PROTECTING WHISTLEBLOWERS AND PROMOTING ACCOUNTABILITY: IS VA DOING ITS JOB?

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

TUESDAY, OCTOBER 29, 2019

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U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION
COMMITTEE ON VETERANS' AFFAIRS
Washington, DC.

The subcommittee met, pursuant to notice, at 2:20p.m., in room 210, House Visitors Center, Hon. Chris Pappas (chairman of the subcommittee) presiding.

Present: Representatives Pappas, Rice, Rose, Cisneros, Bergman, and Bost.

Also present: Representative Takano.

OPENING STATEMENT OF CHRIS PAPPAS, CHAIRMAN

Mr. PAPPAS. Today's hearing will come to order.

Without objection, the chair is authorized to declare a recess at any time.

I ask unanimous consent for our colleague Representative Biggs to participate in today's hearing, should he be able to attend, and, without objection, so ordered.

I would also like to welcome our Full Committee chairman, Mark Takano, who is with us here today too.

Today's Oversight and Investigation Subcommittee hearing is entitled "Protecting Whistleblowers and Promoting Accountability: Is VA Doing Its Job?"

In June, the subcommittee held a hearing to discuss the importance of VA whistleblowers. We heard testimony from people inside the VA who raised major questions and concerns about critical problems that affect the health and well-being of veterans. These witnesses were willing to blow the whistle even when it risked their livelihood and their careers. However, all three of the VA employees that day testified they are still experiencing retaliation as whistleblowers and, unfortunately, they are not alone. My office hears from other whistleblowers describing similar outrageous stories of retaliation and how the VA turns a deaf ear to their plight.

In July, Assistant Secretary Bonzanto, the top official from the Office of Accountability and Whistleblower Protection (OAWP), appeared before our subcommittee. I was not satisfied with her testimony at the time, and I think it is fair to say that the subcommittee members expressed the need for VA to change its cul-

ture and ensure it is listening to and protecting whistleblowers, and that has to be the highest priority.

Last week, the Inspector General (IG) released its report that examined the Office of Accountability and Whistleblower Protection. The IG's findings in this report right here are stark and damning, describing a failure by VA to perform basic missions and investigating allegations and protecting whistleblowers.

The IG report states that the office floundered in its mission to protect whistleblowers. Leaders created an office that was, quote, "sometimes alienating to the very individuals it was meant to protect."

According to press statements, VA is trying to spin the report as simply problems of the past; this is a misreading of the IG's report.

Clearly, the early leaders of OAWP made major missteps. However—and this must be clearly stated—the IG also describes how major failures continue to this day. The IG report lays out 22 recommendations for VA and the Office of Accountability and Whistleblower Protection, 22; all of these recommendations remain open. Oddly, the VA has stated publicly that a number of these recommendations have been resolved and I do not believe this is true, and I hope Mr. Missal will clarify that in his testimony.

I would go further to say this, that this inability to admit failure is also part of the problem that we face. The VA has not recognized how badly it treats whistleblowers and the culture of retaliation that exists.

On September 30th, I joined the Full Committee chair, Mark Takano, in sending a letter to VA, pointing out that OAWP is not performing its basic missions for protecting whistleblowers. The Secretary is not receiving proposals for action that would hold VA leaders accountable, nor is the office training VA supervisors about the rights and protections of whistleblowers, and this is simply unacceptable.

I have said this before and it needs to be repeated: whistleblowers are an important source of information and they can not be ignored. Their rights must be protected, so that future whistleblowers will have confidence that their stories will be heard and assurance that their allegations will be investigated without reprisal.

So far, the office has not achieved this basic mission. We need to have a complete explanation as to how Dr. Bonzanto will get the job done. Whistleblowers are waiting and empty promises will not do.

With that, I would like to recognize Ranking Member Bergman for 5 minutes for any opening remarks he may have.

OPENING STATEMENT OF JACK BERGMAN, RANKING MEMBER

Mr. BERGMAN. Thanks, Mr. Chairman.

I want to start by thanking Inspector General Missal and his staff for their work on this thorough and well-reasoned report; I am confident that they have left no stone unturned.

Accountability at all levels of the Department of Veterans Affairs is one of my, and I know the entire staff's, highest priorities. When we first examined the Office of Accountability and Whistleblower Protection, OAWP, in July 2018, I expressed my concern to Mr. O'Rourke about a breakdown in the Department's chain of com-

mand. Dr. Roe cautioned that, while well-intentioned, OAWP may come to constitute another layer of bureaucracy and, worse, seek to expand beyond the intent of the Accountability Act.

