Mr. Michaud.

We will now welcome our first panel to the table. Joining us is Mr. Randall Williamson, Director of Health Care for the Government Accountability Office; Mr. Joseph G. Sullivan, Deputy Assistant Inspector General for Investigations from the VA Office of the Inspector General; and Mr. William Schoenhard, VA's Deputy Under Secretary for Health Operations and Management, Veterans Health Administration (VHA).

Accompanying Mr. Schoenhard is Dr. Arana, the Acting Assistant Deputy for Health for Clinical Operations; and Mr. Kevin

Hanretta, the Deputy Assistant Secretary for Emergency Management.

Gentlemen, thank you all for joining us this afternoon.

Mr. Williamson, if you would please proceed.

STATEMENTS OF RANDALL B. WILLIAMSON, DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; JOSEPH G. SULLIVAN, JR., DEPUTY ASSISTANT INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND WILLIAM SCHOENHARD, FACHE, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GEORGE W. ARANA, M.D., ACTING ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR CLINICAL OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND KEVIN HANRETTA, DEPUTY ASSISTANT SECRETARY FOR EMERGENCY MANAGEMENT, OFFICE OF OPERATIONS, SECURITY, AND PREPAREDNESS, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF RANDALL B. WILLIAMSON

Mr. WILLIAMSON. Thank you, Chairwoman Buerkle, Ranking Member Michaud, Mr. Miller, and Members of the Subcommittee.

I am pleased to be here today to discuss GAO's recent report on sexual assault incidents at VA medical centers, known as VAMCs. On a prior GAO study, VA clinicians had expressed to us concerns about the safety of patients treated in VA mental health programs that also housed veterans who had previously committed sex crimes.

Subsequently, we performed this study of sexual assault incident reporting and safety precautions. Our review of incident reporting examined these incidents VA-wide, while our review of safety precautions focused on five selected VAMCs, focusing on residential treatment and inpatient mental health units. We found numerous areas that need improvement to better ensure the safety of VA patients and staff alike.

For the period January 2007 to July 2010, we identified 284 sexual assault incidents that were reported by VA Police at 105 different VAMCs. These incidents were suspected, alleged, attempted, and confirmed sexual assaults involving both men and women, including 67 rapes, 185 inappropriate touching incidents, and 32 other types of sexual assaults. Most of the alleged perpetrators and victims were VA patients and employees.

We found that many of the alleged sexual assault incidents were not reported to VA management or to the VA Office of Inspector General. For example, of the 67 alleged rape incidents reported to the VA Police, only 25 were reported to the Office of Inspector General, as required by VA regulation. Also, we contacted officials at four Veterans Integrated Services Networks (VISNs), and found that of the 102 alleged sexual assault incidents reported to VA Police at 29 VAMCs within these VISNs, only 16 were reported to

VISN leadership, and only 11 of these were forwarded to the VA Central Office.

Several factors may contribute to this underreporting. First, VA does not have a common definition of sexual assault for reporting purposes. VAMCs we visited varied in the level of detail of their definitions, including one with no definition at all. VISNs had no definitions in their written VISN policies, and VA Central Office has no definition of sexual assault in its reporting guidance.

Second, VA at all levels does not have clear expectations about the types of incidents that should be reported. For example, VA Police files from one VAMC we visited showed that three alleged perpetrators had been involved in previous sexual assault incidents that were not reported to VA Police because VA clinicians believed that these behaviors were a manifestation of a clinical condition. Also, leadership at one VISN told us they expected to be informed of all alleged sexual assault incidents. However, we found three alleged incidents of rape and one oral sex incident that was not reported to this VISN.

We also identified a number of shortcomings that may hinder effective oversight of sexual assault incidents by Central Office. For one, VA has no system that ensures that pertinent program offices receive all reports of sexual assault incidents that occur in their areas of responsibility. For example, we found that VA Central Office managers of the residential and inpatient mental health programs were not always aware of the sexual assault incidents that had been reported by their units in the field.

Also, there is no central database to collect and store reports of sexual assault or any mechanism to systemically analyze reports and identify trends. Such analyses are important to assess the extent of sexual assaults across VAMCs and to identify methods for preventing future incidents.

Finally, we observed and tested security precautions at five VAMCs we visited, with some disturbing results. For example, police command centers at these VAMCs were sometimes unattended, understaffed, or could not monitor residential treatment facilities due to incompatibility in surveillance systems.

We also noted malfunctions in panic alarm systems. For example, at four VAMCs the panic alarms we tested either did not appropriately alert VA Police of the location of an alarm or were previously disabled without notifying staff. Finally, at all five VAMCs, panic alarm systems did not alert both VA Police and staff on the unit. While we found significant security lapses at these five VAMCs, we did not attempt to link such lapses to specific sexual assault incidents.

In summary, underreporting and poor oversight of sexual assault incidents, coupled with security lapses at VAMCs, can severely compromise the safety of patients and VA staff alike. Decisive actions are needed to correct weaknesses and to better ensure that VAMCs maintain a safe and secure environment. In our report, we recommended a number of specific actions VA can take to accomplish this. That concludes my opening remarks.

[The prepared statement of Mr. Williamson appears on p. 36.]

Ms. BUERKLE. Thank you, Mr. Williamson.

Mr. Sullivan, you may proceed.

STATEMENT OF JOSEPH G. SULLIVAN, JR.

Mr. SULLIVAN. Thank you, Madam Chairwoman, Members of the Subcommittee. Thank you for the opportunity to discuss with you how the Office of Inspector General interacts with the VA Police with regards to reporting felonies, to include sexual assaults at VA facilities and also to tell you what we provided to the GAO for their report.

I am the Deputy Inspector General For Investigations. The Office of Investigations is responsible for conducting criminal and administrative investigations where wrongdoing occurs or is alleged in VA programs or operations, as well as serious misconduct by senior officials. We have 141 criminal investigators at 29 field offices across the country.

The VA Police are a separate entity from the Office of Inspector General in that they are a uniformed police service located at and responsible for the security of the medical centers and other Department facilities. And they have jurisdiction for crimes that occur on VA property. There are two sections of the Code of Federal Regulations (CFR), which we have been mentioned that require all VA employees to report suspected criminal behavior to VA management and/or the OIG: 38 CFR, Section 1.201, requires employees with knowledge or information of possible criminal violations related to VA programs and operations to report that information to their supervisor, any management official, and the OIG; 38 CFR, Section 1.204, requires VA management with information about possible criminal matters involving felonies are to ensure and be responsible for reporting that information to us.

While our field supervisors report that generally VA Police chiefs are complying with this reporting requirement in the CFR, they are aware of instances where failure to timely report suspected felonies does occur. When we become aware of such situations, our field supervisors will visit with the police chief, share our concerns with them, and remind them of their reporting responsibilities under the CFR

Now, with regards to the GAO report, I would like to share with the Subcommittee what we provided to GAO. They requested information about allegations of sexual assaults for the period of January 1, 2007, as was said, through August 1, 2010. And we provided detailed information about our 130 closed investigations. We also provided GAO with de-identified information regarding nine sexual assault investigations that remained open back on August 1, 2010.

Next, GAO asked that we review 42 scenarios regarding alleged sexual assaults that had occurred on VA property but were not, according to GAO research, referred to us by the VA Police. We had four senior agents look at these scenario descriptions and concluded the following: In 23, or 55 percent of the scenarios, we would not have expected VA Police to notify us. Examples included allegations that lacked any evidence of sexual assault obtained as a result of a medical examination, and a victim who quickly recanted her original allegation.

In 14, or 33 percent of the scenarios, we would have expected VA Police to notify us. Examples included a victim with dirt and leaves on her clothes and in her hair, who reported that she had been raped while walking the grounds of the VA facility. We also had

a female physician who reported that a male sexually assaulted her while she was conducting a medical examination. Those are two examples we would have expected to be referred.

In five, or 12 percent of the scenarios, we just couldn't make a judgment because they were either too ambiguous or inadequate information was provided in the scenario description. We welcome GAO's recommendations to automate reminders to VA Police to notify us when entering a felony offense into the police database, and we are pleased with VA Police's intention to also implement an automated notice to our field offices whenever the record of such an offense is created. We believe both measures will greatly reduce the number of times where we will not be notified in the future.

Madam Chairwoman, this concludes my statement, and I would be happy to answer any questions you or Members of the Subcommittee may have.

[The prepared statement of Mr. Sullivan appears on p. 52.]

Ms. BUERKLE. Thank you, Mr. Sullivan.

Mr. Schoenhard, you may proceed.

STATEMENT OF WILLIAM SCHOENHARD, FACHE

Mr. SCHOENHARD. Chairman Miller, Chairwoman Buerkle, Ranking Member Michaud, and Members of the Committee, thank you for the opportunity to discuss the safety and security of our veterans, employees, and visitors.

This issue is a top priority of Secretary Shinseki and of our Department. We constantly strive to ensure a safe environment, and we appreciate and accept the eight recommendations in the GAO report. We owe a safe environment to everyone who enters our doors, whether they be visitor, patient, staff. Anyone who is in our work environment deserves a safe environment.

And as Chairman Miller said, one incident in which one of our patients, visitors, or staff feels victimized is one too many. We deeply regret that anyone would feel victimized and experience any kind of victimization at one of our facilities.

As a Vietnam veteran and someone who comes to VA with 34 years of experience in the private sector, I am impressed that VHA provides exceptional service in what is the most mission-driven organization I have ever been accustomed to or experienced. We are a large integrated system, and we have 14 points of care, but as Chairman Miller pointed out, one incident of anyone feeling victimized is one too many.

The GAO report rightly identifies recommendations for improvements in preventing assaults and in reporting incidents. First, we must do all we can to prevent harm. We need to explore every opportunity we can for prevention of anyone feeling victimized in our facilities. That starts with VA staff, with police officers, with all of our staff involved in training, background investigations, and ongoing vigilance of watching our environments and in taking immediate steps when anyone looks as if they may be at risk.

It also requires that we have physical systems in place, such as panic alarms and closed-circuit television, locks on our doors, and all that is important for physical security. Last Friday evening, I issued a directive to all of our VISN directors asking for a report by June 24 of all review of physical infrastructure in terms of pre-

vention that goes into serving as a deterrence for anyone feeling victimized.

And in terms of reporting, when we look at that, as Secretary Shinseki says, we cannot solve a problem we cannot see. Full and complete reporting is essential to a full investigation of any incident that has been reported. It is also important in that we can aggregate this data, develop system review of the trends, and develop best practices, and learn from our experience in order to make, again in the prevention area, our facilities even safer.

Our Under Secretary for Health, Dr. Petzel, has commissioned a work group chaired by Dr. Arana and Dr. Patricia Hayes, who is our chief consultant for women's services, and that work group is undertaking review of all eight recommendations, but particularly focused on the reporting, with a requirement that by July 15, we receive an initial action report, with a final report of its work by September 30. As we did Friday, we will be immediately following up on any action the work group stimulates for our review. And they have met several times, including this afternoon.

One of the important advances in reporting is the standup of our Integrated Operations Center, or IOC, which was stood up in 2009. This operates 24 hours a day, 7 days a week. It has a VHA watch officer as part of that team. And it is important that we, as was pointed out by Mr. Williamson and others, ensure timely reporting of any report that especially has to do with criminal behavior to the IOC. The requirement is that that be accomplished within 2 hours. While GAO has identified instances where senior VA leadership were not informed, I do wish to assure the Committee that I have every confidence at the local level, when an incident is reported, that local management, in cooperation with the VA Police and with local law enforcement, are investigating these allegations in every way that we possibly can, working closely with law enforcement also to pursue criminal prosecution to the extent the law permits.

Let me repeat again: One incident is one too many. We owe our veterans, our staff, our patients, our visitors, everyone who is associated in our work environment, a safe environment. Our veterans have served this country with distinction. As Madam Chairwoman so eloquently said, we owe them a place of healing, of hope, of respect. And as a mission-driven organization, this is important I think beyond policy, beyond reporting. That is all important. It gets to the culture of VHA. It gets to a care and concern on the part of everyone for what is going on in their environment, and a commitment to ensuring that the utmost of respect is afforded everyone with whom we serve and that we serve.

Thank you for the opportunity to testify. My colleagues and I will be happy to answer questions.

[The prepared statement of Mr. Schoenhard appears on p. 55.]

Ms. BUERKLE. Thank you, Mr. Schoenhard.

I yield to Chairman Miller for 5 minutes for questions.

Mr. MILLER. Thank you for yielding. The report covers 2007 to July of 2010. Can you tell me what the statistics are from July of 2010 until today of sexual assaults that have been reported within the system?

Mr. SCHOENHARD. Sir, we do not have that information available here today, but we will provide that to you.

Mr. MILLER. Would it have been a reasonable expectation that somebody might be asking that question?

Mr. SCHOENHARD. We had not anticipated that question. But we do have the information, and we can provide that to you in short order, sir.

Mr. MILLER. If you would, for the record, so that we can make sure that all Members have the answer to that question. When can we expect it?

Mr. SCHOENHARD. We would provide that, sir, within 3 weeks?

Mr. MILLER. Three weeks?

Mr. SCHOENHARD. Yes, sir. I want to make sure that we have all the information together in a complete way. We will try to provide it sooner.

[The VA subsequently provided the following information:]

Thursday, June 30, 2011

INTERIM REPORTS OF RAPE, INAPPROPRIATE TOUCHING OR OTHER SEXUAL ASSAULT IN VHA WORKPLACES BETWEEN AUGUST 1, 2010 AND MAY 31, 2011 ‡

National Counts of Sexual Assault Incidents in VHA *

		Substantiated **		Un-Substantiated ***	
Type of Incident †	Total	Total	Reported to OIG	Total	Reported to OIG
Alleged/Attempted Rape	6	2	2	4	4
Inappropriate Touching of a Sexual Nature	78	31	7	47	4
Alleged Sexual Assault/Other	57	21	7	36	5
TOTALS	141	54	16	87	13

* *Information is still under review regarding facility reports, police reports and substantiation of allegations.*

† *As reported in the 10N Sexual Assault Management/Police Roll-up Database.*

** *Sexual Assault Incidents as defined below and verified by VA Police and/or Clinical Staff.*

*** *Sexual Assault Incidents as defined below, which following VA Police and/or Clinical Staff investigation/review were not substantiated.*

‡ ***[Update as of September 23, 2011: This report is still interim as cases remain under investigation and so may change categories. VA will be sure to present a final report once it can confirm that all cases have closed.]***

To ensure accurate reporting, sexual assault is defined as:

"Any type of sexual contact or attempted sexual contact that occurs without the explicit consent of the recipient of the unwanted sexual activity. Assaults may involve psychological coercion, physical force, or victims who cannot consent due to mental illness or other factors. Falling under this definition of sexual assault are sexual activities such as [but not limited to] forced sexual intercourse, sodomy, oral penetration, or penetration using an object, molestation, fondling, and attempted rape. Victims of sexual assault can be male or female. This does not include cases involving only indecent exposure, exhibitionism, or sexual harassment."

Of the 54 substantiated incidents, the relationship of perpetrators to victims includes:

(2) Rape

- Patient on employee (charges filed)
- Patient on patient (U.S. Attorney declined prosecution based on evidence compiled)

(19) Patient on employee

(13) Patient on patient

(11) Employee on patient
(6) Employee on employee
(2) Non-patient or employee on employee
(1) Volunteer on employee

Actions VA is Taking

It should be noted that VA is undertaking efforts to ensure that every alleged sexual assault event is identified and tracked by the Department.

- **Timely Reporting:** The VA has established a policy to ensure that every alleged sexual assault incident is reported to a national incident center within 2 hours. This reporting provides leadership with visibility to ensure that each event is resolved.
- **Integrating VA Law Enforcement with Clinical Care:** The VA is performing a review of VA law enforcement personnel classification and compensation. Currently, VA law enforcement staff members are graded below those of comparable staff from other agencies. The VA is assessing integration of VA law enforcement personnel within Title 38. It is critical that VA facility staff and policies view VA law enforcement as an integral team member in establishing a safe, secure environment of care.
- **Focusing on Prevention:** VA will review critical elements for the prevention of sexual assault in our work areas by focusing on:

  1. behavioral surveillance by all VHA staff;
  2. environmental surveillance through the use of technology and specific safety equipment;
  3. education of patients, staff and visitors; and
  4. review and revision of VHA policy as it pertains to workplace safety.

Mr. MILLER. I hope that you have all the information together, and it won't take you 3 weeks. Further, ongoing investigations by Oversight and Investigations, our Subcommittee, shows that senior leadership at least one facility that we are aware of siphoned money away from facility security to provide funds for other projects. I have also been told that staffing security billets, there is some evidence that senior leadership at VA do not see the value of their own security forces. And these consequences of failures involving these is unacceptable, as you might imagine. But what I want to know is, how can we be sure that VA is spending the money that this Congress allocates to them appropriately?

Mr. SCHOENHARD. Sir, that is incumbent on us in leadership to ensure that the funds that are allocated for the purposes that are intended are spent for the purpose that the Congress and all of our appropriators assure. And I guarantee you we will follow up with any instance in which that is not done.

Mr. MILLER. And then thirdly, I think it is ironic, I went to your Web site this afternoon and found a tab, "Women Veterans Health Care, Military Sexual Trauma." And of course, this deals with women's sexual trauma. But as we know from the report, this is men and women.

Mr. SCHOENHARD. Yes.

Mr. MILLER. But it just opens up with the question, "Did you experience any unwanted sexual attention, uninvited sexual advances, or forced sex while in the military? Does this experience continue to affect your life today?" And I guess my question is, don't you find that ironic that this is on the VA's home page?

Mr. SCHOENHARD. Well, sir, we want to be able to invite our veterans who have made—perhaps have experienced that to come forward so that we can treat them.

Mr. MILLER. I yield back.

Ms. BUERKLE. Thank you, Mr. Chairman.

I will just use the last few minutes of the time, if that is okay. Mr. Schoenhard, I want to just go back to some of your comments that you made in your opening statement that I find disturbing and really don't assure me that things are going to happen quickly enough.

Mr. SCHOENHARD. Okay.

Ms. BUERKLE. You mentioned that you are going to review all eight GAO recommendations, and then by July 18, we are going to get an initial action report. What is an initial action report?

Mr. SCHOENHARD. Madam Chairwoman, the requirement by July 15 would be that an action set of recommendations be put forth to the Under Secretary for our review. But we are looking for any information that can be forthcoming sooner than that. I don't know if Dr. Arana may want to speak. He is co-chairing that group, and may want to elaborate.

Dr. ARANA. Madam Chairwoman, the group has met about four times in the past week and a half. It is an interdisciplinary group that includes security, includes caretakers, providers. It includes specialists in sexual trauma from all over the country. And the plan is, by July 15, to have a clear definition of what sexual assault is, and a clear way to track and trend that over the next few years. The plan is to put that in place by July 15.

Also, the plan is to look at behavioral surveillance techniques that we already use in some facilities but we want to promulgate out to the entire system. And we also will look at technical surveillance devices so that we can improve our ability to survey clearly behaviors during off hours and in more remote places. So the plan is if we find something in the next week or 10 days that we want to execute and put in place, the Under Secretary and Mr. Schoenhard have told us, tell us what it is, and we will deploy it immediately. So I think the plan is to really move on this as quickly as we can and be able to report out finally sometime in August about what actions we have taken and how we plan to track and trend that.

Ms. BUERKLE. Thank you.

I yield 5 minutes to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair.

At the VA, of the 46 incidents where the employees of the VA were charged or involved in patient sexual assault, what has been the disciplinary action to those employees, if any?

Mr. SCHOENHARD. Mr. Ranking Member, we are working with the GAO to make sure we understand the specific cases that are mentioned in the 284. And we will be following up. I can assure you this: Every disciplinary action appropriate has an important element of ensuring first and foremost that the veteran or the patient is no longer at risk. And so we are working with the GAO to identify specifically who they have identified in order for that information to be provided.

Mr. MICHAUD. So you don't know if you fired anyone because of rape or sexual assault?

Mr. SCHOENHARD. Yes, we have.

Mr. MICHAUD. You have?

Mr. SCHOENHARD. Yes. Let me be clear. We certainly have cases where employees have been terminated. We have had cases where employees have been convicted. And we have certainly a variety of other instances of disciplinary action. What I want to be clear about, Mr. Ranking Member, is that we are working with the GAO to be sure we understand what 284 instances were identified in their review, which we do not have at this time.

Mr. MICHAUD. And the Vietnam Veterans of America, actually they recommend or point out the need for separate facilities or wards for female patients seeking long-term care. Do you have any comment on that? What settings have the VA set up that actually would allow for separate wards or separate facilities?

Mr. SCHOENHARD. Well, it is certainly important that we provide privacy, respect, and courtesy to our female veterans, an ever-growing number of veterans in our service of those who have served this country. A number of facilities have been constructed throughout VHA in order to provide separate access and concentration of women's services for female veterans. And we are committed, sir, to continuing that investment. It is important that our veterans be treated with dignity and respect.

The comment was made earlier regarding cat calls and the rest. We need to ensure that there is privacy. With regard to residential treatment centers and community living centers, female veterans are isolated closer to the nursing stations so that they can be more closely monitored by the nurses and are certainly kept, as much as we can, separate from male veterans. And we will continue that commitment to ensuring we have the facilities and the program to treat our female veterans, an ever-growing number of veterans that we serve.

Mr. MICHAUD. And what type of training do the VA Police go through? Are they all VA employees? Or do you contract those services out? And if so, what type of training do they have to go through?

Mr. SCHOENHARD. Sir, that is a great question. If I could call on Mr. Hanretta to perhaps comment.

Mr. HANRETTA. Sir, the VA Police, every VA Police officer attends the law enforcement training academy, the VA law enforcement training academy in Little Rock, Arkansas. It is an 8-week program, where they are certified as VA Police officers and working in a health care environment. So their sensitivity to respect responding to incidents and reporting is emphasized throughout the training.

Mr. MICHAUD. My last question, I only have 40 seconds, is how is the VA staff notified that they are treating or housing a convicted sex offender?

Mr. SCHOENHARD. I might call on Dr. Arana, who could give more experience from his own clinical care. But there are universal precautions that are taken in being able to interview our patients and our veterans. And this, by the way, is a subject of our work group that will be undertaking the best practices, a full literature search. We think there is an opportunity to improve our capacity to determine those who may be at risk in order to protect those that are treated in our facilities.

I don't know, Dr. Arana, if you would want to add to that.

Dr. ARANA. The expectation is that all patients who are seen in mental health services, whether they are long term or acute, have a what we call biopsychosocial assessment, which includes a legal history and a history of trauma. And the plan, therefore, is put together for the care of that particular veteran based on that history. Now, it is the case that the GAO did outline one of the recommendations is we needed to improve our ability do that. And we agree 100 percent with that.

Mr. MICHAUD. Thank you.

Ms. BUERKLE. Thank you, Mr. Michaud.

I now yield 5 minutes to the gentleman from Michigan, Dr. Benishek.

Mr. BENISHEK. Thank you, Madam Chairwoman.

I just have a couple questions about the testimony. And one of the things that sort of surprised me was from Mr. Sullivan's statement here, that the GAO had requested the review of some scenarios that hadn't been reported by the VA Police to the OIG, and that 45 percent of the cases that they brought up, you know, 33 percent said they should have been expected to be reported, and the other five cases, there was an inability to make a judgment because of the ambiguous or inadequate information in the scenario description. It just seems to me that, you know, nearly half of the cases that weren't reported seem to show some sort of lack of police procedure really. I mean, five cases don't have adequate information in the report to make a decision and 33 percent seem like they just were improperly reported. That is a relatively high number.

Do you have any information, Mr. Sullivan, on whether there is any investigation into the caliber of training? I mean 8 weeks doesn't seem like a very long period of time I guess for officer training. Have we done anything about this statistic?

Mr. SULLIVAN. To your first question, I would be reluctant to comment on the training that is afforded the VA Police officer.

But by contrast, recognizing that the majority of our agents already come to us well trained from other traditional Federal law enforcement agencies, such as the Federal Bureau of Investigation, the Secret Service, the Postal Inspection Service, Immigration and Customs Enforcement, they come ready to work and with a wealth of experience to be able to adapt to any criminal investigation because of their experience. To transition to Inspector General investigations they will then attend Inspector General training for 3 days. Should we hire new agents, they will attend an 18-week course at the Federal Law Enforcement Training Center in Georgia. That is followed by courses offered at the Inspector General Academy. It is a very robust training program that continues throughout the remainder of their career. Even I have to go through periodic training. So it is a healthy program. It is a good program. I suggest Mr. Hanretta comment on the police training.