Given OAWP's lack of any written policies and procedures at the time, several different members of the committee questioned Mr. O'Rourke about the rationale for and the propriety of the office's activities. We now know that the situation was even worse than we believed. This OIG report leaves no doubt that OAWP misinterpreted its statutory mandate, conducted unsound and biased investigations on multiple occasions, and failed to establish safeguards to protect whistleblowers from retaliation.

Many of the report's findings seem to be indicative of a cynical or self-serving attitude in OAWP under the previous leadership. There is no doubt OAWP was badly in need of top-to-bottom housecleaning to fully turn the page on this disturbing era.

Mr. Chairman, the OIG report makes clear that these leadership deficiencies were the root cause of many of OAWP's problems. I hope we will now focus on the future of OAWP, whose mission you and Chairman Takano described as critical to veterans, rather than dwell in the past regarding individuals who are no longer with the VA.

I am encouraged that Dr. Bonzanto is now leading OAWP. I am pleased to hear that she has already submitted information responsive to ten of the recommendations and I believe—I think I heard you say 22, so we are almost at 50-percent response already; however, this is only the beginning of the office's rehabilitation. This afternoon, I expect to hear what she has accomplished since her confirmation on January 7th, 2019, as well as what her plan looks like to tackle the challenges that remain within her office. I want specifics, including dates, as to when additional reforms will be implemented.

Above all else, OAWP needs to return to focusing on its core statutory mission. This organization has to learn to walk before it can run. The report details example after example of OAWP investigating individuals beyond its authority, while at the same time arbitrarily narrowing the scope of alleged wrongdoing to be considered. Sometimes the investigations appeared to be personally motivated. Many times OAWP would simply refer an investigation back to the office where the allegations originated. All too often, investigations were conducted as disciplinary actions in search of evidence rather than as comprehensive and fair-minded inquiries into all the available evidence.

It would be unreasonable for an office of roughly 100 people to adjudicate misconduct allegations originating from a workforce of over 350,000 people. Let me be clear, I am not advocating supersizing OAWP to do all these things; rather, we need to see a more effective OAWP with a laser-like focus on its statutory mission of receiving, reviewing, and investigating executive misconduct, retaliation, and poor performance, as well as any sort of whistleblower retaliation by senior leaders and managers. Although OAWP's work is difficult, I have no doubt that most of the employees believe in the mission and work hard to do the right thing, even under the previous leadership.

The OIG report notes that many of the original employees were human resources specialists. Human resources and administrative investigations are very different disciplines and it is possible that these employees were never put in a position to succeed. I want to see VA's strategy to recruit and place seasoned investigators in these critical positions. The current strategic pause on recommending new personnel actions makes sense until quality is established, but what comes next?

Holding senior leaders accountable is a core function of this office. I hope that there is some capacity for OAWP to perform reviews at this time and I would like to know what the plan is.

Finally, I expect OAWP to treat whistleblowers with care in all its activities. The report paints a disturbing picture of cavalier culture and careless practices. I think it is not only right, but necessary to hold OAWP to the highest standards of integrity in order for the VA workforce to have confidence in the office's actions. Whistleblowers, to entrust it with their futures, OAWP must project the values of fairness, honesty, and incorruptibility.

With that, Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you for your comments, Mr. Bergman. We will now hear from our witnesses.

First I would like to introduce Dr. Tamara Bonzanto, she is the Assistant Secretary for Accountability and Whistleblower Protection. The subcommittee thanks you for appearing before us today and, Dr. Bonzanto, you have 5 minutes.

STATEMENT OF TAMARA BONZANTO

Ms. BONZANTO. Chairman Pappas, Ranking Member Bergman, and members of the subcommittee, thank you for the opportunity to testify today about VA's Office of Accountability and Whistleblower Protection, OAWP.

OAWP's establishment is meant to highlight the need for accountability in VA. Since my appointment in January, I have expeditiously undertaken actions to ensure that a culture of accountability exists within OAWP, with a goal of regaining the trust of employees, whistleblowers, and veterans.

My written testimony addresses reforms underway in OAWP; however, I want to highlight a few examples.

OAWP's staff was signing off on recommendations not to take disciplinary action without sending those recommendations to me for review. When I identified this was happening, I immediately put a stop to this practice; I now review all recommendations.