Mr. BENISHEK. I just say, doesn't it seem somewhat remarkable there were 45 percent of the cases that were brought forth without a very good answer?

Mr. SULLIVAN. It was difficult for us to interpret. As I understand it, the GAO took the scenario description directly from the uniform officer report of the VA Police. They didn't add anything to it; they didn't delete anything from it. Nor would they share

with us any specifics as to the victim, the perpetrator, or the facility. Had they done so we could have tracked the allegations back to the VA station where this may have occurred. We could have formulated in our minds a sense of what has gone on at the particular facility in the past to assist us with making our decision as to whether or not the case should be referred.

Mr. BENISHEK. So you are saying that you haven't been able to investigate any of these cases then because you don't know which ones you are talking about?

Mr. SULLIVAN. That is right. We don't know. We can't, with the information provided, go into our system and tell you whether or not those 42 scenarios are in our open or closed inventory.

Mr. BENISHEK. It seems like we should investigate those cases, don't you think?

Mr. SULLIVAN. I do. I think we will follow up once we get a better understanding of when these alleged crimes took place. We will also have a conversation with the VA Police officials.

I will tell you, though, in answer to the Congressman's question, we have presently in our inventory, 17 open sexual assault allegations that we are investigating. We had a total of 139 during the period of the GAO review. And 23 were successfully prosecuted of the 139.

Mr. BENISHEK. All right. I guess my time is up. But I would like to ask the Chairwoman if we could get some additional information going further here to make sure that we actually follow up on these, in that the GAO and the Inspector General's office figure out where these cases came from and if there is really a problem.

Mr. SULLIVAN. Yes. The exercise for us was nothing more complicated than here are some scenarios; would you or would you not expect the VA Police to refer them to you? Not would you or would you not choose to investigate.

Mr. BENISHEK. I see.

Ms. BUERKLE. Thank you, Dr. Benishek.

I now yield 5 minutes to Mr. Bilirakis from Florida.

Mr. BILIRAKIS. Thank you, Madam Chair.

I appreciate it very much. This question is for Mr. Schoenhard. One of the GAO's recommendations was to increase security by involving stakeholders into facility design and redesign. I just received word, a VA announcement that a $92 million contract was awarded to construct a new mental health facility at Bay Pines in Florida. This facility will provide residential rehabilitation, acute inpatient mental health services, and outpatient mental health services. This is the question: Were stakeholders, including the clinicians who will provide the care, involved, were they involved in the design of this project? And if not, why?

Mr. SCHOENHARD. Sir, if I could take that question, I will find out for sure. It is absolutely essential that they are involved, because it is important that when an alarm is activated that not only law enforcement, but clinicians are immediately notified. So I will follow up and take that question, sir, and find out.

Mr. BILIRAKIS. Please. I would like you to please get back to me on that as soon as possible.

Mr. SCHOENHARD. Yes, sir.

[The VA subsequently provided the following information:]

It is standard practice to provide clinical professionals extensive input opportunities in each phase of the design for a new facility. Participants from the Bay Pines Mental Health clinical staff, including the Chief of Mental Health and the Chief Nurse for Mental Health, attended numerous meetings to provide input into the location of the building, the architectural design, and the layout and function of each room and in design review meetings at each phase in the process. Overall, representatives from the Medical Center have been active throughout the design process. The design phase of the new Mental Health Center at Bay Pines VAMC is complete and a construction contract has been awarded. Clinical staff will continue to be consulted as construction progresses. Updates are regularly provided to our Mental Health Consumer Council, comprised of Veterans.

Mr. BILIRAKIS. Then also how are the needs of veterans, and I know you touched upon this, especially women veterans, and you just touched on it briefly, so if you can elaborate on that, with regard to privacy and safety being taken into consideration? How are women veterans and veterans in general, as far as privacy is concerned, taken into consideration when these buildings are designed?

Mr. SCHOENHARD. Well, it is important that we have the physical security of electronic locks and key cards to ensure privacy. I think that especially as it relates to care for female veterans, we need to continue to focus not only on facility development to serve their needs, but programmatic development. And we do have a strong program office that is working to ensure that we have both.

Mr. BILIRAKIS. Give me an example of what you have done so far.

Mr. SCHOENHARD. Well, we have constructed on a number of our campuses specific new clinics that are separated from the main frame medical center for care for women. And we have also designed throughout VHA specific specialty clinics for women who have suffered sexual trauma. Dr. Arana may want to speak more regarding the clinical care, if you have anything that you would want to add.

Dr. ARANA. Yeah. In addition, sir, we have—the women's program has reviewed all the facilities in the system. And there are recommendations that have been laid out for increasing security and also increasing privacy. And that is something that is tracked by women's health coordinators at each network.

Mr. BILIRAKIS. Thank you.

Next question for Mr. Schoenhard, and then also Mr. Williamson. In the GAO report, one item addressed was vulnerabilities in physical security precautions. GAO recommended and VA agreed that alarm systems should be routinely tested. How frequently do you believe that these tests should be happening to ensure that they are optimally working? And will you elaborate on where you believe responsibility should fall to ensure these tests are happening?

Mr. SCHOENHARD. Sure. Sir, that is a great question. And let me answer in reverse order. The responsibility to ensure that the testing is done and that the alarms work lies with the medical center director, the VISN director, myself, and on up to the Under Secretary. We have the con for that responsibility.

In hospitals throughout the Nation, this is typically a policy that is developed at the local level in conjunction with Joint Commission standards, our accrediting body. But part of what we want to do in this small work group, and part of what I want to know by June

24 from our VISN directors, is the current state of that. And I think that we will be providing, sir, additional guidance beyond what medical center policies have developed over time in order to meet accreditation requirements. And we will also do that based upon what we find from this system-wide thorough survey of our physical alarm infrastructure.

Mr. BILIRAKIS. Okay. Thank you very much.

I yield back, Madam Chair.

Ms. BUERKLE. Thank you. I now yield 5 minutes to the gentleman from Tennessee, Dr. Roe.

Mr. ROE. Thank you for yielding.

Just an opening comment. Hospitals in general, and VA Hospitals specific, should be places to heal, not harm, as all medical facilities should be. And it should be a safe environment whether you are a patient there or just a visitor there. Having dealt with this for over 30 years, rape is one of the most underreported crimes out there. And it is probably handled as poorly as anything we do about how the emotional effect on the victim, and how we deal with it. So it is imperative that we do that.

A second thing I think that is really important that has not been mentioned, I know that when I was mayor of Johnson City, Tennessee, we paid a lot of attention to crime mapping. Where did it occur? And that is why this reporting is so very important, because if you notice a pattern, maybe it is in a certain part of the hospital, or a community-based outpatient clinic (CBOC), or wherever it may be, you then can point to that area about how to secure it. So I think that is very important about the mapping process about where these crimes occur. If they are random, then it is much harder. But if there is a trend there, it is pretty easy to focus on that and reduce the problem dramatically, whether it is in the clinic or hospital. Just a point that it is not just gathering data to be sent up to sit on a shelf somewhere.

The other thing I would recommend you do, and you probably have done it, but in your Committee that gets together, I would get some worker bees, folks that are out there everyday on the clinical side working, who are out there working with the patients. So I don't know whether you have done that or not, but I would strongly encourage you to do that.

And to Mr. Michaud, what he was saying a minute ago, in his comment about someone who may be questioned, and I know Dr. Arana was mentioning this, but there is no way to do a background check and check and see if what somebody is telling you is the truth? In other words, if a sexual predator, I think that is what he was getting to, and the people there at the hospital don't know because they don't have access to the information, that puts them at a disadvantage in caring for that person, number one, and number two, protecting the people who are there from this individual. Is there any way to get at that?

Mr. SCHOENHARD. That is part of what we want to explore further in the small group, sir. I think that is a very important area for us to thoroughly investigate. As I mentioned earlier, to see what other systems are doing, what literature search may come from this. Because we have a duty to ensure that we can identify those risk behaviors with every patient that we serve. At the same

time, we have a duty to serve that veteran. But the first and foremost responsibility is ensure a culture——

Mr. ROE. It is to do both. We in a community know that if a sexual predator is in your community, you are notified of that. Out in the real world, you can have that happen. I don't know why that wouldn't be the same case on VA property. When someone is noted, let's say the police investigate an alleged rape or sexual assault, is that then—when they gather that information, it is then reported, which wasn't done, it is reported up the chain of command. How is that prosecuted from there? In other words, it is on Federal property. What happens then?

Mr. SCHOENHARD. Sir, may I ask Mr. Hanretta to initially respond to that?

Mr. HANRETTA. Sir, at the VA Medical Center, as Mr. Sullivan mentioned, every VA employee has a responsibility to report if they suspect criminal activity. When that happens, it is either reported to the OIG and/or the local authorities, because the prosecution takes place in the local community, not by the VA Police.

Mr. ROE. No, no, no, I know that. There is an attorney general in Tennessee, but there is also a Federal court. So it is not prosecuted in the Federal system. The local attorney general prosecutor would bring that case, would gather the evidence from the information gathered from the VA Police and whoever the witnesses, however the information is gathered, and then prosecuted. Is that correct?

Mr. HANRETTA. Yes, sir. I would defer to Mr. Sullivan for the actual procedures, but I believe that is correct.

Mr. SULLIVAN. We first, for prosecution purposes, have to identify, as you said, the facility, and whether or not the Federal Government has legislative jurisdiction. Facilities may have exclusive jurisdiction proprietary or concurrent jurisdiction. It is difficult to get many of these cases prosecuted in Federal court. We do rely on the State courts to accomplish this. What we did not have when we reviewed these scenarios, but will have when we look into how we proceed now with these allegations is the State. Because rape and sexual assault definitions can vary by State. So, in order for us to know what we have and where to refer it, we need a little bit more information.

Mr. ROE. The prosecutor decides that in that State.

Mr. SULLIVAN. He does indeed. And it starts back at the beginning with determining the jurisdiction of the medical center. Is it exclusive once the Federal Government has jurisdiction? Is it concurrent where both Federal and State have jurisdiction?

Mr. ROE. I will finish up, I know my time is up, but I think what I started out by saying about how underreported it is, is that there needs to be an attitude that this is a very serious issue and that it needs to be addressed seriously because it is that. And I want to be sure that the VA is handing off to the local prosecutor the information they need to go ahead if a crime has been committed and investigate that crime. That is what I was getting at.

I yield back.

Ms. BUERKLE. Thank, Dr. Roe.

I now yield 5 minutes to the gentleman from New Jersey, Mr. Runyan.

Mr. RUNYAN. Thank you, Madam Chair.

Mr. Sullivan, as you were just responding to that last question, you talked a little bit about—I understand the political State jurisdiction thing. If it is a situation where the State is involved, are the local police departments involved from the get-go?

Mr. SULLIVAN. Yes.

Mr. RUNYAN. They are?

Mr. SULLIVAN. Yes.

Mr. RUNYAN. And they are within the reporting process that we are having problems with getting the information on?

Mr. SULLIVAN. Yes. And typically when we have such serious offenses, they are the first to be notified by the VA Police.

Mr. RUNYAN. Okay.

Mr. SULLIVAN. The sheriff's department, the local police, whoever that may be. We just ask for timely notification. We are not saying we have to be the first to be notified. And in these instances, it is important that the VA Police go to the local jurisdiction immediately.

Mr. RUNYAN. Very well. Mr. Schoenhard, the GAO found a number of facilities that were understaffed. Specifically, there was one, that by criteria, suggested there was supposed to be 19, but there was only 9 on hand. Why have you not been able to staff these facilities fully?

Mr. SCHOENHARD. Congressman, that is a very important question because we need to be fully staffed with police coverage. And that is part of what I am seeking to understand in our current survey of our field. I want to understand better what the retention and the recruitment difficulties are with that and see what steps need to be taken to address those.

Mr. RUNYAN. That was going to be my next question. Do you have an idea of retention problems? Is there a major turnover within the system?

Mr. SCHOENHARD. There is turnover which varies, sir, by facility, and that too is part of what I want to get a better sense of in conjunction with our VSIN and medical center directors, because this is an extremely important part of our staffing.

Mr. RUNYAN. It really is, because having the people around and being used to the procedures is the first step of getting these reported correctly and into prosecution.

Mr. SCHOENHARD. Yes.

Mr. RUNYAN. So it is a huge step.

Madam Chair, I don't have any further questions. I yield back.

Ms. BUERKLE. Thank you, Mr. Runyan.

I now will begin the second round of questions and I will yield myself 5 minutes. I am just so concerned about what I am hearing this afternoon. Correct me if I am wrong, but I understood you to say, Mr. Schoenhard, that as of July 18th this workgroup is going to come together and define sexual assault.

Mr. SCHOENHARD. Madam Chairwoman, let me clarify. The initial action plan for the work group's review of all eight recommendations is due July 15th. However, we are urging Dr. Arana and Dr. Hayes to hold frequent meetings of this work group. And we will be bringing forward everything we can as soon as we can. We are not waiting for July 15th to develop this.

One of the items that was discussed today in the work group was the definition. And so we feel, Madam Chairwoman, a sense of urgency about this, and we will work as quickly as we can to address all eight recommendations.

Ms. BUERKLE. My concern is that you are going to get caught up with defining sexual assault, which has been defined on a number of occasions. I am sure if you looked around you could find a satisfactory definition and not waste the time of this Committee, but to get on within getting these procedures in place and getting a chain of command in place. You talked about employees; some lost their jobs.

Mr. SCHOENHARD. Right.

Ms. BUERKLE. Some perhaps are being disciplined.

Mr. SCHOENHARD. Yes.

Ms. BUERKLE. Without a definition of sexual assault, how do you even know who is guilty and who is not?

Mr. SCHOENHARD. Well, I would agree with you that it should not take us long to develop a common definition. But that is essential in order to ensure we have complete reporting. And we are consistent in that going forward. So we will put that as a top priority.

But let me clarify as it relates to investigation of any incident involving an employee. This is really not a function of a definition. If there is any risk or harm or victimization that someone has reported, we don't need a definition to fully investigate that and take appropriate action with regard to our workforce.

Ms. BUERKLE. I am also concerned with the fact that there doesn't seem to be a clear chain of command once an incident is reported. As was discussed by my colleagues, there are issues of jurisdiction, but if it is a criminal case oftentimes the county and the district attorney's office will handle it. Is there not a protocol in place right now to act as a roadmap that clarifies, if an incident occurs, who it gets reported to, what actions are taken? It seems to me I hear from the various agencies that it is not clear.

It seems to me we should be able to put on a big sheet of paper all of the cases that the GAO reported, and for each one of those victims who shall remain nameless, we should be able to track who it was reported to and the resolution and what happened to the perpetrator. It should all be very clear.

And when I hear the testimony, I don't get any sense of any definition, any clear path here. I am very concerned that it is going to come up on July 15th and we are still going to be struggling with a definition. I think the Committee shares the feeling that this is an outrage that the veteran community, male or female, or the employees of the Department of Veterans Affairs would be victims of a system that isn't taking care of them. Time is of the essence.

You mentioned earlier that this is a priority of Secretary Shinseki. Now, just because it has been brought up, or since 2009 when the Ranking Member made the request and a report was issued now it is just becoming an issue; or has it been a priority right along? These are my concerns, that the clock is ticking and our veterans are paying for this delay.

Mr. SCHOENHARD. Madam Chairwoman, if I could respond. It is clear, as was earlier testified, that anyone who suspects that there is criminal behavior that has been initiated must report that to the

OIG. And part of the benefit of the stand-up of the integrated operation center is that we have those reports within 2 hours after they are reported to local police.

There is also an expectation that we would be fully reporting this up the management line. And this is a subject that I want to get improved process for. And that will be in part aided by a common definition, so we know for sure everything is being reported within what consistently, across all of VHA, is determined to be sexual assault. That definition is important.

But I can assure you we cannot, as I said earlier, solve a problem, track a problem, develop the kind of mapping that Dr. Roe spoke about before, Congressman Roe, unless we have full adequate reporting of all incidents, and we must have that.

Ms. BUERKLE. Thank you. I yield to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair. I too am extremely concerned when you look at the numbers in the GAO report. That was only in five facilities out of the 111 facilities who offer these types of services, so it is probably fair to assume that this is more—the numbers are much greater in that regard.

The question that I have, and actually gets back to, similar to Mr. Roe, when you look at jurisdiction, whether it is a State court or Federal court—and I am not sure—is there a different definition for rape at the Federal level or sexual assault versus at the State level; and if so, why wouldn't that be in Federal court? Because my big concern, for instance, when you look at police officers—and actually this occurred in Maine last year where a Togus police officer shot a veteran and was being investigated. The investigation actually was done by the State, not Federal, because of a memorandum of understanding.

So I am just kind of concerned about are there any other memorandums of understanding that the VA has as it relates to prosecuting rape or sexual assault? Because it gets back to Mr. Williamson's comments in his report. He indicated that the VA medical facilities have the authority to customize and design their own onsite reporting systems in policy.

So I guess my question is: Do you feel that it is better to have a consistent policy within the VA system versus a customized policy, depending on where the VA is located? That is my first question.

And my second question as it gets back to a memorandum of understanding: Are there any memorandums of understanding within the VA system as it relates to sexual assault or rape, whether it will be prosecuted in State or Federal court, and who does the prosecution? Would it be the DA or would it be a U.S. attorney? Those are my three questions.

Mr. SCHOENHARD. Sir, I don't know if Mr. Sullivan should begin with that or Mr. Williamson.

Mr. SULLIVAN. I can speak to the definition, Federal definition of sexual assault, rape, and what have you, which can be found in 18 U.S.C. 2441, which tracks pretty closely with the definition that the GAO used in looking at rapes. So this is the definition we use in the VA OIG for the sexual assault crimes.

To the State crimes, my experience has been that each one may be a little different. Ones that apply perhaps to a juvenile, the language may be a little different when you talk about rape or assaults with a 14- or 15-year old child. With adult perpetrators of crimes in violation of Sate law again in not knowing which States we are talking about, I can't give you a definitive answer: Here is one example in Alabama, here is an example in Massachusetts. I can't do that. But know that they are different. However slightly, they are different.

Mr. MICHAUD. And I mean that is a concern I have is under that definition. And if there are memorandum of understanding, whether it be prosecuted in State court, who does the prosecution, the outcome could become different.

Mr. SULLIVAN. A memorandum of understanding does not enter into our decision or the way we proceed with an investigation. I don't know if they even exist, so I would defer back to the Department.

Mr. MICHAUD. Well, for a shooting incident they do, because in a shooting incident, whether that shooting incident at Togus was a justified shooting or not, it wasn't the Federal agencies that are investigating it, it is actually the State agency because of a memorandum of understanding. So that is a concern I have when you transfer that over to rape or sexual assault; are there any cases where it is going to be just turned over to the State versus a Federal agency? It gets back to Mr. Roe's original question about jurisdiction issues.

Mr. SULLIVAN. I don't have the answer on the shooting. If we look at a medical center that has exclusive jurisdiction, all criminal cases will have to be changed by the Federal Government. If you take something like a restraining order, there is sexual abuse going on in the family, or with relatives or whomever, the restraining order is taken in the State courts. The crime has been committed off VA property, but the perpetrator who violated the restraining order today is on property, and the local police arrest. In that circumstance, because it is Federal property, that must be brought in Federal court. I don't know if that confuses the issue or it lends clarity to the issue, but different scenarios present different challenges, and it all goes back to that jurisdiction.

Mr. MICHAUD. I see my time is expired. But it does. I mean, this incident occurred on Federal property by a Federal employee, but the justification actually went over to the State. So that is why I was kind of curious as it relates to rape or sexual assault, whether that might be the same case even if it is on Federal property.

Mr. SULLIVAN. I am not well versed on that case so I am reluctant to even speculate on that.

Mr. MICHAUD. Thank you. Thank you, Madam Chair.

Ms. BUERKLE. Thank you, Mr. Michaud. The gentleman from Michigan, Dr. Benishek.

Mr. BENISHEK. Madam Chair, I don't really have any more questions. I agree with you that it is sort of appalling there are not better procedures in place to handle this problem, and certainly it should be the focus of our attention in the future. And with that I yield back.

Ms. BUERKLE. Thank you, Dr. Benishek. Dr. Roe from Tennessee.

Mr. ROE. Again, back to where we were talking about how underreported rape is in the military, it is estimated 80 to 90 percent are not reported. So I think there is an attitude about how serious you take these sexual-assault issues on our campuses around the country. Because if the attitude is this is going to be dealt with as the serious crime that it is—and I think that also is because the victims many times realize the harassment that they go through just to get it done, and so they don't report it. There is no telling what the real numbers are, the times that this has happened. And I do think the definition shouldn't be all that hard. I think the courts—I mean that should be pretty easy, really. And it has been defined by the courts many, many times, so I think that won't be very hard for you to do.

But just once again, back to what the Chairman said about how important I believe that this issue is and how important it is for us to take it seriously. I yield back.

Ms. BUERKLE. Thank you, Dr. Roe. The gentleman from New Jersey, Mr. Runyan.

Mr. RUNYAN. I have no further questions, Madam Chair.

Ms. BUERKLE. Thank you, Mr. Runyan.

On behalf of the Subcommittee, thank you all for your time and your testimony today. You are now excused.

I invite the second panel to the witness table. Joining us on our second panel are representatives from many of our veteran service organizations. We have Verna Jones, Director of the Veterans Affairs and Rehabilitation Division of the American Legion; Joy Ilem, Deputy National Legislative Director for the Disabled American Veterans (DAV); Marlene Roll, a member of the National Women Veterans Committee of the Veterans of Foreign Wars (VFW); and Mr. Rick Weidman, Executive Director for Policy and Government Affairs for the Vietnam Veterans of America (VVA).

Thank you all very much for being here this afternoon and for being such strong advocates for your fellow veterans.

Ms. Jones, we will start with you if you would like to begin your testimony.

STATEMENTS OF VERNA JONES, DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; MARLENE ROLL, MEMBER, NATIONAL WOMEN VETERANS COMMITTEE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND RICHARD F. WEIDMAN, EXECUTIVE DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

STATEMENT OF VERNA JONES

Ms. JONES. Thank you, Madam Chairwoman Buerkle, Ranking Member Michaud. On behalf of the American Legion I would like to thank you for inviting us to testify this afternoon about the disturbing findings of the recent GAO report on sexual assaults and safety incidents within the VA health care system. By now everyone has heard in detail the horrifying implications of this report,

so there is little need to recite the litany of grievances. Suffice it to say this is quite simply unacceptable.

We cannot ask veterans, men or women, to go to health care system for treatment if they must fear their own physical integrity. This state of affairs must end, and it must end now.

How can we ask VA to clean up its shop if it doesn't even know how to define the problem? The report states that there is no clear guidance within VA to even define these incidents, let alone standard operating procedures for screening for problems or reporting them as they arise. If you can't even define the problem, how can we hope to fix it?

H.R. 2074, the "Veterans Sexual Assault Prevention Act," directs VA to define terms and policies and to accept accountability with mandatory reporting. The American Legion applauds and fully supports this legislation as a first step toward fixing the problem. But let's not allow this to be another opportunity to add high-level bureaucrats to the system and further exacerbate the problems of a top-heavy operational model.

This problem doesn't require a battalion of senior executives; it requires VA authorizing the employees they have to take charge and manage this on a local level, but with consistency. It requires VA to implement clear accountability goals for the people already in place. Every medical facility is required to have a military sexual trauma coordinator; yet in most facilities, this is not even a full-time job. More often it is an afterthought, additional duties assigned to an employee with other obligations elsewhere.

The American Legion recommends elevating this position to a full-time employee whose duties are fully focused on dealing with the effects of sexual trauma, whether they occurred in service or at any time. Let these employees, already dedicated at least in part to helping these victims, become the front-line soldiers in this battle.

It has often been said of VA facilities in general, if you have seen one VA medical center, you have seen one VA medical center. Consistency is what has to count; even enforcement of standards.