In reviewing recommendations for disciplinary actions, I identified several deficiencies, including investigative reports that did not contain witness interviews. To improve oversight for investigations, I established smaller investigative teams with ten investigators per supervisor. I also brought in a new leadership team, which include individuals with substantial experience managing whistleblower retaliation investigations. I established a quality control team to independently review investigative reports for thoroughness and accuracy.

OAWP is working on standard operating procedures for investigations and customized investigator training.

With regard to the timeliness of investigations, OAWP takes around 215 days to complete an investigation. This resulted in a backlog of 572 cases, some dating back to 2017. My goal is to reduce this timeframe to 120 days and eliminate the backlog by the end of the next calendar year. Some of the above reforms will help us achieve this goal.

I also realigned staff, so that we have investigators. Because of the extensive time that an OAWP investigation takes, I mandated that staff regularly update individuals about the status of their matters. OAWP is leveraging best practices from across the Government to help us ensure that our investigations are timely.

I recognize that individuals have to trust OAWP for them to share information with us. Around August 2019, I found out about a list of individuals that was sent to prior OAWP leadership. This list contained detailed information about the allegation raised by individuals and OAWP staff opinions about the individuals and their allegations. According to OAWP staff, this list was requested by former OAWP leadership and was related to a whistleblower mentorship program, which I have now canceled.

Regardless of the intent, it was inappropriate to utilize whistleblower information to establish such a list and provide opinions about individuals who raised allegations of wrongdoing.

The deficiencies in OAWP have had a substantial impact on whistleblowers and VA employees who disclose wrongdoing. The organizational changes underway bring OAWP into compliance with the law and reflect a fundamental change in the way we do business. I will continue to engage with stakeholders, including OAWP employees, as we address the deficiencies.

As a registered nurse, Navy veteran, and former investigator on this committee, I am committed to accountability in VA. I have the support of the Secretary and VA leadership as I continue to address the deficiencies in OAWP.

I ask for your support and I appreciate the input from you and your staff as I continue to ensure that OAWP does a better job at improving the culture of accountability in VA and protecting whistleblowers.

Mr. Chairman, Ranking Member Bergman, and members of the committee, this concludes my statement. I would be happy to answer any questions you may have.

[THE PREPARED STATEMENT OF TAMARA BONZANTO APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you very much.

I will now recognize our second witness, Mr. Michael Missal, the VA Inspector General. Mr. Missal, you have 5 minutes.

STATEMENT OF MICHAEL MISSAL

Mr. MISSAL. Thank you. Chairman Pappas, Ranking Member Bergman, Chairman Takano, and members of the subcommittee, thank you for the opportunity to discuss the Office of Inspector General's report, "Failures Implementing the VA Accountability and Whistleblower Protection Act of 2017."

In June 2018, we received a request from Members of Congress raising concerns that VA was not properly implementing the Act. In addition, we received complaints directly from VA employees

and others relating to concerns about OAWP's operations. We were also denied access by VA leaders to information about the operations of the OAWP.

In response, we conducted a review focusing on the OAWP's operations from June 23rd, 2017 through December 31st, 2018. During this review, additional allegations arose as new OAWP leaders began making changes, prompting further related work through August 2019.

As detailed in our report, we identified significant deficiencies in the operations of the OAWP. We made six overall findings: first, that the OAWP misinterpreted its statutory mandate, resulting in failures to act within its investigative authority; second, that the OAWP did not consistently conduct procedurally sound, accurate, thorough, and unbiased investigations and related activities; third, they struggled with implementing the act's enhanced authority to hold executives covered by the act accountable; fourth, the OAWP failed to fully protect whistleblowers from retaliation; fifth, VA failed to implement various requirements under the act, including revising supervisors performance plans and developing supervisors training regarding whistleblowers rights; and, sixth, the OAWP lacked transparency in its information management practices.

We recognize that organizing the operation of any new office is challenging, but OAWP leaders made avoidable mistakes early in its development that created an office culture that was sometimes alienating to the very individuals it was meant to protect. Those leadership failures distracted the OAWP from its core mission, and likely diminished the desired confidence of whistleblowers and other potential complainants in the operations of the office.

VA employees who identify serious misconduct must feel protected when coming forward with complaints. They are essential to helping VA spot and address significant problems that may otherwise go undetected and persist, which could increase veterans' risk of harm.

Our report highlights significant failings by OAWP's former leaders that have had a chilling effect on complainants still being felt today.

To address the issues identified, we made 22 recommendations. VA concurred with all recommendations and provided action plans for implementation. However, some of the planned actions lacked sufficient clarity or specific steps to ensure corrective actions will adequately address the recommendations. All 22 recommendations remain open and we will monitor implementation of VA's planned and recently implemented actions to ensure that they have been effective and sustained.