The American Legion urges Congress to continue their oversight of VA to ensure consistency becomes a standard. Through the Legion's own System Worth Saving visits, we strive to document and hopefully improve this consistency. Yet the addition of outside eyes is always helpful. Try as we might, we cannot remove the horror that comes from hearing of these experiences, nor should we. Indeed, only by facing the difficult truth can we hope to overcome them. This is not something to shy away from, this must be confronted head on.

It is important to remember, however, that while the path beyond this crisis is arduous, it is not terribly complicated. Provide clear definitions and policies so all who come to VA, whether patient or employee, know exactly what will not be tolerated and how to proceed when the unthinkable happens. Commit to the seriousness of this topic by upgrading the part-time military sexual trauma coordinator to a full-time job that reflects the importance of its role as a front-line defender of these veterans. Be consistent and clear in the implementation of these policies.

The American Legion again thanks this Committee for including us in this discussion, and we are happy, of course, to answer any questions the Subcommittee may have.

[The prepared statement of Ms. Jones appears on p. 58.]

Ms. BUERKLE. Thank you, Ms. Jones.

Ms. Ilem, you may proceed. Thank you.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee. On behalf of the Disabled American Veterans, we appreciate being invited to present our views on GAO's report on the actions needed to prevent sexual assaults and other safety issues in VA health care facilities.

The deficiencies identified by GAO have uncovered VHA's lack of any consistent or systematic approach to documenting, reporting, and preventing sexual assaults from occurring in its facilities.

Given the findings of the report, it is clear VA must revise and strengthen its safety policies to ensure the environment of care at the VA health facilities keeps veterans, staff, and visitors safe from harm.

As recommended by GAO, VA should establish a comprehensive, consistent approach to documenting, investigating, and reporting sexual assaults as serious crimes of personal violence.

Madam Chairwoman, we noted a statement in the report indicating that many of these matters were brought to leadership's attention and that in early 2011, efforts were said to be underway to correct these problems. However, according to GAO in mid-June, today it does not appear that substantive systemwide changes have been made or instituted. We see this delay not as a deficiency of program management, but a failure of VA leadership.

Sexual assault is not solely a woman's issue, and likewise it is not a health care issue per se. Nevertheless, VHA has assigned the Director of its Women's Health Program Office to be a significant leader in the task force VA created to address it. While we have faith that this office will work hard in an effort to correct these problems and will do so in a responsible manner, we believe the accountability for this problem and for these changes and improvements rests much higher in the organization. Given the serious nature of these issues, it is troublesome that once VA was informed of these incidents that no action, it appears, was immediately taken to institute a comprehensive plan or solution.

GAO noted in its analysis that VA was experiencing significant demographic changes in its health care programs. We agree VA patients are trending younger, with a more visible female presence. These shifts and pressures produce stresses that VA has not previously or recently experienced and may be contributing to the culture of safety challenges that GAO has uncovered.

We see in the current report, in relationship to the residential program sites visited, that only one of the three compensated work-therapy programs evaluated accepted women into the program due to safety and privacy concerns. These safety concerns continue to negatively impact women veterans. In essence, they are denied access to these highly specialized services because VA is not confident that they can provide a safe environment for these women.

Likewise, GAO notes that several clinicians they interviewed for a previous report on women's health services in VA expressed concern for the safety of women veterans placed in VA inpatient mental health programs.

These types of concerns highlight the potential for further assaults unless corrective action is taken. Among the security precautions that must be in place for residential programs are secure accommodations for women veterans, with periodic assessments of facility safety and security issues. We have brought this issue to the attention of the Subcommittee in previous hearings and hope you will consider oversight to ensure as VA moves forward to improve their overall culture of safety in VA facilities, that it specifically addresses these safety issues related to the care of women veterans. Additionally, VA must establish a risk assessment tool to ensure the safety of all VA patients.

While acknowledging its findings could not be generalized to VA as a whole, GAO outlined eight recommendations, we endorse these ideas and note that VA has concurred with each of them as well. We urge VA to move forward expeditiously to implement them and to provide regular reports to Congress on its progress.

Madam Chairwoman, every veteran should be assured of the highest level of quality care and patient safety while receiving care in a VA facility. A veteran should never fear for his or her own personal safety.

We are pleased that VA has taken action with the establishment of a multidisciplinary work group to define what actions need to be taken to prevent sexual assault and to respond appropriately to reports and allegations of sexual victimization of veterans or VA employees.

In closing, we are hopeful that GAO's findings can serve VA and veterans in providing a roadmap to promote a new environment of care and safety, one that should be closely monitored by this Subcommittee as VA completes these changes.

That completes my statement and I am happy to answer any questions that you or the Subcommittee Members may have.

[The prepared statement of Ms. Ilem appears on p. 61.]

Ms. BUERKLE. Thank you, Ms. Ilem.

Ms. Roll, you may proceed.

STATEMENT OF MARLENE ROLL

Ms. ROLL. Madam Chairwoman, Members of the Subcommittee, thank you for asking me here today. As a female veteran and an accredited service officer, I can tell you what the seriousness is of the GAO findings for all our veterans, but especially for our women veterans.

To sit and talk to a woman who has been sexually assaulted, you see a person who is unsure of themselves and everyone around them. They are anxious and they may make little eye contact or no eye contact at all, but glance at the door every little while. I have witnessed them physically recoil at the sight of a man walking into a room. I have met with victims at neutral sites because of their reluctance to come to my office and use an elevator because of their fear that a man might enter that elevator.

Anyone who has been sexually assaulted has had their life changed forever. That is unacceptable. The damage is often lifelong and "trust" is a word that they can no longer use. Our soldiers have volunteered to keep their country safe and they deserve nothing less when seeking treatment. The VA hospitals and clinics are there to help and heal our veterans, and trust is the very foundation of that service. That is why a zero tolerance has to be implemented and maintained.

The GAO findings are disturbing, and now that we have the information, what will be done to ensure that "trust" and "safety" are two words that we can use to describe the VA again?

The VFW understands that protocols have been in place, but they are weak. We also believe that they need to be unified throughout the VA system, and to remove the ability at each management level to stop the upward reporting of these incidences because they have determined that the issue has been resolved. Reporting is how a problem is acknowledged and then resolved.

Staff training with the emphasis on reporting at all levels needs to be enhanced and enforced. I know the VA does online PowerPoint presentations for their staff, but they cannot impress the importance of a topic like having a face-to-face class with an instructor, or the additional comments of other attendees. Definitions need to be clear so that there are no misunderstandings.

Additionally, camera monitoring in all units, outpatient clinics, can help deter behavior as well as sustain allegations. I believe that the directors of each VISN and hospitals are in the best position to ensure all protocols are followed and to set the tone of safety and secure environment for all our veterans to seek treatment in.

The VFW trusts VA will address these issues swiftly and the VA will continue to monitor their progress. This concludes my testimony and thank you.

[The prepared statement of Ms. Roll appears on p. 63.]

Ms. BUERKLE. Thank you, Ms. Roll.

Mr. Weidman, you may proceed.

STATEMENT OF RICHARD F. WEIDMAN

Mr. WEIDMAN. Madam Chairwoman, thank you for including Vietnam Veterans of America in this hearing to take our comments. In our legislative agenda, it is typical that the number one legislative priority of an organization be a particular piece of law or a particular policy to change. But our number one priority for the 112th Congress is accountability. And that is really what is broken down here within the VA.

The GAO report—you certainly are to be commended, you and Mr. Michaud, for having this hearing today. And Chairman Miller and Mr. Filner sure are to be commended for just focusing attention on it.

Dr. Roe hit the nail on the head earlier when he said if, in fact, people take sexual assault seriously, they are much more likely to report it. And I think he is probably right, that we are only seeing the tip of the iceberg, and it is that taking of these heinous acts seriously by VA management that has been lacking throughout.

This is not something that, if it was taken seriously by the hospital directors and the network directors, would have asked for a definition a long time ago, and apparently it has not been taken seriously. So it is something that the work group needs to—shouldn't waste too much time, and it should be able to come to the conclusion pretty quickly.

The eight recommendations from GAO all seem pretty logical and pretty sensible. One of the things that GAO recommended, though, was nowhere in the VA response to the General Accountability Office, and that is to have stakeholder involvement at every step of the process. Stakeholders include employees who work on these wards and work various places in the hospital, but it also includes veterans. And there is not one single mention anywhere in the VA's response of including women veteran leaders and the veteran service organizations in finding the solutions. This is not because we are looking around for something to do, Madam Chairwoman, but because we bring something to the table. And certainly if I can't bring it, my three distinguished colleagues to my right certainly bring experiences that need to be taken into account as they set forth to modify facilities, physical facilities, and as they put in place the training and the—policies first, and then training that will work at the local level.

The old saw in the military is a unit does well that which a commander checks well. And the commander has not been checking this issue carefully, because it has not even been defined, much less reported properly.

There was one VISN, which actually startled me, if you look through one of the tables that reported no sexual assaults over a 2½ year period. I wish to God that is true, but I don't believe it. I just think that it is so lax in that VISN that nothing was reported and pushed up the line.

So the final recommendations that I would have to this Committee, Madam Chairwoman, is not for more statutes, but for more oversight hearings in association with your colleagues at the Oversight and Investigation Subcommittee and continued pressure and follow-up.

One of the things that those of us who have been reading GAO reports for years and OIG reports for years is there is always a great flurry when the report comes out, and the press covers it and Members get excited about it—and genuinely so—and are committed to seeing something done. But then it is not in the limelight and nothing happens, and nobody inside the VA follows up to find out did they in fact carry out that correction plan that VA management said they were going to do.

And that is what I implore you, Madam Chair and Mr. Michaud, to make sure that this Subcommittee and this Committee as a whole follows up to keep the pressure on until this problem becomes resolved at each and every VHA facility nationwide.

Thank you very much for the opportunity to share our views here this afternoon and thank you so much for having this hearing.

[The prepared statement of Mr. Weidman appears on p. 65.]

Ms. BUERKLE. Thank you, Mr. Weidman.

Thank you to all of our witnesses for their testimony today.

I will now yield myself 5 minutes for questions. This question is for all four of you: Has the VA reached out to any one of your organizations or any other organizations that you might know of, to participate in this work group that we just heard about, previous to this hearing?

Ms. ILEM. Not to the DAV.

Ms. JONES. Not to the American Legion.

Ms. ROLL. Not to the VFW.

Mr. WEIDMAN. No, ma'am.

Ms. BUERKLE. Thank you.

In the written testimony, the VA states that it currently uses both VA staff and physical infrastructure systems to ensure the security of VA facilities, for example: closed circuit cameras, locks, alarms, separate facilities, specialized training.

Do you have any comment—and we can just go right down starting with Ms. Jones—do you have any comment on that approach?

Ms. JONES. I think that approach would be great. Those closed circuit cameras would help them to be able to monitor the activities that are going on and hopefully deter that kind of activity from happening.

You know, we recently did a national survey of women veterans in January. We had 3,012 respondents, and one of the questions was about security. And 25 percent of those women who answered our question about security indicated that they were uncomfortable, they didn't feel safe in a VA environment. So I think that the use of those security cameras would certainly help.

Ms. BUERKLE. Ms. Ilem.

Ms. ILEM. I think we have heard of longstanding problems in VA with infrastructure issues related to women veterans. It has been an ongoing focus in the GAO reports over the years. And although I don't have specifics, I think even in this GAO report, it is pointed out about the concern, or in previous reports, that clinicians have concerns about putting a female veteran on an inpatient mental health unit. So that really gives me pause in terms of, you know, as being a veteran myself, among veterans, who uses the VA system, should I be hospitalized, I would surely hate to be worrying about those types of issues.

I would like to know that all VA patients are safe and I don't feel that I should be isolated. I feel I should be safe in a VA facility and that the people that are charged for my care would be watching out and making sure all of those systems are in place to make sure a safe environment for any patient, especially women.

Ms. BUERKLE. Thank you. Ms. Roll.

Ms. ROLL. Well, while the cameras and other security issues would certainly deter, I still believe that the line defense is from our staff itself. They have to be the ones to stand up for the veterans and advocate for them that this will not be tolerated; and if anything does come down and does present itself, that it is dealt with swiftly and they know about it, that the veterans themselves know that it was taken care of and it has been addressed and that they are being looked after. I think that is their main issue. They just want to know that while they are there, they have eyes that have their back.

Ms. BUERKLE. Mr. Weidman.

Mr. WEIDMAN. I would associate myself with the remarks of my three colleagues in that it is much more a question of corporate culture than anything else. You can have all the bells and whistles and all the fancy equipment you want, but if you don't monitor the monitors, if you will, and if you don't have swift and sure action when something untoward happens, then you don't have a corporate culture where people feel safe, one; and two, where miscreants know that if they step out of line, that justice will be swift and sure. And that is much more important than anything else.

And it is really when you think about it, particularly the veteran-on-veteran violence that is done is the ultimate betrayal. We have a saying in Vietnam Veterans of America that is their founding principle, which is, "Never again shall one generation of American veterans abandon another." And we have boiled that down into a button that just says, "Leave no veteran behind."

And to perpetrate a sexual assault upon someone else who has pledged their life in defense of the Constitution is really the ultimate betrayal. And it is something that needs to be hammered home and it is something that needs to be taken seriously by VA management at every level, and it will permeate down. But it is not a question of bells and whistles, it is a question of organizing things and holding the senior people at each facility accountable for clear guidelines on how do you keep people safe.

Ms. BUERKLE. Thank you very much. I now yield 5 minutes to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair. Mr. Weidman, my question to you—because if I understood correctly Ms. Jones, Ms. Ilem, Ms. Roll, they all agreed that the VA should have a standardized policy throughout the VA system rather than leaving it up to each individual to determine what policies and what definitions are.

I am not sure about VVA. Do you believe that there should be a standardized definition in policy throughout the VA system?

Mr. WEIDMAN. I do, sir. And the only thing that I regret, which is that working group doesn't include one of the two most important groups, and that is—in fact, it doesn't include the other one either—there is no union representation on that of the Nurses Association. They are not represented either, and neither are women veterans.

Mr. MICHAUD. My next question gets back to actually what Dr. Roe was mentioning earlier, is jurisdiction issues. So if the VA does adopt a standardized policy nationwide on how to deal with reporting and what the definition is, that definitely could conflict with actually what State laws in different States are. So I can see that that could cause a problem for a VISN director.

My next question, actually for all organizations: Do you feel that if we have a standardized system and definitions for rape and sexual assault, that that should be dealt with in Federal court versus State court? And I will start with Ms. Jones and work on down.

Ms. JONES. My feeling is that it should be dealt with in Federal court. On a Federal facility, it is the VA, and it should be standardized so there are no questions, no room for leeway, you know, for each State. I think it should be standardized across the board. If

it happens it should be dealt with in Federal court in a systematic manner.

Ms. ILEM. I don't know that I can provide a response to that, just not knowing enough to feel that I have the expertise. But certainly let me provide something to the Committee for a response on that from our organization.

[Ms. Ilem subsequently provided the following information:]

> Ranking Member Michaud, Disabled American Veterans (DAV) does not have a national resolution from our membership that deals with the specific issue of courts of jurisdiction in the case of rape or other sexual assaults that may occur on Department of Veterans Affairs (VA) property. Therefore, we can take no formal position on the matter. Nevertheless, we believe that any sexual assault, of a veteran or non-veteran, on VA grounds, should be reported to proper legal authorities and receive justice through the courts. Additionally, veterans should have access to treatment to assuage the effects of this violent and highly personal crime.
>
> On the specific question of jurisdiction, we suggest this matter be reviewed either by the VA General Counsel or by the Attorney General, either of which is in better position than DAV to advise you and the Subcommittee on this matter.

Ms. ROLL. I, too, do not come from a background that I can speak intelligently to that, so if I could also bring that back to the Committee.

[Ms. Roll subsequently provided the following information:]

> In a perfect world, yes, the VFW would like to see a standardized system and definitions and that all crimes should be heard in Federal courts, seeing that most Veterans Affairs property is federally owned. However, many properties are leased or shared. In cases when the Federal Government has sole ownership of property, they have exclusive jurisdiction, unless law enforcement is shared between the Federal Government and a State or local government. In these cases, the jurisdiction becomes concurrent legislative. Title 38 U.S.C., Section 902, allows VA to enter into agreements with other law enforcement agencies, making these properties concurrent legislative jurisdiction.
>
> The question VFW has is why does VA have this authority? Is it because there are so many leased properties or properties that are shared with private or public institutions that would cause them to be in fact concurrent legislative jurisdictions, making the jurisdiction shared? If this is true, to insist that all crimes in VA facilities be investigated and tried in Federal court may violate the 4th Amendment "Property Clause." VFW does not have expertise in property ownership or law enforcement jurisdiction, but these are things to consider.
>
> Also, if the property is remote and it is not economically feasible to employ a full criminal investigative team, then perhaps allowing concurrent legislative jurisdiction might be the only solution to quickly and accurately investigate a crime.
>
> There is no doubt there need to be a very clear, linear process to investigating and prosecuting crimes that occur in VA facilities. These guidelines must be developed, taught to VA law enforcement personnel, and followed. There may need to be multiple guidelines, depending on the jurisdiction(s) of the facility. At the end of the day, a quality investigation and prosecution rests on two things: (a) the resources to conduct the investigation, and (b) the reliability of the investigators to do a thorough investigation.
>
> The VFW suggests that to ensure that victims of crimes have due process and a quality investigation, that VA produce clear procedural regulations for each jurisdictional scenario and insist on training to those regulations.

Mr. WEIDMAN. I think, perhaps fool-heartedly, I will go ahead and give you an answer. But, you know, this is really part of taking this issue seriously. What the gentleman from the OIG's office didn't come out and clearly say is that the U.S. attorneys don't want to prosecute this. They consider it a minor crime. This is not a minor crime. This is a major crime and it is—against any cit-

izen—but it is made all the more heinous because it was committed against an individual who put their life and limb on the line in defense of the Constitution and of their country. So part of taking it seriously is perhaps this Committee working closely with the Judiciary Committee, and make sure that our Federal court system starts to take rape and sexual assault seriously.

Mr. MICHAUD. And like some of you, I am not an expert in this area either and it brings back the situation where deadly force was used, and there was a memorandum of understanding. Actually, the State took jurisdiction to investigate whether deadly force was justified. So I can see a problem if we do have a standardized definition systemwide, that actually the enforcement piece could be different; because whether it is State versus Federal so I don't know if that is something that we actually could and should do and work with the Judiciary Committee to make sure that there is some type of consistency there as well.

My last question actually is for the Legion. You mentioned that 25 percent of female veterans do not feel secure. If there is any specific one issue that we should deal with, what should that be? I know you talked about cameras, the security issue, but is there any specific issue that we should focus on?

Ms. JONES. Well, the question we asked was about security. In this particular survey, we just talked to them about physical security and information security. I do not have the breakdown with me about physical security or information security. I will get back to you with the information.

Dissatisfaction levels of over 25 percent for this attribute, which was for security, suggested there is considerable room for improvement in security-related issues for the VA to include physical security and a degree of sensitivity around the patient's personal information. So I will get back with you with a breakdown of those who felt the most need of physical security.

[Ms. Jones subsequently provided the following information:]

Mr. MICHAUD. Thank you very much. And thank you very much, Madam Chairwoman, and look forward to working with you to move this issue forward to the forefront, and hopefully we will be able to keep a close eye on it as well. Thank you.

Ms. BUERKLE. And I thank the Ranking Member. Thank you very much.

Mr. WEIDMAN. Madam Chair, may I comment? Mr. Michaud referred to an incident that I am familiar with. And that is a perfect case about why it should be under Federal control. There were four different local and State law enforcement officials involved in that incident, and that veteran did not have to die. If the VA police had been in charge and well-trained in how to deal with him, he only had a .22 and he never discharged his weapon and yet he was shot several times. I think it was like nine times.

It didn't have to happen. And it was only because there wasn't a clear policy and a clear Federal mandate that this be handled internally by the VA because it occurred on Federal property. And I think the same thing is true of sexual assault and other crimes on VA property, because it is Federal property. If you get a whole pastiche of local law enforcement officials, you are going to have the

kind of miscommunication that is going to lead to veterans needlessly dying.

Ms. BUERKLE. Thank you, Mr. Weidman.

I now yield 5 minutes to the gentleman from Michigan, Dr. Benishek.

Mr. BENISHEK. I would like to thank all of you for coming. It has been very educational for me. I don't really have any more questions. I just want to comment that I am so thankful that you guys are involved, and that we just hope that we can get the VA to cooperate with the veteran service organizations to develop a plan to stop this. So I am all behind that.

And with that I yield back my time.

Ms. BUERKLE. Thank you, Dr. Benishek. Are there any further questions from the Committee?

Thank you to our second panel for sharing your time and your expertise with us this afternoon, and you are now all excused. Thank you.

I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include any extraneous materials. Without objection, so ordered.

Ms. BUERKLE. Thank you once again to all of our witnesses and to our members in the audience for joining today's extremely difficult but very necessary conversation. We will hold the VA leadership accountable at the highest level and we will work to ensure justice is served for our veterans, our heroes, who have served our Nation across the country. The hearing now is adjourned.

[Whereupon, at 5:47 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of the Hon. Ann Marie Buerkle, Chairwoman, Subcommittee on Health

Good afternoon, this hearing will come to order.

Today, the VA's Subcommittee on Health will address a very serious issue: the vulnerability and underreporting of sexual assault and other safety incidents at VA residential and inpatient psychiatric treatment facilities.

As a registered nurse and domestic violence counselor, I have seen firsthand the pervasive and damaging effects sexual assault can have on the lives of those who experience it.

Last week, the Government Accountability Office (GAO) released a deeply troubling report entitled "VA Health Care: Actions Needed to Prevent Sexual Assaults and Other Safety Incidents. "GAO found that between January 2007 and July 2010, nearly 300 sexual assault incidents, including 67 alleged rapes, were reported to VA police. Many of these alleged crimes were not reported to VA leadership officials or the VA Office of the Inspector General, in direct violation of VA policy and Federal regulations.

The findings of the GAO are disturbing for many reasons. Foremost, they represent a betrayal of trust by a system that was designed to treat our veterans at their most vulnerable time.

The gross failure of VA leadership to protect the safety and security of our veterans and VA staff and systematically report and respond to sexual assault and safety incidents is a contempt of justice. It also requires immediate action. This is not the way to run a health care system and it is certainly no way to treat the men and women who sacrificed so much on our Nation's behalf.

Abuse like the kind GAO references in their report is repugnant and inexcusable in any corner of our society. But for it to occur in what should be an environment of healing for our wounded warriors is an affront to VA's very mission.

So disturbed was I upon reading an early draft of GAO's report, that I—along with Chairman Miller—introduced legislation to ensure a safer and more secure VA medical facilities. Our bill, H.R. 2074, the Veterans Sexual Assault Prevention Act, would address the Department's safety vulnerabilities, security problems, and oversight failures and create a fundamentally safer environment for our veterans and VA employees.

Never should a warrior in need take the brave step of getting help and be met with anything less than safe, supportive, and high quality care in an atmosphere of hope, health, and healing.

Let me assure each of you, that I and the other Members of this Committee will remain committed to righting the many wrongs uncovered by the GAO.

Prepared Statement of Hon. Michael H. Michaud, Ranking Democratic Member, Subcommittee on Health

Good morning. I would like to thank everyone for attending this important hearing today.

The purpose of today's hearing is to examine how changes in patient demographics present unique challenges for VA in providing safe environments for all veterans treated in VA facilities.

In 2008, I requested that GAO report on women veterans' services, such as research on the unique physical and mental health treatment needs of female veterans, how VA is addressing the needs of women veterans, what health care services offered by VA are tailored to women veterans, and what barriers may prevent female veterans from accessing VA health care services.

In July 2009, this Subcommittee held a hearing on the findings of the report. During the conduct of this report, GAO was made aware of safety issues involving women veterans and sexual assault in some VA facilities.

Subsequent to that report, then Full Committee Chairman, Mr. Filner, submitted a request for GAO to look further into sexual assault incidents.

We know that the wars in Afghanistan and Iraq have seen the unprecedented call up of the National Guard and Reserve components.

Today, women serve in the Guard and Reserve at a rate of over 17 percent which is 3 percent higher than that of the active duty military.

VA recently reported that within 10 years, women are expected to become 10 percent of VA's patient population.

However, the VA health care system was built to accommodate the war related illnesses and injuries of male veterans.

As women are serving in combat conditions alongside their male counterparts, it is important that the Department embrace and recognize the needs of all veterans, both men and women alike.

In the 110th and 111th Congresses, this Committee held a series of hearings to examine the needs of women veterans.

The veterans who testified shared stories of feeling unwelcomed, alienated, and disrespected in some VA medical centers so that they are now reluctant to pursue the benefits and services that they have earned with their service to our country.

Women veterans should not have to worry about being subject to "cat calls" upon entering a facility, and they certainly should not have to worry about falling victim to sexual assault while receiving care.

While sexual assault is often considered an issue only affecting women, in fact, both men and women suffer sexual assaults.

Further, victims may be assaulted by perpetrators of the same or of the opposite sex.

Like other types of trauma, sexual trauma can leave lasting scars upon the physical and mental health of its victims.

As Government Accountability Office (GAO) has recently uncovered, many of the nearly 300 sexual assault incidents reported to the VA police since 2007 were not reported to VA leadership.

Incidents like these simply need not happen.

When policies and procedures are not in place—or worse— not followed, we fall far short of our national commitment to provide the utmost level of care possible.

Thank you to our panelists for appearing today.

I am committed to working with you to ensure that safeguards are in place so that no veteran, male or female, falls victim to sexual assault while under VA care.

Madam Chair, I yield back.

Prepared Statement of Hon. Jeff Miller, Chairman, Committee on Veterans' Affairs

Thank you Madam Chairwoman for having me here today at this very important hearing. Upon reading GAO's draft report, I was sickened by its findings—the prevalence of sexual assault incidents at VA facilities, the lack of accountability from VA leadership and the lack of safeguards in place for these victims.

As a co-requester of the GAO investigation (with Ranking Member Filner), I immediately contacted Secretary Shinseki and urged him to provide an immediate official response to GAO so the report could be made public and we could hold this hearing today. I thank the Secretary for complying with my request.

These findings are intolerable, so Ms. Buerkle and I decided to act immediately by introducing H.R. 2074—the Veteran Sexual Assault Prevention Act. We intend to move this legislation expeditiously so that veterans are not undermined by the very system which is supposed to protect them.

In the past week, some have dismissed these allegations, comparing the size of the VA system and the number of allegations, to the private sector. Let me be very clear on this point—there is no comparison. Just one assault of this nature, one sexual predator, or one veteran's rights being violated within the VA is one too many and is absolutely unacceptable. If we need to do more to protect our veterans and VA employees, we will.

Rape, in particular, has always been a hard charge to prosecute. And though we have made strides in getting victims to speak out, we know that for every rape that is reported, that many more are not. Therefore, we need to know how many victims have not spoken out and how we can reach to them so that not only is justice done,

but that we can provide them with the proper care and support. Today, we expect to get answers to the followings questions:

- How widespread are assaults at VA facilities, because as found by GAO the lack of protocols at VA are not conducive to reporting sexual assault?
- How many cases have been prosecuted? How many are still pending?
- How many employees who allegedly perpetrated assaults are still working in VA?
- What has been done to protect patients from fellow patients?
- What is VA doing to ensure this *never* happens again in the future?

The safety and security of our veterans is paramount. We demand these answers so to assure fellow veterans and the public that VA facilities are safe havens for veterans, VA employees are safe, and no one's rights are violated.

Again, thank you for the time, Madam Chairwoman. I yield back.

Prepared Statement of Randall B. Williamson, Director, Health Care, U.S. Government Accountability Office

VA Health Care: Improvements Needed for Monitoring and Preventing Sexual Assaults and Other Safety Incidents

GAO Highlights

Why GAO Did This Study

During GAO's recent work on services available for women veterans (GAO–10–287), several clinicians expressed concern about the physical safety of women housed in mental health programs at a Department of Veterans Affairs (VA) medical facility. GAO examined (1) the volume of sexual assault incidents reported in recent years and the extent to which these incidents are fully reported, (2) what factors may contribute to any observed underreporting, and (3) precautions VA facilities take to prevent sexual assaults and other safety incidents.

This testimony is based on recent GAO work, *VA Health Care: Actions Needed To Prevent Sexual Assaults and Other Safety Incidents,* (GAO–11–530) (June 2011). For that report, GAO reviewed relevant laws, VA policies, and sexual assault incident documentation from January 2007 through July 2010. In addition, GAO visited five judgmentally selected VA medical facilities that varied in size and complexity and spoke with the four Veterans Integrated Service Networks (VISN) that oversee them.

What GAO Recommends

GAO reiterated recommendations that VA improve both the reporting and monitoring of sexual assault incidents and the tools used to identify risks and address vulnerabilities at VA facilities. VA concurred with GAO's recommendations and provided an action plan to address them.

What GAO Found

GAO found that many of the nearly 300 sexual assault incidents reported to the VA police were not reported to VA leadership officials and the VA Office of the Inspector General (OIG). Specifically, for the four VISNs GAO spoke with, VISN and Veterans Health Administration (VHA) Central Office officials did not receive reports of most sexual assault incidents reported to the VA police. Also, nearly two-thirds of sexual assault incidents involving rape allegations originating in VA facilities were not reported to the VA OIG, as required by VA regulation.

GAO identified several factors that may contribute to the underreporting of sexual assault incidents. For example, VHA lacks a consistent sexual assault definition for reporting purposes and clear expectations for incident reporting across its medical facility, VISN, and VHA Central Office levels. Furthermore, VHA Central Office lacks oversight mechanisms to monitor sexual assault incidents reported through the management reporting stream.

VA medical facilities GAO visited used a variety of precautions intended to prevent sexual assaults and other safety incidents. However, GAO found some of these measures were deficient, compromising medical facilities' efforts to prevent sexual assaults and other safety incidents. For example, medical facilities used physical security precautions—such as closed-circuit surveillance cameras to actively monitor areas and locks and alarms to secure key areas. These physical precautions were intended to prevent a broad range of safety incidents, including sexual assaults. However, GAO found significant weaknesses in the implementation of these phys-

ical security precautions at the five VA medical facilities visited, including poor monitoring of surveillance cameras, alarm system malfunctions, and the failure of alarms to alert both VA police and clinical staff when triggered. Inadequate system configuration and testing procedures contributed to these weaknesses. Further, facility officials at most of the locations GAO visited said the VA police were understaffed. (See table below.) Such weaknesses could lead to delayed response times to incidents and seriously erode VA's efforts to prevent or mitigate sexual assaults and other safety incidents.

Weaknesses in Physical Security Precautions in Residential Programs and Inpatient Mental Health Units at Selected VA Medical Facilities

Monitoring precautions	Security precautions	Staff awareness and preparedness precautions
• Inadequate monitoring of closed-circuit surveillance cameras	• Alarm malfunctions of stationary, computer-based, and personal panic alarms • Inadequate documentation or review of alarm testing • Failure of alarms to alert both unit staff and VA police • Limited use of personal panic alarms	• VA police staffing and workload challenges • Lack of stakeholder involvement in unit redesign efforts

Source: GAO.

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee:

I am pleased to be here today as the Subcommittee discusses policies and actions to prevent sexual assaults and other safety incidents at Department of Veterans Affairs (VA) medical facilities. During our recent work on services available for women veterans in VA medical facilities, several clinicians expressed concern about the safety of women veterans housed in mental health programs at a VA medical facility's residential mental health unit that also housed veterans who had committed past sexual crimes.[1] Clinicians were also concerned about the adequacy of existing safety precautions to protect women veterans being treated in the inpatient mental health units of this same facility. These concerns highlight the importance of VA having effective security precautions to protect all patients—especially those with residential and inpatient mental health programs—and a consistent way to exchange information about and discuss safety incidents, including sexual assaults.[2, 3]

My testimony today is based on our June 7, 2011 report:[4] (1) the volume of sexual assault incidents reported in recent years and the extent to which these incidents are fully reported, (2) what factors may contribute to any observed underreporting, and (3) the precautions in place in residential and inpatient mental health settings to prevent sexual assault and other safety incidents and any weaknesses in these precautions.

To examine the volume of sexual assault incidents reported to VA in recent years, the extent to which these incidents were fully reported, and factors that may contribute to any observed underreporting, we reviewed relevant VA and Veterans Health Administration (VHA) policies, handbooks, directives, and other guidance

[1] See GAO, *VA Health Care: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes,* GAO–10–287 (Washington D.C.: Mar. 31, 2010).

[2] In this report, we use the term safety incident to refer to intentionally unsafe acts—including criminal and purposefully unsafe acts, clinician and staff alcohol or substance abuse-related acts, and events involving alleged or suspected patient abuse of any kind. These safety incidents are excluded from the reporting requirements outlined by the VA National Center for Patient Safety (NCPS).

[3] In this report, we use the term sexual assault incident to refer to suspected, alleged, attempted, or confirmed cases of sexual assault. All reports of sexual assault incidents do not necessarily lead to prosecution and conviction. This may be, for example, because an assault did not actually take place or there was insufficient evidence to determine whether an assault occurred.

[4] See GAO, *VA Health Care: Actions Needed To Prevent Sexual Assaults and Other Safety Incidents,* GAO–11–530 (Washington, D.C.: June 7, 2011).

documents regarding the reporting of safety incidents.[5] We also interviewed VA and VHA Central Office officials involved with the reporting of safety incidents—including officials with VA's Office of Security and Law Enforcement (OSLE) and VHA's Office of the Deputy Under Secretary for Health for Operations and Management and Office of the Principal Deputy Under Secretary for Health.[6] In addition, we conducted site visits to five VA medical facilities. These judgmentally selected medical facilities were chosen to ensure that our sample: (1) had both residential and inpatient mental health settings; (2) reflected a variety of residential mental health specialties, including military sexual trauma; (3) had medical facilities with various levels of experience reporting sexual assault incidents; and (4) varied in terms of size and complexity.[7] During the site visits, we interviewed VA medical facility leadership officials and residential and inpatient mental health unit managers and staff to discuss their experiences with reporting sexual assault incidents. We also spoke with officials from the four Veterans Integrated Service Networks (VISN) responsible for managing the five selected VA medical facilities to discuss their expectations, policies, and procedures for reporting sexual assault incidents.[8] Information obtained from these VISNs and VA medical facilities cannot be generalized to all VISNs and VA medical facilities. In addition, we interviewed officials from the VA Office of the Inspector General's (OIG) Office of Investigations—Criminal Investigations Division to discuss information they receive from VA medical facilities about sexual assault incidents that occur in these facilities. Further, we reviewed Federal statutes related to sexual offenses and sentencing classification for felonies to verify that all rape allegations included in our review met the statutory criteria for felonies under Federal law. Finally, we reviewed documentation of reported sexual assault incidents at VA medical facilities provided by VA's OSLE, the VA OIG, and VISNs from January 2007 through July 2010, to determine the number and types of incidents reported, as well as which VA and VHA offices were notified of those incidents. For this analysis, we used a definition of sexual assault that was developed for the purpose of this report.[9] Our analysis of VA police and VA OIG reports was limited to only those incidents that were reported and cannot be used to project the volume of sexual assault incident reports that may occur in future years. Following verification that VA police and VA OIG incidents met our definition of sexual assault and comparisons of sexual assault incidents reported by the two groups within VA, we found data derived from these reports to be sufficiently reliable for our purposes.

To examine the precautions in place to prevent sexual assault and other safety incidents, we reviewed relevant VA, VHA, VISN, and selected medical facility policies related to the security of residential and inpatient mental health programs. We also interviewed VA, VHA, VISN, and selected VA medical facility officials about the precautions in place to prevent sexual assault incidents and other violent activities in the residential and inpatient mental health units. Finally, to assess any weaknesses in physical security precautions at the VA medical facilities selected for this review, we conducted an independent assessment of the precautions in place at each of our selected medical facilities—including the testing of alarm systems. These assessments were conducted by physical security experts within our Forensic Audits and Investigative Services team using criteria based on generally recognized security standards and selected VA security requirements. Our review of physical security precautions was limited to only those medical facilities we reviewed and does not represent results from all VA medical facilities.

---

[5] Within VA, VHA is the organization responsible for providing health care to veterans at medical facilities across the country.

[6] We also spoke with officials from VHA's Office of Mental Health Services and the Women Veterans Health Strategic Health Care Group.

[7] VA medical facilities were selected to ensure that at least one facility with no experience reporting sexual assault incidents was included in our judgmental sample of facilities. Other selected medical facilities all had some experience reporting sexual assault incidents. To determine facilities' histories of reporting sexual assault incidents, we reviewed closed investigations conducted by the VA Office of the Inspector General (OIG) Office of Investigations—Criminal Investigations Division. This selection allowed us to ensure that a greater variety of perspectives on sexual assault incidents were captured during our field work.

[8] Two of the facilities we visited were located within the same VISN.

[9] For the purposes of this report, we define sexual assault as any type of sexual contact or attempted sexual contact that occurs without the explicit consent of the recipient of the unwanted sexual activity. Assaults may involve psychological coercion, physical force, or victims who cannot consent due to mental illness or other factors. Falling under this definition of sexual assault are sexual activities such as forced sexual intercourse, sodomy, oral penetration or penetration using an object, molestation, fondling, and attempted rape or sexual assault. Victims of sexual assault can be male or female. This does not include cases involving only indecent exposure, exhibitionism, or sexual harassment.

We conducted our performance audit from May 2010 through June 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

Background

VHA Central Office has responsibility for monitoring and overseeing both VISN and medical facility operations, including security precautions.[10] Day-to-day management of medical facilities, including residential and mental health treatment units, is the responsibility of the VISNs.

Residential Programs

VA has 237 residential programs at 104 of its medical facilities. These programs provide residential rehabilitative and clinical care to veterans with a range of mental health conditions, including those diagnosed with post-traumatic stress disorder and substance abuse. VA operates three types of residential programs in selected medical facilities throughout its health care system:

- *Residential rehabilitation treatment programs (RRTP)*. These programs provide intensive rehabilitation and treatment services for a range of mental health conditions in a 24 hours per day, 7 days a week structured residential environment at a VA medical facility.
- *Domiciliary programs*. In its domiciliaries, VA provides 24 hours per day, 7 days a week, structured and supportive residential environments, housing, and clinical treatment to veterans. Domiciliary programs may also contain specialized treatment programs for certain mental health conditions.
- *Compensated work therapy/transitional residence (CWT/TR) programs*. These programs are the least intensive residential programs and provide veterans with community-based housing and therapeutic work-based rehabilitation services designed to facilitate successful community reintegration.[11]

Inpatient Mental Health Units

Most (111) of VA's 153 medical facilities have at least one inpatient mental health unit for patients with acute mental health needs. These units are generally a locked unit or floor within each medical facility, and the size of these units varies throughout VA. Care on these units is provided 24 hours per day, 7 days a week, and consists of intensive psychiatric treatment designed to stabilize veterans and transition them to less intensive levels of care, such as RRTPs and domiciliary programs. Inpatient mental health units are required to comply with VHA's Mental Health Environment of Care Checklist that specifies several safety requirements for these units, including several security precautions, such as the use of panic alarm systems and the security of nursing stations within these units.

VA's Two Reporting Streams for Safety Incidents

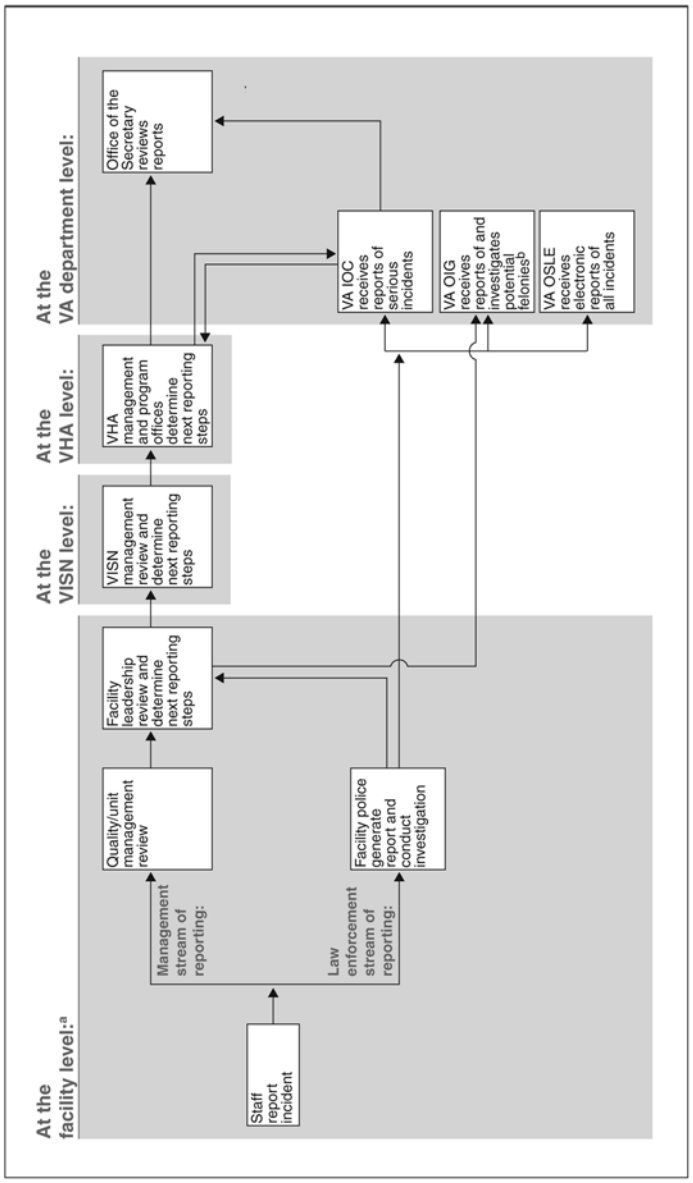
Safety incidents, including sexual assaults, may be reported to senior leadership as part of two different streams—a management stream and a law enforcement stream. The management reporting stream—which includes reporting responsibilities at the VA medical facility, VISN, and VHA Central Office levels—is intended to help ensure that incidents are identified and documented for leadership's attention. In contrast, the purpose of the law enforcement stream is to document incidents that may involve criminal acts so they can be investigated and prosecuted, if appropriate. VHA policies outline what information staff must report for each stream and define some mechanisms for this reporting, but medical facilities have the flexibility to customize and design their own site-specific reporting systems and policies that fit within the broad context of these requirements. (Fig. 1 summarizes the major steps involved in each stream.)

---

[10] VHA oversees VA's health care system, which includes 153 medical facilities organized into 21 VISNs.

[11] Compensated work therapy is a VA vocational rehabilitation program that matches work-ready veterans with competitive jobs, provides support to veterans in these positions, and consults with business and industry on their specific employment needs.

Figure 1: VA Reporting Process for Sexual Assaults and Other Safety Incidents



Source: GAO.

[a]Facility reporting processes described in this graphic are based on our review of five selected VA medical facilities.

[b]VA OIG receives reports of potential felonies through additional reporting streams, including the VA OIG hotline and congressional contacts.

Management reporting stream. Reporting responsibilities at each level for this stream are as follows.

- *Local VA medical facilities*. Local incident reporting is typically handled through a variety of electronic facility-based systems. It is initiated by the first staff member who observed or was notified of an incident, who completes an incident report in the medical facility's electronic reporting system that is then reviewed by the medical facility's quality manager. VA medical facility leadership is then notified, and is responsible for reporting serious incidents to the VISN.

- *VISNs*. VA medical facilities can report serious incidents to their VISN through two mechanisms—issue briefs that document specific factual information and "heads up" messages that allow medical facility leadership to provide a brief synopsis of the issue while facts are being gathered for documentation in an issue brief. VISN offices are typically responsible for direct reporting to the VHA Central Office.
- *VHA Central Office*. VISNs typically report all serious incidents to the VHA Office of the Deputy Under Secretary for Health for Operations and Management, which then communicates relevant incidents to other VHA offices, including the Office of the Principal Deputy Under Secretary for Health, through an e-mail distribution list.

Law enforcement reporting stream. Responsibilities at each level are described below.

- *Local VA police*. Most VA medical facilities have a cadre of VA police officers, who are Federal law enforcement officers charged with protecting the medical facility by responding to and investigating potentially criminal activities. Local policies typically require medical facility staff to notify the medical facility's VA police of incidents that may involve criminal acts, such as sexual assaults. VA medical facility police also often notify and coordinate with local area police departments and the VA OIG when criminal activities or potential security threats occur.
- *VA's OSLE*. This office is the department-level VA office responsible for developing policies and procedures for VA's law enforcement programs at local VA medical facilities. VA OSLE receives reports of incidents at VA medical facilities through its centralized police reporting system. Additionally, local VA police are required to immediately notify VA OSLE of serious incidents, including reports of rape and aggravated assaults.
- *VA's Integrated Operations Center (IOC)*. The IOC, established in April 2010, serves as the department's centralized location for integrated planning and data analysis on serious incidents.[12] Serious incidents on VA property are reported to the IOC either by local VA police or the VHA Office of the Deputy Under Secretary for Health for Operations and Management. The IOC then presents information on serious incidents to VA senior leadership officials through daily reports and, in some cases, to the Secretary through serious incident reports.
- *VA OIG*. Federal regulation requires that all potential felonies, including rape allegations, be reported to VA OIG investigators.[13] VHA policy reiterates this by specifying that the OIG must be notified of sexual assault incidents when the crime occurs on VA premises or is committed by VA employees.[14] Typically, either the medical facility's leadership team or VA police are responsible for reporting potential felonies to the VA OIG.[15] Once a case is reported, VA OIG investigators can be the lead agency on the case or advise local VA police or other law enforcement agencies conducting the investigation.

---

[12] VA defines serious incidents as those that involve: (1) public information regarding the arrest of a VA employee; (2) major disruption to the normal operations of a VA facility; (3) deaths on VA property due to suspected homicide, suicides, accidents, and/or suspicious deaths; (4) VA police-involved shootings; (5) the activation of occupant emergency plans, facility disaster plans, and/or continuity of operations plans; (6) loss or compromise of VA sensitive data, including classified information; (7) theft or loss of VA-controlled firearms or hazardous material, or other major theft or loss; (8) terrorist event or credible threat that impacts VA facilities or operations; and (9) incidents on VA property that result in serious illness or bodily injury, including sexual assault, aggravated assault, and child abuse. See VA Directive 0321, *Serious Incident Reports* (Jan. 21, 2010).

[13] See 38 CFR § 1.204 (2010). Criminal matters involving felonies must be immediately referred to the OIG, Office of Investigations. VA management officials with information about possible criminal matters involving felonies are responsible for prompt referrals to the OIG. Examples of felonies include but are not limited to, theft of government property over $1,000, false claims, false statements, drug offenses, crimes involving information technology systems, and serious crimes against the person, i.e., homicides, armed robbery, rape, aggravated assault, and serious physical abuse of a VA patient. Additionally, another VA regulation requires that all VA employees with knowledge or information about actual or possible violations of criminal law related to VA programs, operations, facilities, contracts, or information technology systems immediately report such knowledge or information to their supervisor, any management official, or directly to the VA OIG. 38 CFR § 1.201 (2010).

[14] VHA Directive 2010–014, Assessment and Management of Veterans Who Have Been Victims of Alleged Acute Sexual Assault (May 25, 2010).

[15] The VA OIG may also learn of incidents from staff, patients, congressional communications, or the VA OIG hotline for reporting fraud, waste, and abuse.

Nearly 300 Sexual Assault Incidents Reported to VA Police, but Many Were Not Reported to VHA or the VA OIG

We found that there were nearly 300 sexual assault incidents reported to the VA police from January 2007 through July 2010—including alleged incidents that involved rape, inappropriate touching, forceful medical examinations, forced or inappropriate oral sex, and other types of sexual assault incidents. Many of these sexual assault incidents were not reported to officials within the management reporting stream and to the VA OIG.

Nearly 300 Sexual Assault Incidents Reported to VA Police From January 2007 Through July 2010

We analyzed VA's national police files from January 2007 through July 2010 and identified 284 sexual assault incidents reported to VA police during that period.[16,17] These cases included incidents alleging rape, inappropriate touching, forceful medical examinations, oral sex, and other types of sexual assaults (see table 1).[18] However, it is important to note that not all sexual assault incidents reported to VA police are substantiated. A case may remain unsubstantiated because an assault did not actually take place, the victim chose not to pursue the case, or there was insufficient evidence to substantiate the case. Due to our review of both open and closed VA police sexual assault incident investigations, we could not determine the final disposition of these incidents.[19]

Table 1: Number of Sexual Assault Incidents by Category Reported to VA Police by Year, January 2007 through July 2010

Year	Rape[a]	Inappropriate touch[b]	Forceful medical examination	Forced or inappropriate oral sex	Other[c]	Total
2010[d]	14	44	3	5	0	**66**
2009	23	66	3	3	9	**104**
2008[e]	13	42	1	3	1	**60**
2007[e, f]	17	33	1	2	1	**54**
Total[g]	**67**	**185**	**8**	**13**	**11**	**284**

Source: GAO (analysis); VA (data).