We recognize that there have been changed made by Assistant Secretary Bonzanto to attempt to establish the trust of whistleblowers and other complainants due to missteps and a culture set by former leaders. Recent communications to the OIG hotline, however, indicate that some individuals continue to harbor a fear of OAWP retaliation or disciplinary action for reporting suspected wrongdoing. The OIG wants the goals of the act to be accomplished. Whistleblowers play a critical role in oversight and they need to have confidence that their concerns will be heard and properly considered, and that their identities will be protected.

The OAWP leaders and staff who are committed to improving VA programs and operations face considerable challenges in overcoming the deficiencies identified in our report.

Mr. Chairman, this concludes my statement, and I am happy to answer any questions that you or other members of the subcommittee may have.

[THE PREPARED STATEMENT OF MICHAEL MISSAL APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you very much for your testimony, Mr. Missal.

We will now move to the question portion of the hearing today and I would like to start by recognizing myself for 5 minutes.

Dr. Bonzanto, thanks for your testimony. One of your main responsibilities as Assistant Secretary to provide recommendations for disciplinary action to the Secretary. You have acknowledged that over your tenure you have sent one single recommendation for action so far; is that correct?

Ms. BONZANTO. Yes, sir.

Mr. PAPPAS. I would like to be frank. In light of that, is that adequate? Are you meeting the responsibilities of your job?

Ms. BONZANTO. At this time, I can say that I am also equally frustrated that I have not been able to send additional recommendations to the Secretary for disciplinary action, but as the IG highlighted and I found in the recommendations I reviewed, there was significant deficiencies in the investigative report and it needed to be sent back for review.

Mr. PAPPAS. Sure. I understand you have those quality concerns about the office's investigations and rightfully so, given what Mr. Missal has found. No one would suggest that you should recommend disciplinary action based on shoddy investigations, but the office continues to conduct investigations without procedures for how they should be done and in fact, despite your stated concerns over quality, you increased the number of investigations that each investigator is expected to handle.

Help me understand the logic behind that. Why are you directing your staff to continue investigations when you have not developed necessary guidance or training to address your concerns about quality, and is your office going to have to go back and redo some of these investigations?

Ms. BONZANTO. No. To your address your concern regarding the staff training, staff has had training in the past prior to my arrival, they also had training when I came on board. The staff also, we have a quality team that is going to be reviewing the investigations and increasing the number of investigations that they are carrying. When I came on board, the staff were carrying two investigations per investigator on average and that resulted in a significant backlog, there was a lack of oversight. To improve that, we also made the teams smaller and had smaller teams with at least ten investigators per supervisor.

Before those recommendations come to me, they are getting reviewed by a supervisor, getting reviewed by a quality team, and then being sent up for review by myself.

Mr. PAPPAS. What about the standard operating procedures?

Ms. BONZANTO. The standard operating procedures is currently in development. We most recently in September published our directive and we needed the framework for investigations, that framework will then be used to develop our internal processes, and that is currently in draft and I expect that to be completed by the end of this calendar year.

Mr. PAPPAS. By the end of 2019?

Ms. BONZANTO. Yes, sir.

Mr. PAPPAS. Mr. Missal, could you be clear about one major point here. The major failures that you identified in your report continue today?

Mr. MISSAL. We have not closed out any of the recommendations, so the report is our most current information.

Mr. PAPPAS. The 22 recommendations have not been closed out, all remain open. You did say in your testimony that some of the actions lacked specificity and you still have concerns about the action plan; is that correct?

Mr. MISSAL. That is correct.

Mr. PAPPAS. Dr. Bonzanto, we hear from whistleblowers that they often experience retaliation in the form of a hostile work environment, things like being isolated in a basement office, about being assigned to a room without working air conditioning or heat, not being given the tools an individual needs to complete his or her job.

In June, we heard from Mr. Jeff Dettbarn, a VA X-ray technologist who described the retaliation he has experienced after blowing the whistle on concerns about the quality of veterans' care. It has been years since Mr. Dettbarn reported concerns to OAWP, yet he continues to face a hostile work environment and has had his duties reduced to only menial tasks.

Other than placing stays on terminations, how else does your office protect whistleblowers like Mr. Dettbarn?

Ms. BONZANTO. Since I have been on board, I have actually mandated that staff reaches out to whistleblowers and communicate with them. Communication and transparency is key in building trust with the whistleblowers that we are serving and the VA employees that are coming forward. This way it is giving us the opportunity to identify if they are facing retaliation early in the process.