Note: In this report, we use the term sexual assault incident to refer to suspected, alleged, attempted, or confirmed cases of sexual assault. All reports of sexual assault incidents do not necessarily lead to prosecution and conviction. This may be, for example, because an assault did not actually take place or there was insufficient evidence to determine whether an assault occurred.

[a] The rape category includes any case involving allegations of rape, defined as vaginal or anal penetration through force, threat, or inability to consent. For cases that included allegations of multiple categories including rape (i.e., inappropriate touch, forced oral sex, and rape) the category of rape was applied. Cases where staff deemed that one or more of the veterans involved were mentally incapable of consenting to sexual activities described in the case were considered rape.

[b] The inappropriate touch category includes any case involving only allegations of touching, fondling, grabbing, brushing, kissing, rubbing, or other like terms.

[c] The other category included any allegations that did not fit into the other categories or if the incident described in the case file did not contain sufficient information to place the case in one of the other designated categories.

[d] Analysis of 2010 records was limited to only those received by VA police through July 2010.

[e] Due to the lack of a centralized VA police reporting system prior to January 2009, VA medical facility police sent reports to VA's OSLE for the purpose of this data request, which may have resulted in not all reports being included in this analysis.

---

[16] Our analysis was limited to only those reports that were provided by the VA OSLE and does not include reports that may never have been created or were lost by local VA police or VA OSLE.

[17] We could not systematically analyze sexual assault incidents reported through VA's management stream due to the lack of a centralized VA management reporting system for tracking sexual assaults and other safety incidents.

[18] To conduct this analysis, we placed VA police case files into these categories to describe the allegations contained within them.

[19] We could not consistently determine whether or not these sexual assault incidents were substantiated due to limitations in the information VA provided, including inconsistent documentation of the disposition of some incidents in the police files.

[f] Our ability to review files for the entire year was limited because VA police are required to destroy files after 3 years under a records schedule approved by the National Archives and Records Administration (NARA).

[g] Cases not reported to VA police were not included in our analysis of sexual assault incidents.

In analyzing these 284 cases, we observed the following:

- Overall, the sexual assault incidents described above included several types of alleged perpetrators, including employees, patients, visitors, outsiders not affiliated with VA, and persons of unknown affiliation. In the reports we analyzed, there were allegations of 89 patient-on-patient sexual assaults, 85 patient-on-employee sexual assaults, 46 employee-on-patient sexual assaults, 28 unknown affiliation-on-patient sexual assaults, and 15 employee-on-employee sexual assaults.[20]
- Regarding gender of alleged perpetrators, we also observed that of the 89 patient-on-patient sexual assault incidents, 46 involved allegations of male perpetrators assaulting female patients, 42 involved allegations of male perpetrators assaulting male patients, and 1 involved an allegation of a female perpetrator assaulting a male patient. Of the 85 patient-on-employee sexual assault incidents, 83 involved allegations of male perpetrators assaulting female employees and 2 involved allegations of male perpetrators assaulting male employees.

Sexual Assault Incidents Are Underreported to VISNs, VHA Central Office, and the VA OIG

VISN and VHA Central Office officials did not receive reports of all sexual assault incidents reported to VA police in VA medical facilities within the four VISNs we reviewed. In addition, the VA OIG did not receive reports of all sexual assault incidents that were potential felonies as required by VA regulation, specifically those involving rape allegations.

VISNs and VHA Central Office Receive Limited Information on Sexual Assault Incidents

VISNs and VHA Central Office leadership officials are not fully aware of many sexual assaults reported at VA medical facilities. For the four VISNs we spoke with, we examined all documented incidents reported to VA police from medical facilities within each network and compared these reports with the issue briefs received through the management reporting stream by VISN officials. Based on this analysis, we determined that VISN officials in these four networks were not informed of most sexual assault incidents that occurred within their network medical facilities.[21] Moreover, we also found that one VISN did not report any of the cases they received to VHA Central Office. (See table 2.)

Table 2: Sexual Assault Incidents Reported to Four Selected VISNs and VHA Central Office Leadership, January 2007 through July 2010

VISN	Total number of sexual assault incidents reported to VA police from VISN medical facilities [a, b]	Total number of sexual assault incidents reported to VISN leadership by VISN medical facilities	Total number of sexual assault incidents reported by VISNs to VHA Central Office leadership
VISN A	13	0	0
VISN B	21	10	5
VISN C	34	4	4
VISN D	34	2	2

Source: GAO (data and analysis); VA (data).

[20] Other allegations by relationship included: 1 employee-on-outsider assault, 2 employee-on-visitor assaults, 2 outsider-on-employee assaults, 2 outsider-on-outsider assaults, 1 outsider-on-patient assault, 1 outsider-on-visitor assault, 3 patient-on-visitor assaults, 3 unknown-on-employee assaults, 3 unknown-on-visitor assaults, 1 visitor-on-employee assault, and 2 visitor-on-patient assaults.

[21] Our review of the reports received by both VISN and VA Central Office officials was limited to only those documented in issue briefs and did not include the less formal heads-up messages. This is because heads-up messages are not formally documented and often are a preliminary step to a more formal issue brief.

Note: In this report, we use the term sexual assault incident to refer to suspected, alleged, attempted, or confirmed cases of sexual assault. All reports of sexual assault incidents do not necessarily lead to prosecution and conviction. This may be, for example, because an assault did not actually take place or there was insufficient evidence to determine whether an assault occurred.

[a] Cases not reported to VA police were not included in our count of sexual assault incidents.

[b] Due to the absence of systemwide requirements on what medical facilities must report to these VISNs, we could not determine the accuracy of VISN reporting.

VA OIG Did Not Receive Reports of about Two-Thirds of Sexual Assault Incidents Involving Rape Allegations

To examine whether VA medical facilities were accurately reporting sexual assault incidents involving rape allegations to the VA OIG, we reviewed the 67 rape allegations reported to the VA police from January 2007 through July 2010 and compared these cases with all investigation documentation provided by the VA OIG for the same period. We found no evidence that about two-thirds (42) of these rape allegations had been reported to the VA OIG.[22] The remaining 25 had matching VA OIG investigation documentation, indicating that they were correctly reported to both the VA police and the VA OIG.

By regulation, VA requires that: (1) all criminal matters involving felonies that occur in VA medical facilities be immediately referred to the VA OIG and (2) responsibility for the prompt referral of any possible criminal matters involving felonies lies with VA management officials when they are informed of such matters.[23] This regulation includes rape in the list of felonies provided as examples and also requires VA medical facilities to report other sexual assault incidents that meet the criteria for felonies to the VA OIG.[24,25] However, the regulation does not include criteria for how VA medical facilities and management officials should determine whether or not a criminal matter meets the felony reporting threshold. We found that all 67 of these rape allegations were potential felonies because, if substantiated, sexual assault incidents involving rape fall within Federal sexual offenses that are punishable by imprisonment of more than 1 year.

In addition, we provided the VA OIG the opportunity to review summaries of the 42 rape allegations we could not confirm were reported to them by the VA police. To conduct this review, several VA OIG senior-level investigators determined whether or not each of these rape allegations should have been reported to them based on what a reasonable law enforcement officer would consider a felony. According to these investigators, a reasonable law enforcement officer would look for several elements to make this determination, including (1) an identifiable and reasonable suspect, (2) observations by a witness, (3) physical evidence, or (4) an allegation that appeared credible. These investigators based their determinations on their experience as Federal law enforcement agents. Following their review, these investigators also found that several of these rape allegations were not appropriately reported to the VA OIG as required by Federal regulation. Specifically, the VA OIG investigators reported that they would have expected about one-third (33 percent) of the 42 rape allegations to have been reported to them based on the incident summary containing information on these four elements. The investigators noted that they would not have expected approximately 55 percent of the 42 rape allegations to have been reported to them due to either the incident summary failing to contain these same four elements or the presence of inconsistent statements made by the alleged vic-

---

[22] We did not require VA OIG to provide documentation for 9 incidents currently under investigation due to the sensitive nature of these ongoing investigations. Since we did not require this documentation, it is possible that some of these 9 ongoing investigations were included in the 42 rape allegations we could not confirm were reported to the VA OIG.

[23] See 38 CFR § 1.204 (2010). Examples of felonies listed in this regulation include theft of government property over $1,000, false claims, false statements, drug offenses, crimes involving information technology systems, and serious crimes against the person, i.e., homicides, armed robbery, rape, aggravated assault, and serious physical abuse of a VA patient.

[24] The VA Security and Law Enforcement Handbook defines a felony as any offense punishable by either imprisonment of more than 1 year or death as classified under 18 U.S.C. § 3559. See VA Handbook 0730, *Security and Law Enforcement* (Aug. 11, 2000). Federal statutes define certain sexual acts and contacts as Federal crimes. See 18 U.S.C. §§ 2241–2248. All Federal sexual offenses are punishable by imprisonment of more than 1 year; therefore all Federal sexual offenses are felonies and must be immediately referred to the VA OIG for investigation in accordance with VA regulation.

[25] For the purposes of our analysis, we focused only on sexual assault incidents involving rape allegations. Neither Federal statutes nor VA regulations define rape; however, the definition of rape we developed for our analysis falls within the Federal sexual offenses of either aggravated sexual abuse or sexual abuse. See 18 U.S.C. §§ 2241 and 2242. These two offenses are felonies under Federal statute; therefore, all rapes that meet our definition are felonies.

tims.[26] For the remaining approximately 12 percent, the investigators noted that the need for notification was unclear because there was not enough information in the incident summary to make a determination about whether or not the rape allegation should have been reported to the VA OIG.

VHA Guidance and Oversight Weaknesses May Contribute to the Underreporting of Sexual Assault Incidents

Several factors may contribute to the underreporting of sexual assault incidents to VISNs, VHA Central Office, and the VA OIG—including VHA's lack of a consistent sexual assault definition for reporting purposes; limited and unclear expectations for sexual assault incident reporting at the VHA Central Office, VISN, and VA medical facility levels; and deficiencies in VHA Central Office oversight of sexual assault incidents.

VHA Does Not Have a Consistent Sexual Assault Definition for Reporting Purposes

VHA leadership officials may not receive reports of all sexual assault incidents that occur at VA medical facilities because there is no VHA-wide definition of sexual assault used for incident reporting. We found that VHA lacks a consistent definition for the reporting of sexual assault through the management reporting stream at the medical facility, VISN, and VHA Central Office levels. At the medical facility level, we found that the medical facilities we visited had a variety of definitions of sexual assault targeted primarily to the assessment and management of victims of recent sexual assaults. Specifically, facilities varied in the level of detail provided by their policies, ranging from one facility that did not include a definition of sexual assault in its policy at all to another facility with a policy that included a detailed definition. At the VISN level, officials with whom we spoke in the four networks said they did not have definitions of sexual assault in VISN policies.[27] Finally, while VHA Central Office does have a policy for the clinical management of sexual assaults, this policy is targeted to the treatment of victims assaulted within 72 hours and does not include sexual assault incidents that occur outside of this time frame. In addition, no definition of sexual assault is included in VHA Central Office reporting guidance.

VHA Central Office, VISNs, and VA Medical Facilities' Expectations for Reporting Are Limited and Unclear

In addition to failing to provide a consistent definition of sexual assault for incident reporting, VHA also does not have clearly documented expectations about the types of sexual assault incidents that should be reported to officials at each level of the organization, which may also contribute to the underreporting of sexual assault incidents. Without clear expectations for incident reporting there is no assurance that all sexual assault incidents are appropriately reported to officials at the VHA Central Office, VISN, and local medical facility levels. We found that expectations were not always clearly documented, resulting in either the underreporting of some sexual assault incidents or communication breakdowns at all levels.

- *VHA Central Office*. An official from VHA's Office of the Deputy Under Secretary for Health for Operations and Management told us that this office's expectations for reporting sexual assault incidents were documented in its guidance for the submission of issue briefs. However, we found that this guidance does not specifically reference reporting requirements for any type of sexual assault incidents. As a result, VISNs we reviewed did not consistently report sexual assault incidents to VHA Central Office.
- *VISNs*. Officials from the four VISNs we reviewed did not include detailed expectations regarding whether or not sexual assault incidents should be reported to them in their reporting guidance, potentially resulting in medical facilities

[26] The VA OIG senior-level investigators who conducted this review noted that they identified at least one incident summary that was readily identifiable as a case currently under investigation by the VA OIG. Due to the general nature of the incident summaries we provided for their review and the sensitive nature of specific details of ongoing investigations, we did not require the VA OIG to provide specific details on exactly how many of the 42 rape allegations we asked them to review were currently under investigation by their office; however, the total number of ongoing sexual assault incident investigations for the time period of our analysis was only 9.

[27] However, some VISN officials stated they used other common definitions, including those from the National Center for Victims of Crime and The Joint Commission.

failing to report some incidents.[28] For example, officials from one VISN told us they expect to be informed of all sexual assault incidents occurring in medical facilities within their network, but this expectation was not explicitly documented in their policy. We found several reported allegations of sexual assault incidents in medical facilities in this VISN—including three allegations of rape and one allegation of inappropriate oral sex—that were not forwarded to VISN officials.[29]

- *VA medical facilities*. At the medical facility level, we also found that reporting expectations may be unclear. In particular, we identified cases in which the VA police had not been informed of incidents that were reported to medical facility staff. For example, we identified VA police files from one facility we visited where officers noted that the alleged perpetrator had been previously involved in other sexual assault incidents that were not reported to the VA police by medical facility staff. In these police files, officers noted that staff working in the alleged perpetrators' units had not reported the previous incidents because they believed these behaviors were a manifestation of the veterans' clinical condition. In addition, at this same medical facility, quality management staff identified five sexual assault incidents that had not been reported to VA police at the medical facility, despite these incidents being reported to their office.

Oversight Deficiencies at VHA Central Office Contribute to the Underreporting of Sexual Assault Incidents

We found weaknesses both in the way sexual assault incidents are communicated to VHA Central Office and in the way that information about such incidents is collected and analyzed for oversight purposes.

Poor Communication About Sexual Assault Incidents Resulted in Incomplete Reporting Within VHA Central Office

Currently, VHA Central Office relies primarily on e-mail messages to transfer information about sexual assault incidents among its offices and staff. (See fig. 2.) Under this system, VHA Central Office is notified of sexual assault incidents through issue briefs submitted by VISNs via e-mail to the VHA Office of the Deputy Under Secretary for Health for Operations and Management.[30] Following review, the Director for Network Support forwards issue briefs to the Office of the Principal Deputy Under Secretary for Health for distribution to other VHA offices on a case-by-case basis, including the program offices responsible for residential programs and inpatient mental health units. Program offices are sometimes asked to follow up on incidents in their area of responsibility.

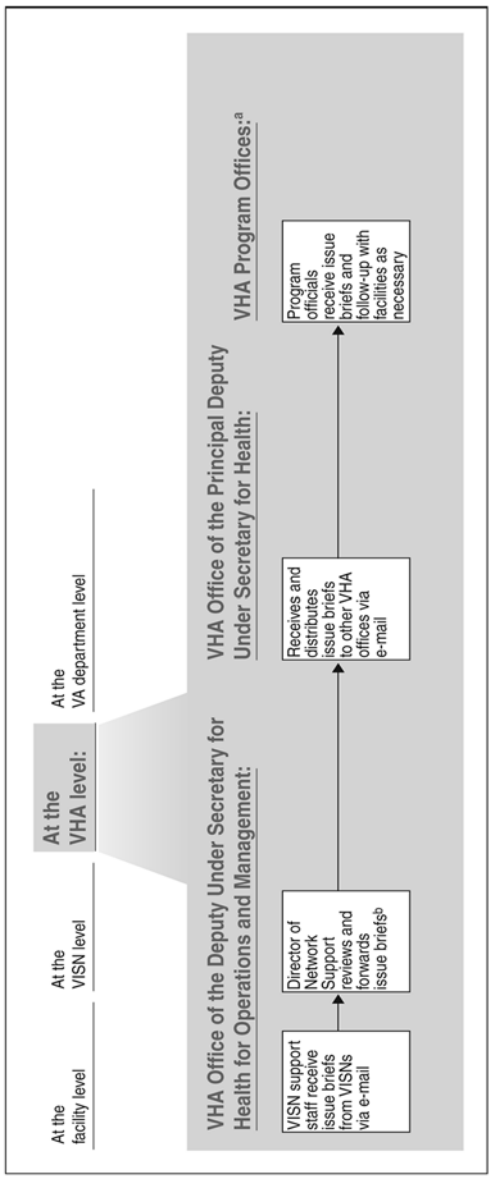
---

[28] While two of the four VISN policies reference The Joint Commission's definition of sentinel events, which includes rape, this definition does not include the broader category of sexual assault incidents as defined in this report.

[29] When asked about these four allegations, VISN officials told us that they would only have expected to be notified of two of them—one allegation of rape and one allegation of inappropriate oral sex—because the medical facilities where they occurred contacted outside entities, including the VA OIG. VISN officials explained that the remaining two rape allegations were unsubstantiated and were not reported to their office; the VISN also noted that unsubstantiated incidents are not often reported to them.

[30] VISNs may also send a heads-up message to this office either by e-mail or phone to inform the Office of the Deputy Under Secretary for Health for Operations and Management of emerging incidents. These heads-up messages are typically the precursor to issue briefs received by the office.

Figure 2: VHA Central Office Reporting Process for Sexual Assaults and Other Safety Incidents



Source: GAO.

[a]Program offices include those responsible for residential programs and inpatient mental health units.

[b]Office of the Deputy Under Secretary for Health for Operations and Management officials reported that they may distribute issue briefs directly to program officials depending on the severity of the incident.

We found that this system did not effectively communicate information about sexual assault incidents to the VHA Central Office officials who have programmatic responsibility for the locations in which these incidents occurred. For example, VHA program officials responsible for both residential programs and inpatient mental health units reported that they do not receive regular reports of sexual assault incidents that occur within their programs or units at VA medical facilities and were not aware of any incidents that had occurred in these programs or units. However, during our review of VA police files, we identified at least 18 sexual assault incidents that occurred from January 2007 through July 2010 in the residential pro-

grams or inpatient mental health units of the five VA medical facilities we reviewed. If the management reporting stream were functioning properly, these program officials should have been notified of these incidents and any others that occurred in other VA medical facilities' residential programs and inpatient mental health units.[31] Without the regular exchange of information regarding sexual assault incidents that occur within their areas of programmatic responsibility, VHA program officials cannot effectively address the risks of such incidents in their programs and units and do not have the opportunity to identify ways to prevent incidents from occurring in the future.

In early 2011, VHA leadership officials told us that initial efforts, including sharing information about sexual assault incidents with the Women Veterans Health Strategic Health Care Group and VHA program offices, were underway to improve how information on sexual assault incidents is communicated to program officials. However, these improvements have not been formalized within VHA or published in guidance or policies and are currently being performed on an informal ad hoc basis only, according to VHA officials.

VHA Does Not Systematically Monitor and Track Sexual Assault Incidents

In addition to deficiencies in information sharing, we also identified deficiencies in the monitoring of sexual assault incidents within VHA Central Office. VHA's Office of the Deputy Under Secretary for Health for Operations and Management, the first VHA office to receive all issue briefs related to sexual assault incidents, does not currently have a system that allows VHA Central Office staff to systematically collect or analyze reports of sexual assault incidents received from VA medical facilities through the management reporting stream. Specifically, we found that this office does not have a central database to store the issue briefs that it receives and instead relies on individual staff to save issue briefs submitted to them by e-mail to electronic folders for each VISN. In addition, officials within this office said they do not know the total number of issue briefs submitted for sexual assault incidents because they do not have access to all former staff members' files. As a result of these issues, staff from the Office of the Deputy Under Secretary for Health for Operations and Management could not provide us with a complete set of issue briefs on sexual assault incidents that occurred in all VA medical facilities without first contacting VISN officials to resubmit these issue briefs.[32] Such a limited archive system for reports of sexual assault incidents received through the management reporting stream results in VHA's inability to track and trend sexual assault incidents over time. While VHA has, through its National Center for Patient Safety (NCPS), developed systems for routinely monitoring and tracking patient safety incidents that occur in VA medical facilities, these systems do not monitor sexual assaults and other safety incidents. Without a system to track and trend sexual assaults and other safety incidents, VHA Central Office cannot identify and make changes to serious problems that jeopardize the safety of veterans in their medical facilities.

Serious Weaknesses Observed in Several Types of Physical Security Precautions Used in Selected Medical Facilities

Physical precautions in the residential programs and inpatient mental health units at the medical facilities we visited included monitoring precautions used to observe patients, security precautions used to physically secure facilities and alert staff of problems, and staff awareness and preparedness precautions used to educate staff about security issues and provide police assistance. However, we found serious deficiencies in the use and implementation of certain physical security precautions at these facilities, including alarm system malfunctions and inadequate monitoring of security cameras.

Several Types of Physical Security Precautions Are in Place in Selected Medical Facilities

VA medical facilities we visited used a variety of physical security precautions to prevent safety incidents in their residential programs and inpatient mental health units. Typically, medical facilities had discretion to implement these precautions based on their own needs within broad VA guidelines.

---

[31] See GAO, *Internal Control: Standards for Internal Control in the Federal Government,* GAO/AIMD–00–21.3.1 (Washington, D.C.: November 1999). Standards for internal control in the Federal Government state that information should be recorded and communicated to management and others within the agency that need it in a format and time frame that enables them to carry out their responsibilities.

[32] See GAO/AIMD–00–21.3.1. Standards for internal control in the Federal Government state that agencies should design internal controls that assure ongoing monitoring occurs in the course of normal operations, is continually performed, and is ingrained in agency operations.

In general, physical security precautions were used as a measure to prevent a broad range of safety incidents, including sexual assaults. We classified these precautions into three broad categories: monitoring precautions, security precautions, and staff awareness and preparedness precautions. (See table 3.)

Table 3: Physical Security Precautions in Residential Programs and Inpatient Mental Health Units at Selected VA Medical Facilities

Monitoring precautions	Security precautions	Staff awareness and preparedness precautions
• Closed-circuit surveillance camera use and monitoring • Unit rounds by VA staff	• Locks and alarms at entrance and exit access points • Locks and alarms for patient bedrooms and bathrooms • Stationary, computer-based, and portable personal panic alarms • Separate or specially designated areas for women veterans	• Staff training • VA police presence on units • VA police staffing and command and control operations

Source: GAO.

Note: Physical security precautions varied by VA medical facility and program and were not necessarily in place at all VA medical facilities and programs we visited.

- *Monitoring precautions*. These measures were those designed to observe and track patients and activities in residential and inpatient settings. For example, at some VA medical facilities we visited, closed-circuit surveillance cameras were installed to allow VA staff to monitor areas and to help detect potentially threatening behavior or safety incidents as they occur. Cameras were also used to passively document any incidents that occurred.
- *Security precautions*. These precautions were those designed to maintain a secure environment for patients and staff within residential programs and inpatient mental health units and allow staff to call for help in case of any problems. For example, the units we visited regularly used locks and alarms at entrance and exit access points, as well as locks and alarms for some patient bedrooms. Another security precaution we observed was the use of stationary, computer-based, and portable personal panic alarms for staff.[33]
- *Staff awareness and preparedness precautions*. These measures were designed to educate and prepare residential program and inpatient mental health unit staff to deal with security issues and to provide police support and assistance when needed. For example, there was a regular VA police presence within some residential programs we visited. Also, all medical facilities we visited had a functioning police command and control center, which program staff could contact for police support when needed.

Significant Weaknesses Existed in the Use and Implementation of Certain Physical Security Precautions at Selected VA Medical Facilities

While security precautions have been established in most cases to prevent patient safety incidents, including sexual assaults, these precautions had not been effectively implemented by VA medical facility staff in the five facilities we visited. During our review of the physical security precautions in use at the five VA medical facilities we visited, we observed seven weaknesses in these three categories.[34] (See table 4.)

[33] Stationary panic alarms are fixed to furniture, walls, or other stationary items and can be used to alert VA staff of a problem or call for help if staff feel threatened. Computer-based panic alarms are activated by depressing a specified combination of keys on a medical center keyboard. Portable personal panic alarms are small devices that staff can carry with them while on duty that can also alert VA staff of a problem if activated.

[34] Our review of physical security precautions at the five VA medical facilities we visited was limited to the residential programs, inpatient mental health units, and medical facility command and control centers.

Table 4: Weaknesses in Physical Security Precautions in Residential Programs and Inpatient Mental Health Units at Selected VA Medical Facilities

Monitoring precautions	Security precautions	Staff awareness and preparedness precautions
• Inadequate monitoring of closed-circuit surveillance cameras	• Alarm malfunctions of stationary, computer-based, and personal panic alarms • Inadequate documentation or review of alarm testing • Failure of alarms to alert both unit staff and VA police • Limited use of personal panic alarms	• VA police staffing and workload challenges • Lack of stakeholder involvement in unit redesign efforts

Source: GAO.

Inadequate monitoring of closed-circuit surveillance cameras. We observed that VA staff in the police command and control center were not continuously monitoring closed-circuit surveillance cameras at all five of the VA medical facilities we visited. For example, at one medical facility, the system used by the residential programs at that medical facility could not be monitored by the police command and control center staff because it was incompatible with systems installed in other parts of the medical facility. According to VA police at this medical facility, the residential program staff did not consult with VA police before installing their own system. At another medical facility, where staff in the police office monitor cameras covering the residential programs' grounds and parking area, we found that the police office was unattended part of the time. In addition, at the remaining three medical facilities we visited, staff in the police command and control centers assigned to monitor medical facility surveillance cameras had other duties, such as serving as telephone operators and police/emergency dispatchers. These other duties sometimes prevented them from continuously monitoring the camera feeds in the police command and control center.[35] Although effective use of surveillance camera systems cannot necessarily prevent safety incidents from occurring, lapses in monitoring by security staff compromise the effectiveness of these systems.

Alarm malfunctions. At least one form of alarm failed to work properly when tested at four of the five medical facilities we visited. For example, at one medical facility, we tested the portable personal panic alarms used by residential program staff and found that the police command and control center could not accurately pinpoint the location of the tester when an alarm was activated outside the building. At another medical facility that used stationary panic alarms in inpatient mental health units, residential programs, and other clinical settings, almost 20 percent of these alarms throughout the medical facility were inoperable. At an inpatient mental health unit in a third medical facility, three of the computer-based panic alarms we tested failed to properly pinpoint the location of our tester because the medical facility's computers had been moved to different locations and were not properly reconfigured. Finally, at a fourth medical facility, alarms we tested in the inpatient mental health unit sounded properly, but staff in the unit and VA police responsible for testing these alarms did not know how to turn them off after they were activated. In each of the cases where alarms malfunctioned, VA staff were not aware the alarms were not functioning properly until we informed them.

Inadequate documentation or review of alarm system testing. One of the five sites we visited failed to properly document tests conducted of their alarm systems for their residential programs, although testing of alarms is a required element in VA's Environment of Care Checklist. Testing of alarm systems is important to ensure that systems function properly, and not having complete documentation of alarm system testing is an indication that periodic testing may not be occurring. In addition, three medical facilities reported using computer-based panic alarms that are designed to be self-monitoring to identify cases where computers equipped with the system fail to connect with the servers monitoring the alarms. Officials at all three of these medical facilities stated that due to the self-monitoring nature of these alarms, they did not maintain alarm test logs of these systems. However, we found that at two of these three medical facilities, these alarms failed to properly alert VA police when tested. Such alarm system failures indicate that the self-moni-

[35] At some facilities, just one person was assigned to serve both functions, while at another location two people were expected to share those functions but only one person was present at the time of our visit due to staffing vacancies, illness, or shortages.

toring systems may not be effectively alerting medical facility staff of alarm malfunctions when they occur, indicating the need for these systems to be periodically tested.

Alarms failed to alert both police and unit staff. In inpatient mental health units at all five medical facilities we visited, stationary and computer-based panic alarm systems we tested did not alert staff in both the VA police command and control center and the inpatient mental health unit where the alarm was triggered. Alerting both locations is important to better ensure that timely and proper assistance is provided. At four of these medical facilities, the inpatient mental health units' stationary or computer-based panic alarms notified the police command and control centers but not staff at the nursing stations of the units where the alarms originated. At the fifth medical facility, the stationary panic alarms only notified staff in the unit nursing station, making it necessary to separately notify the VA police. Finally, none of the stationary or computer-based panic alarms used by residential programs notified both the police command and control centers and staff within the residential program buildings when tested.[36]

Limited use of portable personal panic alarms. Electronic portable personal panic alarms were not available for the staff at any of the inpatient mental health units we visited and were available to staff at only one residential program we reviewed. In two of the inpatient mental health units we visited, staff were given safety whistles they could use to signal others in cases of emergency, personal distress, or concern about veteran or staff safety. However, relying on whistles to signal such incidents may not be effective, especially when staff members are the victims of assault. For example, a nurse at one medical facility we visited was involved in an incident in which a patient grabbed her by the throat and she was unable to use her whistle to summon assistance. Some inpatient mental health unit staff with whom we spoke indicated an interest in having portable personal panic alarms to better protect them in similar situations.

VA police staffing and workload challenges. At most medical facilities we visited, VA police forces and police command and control centers were understaffed, according to medical facility officials. For example, during our visit to one medical facility, VA police officials reported being able to staff just two officers per 12-hour shift to patrol and respond to incidents at both the medical facility and at a nearby 675-acre veteran's cemetery. While this staffing ratio met the minimum standards for VA police staffing, having only two police officers to cover such a large area could potentially increase the response times should a panic alarm activate or other security incident occur on medical facility grounds. Also, we found that there was an inadequate number of officers and staff at this medical facility to effectively police the medical facility and maintain a productive police force. The medical facility had a total of 9 police officers at the time of our visit; according to VA staffing guidance, the minimum staffing level for this medical facility should have been 19 officers. Not all medical facilities we visited had staffing problems. At one medical facility, the VA police appeared to be well staffed and were even able to designate staff to monitor off-site residential programs and community-based outpatient clinics.

Lack of stakeholder involvement in unit redesign. As medical facilities undergo remodeling, it is important that stakeholders are consulted in the design process to better ensure that new or remodeled areas are both functional and safe. We found that such stakeholder involvement on remodeling projects had not occurred at one of the medical facilities we visited. At this medical facility, clinical and VA police personnel were not consulted about a redesign project for the inpatient mental health unit. The new unit initially included one nursing station that did not prevent patient access if necessary. After the unit was reopened following the renovation, there were a number of assaults, including an incident where a veteran reached over the counter of the unit's nursing station and physically assaulted a nurse by stabbing her in the neck, shoulder, and leg with a pen. Had staff been consulted on the redesign of this unit, their experience managing veterans in an inpatient mental health unit environment would have been helpful in developing several safety aspects of this new unit, including the design of the nursing station. Less than a year after opening this unit, medical facility leadership called for a review of the units' design following several reported incidents. As a result of this review, the unit was split into two separate units with different veteran populations, an additional nursing station was installed, and changes were planned for the structure of both the original and newly created nursing stations—including the installation of a new shoulder-height Plexiglas barricade on both nursing station counters.

---

[36] One of the residential programs we reviewed did not use stationary panic alarm systems. This facility relied on portable personal panic alarms for its residential program staff.

In conclusion, weaknesses exist in the reporting of sexual assault incidents and in the implementation of physical precautions used to prevent sexual assaults and other safety incidents in VA medical facilities. Medical facility staff are uncertain about what types of sexual assault incidents should be reported to VHA leadership and VA law enforcement officials and prevention and remediation efforts are eroded by failing to tap the expertise of these officials. These officials can offer valuable suggestions for preventing and mitigating future sexual assault incidents and help address broader safety concerns through systemwide improvements throughout the VA health care system. Leaving reporting decisions to local VA medical facilities—rather than relying on VHA management and VA OIG officials to determine what types of incidents should be reported based on the consistent application of known criteria—increases the risk that some sexual assault incidents may go unreported. Moreover, uncertainty about sexual assault incident reporting is compounded by VA not having: (1) established a consistent definition of sexual assault, (2) set clear expectations for the types of sexual assault incidents that should be reported to VISN and VHA Central Office leadership officials, and (3) maintained proper oversight of sexual assault incidents that occurred in VA medical facilities. Unless these three key features are in place, VHA will not be able to ensure that all sexual assault incidents will be consistently reported throughout the VA health care system. Specifically, the absence of a centralized tracking system to monitor sexual assault incidents across VA medical facilities may seriously limit efforts to both prevent such incidents in the short and long term and maintain a working knowledge of past incidents and efforts to address them when staff transitions occur.

In addition, ensuring that medical facilities maintain a safe and secure environment for veterans and staff in residential programs and inpatient mental health units is critical and requires commitment from all levels of VA. Currently, the five VA medical facilities we visited are not adequately monitoring surveillance camera systems, maintaining the integrity of alarm systems, and ensuring an adequate police presence. Closer oversight by both VISNs and VHA Central Office staff is needed to provide a safe and secure environment throughout all VA medial facilities.

To improve VA's reporting and monitoring of allegations of sexual assault, we are making numerous recommendations—in a report that we issued last week. We recommended VA improve the reporting and monitoring of sexual assault incidents, including ensuring that a consistent definition of sexual assault is used for reporting purposes, clarifying expectations for reporting incidents to VISN and VHA leadership, and developing and implementing mechanisms for incident monitoring. To address vulnerabilities in physical security precautions at VA medical facilities, we recommended that VA ensure that alarm systems are regularly tested and kept in working order and that coordination among stakeholders occurs for renovations to units and physical security features at VA medical facilities.

In responding to a draft of the report on which this testimony is based, VA generally agreed with the report's conclusions and concurred with our recommendations. In addition, VA provided an action plan, which described the creation of a multidisciplinary workgroup to manage the agency's response to many of our recommendations. According to VA's comments, this workgroup will provide the Under Secretary for Health and his deputies with monthly verbal updates on its progress, as well as an initial action plan by July 15, 2011, and a final report by September 30, 2011.

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee, this concludes my prepared statement. I would be happy to respond to any questions either of you or other Members of the Subcommittee may have.

Contacts and Acknowledgments

For further information about this testimony, please contact Randall B. Williamson at (202) 512–7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Individuals who made key contributions to this testimony include Marcia A. Mann, Assistant Director; Emily Goodman; Katherine Nicole Laubacher; and Malissa G. Winograd.

Prepared Statement of Joseph G. Sullivan, Jr., Deputy Assistant Inspector General for Investigations, Office of Inspector General, U.S. Department of Veterans Affairs

Madam Chairwoman and Members of the Subcommittee, thank you for the opportunity to discuss how the Office of Inspector General (OIG) interacts with the Department of Veterans Affairs (VA) with regards to reporting alleged felonies, includ-

ing sexual assaults at VA medical facilities. I would also like to share some other work by the OIG in the area of safety at VA medical facilities.

BACKGROUND

The OIG's Office of Investigations conducts criminal and administrative investigations involving crimes impacting the Department's programs and operations and serious misconduct by senior management. When evidence of a crime or serious misconduct is developed during an investigation, we seek appropriate prosecution and/or administrative action to assist the VA in maintaining an environment that is safe for employees, patients, and visitors and protected against criminal activity.

VA maintains a police force at all VA Medical Centers (VAMCs) that has jurisdiction over alleged crimes that happen on VA property. In the last few years, the relationship between the OIG and VA Police has improved. The OIG requires all of our field supervisors to, whenever possible, identify a specific special agent to each VAMC Director, Pharmacy Chief, and Police Chief to serve as a primary liaison with that VAMC.

Additionally, in order to deter crime, criminal investigators continue to provide approximately 200 crime awareness briefings each fiscal year to about 13,000 employees at VA facilities nationwide. These briefings are intended to ensure that VA employees are aware of the many types of fraud and criminal activity that can victimize VA, VA employees, and veterans. These briefings have resulted in additional referrals of alleged criminal activity.

Finally, either the Assistant Inspector General for Investigations or I have addressed the VA Police Chiefs at their annual conference for the last 3 years. In each of these liaison efforts, we remind VA Police and other VA personnel of the requirement to report suspected felonies to the OIG. We emphasize that failure to provide timely notification may jeopardize our ability to successfully investigate an allegation. Recognizing our limited staffing and geographic footprint, we advise that we do not expect to be notified before local law enforcement but that we do expect to be notified in a timely manner. We provide nearly immediate feedback whether or not we will open an investigation.

The Code of Federal Regulations (CFR) require all VA employees to report suspected criminal behavior to VA management and/or the OIG.

- 38 CFR § 1.201—Employee's duty to report—All VA employees with knowledge or information about actual or possible violations of criminal law related to VA programs, operations, facilities, contracts, or information technology systems shall immediately report such knowledge of information to their supervisor, any management official, or directly to the Office of Inspector General.
- 38 CFR § 1.204—Information to be reported to the Office of Inspector General—Criminal matters involving felonies will also be immediately referred to the Office of Inspector General, Office of Investigations. VA management officials with information about possible criminal matters involving felonies will ensure and be responsible for prompt referrals to the OIG. Examples of felonies include but are not limited to, theft of Government property over $1000, false claims, false statements, drug offenses, crimes involving information technology systems and serious crimes against the person, i.e., homicides, armed robbery, rape, aggravated assault and serious physical abuse of a VA patient.

Government Accountability Office review

When the Government Accountability Office (GAO) contacted the OIG for information involving allegations of sexual assault, we provided detailed information and OIG investigative reports about 119 OIG investigations completed between January 2005 and June 2010 that involved allegations of sexual assault ranging from inappropriate touching to rape. Subsequently, GAO advised that the 2005 and 2006 data would not be used in their analysis; however, they requested an additional 6 weeks of 2010 data as well as any cases that were open during the previous search, but were now closed. We found information associated with 11 additional closed cases that we provided to GAO. We also provided GAO with de-identified information about nine sexual assault investigations that remained in an open status as of August 1, 2010.

Later, GAO requested that we review 42 scenarios regarding alleged sexual assaults that had occurred on VA property, but were not, according to GAO's research, referred by VA Police to the OIG. We had four senior agents review the information and they concluded the following:

- In 23 (55 percent) of the scenarios, we would not have expected VA Police to notify the OIG. Examples included allegations that lacked any evidence of sexual assault obtained as a result of a medical examination, to include a sexual

assault collection kit that did not reveal signs of sexual assault, and a victim who quickly recanted the original allegation. Also included in this group were allegations of a rape by a "celestial being" and consensual sex engaged in by two inpatients.
- In 14 (33 percent) of the scenarios, we would have expected VA Police to notify the OIG. Examples included a victim with dirt and grass on her clothing and in her hair who reported that she had been raped while walking on the grounds of a VA Medical Center, and a female physician who reported that a male patient sexually assaulted her while conducting an examination.
- In 5 (12 percent) of the scenarios, we could not make a judgment because of either ambiguous or inadequate information in the scenario description.

We also advised GAO that we recognized at least one scenario as an open case that had been originally reported to us by VA Police. Because GAO would not provide us any information that might identify the victim, accused subject, or facility associated with any of the 42 scenarios, we could not determine if there were other open cases that may have been reported to us.

The following examples illustrate cases originally reported to us by the VA Police that we worked jointly with them:

- A female veteran reported that a VA employee had made sexually inappropriate conversation and physical contact with her during several treatment sessions. The employee has been charged with attempted criminal sexual abuse and simple battery.
- A VA patient reported that a fellow inpatient at the VAMC sexually assaulted her on a number of occasions during her stay in a locked psychiatric unit. The suspect pled guilty to sexual assault in the 3rd degree and was sentenced to 1 year of incarceration and 3 years' probation.
- A VA patient residing in a VAMC assisted living area reported being sexually assaulted by his roommate, a convicted sex offender. The suspect was indicted on two counts of rape, two counts of sexual battery, and two counts of gross sexual imposition. He pled guilty to two counts of sexual battery and was sentenced to 6 months in county custody and 3 years of community controls by the county's sex offender unit. In addition, the judge classified him as a Tier III sex offender, and he will have to register his address in person every 90 days for life.
- A VA Chief Financial Officer sexually assaulted his minor daughter on numerous occasions in his apartment, which was located on VAMC property. This employee was recently sentenced to 36 months' incarceration. Our investigation also revealed that the defendant sexually assaulted the same daughter in a Las Vegas hotel. Subsequently, he was sentenced to a year's incarceration in Nevada.

While these examples demonstrate VA Police complying with the CFR reporting requirements, we are aware of instances of failure to timely report suspected felonies to the OIG. This decreases the likelihood of a successful resolution especially if VA Police have already conducted interviews and done other work. For example, after receiving a report from a female inpatient that 2 days earlier she had been raped, VA Police interviewed both the victim and the suspect, searched the vehicles of both the suspect and victim, took possession of the suspect's cell phone, and interviewed common acquaintances prior to contacting our local office, which is approximately 15 to 20 minutes from the VAMC. When OIG special agents joined the investigation, they added value by obtaining additional information from the victim and transporting her to a local hospital where she was examined by a Sexual Assault Response Team nurse. Additionally, when the OIG agents searched the suspect's vehicle, they discovered potential evidence, a used condom. Finally, had the victim not withdrawn her allegation and admitted to the consensual nature of the event, some evidence recovered prior to our involvement in the investigation may have been suppressed because the consent obtained to search the suspect's cell phone was verbal, not written.

We welcome GAO's recommendation to automate reminders to VA Police to notify the OIG when entering a felony offense into the VA Police database. We are pleased with the VA Police's intention to also implement an automated notice to our field offices whenever the record of such an offense is created. We believe both measures will greatly reduce the number of instances when we are not notified of alleged felonies.

OTHER OIG WORK

The OIG, in October 2008, issued an *Audit of the Veterans Health Administration's Domiciliary Safety, Security, and Privacy* (October 9, 2008) in which we as-

sessed the effectiveness of safety, security, and privacy of veterans residing in VA domiciliaries. We found that the Veterans Health Administration needed to implement additional national procedures and clarify national guidance to ensure that safety, security, and privacy issues are sufficiently identified, reported, and corrected throughout the year. We reported on three issues that impacted all 49 domiciliaries:

- There is a need to establish national procedures for the inspections of veterans' room.
- Additional safety, security, and privacy procedures are needed for female veterans along with security initiatives for all veteran residents.
- Improvements are needed in annual safety, security, and privacy reporting as well as the follow-up process.

The report contained eight recommendations, which according to VA have all been implemented.

CONCLUSION

The OIG and the VA Police have enhanced our working relationship over the last several years in order to protect patients, visitors, and employees at VA medical facilities. It is a commitment that both organizations take seriously. The Director of VA's Law Enforcement and Security Office e-mailed me recently stating "As we all agree, we are one team of law enforcement professionals and I and my senior team believe in working together." We in the Office of Inspector General share that sentiment.

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

Prepared Statement of William Schoenhard, FACHE, Deputy Under Secretary for Health for Operations and Management, Veterans Health Administration, U.S. Department of Veterans Affairs

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Committee: Thank you for the opportunity to appear and discuss the Department of Veterans Affairs' (VA) policies and actions to prevent sexual assaults and other safety incidents at VA medical facilities. The safety and security of our Veterans, employees, and visitors are paramount to us, and we appreciate the work of the Government Accountability Office (GAO) to help us further improve our programs and facilities. Secretary Shinseki has made this issue a top priority for the Department, and this commitment is reflected in our investments over the last 2 years. This includes integrating safety and security considerations into our Strategic Capital Investment Decision Model, which evaluates and ranks proposed construction and renovation projects, as a high priority consideration that is significantly weighted. As a result, those projects designed to improve facility security are consistently among the highest rated projects we support.

I am accompanied today by my colleagues George Arana, M.D., Acting Assistant Deputy Under Secretary for Health for Clinical Operations, and Kevin Hanretta, Deputy Assistant Secretary for Emergency Management.

VA currently uses both VA staff and physical infrastructure systems to ensure the security of our facilities, particularly residential and inpatient mental health programs. Closed circuit cameras, locks, alarms, separate facilities, and specialized training for health care professionals are some of the steps we have taken so far. However, to develop an even more robust and secure health care system, we have convened a multi-disciplinary Workgroup to define what the Veterans Health Administration (VHA) must do to prevent sexual assault incidents and to respond to allegations of sexual victimization. This Workgroup includes representatives from VHA and VA corporate offices, including the Office of Operations, Security, and Preparedness, and the Office of General Counsel. The Workgroup held its first meeting on June 6, 2011.

VA must, and will, proactively assess and manage risks and institute appropriate precautions to maximize prevention and response measures. We must also improve our mechanisms for Veterans and staff to report incidents to law enforcement so that offenders can be held accountable. These mechanisms must also provide information to VA management so that concerns can be monitored and addressed appropriately and timely.

My testimony today will first discuss the prevalence of sexual assault and other safety incidents in VA medical facilities. It will then cover VA policies and proce-

dures for reporting and monitoring such incidents. I will next detail the use of physical security precautions and the ability of VA's Central Office to respond, provide oversight, and address vulnerabilities. I will conclude by discussing VA's next steps as we continue to improve the safety of our facilities for all those on our property.

Prevalence of Sexual Assault and Other Safety Incidents

VA provided health care services to 6 million unique patients in fiscal year (FY) 2010 at more than 1,300 sites of care, and VHA employs more than 244,000 individuals. While the overwhelming majority of experiences in VA facilities are safe, no system is perfect. During the 3 and a half year period of the GAO review, VA provided approximately 240 million outpatient visits and more than 2 million inpatient admissions. As stated in GAO's report, **"VA HEALTH CARE: Actions Needed to Prevent Sexual Assaults and Other Safety Incidents"** (GAO–11–530), between January 2007 and July 2010, a period of 43 months, there were 284 alleged sexual assault incidents reported to VA police. Even one incident is one too many, and we must take every step we can to prevent assaults before they happen.

The GAO report indicates that these events may be under-reported. We must have procedures in place to provide the best data we can obtain. To reduce the potential for under-reporting, we will continue to encourage Veterans, families, employees and visitors to report information about an incident or a threatened incident to VA clinicians and VA police officers. We also will take additional steps, such as improving staff training, improving lighting, promoting awareness among staff and visitors, expanding access for reporting options, improving the reliability of panic alarms, and posting signs that advise staff and visitors how to report any incidents to the proper authorities. It is VHA's policy that emergency departments, urgent care clinics, outpatient clinics, and all inpatient and residential settings have plans in place to appropriately manage the medical and psychological assessment, treatment, and collection of evidence from male and female Veterans who report acute sexual assault. We also will develop a consistent definition for these incidents that will ensure the data we collect are as accurate and reliable as possible.

VA Policies and Procedures for Reporting and Monitoring Safety Incidents

The GAO's investigation found that many of these alleged assaults were not reported to VA leadership officials and the Office of Inspector General (OIG) as required by VA regulation. We appreciate this finding and recognize the need to improve structures for reporting incidents involving sexual victimization and other safety concerns. We are identifying several mechanisms and reporting structures to ensure the effective coordination of both prevention and response activities, and we will focus principally on strategies that provide universal precautions against sexual victimization. In addition, we recognize the importance of our risk assessment and risk management mechanisms. Critically important, though, is a clear definition of what acts constitute an offense and how this information should be used within the required limits of patient confidentiality and privacy protections. This was GAO's first recommendation. We agree that there is a need to establish consistent definitions of sexual assault and other safety incidents for reporting information from medical facilities to VA leadership at the Veterans Integrated Service Network (VISN) level and to VA Central Office. We will develop action plans with clear and aggressive timelines for implementation developed by July 15, and a final report to GAO on implementation by September 30, 2011, to address this concern.