Also, improving investigations and improving the work product of the team will help protect whistleblowers, because then we can have thorough and accurate investigations.

Mr. PAPPAS. Well, what about the fear that some individuals have—and Mr. Missal cited it here today—of the fear that they have in reaching out to OAWP, that they are not going to be protected or have the advocate in their corner that they need, is that of concern to you?

Ms. BONZANTO. That is of concern. As the IG report highlighted, the fear was substantiated in the investigations that were done and there were a lot of examples in there where whistleblowers themselves were not interviewed. That fear is real and I acknowledge that. I have taken—as I said, we have taken a totally different direction. I want to be transparent with whistleblowers, I want them to trust that they can come forward and know that we are here to hear their concerns and protect them from retaliation.

Mr. PAPPAS. Well, I know we have spoken about this and I really want you to be an advocate for whistleblowers across the VA system. It is critically important that these individuals who are just looking out for veterans have the ability to come forward to talk about waste, fraud, and abuse that they see, and to be a part of improvements ultimately for veterans in the end.

I think we need to continue to see more work on that front, we need to continue to insist that you meet some of the dates that you have said here today in your testimony about how you are going to introduce, you know, some of these proposals to move OAWP forward.

With that, my time is up. I would like to turn it over to Ranking Member Bergman for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman.

Dr. Bonzanto, you know and being in the Navy, you join a command, you become part of a command, in some cases you are the commander, and it is the commander's responsibility to establish a command climate and also that command culture. When you are a commander coming into a unit that is already established, good or bad, you inherit what you inherit. It is what it is and it is not necessarily what you want it to be yet. That is where you put your fingerprints on it and your stamp on it to make it that superior command that you want to pass along to the next person.

Having said that, I know you are doing everything you can at this point given what you were given. Your office is responsible for actions by senior leaders and executives, as well as managers, when whistleblower retaliation is alleged. Approximately how many VA employees fall within this jurisdiction, how many senior leaders and executives?

Ms. BONZANTO. I would say around 540 falls in that core group——

Mr. BERGMAN. Okay.

Ms. BONZANTO.—of senior executives.

Mr. BERGMAN. Basically, that is a relatively small subset of the VA total workforce. I understand that you put disciplinary recommendations on hold out of concerns for the quality of the investigations, but I hope you have some current capacity, and we kind of talked about this already, investigate properly. What is your plan to lift the hold and resume a full level, if you will, of investigative capability?

Ms. BONZANTO. Currently—so, coming on board, we actually—what I saw, there was a need for oversight, so these are some of the steps I have taken to get to this point right now. We have increased the oversight operation by having smaller teams. We have also—I am now reviewing all the investigative reports for recommendation and for closure. Whistleblowers are contacted every 14 days; that improves transparency in the process. I have also realigned the organization to basically eliminate duplicative efforts that was happening within the teams.

We have issued a directive of hired most recently investigative leadership with a background in investigating whistleblower retaliation cases and doing administrative investigations. We have also implemented a case management system, which allows us to track

cases and have a platform for staff to document, and we have the quality review team that is in place.

Those are the things that are currently done. The priorities to continue working on this is to hire additional leadership for stability to establish the Standard Operating Procedures (SOPs) for the investigators to be able to do their job, and to establish performance standards for the investigators, so that they can be held accountable for doing their jobs.

Mr. BERGMAN. Dr. Bonzanto, if I was a whistleblower working at VA and suffering retaliation by my supervisor today, should I have confidence in OAWP to handle my allegations competently and fairly?

Ms. BONZANTO. Yes.

Mr. BERGMAN. Is it perfect or have you still got some improvements?

Ms. BONZANTO. Sir, we still have a lot of work to do.

Mr. BERGMAN. Okay. Mr. Missal, do you agree with that?

Mr. MISSAL. I think it still remains to be said. Certainly, from our review, we found that they were not handling the investigations appropriately. I know Dr. Bonzanto is trying to make changes, but it is going to take some time for them to go through.

I would just like to add one thing that is somewhat disturbing, it is if you look at the organizational chart that Dr. Bonzanto included in her testimony, there are a lot of empty positions and, as she just pointed out, she needs to fill those positions. Until that leadership structure gets filled out, it is going to be really hard to make the changes that I know she wants to make.

Mr. BERGMAN. Dr. Bonzanto, is OAWP still closing and declining to investigate matters that fall within your statutory authority?

Ms. BONZANTO. No, sir.