The GAO report identified two mechanisms for reporting incidents: the management stream of reporting and the law enforcement stream of reporting. GAO recommended that VA implement a centralized tracking mechanism to allow both alleged and substantiated sexual assault incidents to be monitored consistently and reported to senior leadership; this information will be de-identified to protect the confidentiality of victims and will be subject to strict controls on access by VA employees. VA agrees with this recommendation, and will build on our work to establish a common set of definitions to support this objective. Already, we have begun to review the existing organizational strategies, structures, and policies to identify how best we can change or strengthen oversight and reporting processes. The multidisciplinary Workgroup has been charged with developing and implementing this centralized reporting mechanism. VA will prepare a detailed action plan with specific deadlines by July 15 and a final report by September 30, 2011.

An important element in ensuring the accuracy and timeliness of our procedures for reporting and monitoring safety and security incidents is the establishment and growth of the Integrated Operations Center (IOC). Established in 2009, the IOC, which operates 24 hours a day, 7 days a week, serves as a fusion point for operational, safety and security information. The IOC was established, in part, to provide the Secretary with a single office responsible for "proactively collecting, coordinating, and analyzing information in order to make recommendations to VA leader-

ship." VA Directive 0322, dated April 29, 2010. The IOC manages VA's Serious Incident Report Directive (published, January 25, 2010), which mandates reporting of among other things, incidents of alleged sexual assault that occur on VA property.

Existing Security Precautions and VA Response

The GAO report notes that VA has a number of systems in place to identify potential safety risks, but concluded that these systems are deficient in critical aspects. For example, the GAO found that some physical security precautions are not properly maintained or monitored and that inadequate installation or testing procedures contributed to these weaknesses. The GAO's concern is that these weaknesses could lead to delayed response times to incidents and otherwise undermine our efforts to prevent or mitigate sexual assaults and other safety incidents.

We agree with these findings and will take the necessary steps to improve our systems accordingly. While VA medical centers are currently expected to have policies addressing the use and testing of panic alarm systems in compliance with the standards of The Joint Commission, VA will re-emphasize the need for routine testing of these panic alarms to ensure they are functioning properly. We will review whether existing policy needs to be revised to ensure regular preventative maintenance occurs consistent with manufacturer requirements. Regular testing of alarms is critical to ensuring the safety and security of Veterans, staff, and visitors. VA will require VISN Directors to ensure that local facilities have established systems that meet the unique needs of that location and Veteran population. Furthermore, by mid-July, the multidisciplinary Workgroup will complete an action plan, with specific deadlines, that will recommend any necessary policy changes.

Next Steps to Improve Safety

As VA continues to improve its incident reporting and safety monitoring systems, we know there are additional, more immediate, measures we can take to improve the safety of all those within our facilities. Participants in the multi-disciplinary Workgroup have begun already to analyze deficiencies in our system based on GAO's recommendations, and propose specific solutions to these issues. The full Workgroup met on June 6, 2011, and began to identify solutions for improvement. VA will brief the Committee and GAO in August after these near term recommendations are complete. VA has taken steps to improve the quality of reporting alleged incidents so we have a better understanding of the context and frequency of events. In January 2010, VA published Directive 0321 on Serious Incident Reporting, which required VA facilities to report such data in a consistent manner. This Directive did not include, however, a common definition for alleged sexual assaults. We are correcting that omission. VA's multidisciplinary Workgroup will identify the scope and develop definitions for sexual victimization of Veterans, employees, and visitors. The Workgroup will also prescribe how these incidents are to be reported. Having a consistent definition for sexual assault and standardized reporting procedures will enable the IOC to collect more data that are reliable, and more easily identify trends. Analysis of this data will help VA leaders gain a better understanding of the prevalence of sexual assaults and other safety incidents in VA health care facilities and will support the development of solutions that will make our facilities even safer. Another important step towards safer facilities will be to expand the involvement of security experts in the planning and construction phases of renovation or construction projects to ensure that safety and security issues are identified and addressed as early as possible. We will also review the availability of existing resources to determine if further training, support, or assistance is needed to improve the safety and security of our facilities.

Conclusion

While the VA health care system provides exceptional service to millions of Veterans and family members every year, even one incident that threatens the safety and well-being of a Veteran, a family member, an employee, or a visitor is unacceptable. Sexual assault is a devastating experience for victims. We are using external reviews, such as GAO's report, and internal assessments to identify deficiencies and to correct them immediately. The Veterans Health Administration is working together with the IOC to identify, report, and monitor incidents in an almost real-time environment. We will use the Workgroup to recommend solutions with specific timelines to improve our prevention and surveillance efforts. These are important steps toward ensuring a safer and more secure system. We take a zero tolerance approach to sexual assault and will enforce the law and our policies to the maximum extent in the best interests of our Veterans, their families, and our staff. Thank you again for the opportunity to testify today. My colleagues and I would be pleased to answer any questions you may have.

Prepared Statement of Verna Jones, Director, National Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Committee:

The American Legion applauds this Committee for utilizing its oversight authority to delve into this deeply troubling issue. The men and women of our armed forces are trained to go into hazardous locations in the performance of their duties. They are trained to operate under some of the most grueling and psychologically challenging circumstances. When they swear their oath they take on these challenges, and meet them with grace and valor unlike any other armed force in history.

They should not, and *must* not, meet grueling and psychologically challenging conditions undertaking the most basic of tasks in their civilian life post military service—seeking and receiving the health care services they have earned in the Department of Veterans Affairs (VA).

The findings of the most recent Government Accountability Office (GAO) report "Actions Needed to Prevent Sexual Assaults and Other Safety Incidents" (GAO–11–530) and previous reports addressing this matter such as "VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Procedures" (GAO–10–287) are disturbing. There are veterans who do not feel safe using the facilities provided for them for health care, and they don't feel safe for a reason. In the last 3 years alone, nearly 300 incidents of sexual assault were reported to the VA police. Staggeringly, the vast majority of these reported incidents were *not* reported to VA leadership and/or the Office of the Inspector General (OIG). VA cannot be expected to solve patient security issues if they remain unaware of the problem at critical leadership levels.

The American Legion is aware of these concerns. Furthermore, the Legion believes the overall VA Health Care system is generally an excellent and deserved resource, and no veterans should feel they cannot utilize the system for fear of inappropriate behavior. With that in mind, The American Legion offers the following insights into the GAO report and our own research, and recommendations to improve the system and preserve the sanctity of the VA Health Care system.

What GAO Found

GAO's most recent report tackled the period ranging from January 2007–July 2010 with recognition that changing patient demographics were presenting unique challenges to VA in terms of providing a safe environment for all veterans. In particular, this study examined security issues stemming from unwanted sexual behavior and advances. Whether such behavior took the form of rape, inappropriate touching, forced examination, forced oral sex or other forms of sexual assault, the findings were clear. Not only were such illegal and horrifying actions occurring, over two thirds of these incidents went unreported to VA management and the OIG despite being reported to VA police.

GAO found fault with the risk assessment protocols. The protocols are simply a self-reporting process utilized to inform clinicians of sexual assault related risks, specifically regarding the lack of guidance about information collection. Because of a lack of "evidence based risk assessment tools" VHA relies on "professional judgment of clinicians" which is subjective at best. This is clearly problematic when dealing with an organization as large as VA, and one as criticized as VA is for a lack of consistency on a regional level. Because the information used to make these assessments is self-reported it is frequently incomplete, further complicating the issue.

The report found a lack of adequate precautions in place at VA residential and inpatient facilities. While the sample of facilities examined was relatively small, GAO surveyed five facilities out of a system that includes 153 full medical centers, the omissions in procedures and security precautions raise large warning flags. Basic measures such as security cameras, alarm systems and so forth are inadequate or not present. In other places, there was inconsistency in the types of precautions taken, ranging from "patient behavior contracts" that varied from facility to facility, to a difference of procedures in place.

Perhaps one of the most common themes in the findings of the report was the lack of clear guidance. VA Staff had questions about what should and should not be reported. Staff frequently noted they were unclear as to the proper procedures for reporting, or even as noted above, taking histories.

Amongst other considerations, the findings seem to solidify one of the chief concerns about the entire medical system cited often in the past by The American Legion—inconsistency. As the saying goes "If you've seen one VA Medical Center, you've seen one VA Medical Center." From VAMC to VAMC to VISN to VISN to CBOC to CBOC, each seems sometimes to operate as its own private fiefdom with-

out consistency. The American Legion believes that while the overall plan for VA is strong, inconsistent application of that plan only leads to failure on a local level. VA must increase consistency.

What The American Legion Found

The American Legion utilizes multiple tools to find firsthand information about patients in the VA Health Care system. Annually, The American Legion conducts site visits to VA medical facilities as the basis of our "System Worth Saving" (SWS) report. The SWS report covers all aspects of VA medical facility operations, and concerns of veterans utilizing the system are one of the many facets of these information gathering site visits.

In December of 2010, The American Legion further contracted with ProSidian Consulting to conduct a survey of women veterans to assess their satisfaction with the quality of health care delivered by the VA system. While women are by no means the only targets of sexual assault in VA and DoD facilities, Military Sexual Trauma (MST) is one of the key concerns noted specifically with reference to women veterans, and the Women Veterans Survey addressed concerns about security within VA facilities.

In the survey, 18 percent of women, or approximately one in five, stated they were "dissatisfied or very dissatisfied" with their sense of security in the VA health care system. When compared with recent figures which indicate approximately the same percentage of women in DoD have experienced military sexual trauma—21 percent according to Department of Defense Sexual Assault Prevention and Response Office (SAPRO)—it is not unreasonable to start asking questions about whether there are lingering artifacts of the pervasive culture of the military that foster sexual assault without long term consequences.

The American Legion is deeply concerned to learn the VA and DoD actions to address this dire issue are lagging. In March 2010 the GAO conducted site visits to nine VA medical centers and ten Community Based Outpatient Clinics (CBOCs) to examine the availability of health care to women veterans, VA's compliance with their policies and the challenges that they face in providing care. The GAO reported only two of the VAMCs visited had specialized residential treatment programs specifically for women who have experienced MST. Although the VA has taken steps to inform staff about their various programs offering MST treatment and counseling, VA has been thus far ineffective in informing veterans of these options. The VA has not provided this information on their external Web site where veterans can easily access it.

In site visits conducted as a part of the System Worth Saving Task Force, one American Legion staffer noted a woman came to VA enrollment desk seeking to report military sexual trauma. The veteran was directed to "fill out that packet over there and send it in" with no further follow up or concern from the VA employee. This veteran could have, and should have, been connected with the facility's Military Sexual Trauma Coordinator and the employee could further have assisted the veteran by asking to speak to her in a more appropriate setting instead of drawing out the conversation in full view of the public in the waiting area. Sensitivity in this area goes a long way towards establishing trust with veterans whose trust has already been damaged. While the Legion staffer was able to conduct outreach to that veteran on the spot and immediately to ensure she got the treatment and aid needed, VA should not and must not rely on outside service organizations to conduct their vital role of outreach.

Put simply, The American Legion has found all too often that even if proper programs are in place and the resources are available to veterans, staff indifference and poor advertisement of these programs, including but not limited to poorly conveyed information in facilities and on VA's own Web site, contributes to an veterans feeling there is no support for them in the system. The findings of GAO indicate there are serious flaws in the system to begin with, but when VA cannot even implement what is there already in the system, they are failing veterans. These veterans need to have access to and utilize the tools available to them.

What The American Legion Recommends

The problems represented within VA are hardly unique to VA. The American Legion recognizes there are cultural considerations both DoD and VA have long strove to overcome. Previous testimony has addressed concerns about those cultural considerations. If there is to be substantial change to rectify the unsatisfactory state of affairs, the change must affect the cultural environment. Clearly, no agency would support the sad state described in the GAO report. VA has regulations and policies already existing which attempt to provide a means to counter unwanted sexual behavior. However, it is abundantly clear these policies are not being consistently en-

forced, if enforced at all. Actions speak louder and more convincingly than words. VA's actions must show their commitment to a policy geared towards ending the sexual assaults and other security incidents.

There are signs of an encouraging start. **VHA Directive 2010–033** issued July 14, 2010 provided for VISN level MST Coordinators, as well as MST Coordinators at a facility level. The American Legion supports the establishment of such coordinators and recognizes the strength of such assets in outreach to veterans and spreading the message of support services available as well as following up on behalf of any veterans within the system who may experience these issues. However, although the Legion has determined all facilities now have such a coordinator, in many or most locations, the position is not a full time position, and is often an additional duty of an employee tasked with other responsibilities.

The American Legion strongly recommends enhancing the role of these coordinators to full time status, and giving them the authority and scope of mission to act as advocates within the system for veterans who experience sexual trauma, and to ensure policies are carried out in VA facilities in keeping with the nature of the expectations of VA Central Office. Utilize these employees to be the front line defenders for those veterans who experience sexual trauma, whether it be in DoD or in VA itself.

The disorganized nature of VA's overall plan for dealing with incidents of this nature requires revision. In this The American Legion agrees with the findings of the GAO report. Clarity and direction is necessary in multiple areas, including standards procedures for reporting, risk assessment and ensuring implementation of procedures again as noted by GAO.

VA must act now to meet the basic needs found in the GAO report. Promote a clear understanding of the definition of sexual assault. Establish a clear set of expectations regarding what should and should not be reported up the chain of command. GAO's recommendations also call for an automated system to forward all reports of a criminal nature brought to the attention of VA security to the attention of OIG for investigation. Given previous records of reporting of material to OIG for proper follow up and investigation, automating this procedure may overcome whatever institutional roadblocks are already in place.

One of the stated concerns was the establishment of a centralized tracking system to monitor sexual assault incidents across VA medical facilities. Obviously this idea has merit and is an important tool. VA's existing medical health care record system is already a recognized tool of excellence in necessary information sharing for medical treatment. However, given VA's past record regarding data security, and the extremely sensitive nature of the subject matter involved and the already damaged psychological picture of the victims involved, the absolute utmost care is necessary to ensure such a system is secure beyond doubt. This is material of the most sensitive nature possible, and past VA mistakes and missteps with data security must not be allowed to compromise this reporting system. In The American Legion's survey of women veterans, fully one quarter of these veterans felt VA's handling of personal and sensitive information was "Poor to Moderate [Moderate being defined as less than Good]".

The American Legion would note the most important consideration in reacting to this problem is to avoid the previous pattern exemplified by VA response to incidents of concern. In the past, VA policy has been to create an expanded section of Central Office to "manage and provide oversight" over a certain field, and enhanced Central Office bloat while allowing the problem to perpetuate at the local level because of a lack of direct oversight to the ground level operating environment. What is *not* needed is another floor of VA bureaucracy to deal with this issue.

What *is* needed is a clearly dictated policy made transparent to employees and the public at all levels, increased scrutiny at a ground floor level to ensure operations are complying with the stated mission, and accountability for those employees who fail to meet the standards. Put simply, hold individuals accountable for their actions, and make clear in no uncertain terms that this kind of behavior will not be tolerated. Then allow the local level to act out that policy without need for another hundred bureaucrats in Washington.

House Resolution 2074, the "Veterans Sexual Assault Prevention Act" works very much in the spirit of what The American Legion is proposing here. The bill provides for exactly the sort of concise and clear definitions and consistent policy required to help right the ship of VA's treatment of these matters. The American Legion supports this legislation, but also notes continued oversight and follow up will be necessary to ensure compliance. The lack of clarity and consistency within VA on this matter indicate a potentially resistant culture, which will require the actions of all stakeholders to rectify. The American Legion stands ready to work with Congress, the VA, and all affected veterans and veteran service organizations to ensure proper

due diligence is exercised and this matter does not slip from the forefront of our attention. This is a problem we all must work to solve, and The American Legion is eager to help.

Prepared Statement of Joy J. Ilem, Deputy National Legislative Director, Disabled American Veterans

Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee:

On behalf of the Disabled American Veterans (DAV) and our 1.2 million members, all of whom are wartime disabled veterans, I am pleased to be here today to present our views on a recently released Government Accountability Office (GAO) report (GAO–11–530)—*Actions Needed to Prevent Sexual Assaults and Other Safety Incidents* (herein after GAO report or Report) to the Committee on the issue of the prevention of sexual assaults and other related safety incidents occurring in Department of Veterans Affairs (VA) health care facilities.

In reading the GAO Report we were disturbed to find that between 2007 and 2010, GAO identified 284 alleged sexual assaults reported through one of two reporting streams. However, many times, the victims' reports were mishandled or inappropriately acted upon based on decisions made by local physicians or administrators and most had not been reported to appropriate program officials and leadership in VA—even though rape allegations are considered potential felonies and are required by regulation to be reported to the VA's Office of the Inspector General (OIG). Although VA officials at one sampled facility noted they did expect to be notified of all sexual assault incidents—this expectation was not specifically documented in their policy.

At the outset, let it be known that DAV believes in the strongest possible terms that veterans, VA employees, visitors and others who occasion visits to VA facilities should always be assured of their physical safety and personal security. Likewise, every veteran hospitalized or housed at a VA medical center (VAMC) or treatment facility should be afforded a safe, secure environment and be treated with respect and dignity. In addition to the Veterans Health Administration's (VHA's) benchmark of continuous quality improvement programs ensuring that patients receive safe and effective health care, VA must reevaluate and strengthen its safety program to ensure that the environment of care at VA health facilities keeps veterans, staff and visitors safe from physical harm, including sexual assaults.

VA has received numerous prestigious national awards and been lauded by the National Academy of Science's Institute of Medicine for its outstanding patient safety programs, including alerts embedded in its Veterans Health Information Systems and Technology Architecture (VistA)/Computerized Patient Record System (CPRS) electronic health record, its barcode medication administration program that reduces medication errors, and its patient safety reporting systems. It is therefore surprising that the National Patient Safety Center has not encouraged VAMCs to perform: (1) a root cause analysis on incidents involving sexual assaults, (2) a national data roll-up and analysis of methods to prevent or mitigate the risk of sexual assault, or (3) further study of this important patient safety issue.

GAO's report concerns us on several levels. Initially, it documents loose and inattentive reporting of incidents of personal violence committed in VAMCs against veterans, staff and visitors; the failure of or reluctance to share information about these incidents; inadequate police staffing and monitoring of security cameras in certain facilities; the lack of proper investigative procedures and follow up; the lack of a uniform definition of sexual assault to ensure consistent reporting; lack of a centralized database for tracking and trending assault incidents; destruction of incident reports and police records; and lack of information sharing by VHA Operations and Management staff with other internal stakeholders. We are also concerned that the lack of information sharing could be further complicated with the recent VHA reorganization that has separated the operations and policy functions of many service lines, including mental health programs, if recommended policy changes are not implemented. We concur with GAO that without the regular exchange of sexual assault report incidents that occur within their areas of programmatic responsibility, VHA officials cannot effectively address potential risks in their programs and local facilities do not have the opportunity to identify ways to prevent such incidents. These critical deficiencies identified by GAO have uncovered not only the individual program and policy gaps noted, but also highlight VHA's lack of a methodical and systematic approach to eradication of sexual assaults from its facilities.

In addition to its failure to communicate with VHA Program Offices, it appears VHA lacks an open approach to communication regarding sexual assaults with other

VA offices, including the OIG. According to the report, by regulation, all potential felonies, including rape allegations, must be reported to VA OIG investigators. GAO also found that VAMC Police are not consistently reporting felony sexual assaults to the other VA offices with responsibility for investigating crimes.

These practices and lack of systemic consistency cannot be defended and must be addressed by VHA with a sense of urgency. VA must establish a comprehensive, consistent approach to documenting, investigating and reporting sexual assaults—a serious crime of personal violence apparently occurring at several VA health care facilities. Given the limited number of facilities surveyed by GAO, we are concerned about the extent of the problem systemwide. For these reasons we suggest the creation of a task force to ensure the VA adopts a culture of safety and promptly develops a uniform policy for the reporting of all sexual assaults. It is clear these reports cannot be solely handled by the local facility involved and that mandatory reporting of these incidents to all the appropriate officials is necessary. We are pleased to see that VA has established a "multi-disciplinary workgroup" to define what actions need to be taken to prevent sexual assault incidents and to respond to reports and allegations of sexual victimization of veterans and VA employees.

We noted in the report a footnote on page 13 that indicates VA police routinely destroy their investigation reports of VA sexual assaults 3 years after making such reports, under a records retention policy of the National Archives and Records Administration. We oppose the destruction of these reports on the same basis that we oppose the destruction of reports of military sexual trauma (MST) that occur within the military services. More information on our position with respect to destruction of MST records may be found in DAV's testimony before this Subcommittee on May 20, 2010. The destruction of these reports contributes to the problem of the lack of consistent information and information sharing, and obstructs analysis that could be immensely helpful not only to improve safety in VA facilities but to promote a better understanding of the incidence of sexual assaults in VA. Also, a number of these cases could result in tort claims or VA disability claims. The lack of documentation can contribute to loss of benefits and equity for these victims.

GAO noted in its analysis that VA is experiencing significant demographic changes in its health care programs due to initiatives targeting several specific veteran populations—including women veterans, veterans who have served in Operations Enduring and Iraqi Freedom (Web site/OIF), and veterans facing legal issues or those currently incarcerated. New VA enrollees are trending younger, with a more visible presence of women veterans. According to VA, about one-half of all women who served in OEF/OIF and separated from the military since September 11, 2001, are enrolled in VA health care. VA is also outreaching to justice-involved veterans with post-deployment mental health problems, such as combat-related post-traumatic stress disorder (PTSD) to help them avoid incarceration and enter into appropriate specialized VA programs for PTSD, traumatic brain injury (TBI) and substance-use disorder treatment. The same holds true for homeless veterans and family caregivers of severely injured and ill veterans. VA is also seeing a significant new workload in mental health care while trying to use the least-restrictive environment to do so.

VA is also under stress to treat a seriously and moderately disabled young veteran population returning from war with myriad unmet needs and high expectations for state of the art services across the continuum of health care and rehabilitation. This changing demographic and the need for comprehensive mental health care and polytrauma care has made it even more crucial that VA address the safety and security issues raised by GAO. Of the 1.2 million individuals who have served in the wars in Iraq and Afghanistan, over 654,000 (more than 50 percent) have enrolled in VA health care since fiscal year 2002. Although these patient populations are a small percentage of the overall enrolled population using VA, we believe these changes have affected VA's environment of care, in both expected and unexpected ways.

In addition to the environment of care issues, VA must also raise awareness among its staff through education and training in order to enhance its climate and culture of safety. VA's clinical care staff are accustomed to caring for a predominantly older, male population with chronic medical conditions rather than the one they are now being charged to treat. These shifts and pressures produce stresses that VA has not previously or recently experienced and may be contributing to the culture of safety challenges that GAO aptly uncovered and documented in this report. These demographic changes are projected to continue in the foreseeable future.

GAO primarily focused on three distinct VA settings in its report—residential rehabilitation treatment programs (RRTP), inpatient and residential mental health units and compensated work therapy/transitional residence (CWT/TR) settings. For years GAO has addressed safety and privacy deficiencies in VA health care facili-

ties, specifically related to women veterans. We see in the current report, in relationship to the residential program sites, that only one of the three CWT/TR programs evaluated accepted women due to safety and privacy concerns. These safety concerns continue to negatively impact women veterans—in essence they are denied access to needed specialized services because VA is not confident they can provide a safe environment for women. Likewise, GAO notes that several clinicians they interviewed for a previous report on women's health services in VA expressed concern for the safety of women veterans placed in VA inpatient mental health programs. These types of concerns highlight an inequity in access to care for women veterans and the potential for further assaults unless corrective action is taken. Among the security precautions that must be in place for residential programs are secure accommodations for women veterans with periodic assessments of facility safety and security issues. We have brought this issue to the attention of the Subcommittee over the years and hope you will consider oversight to ensure as VA moves forward to improve their overall culture of safety in VA facilities, and that VA specifically address these safety issues related to care for women veterans.

While acknowledging its findings could not be generalized to VA as a whole, and that the report was based on visits to only five VA medical centers in four networks of care, GAO tendered nine recommendations from its review. We endorse these ideas and note that VA has concurred in each of them as well. Given the seriousness of this issue, we urge VA to move forward expeditiously to implement them within the spirit in which they were made. While not one of the recommendations, we also believe that the organizational placement of VA's police force should be a subject of review, as well as the sufficiency of its staffing levels across the system and its operating mandate. Historically, VA police officers were VA medical center employees, appointed locally and directly responsible to the VAMC director to ensure safety of persons and property, including real property. In recent years, however, the VA police force has been organizationally centralized to report to a Deputy Assistant Secretary for Law Enforcement.

Madam Chairwoman, every veteran should be assured of the highest level of quality care and patient safety while receiving health care in a VA facility. A veteran should never fear for his or her own personal safety while visiting a VA facility. VA was established as a place of care, not a place of fear, for veterans, visitors and staff. We concur with GAO that when a veteran has a history of sexual assault or violent acts, VA must be vigilant in identifying the risks that such veterans pose to the safety of others at its medical facilities. VA needs to take decisive actions to improve personal safety and promote an environment of care that includes protection from personal assaults, including sexual assaults. To do so will take a commitment from all levels of VA and especially VA's senior leadership. We commend GAO for making this critical report. Hopefully, GAO's findings can serve VA and veterans well in providing a roadmap to promote a new environment of care that encompasses a strong consistent culture of safety, and one that can be closely monitored by this Subcommittee as VA completes the recommended changes.

Madam Chairwoman, this concludes my statement, and I would be pleased to consider questions from you and other Members of the Subcommittee.

Prepared Statement of Marlene Roll, Member, National Women Veterans Committee, Veterans of Foreign Wars of the United States

MADAM CHAIRWOMAN AND MEMBERS OF THIS COMMITTEE:

On behalf of the 2.1 million members of the Veterans of Foreign Wars of the United States and our Auxiliaries, I thank you for this opportunity to share our views on this exceedingly important topic.

The June 7 GAO report, entitled "VA Health Care: Actions Needed to Prevent Sexual Assaults and Other Safety Incidents," doesn't provide enough detail to fully grasp the depth of this problem, but there are some things we do know: One incident of assault, of a sexual nature or otherwise, is one too many. We also know that interested parties—Veterans, VA, Congress, VSOs, and the American people—cannot look the other way once we know this is occurring. Thanks to the GAO, we now know it's happening at VA.

Sexual assault is among the most serious of problems an individual or any organization—especially one in the service industry like the VA Health Administration—could ever confront. VA must immediately work to address this problem head on.

The VFW affirms, in no uncertain terms, the need for a zero-tolerance policy. Less than that is unacceptable and inexcusable.

Every confirmed instance of sexual assault must be dealt with swiftly and to the maximum extent of the law. VA employees and veterans who commit or know of

these acts must be held accountable. We entrust VA to care for the brave men and women who have gone to war and returned home physically and/or emotionally traumatized. They must never have to visit a VA medical facility with concerns about their personal safety.

The allegations in the GAO report are as troubling as they are unacceptable. The report makes it sound as if VHA has a culture of condoning this type of behavior, which we believe is not the case. But what is the case is that the facilities and networks visited by GAO have a severe problem that we can only hope is not systemwide.

VA must swiftly address the many problems identified by the GAO in its report. They must also clarify what constitutes sexual assault, because the lack of a clear, consistent, VA-wide definition has allegedly led to many events not being reported or resulted in no action on those events that were reported. This is an appalling abdication of a solemn responsibility, and it must stop immediately. VA must standardize the type of information that will be recorded as well as the type of incidents that will be immediately reported to the VA Central Office and/or to local law enforcement officials. This will help ensure every incident is properly documented, which will lead to more thorough investigations, and hopefully help prevent similar incidents from occurring at other facilities. This is a zero tolerance issue in the military world and in the civilian world; it must be so in the VA world, too. Only quick and decisive action will restore public confidence in the VA.

GAO also recommended VA police create a system-wide process that would result in cases involving potential felonies to be automatically reported to the VA Office of the Inspector General. Frankly, we are shocked that such a common-sense Standard Operating Procedure doesn't already exist.

Another critical suggestion by GAO—implementing a centralized tracking mechanism for VHA Central Office personnel—speaks volumes about the failure of leadership at many levels to understand the importance of this issue and respond appropriately.

The most important issue that we believe is missing is the lack of a comprehensive and continuous training program. All efforts to properly identify sexual assault and to create programs to forward allegations to appropriate officials are in vain if employees aren't trained to be vigilant and to identify problem situations. We strongly believe that VA must institute an ongoing training program that is informative, that encourages people to report what they believe is inappropriate, and that is mandatory for ***all*** VA employees to attend.

Today, VA is caring for an ever-increasing caseload of women veterans. It is imperative that women come to VA for the care they have earned and when they need it. Establishing and maintaining trust is an essential ingredient in making sure that happens. Anything less than immediate and comprehensive action to remedy this situation could set VA back in the proper care of our deserving women veterans.

Total leadership is essential from everyone in VA. Secretary Shinseki and his Senior Executive staff are sincerely involved, and the VFW knows they will do everything within their power to end sexual assaults in the VA workplace. Yet the solution to stamping out this problem is not in Washington; the solution is in the field in every Network Director, Medical Center Director, Clinic Director, and their senior staffs, frontline supervisors and in every employee. The GAO report identifies a shared problem that reflects upon the integrity of the entire VA. Its eradication can only lie in a total commitment by those very same employees at every level.

We thank Health Subcommittee Chairwoman Buerkle and Chairman Miller for introducing H.R. 2074, the "Veterans Sexual Assault Prevention Act," to fix this fractious and ineffective policy by establishing in law a comprehensive policy on reporting, tracking, and investigating claims of inappropriate sexual and other safety incidents. VA leadership has failed in their obligations for too long, and the hidden nature of this unacceptable problem requires Congress to act quickly.

We want the guilty punished, but we also strongly believe that any legislation signed into law should specifically direct VA to ensure exonerated employees are not indirectly punished professionally. They have the most to lose if allegations are not handled properly. The VFW does not want to see dedicated employees leave the VA system for this reason, so any successful cultural change within VA must include protections for innocent employees wrongfully accused. VA must recognize this and be prepared to responsibly handle allegations that are proven to be false.

We greatly appreciate the importance this Committee places on this issue, and we hope that you will continue to provide the necessary oversight to ensure VA responds aggressively to address our concerns.

Prepared Statement of Richard F. Weidman Executive Director for Policy and Government Affairs, Vietnam Veterans of America

Madam Chairwoman, Ranking Member Michaud, and distinguished Members of the House Veterans' Affairs Subcommittee on Health, Vietnam Veterans of America (VVA) appreciates the opportunity to present our views in regard to the substance contained in GAO–11–530 report, Preventing Sexual Assaults and Safety Incidents at U.S. Department of Veterans Affairs Facilities.

VVA commends Chairman Miller and Ranking Member Filner for requesting this review, commends you and Mr. Michaud for holding this hearing, and commends the General Accountability Office (GAO) for doing their usual measured and thorough report on this volatile issue. My name is Rick Weidman, and I have the privilege of serving as Executive Director for Policy and Government Affairs at VVA.

First we note that just as one veteran committing suicide is too many, even one sexual assault within the VA facilities anywhere in America is too many. Having said that, the context which we consider this very serious matter is important. The United States has a rate of reported rapes of about 3 per 10,000 of population, which ranks us as tenth most in the world of reported rapes. We do not know how many employees or how many patients were present at any given time during the 30 months of the time period at the five medical centers studied by the GAO, so do not know how to compare these terrible statistics to that of the population at large. In addition, there does not seem to be any way to tell how many sexual assaults go unreported. What we do know is that the more seriously rape/sexual assault is taken by the society or subset of the society, the more the rate of reporting goes up. That does not mean that sexual assault increases, but rather those victims become much more likely to report such inexcusable incidents when those in positions of authority back up and protect the victim against further harm.

The mere fact that this study was done and that you are having this hearing today will have a salutary effect on both making it clear that such behavior cannot and will be tolerated against any staff member or veteran in the Veterans Health Administration (VHA) system, and spurring action to make it less likely that such events will occur in the future.

The recommendations of the GAO that were accepted by the VA are sensible steps to improve definitions and reporting, improve training in procedures, and take physical steps to reduce risk to both patients and staff.

The initial step of creating a workgroup to define sexual assault, and the various manifestations, as well as clarifying when and how such incidents should be reported within the VA structure is a wise and necessary first step, and with a reasonable deadline of July 15. Similarly, creating a centralized tracking mechanism to allow management to be able to monitor such assaults is also a much needed step.

Addressing vulnerabilities in physical structures, particularly in regard to locked inpatient wards is also a pressing need that should be addressed as soon as possible at each and every facility.

The recommendation about establishing legal histories on individuals beyond the self reported information now used is, of course, perhaps the trickiest recommendation from the GAO to implement, as it involves elements of privacy, ethics, and legal constraints as well as perhaps conflicting obligations to all parties concerned. While this may be the most difficult task, it is perhaps the most important in terms of identifying high risk individuals. Exactly how to do this risk assessment in a way that protects others in the medical setting, while not compromising the supportive atmosphere necessary for treating veterans with mental health issues, will require careful thought, good training, and conscientious supervision.

Among a number of things that would seem to be evident from the findings is the need for a standardized "panic button" electronic device that every staff member can carry on his or her person to alert others when faced with imminent physical danger.

While it is not specifically mentioned in the GAO report in question, it is clear that there needs to be separate facilities/wards for female patients on the long term treatment wards. It has also long been the position of VVA that there is a need for a specific women's clinic that does the full range of care, including psychological evaluations and treatment. Such a women's clinic should be large enough to house most of the elements involved in a "one stop shop" for women veterans, and be situated in a location that is not isolated within the facility while still protecting confidentiality.

The GAO specifically noted how important it is to have involvement of all stakeholders in planning for steps that can and should be taken to modify physical structures to better protect personal safety. The GAO also noted that all stakeholders

should be involved in modifying regulations, definitions, reporting pathways, and other elements that need to be modified to make VA medical facilities as safe as possible for all concerned.

Perhaps we should not be surprised that conspicuous by absence anywhere in the official VA response was any mention of the veterans who are the consumers of VA health care. The veterans are clearly stakeholders in this process, and the majority of the incidents discussed in the report were incidents where a veteran patient was the victim. Yet nowhere in the guidance to the local facility or the VISN is any mention of the need/importance of consulting veterans or veterans' representatives. The VA response also had no mention of consulting with veteran stakeholders at the national workgroup level, much less having a VSO representative as part of this group.

This is unfortunately consistent with the attitudes toward veteran stakeholders that sometimes seem to pervade much of VHA. Frankly, for all the talk about increasing transparency, VHA was much more open and transparent 7 years ago than it is today, and seemed to value input from veteran stakeholders much more than is the case today. Suffice it to say that it is important that stakeholders be consulted at every level, and listened to seriously. Further, since the attacks delineated in the GAO report are mostly on females, it would seem obvious to us that in particular female veterans who are consumers or their representatives should be involved in a meaningful way at the national, VISN, and at the local medical facility level. Similarly VHA female staff members at risk should be involved in the process as well.

Madame Chairwoman, thank you for the opportunity to appear here this afternoon to express the views of VVA. I will be pleased to answer any questions, Madam Chair.

Statement of Hon. Russ Carnahan,
a Representative in Congress from the State of Missouri

Madam Chairwoman and Members of the Subcommittee, thank you for hosting this hearing to discuss the prevention of sexual assault and other related safety incidents occurring in VA facilities. Sexual assault is one the most severe concerns in any organization and can leave lasting physical and mental trauma to the victim. The Government Accountability Office (GAO) has helped shed light on this very pressing issue, and we need to confront this problem head on.

We must work together to improve the safety of our VA health facilities. And should an incident of sexual assault occur, it must be properly documented and adjudicated with the fullest extent of the law. Today's hearing provides a important dialogue between Congress and those with intimate knowledge of what needs to be done to guarantee the safety of our veterans.

The GAO's findings reveal that nearly 300 cases of sexual assault incidents involving rape allegations went unreported to the VA Office of the Inspector General. After fighting to protect our Nation, our heroes have the right to safe and secure access to the Veterans Health Administration system. They also have the right to justice if an incident of sexual assault does occur.

We must ensure that all veterans feel completely comfortable using their provided health care locations. This means implementing the necessary security precautions in medical facilities, including effective alarm systems and closed circuit cameras with continuous safety monitoring.

Consistency and communication are vital. Currently, no VHA-wide definition of sexual assault exists. The GAO has recommended the creation of a workgroup to establish a new clear definition. This will greatly help incident reporting, assessment, and management on all levels. Only when every case is properly documented and investigated can other similar incidents be prevented. We must work to ensure that a centralized reporting and tracking mechanism is implemented. Strengthened oversight is key in managing and combating sexual assault incidents.

With a growing number of women veterans, improved VA health services are necessary. It is paramount that all veterans receive the care they need and deserve. This can only occur if veterans feel safe in VA facilities. No victim of sexual assault should feel reluctant to report their case. No veteran should fear being ignored or even blamed.

I look forward to hearing from our witnesses on ways we can ensure a safe and secure environment at all VA facilities.

MATERIAL SUBMITTED FOR THE RECORD

The American Legion
Washington, DC.
September 12, 2011

Ms. Diane Kirkland
Printing Clerk
Committee on Veterans' Affairs
House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Dear Ms Kirkland:

In reply to your email dated September 7, 2011 regarding information you requested for Ms. Verna Jones of The American Legion please accept the following testimony:

> "After a more detailed review of the survey analysis, 18 percent of the respondents stated they were "very dissatisfied" or "somewhat dissatisfied." Because the question defined 'security' as "physical safety, financial security, access to information, and other privacy sensitivities of the patient" it is impossible to quantify those who were dissatisfied with physical security versus information security.
>
> In the second phase of the survey, yet to be initiated, we will be meeting with focus groups and get more specific and anecdotal background to the specific dissatisfaction. Until that is complete, we are left with the overall survey result of 18 percent dissatisfaction levels."

In addition, attached you will find excerpts from The American Legion—Women Veterans Survey 2011, pp. 50–52, which provide further information regarding Ranking Member Michaud's request.

Thank you for your assistance in this matter. If you need further information please contact me at 202.861.2700 or dstoline@legion.org.

Dean Stoline, Deputy Director
National Legislative Commission

Attachment

The American Legion—WOMEN VETERANS SURVEY 2011

SECURITY

Security is the freedom from danger, risk or doubt. The SERVQUAL attribute of security in The American Legion's Women Veteran's Survey also includes consideration for the patient's best interests such as privacy and confidentiality (Are dealings with the patient held private?).

This includes physical safety that affirms management's commitment to a patient and worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client.

Financial security is also included in this category and addresses the increased cost of health care, to make sure patients have enough income and health care to maintain their health care standard.

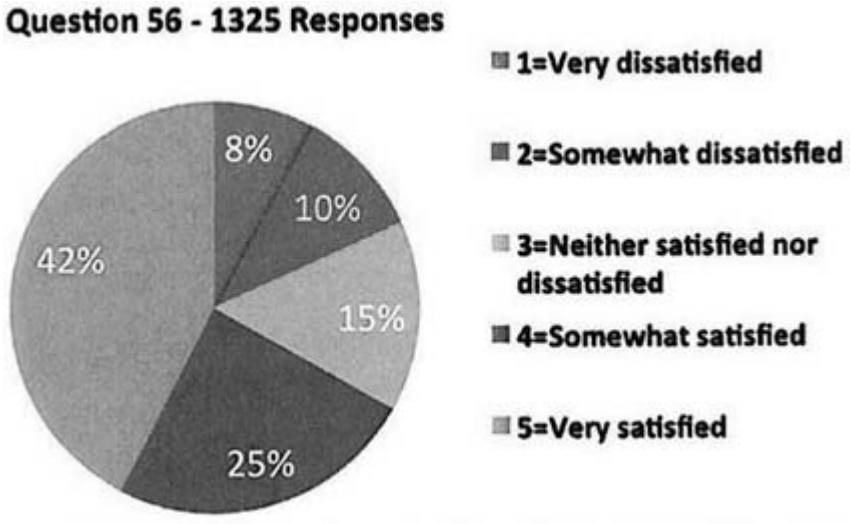
Additionally, this attribute ensures access to information is both protected and available with an expected degree of personalization. This attribute addresses personalization and the ability to satisfy specific needs of individual customers while maintaining privacy for customers.

This includes the ability to acquire customer information in exchange for personalized services. Regardless of the nature of environments, personalization depends on the knowledge about an individual customer and the ability to cater to her needs.

There are four (4) questions in this category.

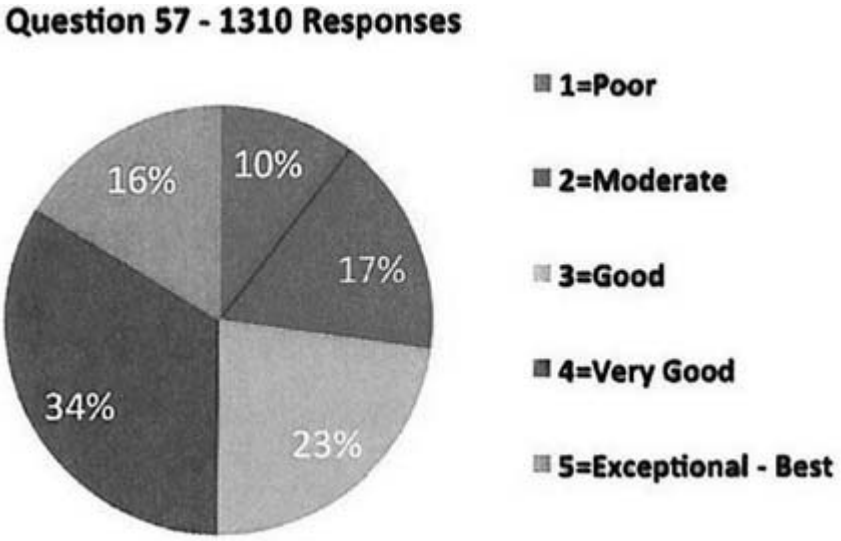
Questions—Security

Question 56	Security is defined as freedom from danger, risk or doubt. It includes considerations for customer's best interests such as privacy and confidentiality. It also includes physical safety, financial security, access to information and other privacy sensitivities of a patient. Based on your perceptions of and satisfaction level with measures of security in Women Veterans health care; how would you COMPARE health care provided by the VA to private practitioners and other health care providers?	1=Very Dissatisfied 2=Somewhat Dissatisfied 3=Neither Satisfied nor Dissatisfied 4=Somewhat Satisfied 5=Very Satisfied



Based on the responses, 67 percent of the Women Veterans responding stated that they were satisfied or very satisfied with measures of security with measures of security defined as freedom from danger, risk or doubt, and considerations for customer's best interests in health care provided by the VA. In contrast 18 percent of the Women Veterans responding stated that they were either very dissatisfied or somewhat dissatisfied with physical safety, financial security, access to information, and other privacy sensitivities related to Women Veterans health care at the VA when compared to private practitioners and other health care providers. While the majority indicated favorable responses, more than 20 percent were not. This result indicates that practices and policies related to security may require additional enhancement in order to increase favorable perceptions.

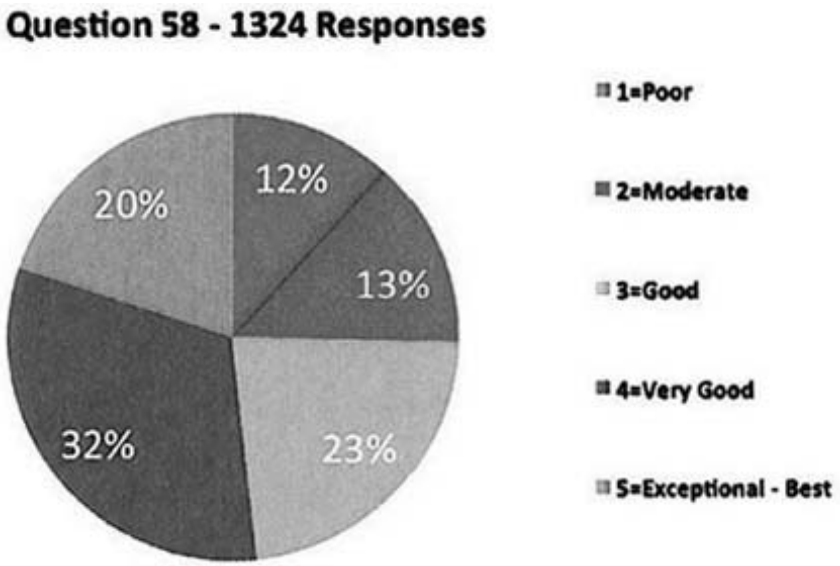
Question 57	Based on your perceptions of and satisfaction level with Women Veterans health care in the VA system and other benefits delivered, how would you rank the VA Healthcare System in terms of access to information which is both protected and available with an expected degree of personalization.	1=Poor 2=Moderate 3=Good 4=Very Good 5=Exceptional—Best



Based on the responses, 27 percent of the Women Veterans responding stated that they would rank the VA Healthcare System as Poor or Moderate in terms of access to information which is both protected and available with an expected degree of personalization.

There were 23 percent who ranked the VA as Good in terms of an expected degree of personalization while ensuring information is both protected and available. However, 16 percent of the Women Veterans responding stated that they felt the VA was exceptional to best in this regard.

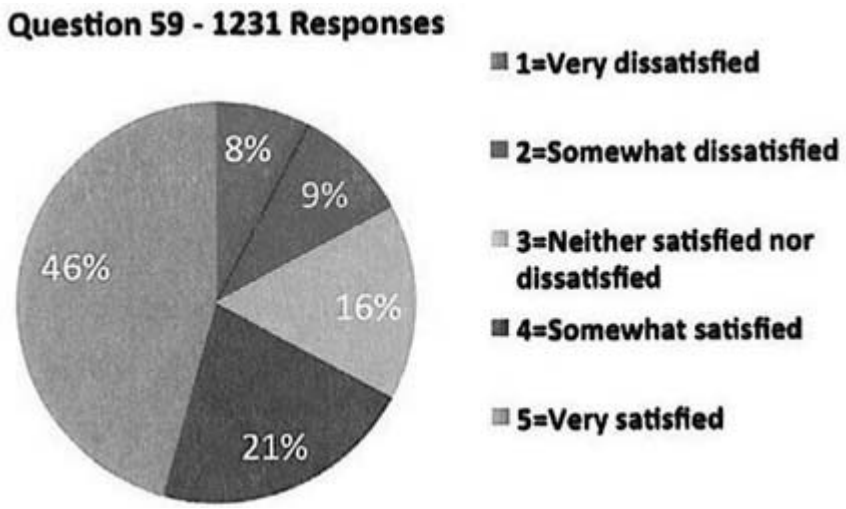
Question 58	Based on your perceptions of and satisfaction level with Women Veterans health care in the VA system and other benefits delivered, how would you rank the VA Healthcare System in terms of sensitivity to the patient's personal information and the collection and storing of patient information?	1=Poor 2=Moderate 3=Good 4=Very Good 5=Exceptional—Best



Fully 25 percent of the Women Veterans responding stated that they would rank the VA Healthcare System as either Poor or Moderate in terms of sensitivity to the patient's personal information and the collection and storing of patient information.

There were 23 percent who ranked the VA Healthcare System as Good in terms of sensitivity to the patient's personal information. 52 percent of the Women Veterans responding stated that they rank the VA Healthcare System as Exceptional-Best or Very Good. While nearly 75 percent rated this area favorably, a 25 percent negative evaluation suggests significant room for improvement in the view of Women Veterans.

Question 59	How would you COMPARE the security and privacy protection mechanisms for health care provided by the VA to private practitioners and other health care providers?	1=Very Dissatisfied 2=Somewhat Dissatisfied 3=Neither Satisfied nor Dissatisfied 4=Somewhat Satisfied 5=Very Satisfied



When compared to private practitioners and other health care providers, Women Veterans were slightly more positive. Of the respondents, 17 percent stated that they were either Very Dissatisfied or Somewhat Dissatisfied with the security and privacy protection mechanisms for health care provided by the VA when compared to private practitioners and other health care providers.

Of the Women Veterans responding 67 percent stated that they were Somewhat Satisfied or Very Satisfied with security and privacy protection mechanisms for health care provided by the VA.

Observations and Recommendations—Security

Security is defined as freedom from danger, risk, or doubt, and includes consideration for customers' best interests such as privacy and confidentiality. It also includes physical safety, financial security, access to information, and other privacy sensitivities. Nearly 75 percent of the respondents rated the sensitivity to patients' personal information (question 58) favorably (Good or higher), and 67 percent stated that they were Satisfied or Very Satisfied with the security and privacy protection mechanisms provided by the VA (question 59). On the other hand, 17 percent of the women veterans suggest that there is room for improvement in Security-related issues for the VA health care services.

○