Mr. BERGMAN. Okay. Is OAWP still opting to investigate individuals in matters outside of its jurisdiction?

Ms. BONZANTO. OAWP is investigating matters with an authorized scope, sir.

Mr. BERGMAN. Okay. Dr. Bonzanto, is OAWP now cooperating with the Office of Inspector General and can give me some tangible examples of how this is—you know, it is changed that you are cooperating?

Ms. BONZANTO. Yes, sir. Mr. Missal and I actually meet monthly or as needed, as often as we need to do with the staff. We have had great communication between us since I have been on board. We have been collaborating on a lot of the improvements or I have been actually asking his staff for best practices of things they are doing well. Those are the examples I can give you and I am sure there is more.

Mr. PAPPAS. Mr. Missal, do you agree with that statement?

Mr. MISSAL. Yes. There is certainly jurisdiction that overlaps, and so what really needs to be done is to ensure that the right organization is handling a particular matter. Aside from OAWP, there is the Office of Special Counsel, there is the Office of Resolution Management, there are a number of different avenues a complainant can go to. Unless all of those offices coordinate their efforts and communicate together, it is going to make it really tough.

I would agree with Dr. Bonzanto that the lines of communication between our office and OAWP has drastically improved since she came on board.

Mr. BERGMAN. Thank you.

Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you, Mr. Bergman.

I would now like to recognize Chairman Takano for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

Dr. Bonzanto, you have expressed a lot of concerns about the quality and consistency of the work that OAWP has done, some of which was prior to your confirmation as Assistant Secretary. Are all these issues surprising to you given the lack of standard operating procedures for investigations?

Ms. BONZANTO. These issues were not surprising given the fact that there are a lot of leadership vacancies in the organization, so it goes beyond the standard operating procedures. I need to fill those vacancies in order to be able to have a team, to build a team out.

Mr. TAKANO. Well, but there is a connection to the quality, the lack of quality, and the consistency of the work, and the lack of standard operating procedures?

Ms. BONZANTO. I would say I need investigators with a background in investigations and the H.R. staff that I currently have on board also to ensure that they have the training to be able to do the investigations, then establish. We recently——

Mr. TAKANO. Well, let me ask you, is it correct that it took 9 months after your appointment to publish a basic policy on investigations?

Ms. BONZANTO. Yes.

Mr. TAKANO. Your office still does not have standard operating procedures to guide investigations; is that true?

Ms. BONZANTO. Right. We published in September the framework and now we are developing the standard operating procedures based on that framework.

Mr. TAKANO. They are still yet to be established this many months into your tenure.

Ms. BONZANTO. Basically, it has taken time to get to this point. As the IG found, there were substantial issues with the office and operations of the office. I identified a lot of issues that were deep-rooted and started addressing those issues. Then I had vacancies in leadership that also slowed progress and I wanted to ensure that the changes——

Mr. TAKANO. Well, in claiming my time, I need to get to—I am sorry.

Ms. BONZANTO. Okay.

Mr. TAKANO. Mr. Missal, can you speak to how the office's lack of standard operating procedures contributes to all of the failures that your report has identified?

Mr. MISSAL. It is very critical. If you do not have standard operating procedures, you are going to have inconsistencies, and if one of the goals is to earn and get the trust of whistleblowers, it is hard for them to have that trust if they recognize that the office to whom that they are going to make a complaint does not have standard operating procedures to do investigations.

Mr. TAKANO. This many months into Dr. Bonzanto's tenure, you know, it is critical—I mean, this is a missing piece, a critical missing piece of the standard operating procedures and it seems to be, as you said, the heart of gaining the confidence of potential whistleblowers to come to the office.

Mr. MISSAL. It is one of the missing pieces, along with filling out the leadership team.

Mr. TAKANO. Okay, great.

Dr. Bonzanto, you have cited the need for training for your staff to appropriately conduct investigations and perform quality assurance steps, and you noted that your staff has received initial training on these topics. The Project on Government Oversight recently reported major concerns about the quality of this training. In one surprising point, their analysis shows that portions of the training materials appear to be pulled from Wikipedia. The article even noted that participants referred to the training as, quote, "not even remotely useful," end quote, and that the instructors had to make changes to the material on the fly.

Dr. Bonzanto, has this training provided you any more confidence that your office will be able to produce high-quality investigations?

Ms. BONZANTO. I want to take this opportunity to address that concern in the article regarding the training. I just want to say that the contractor that was identified was a veteran-owned small business contract. We started working on this contract for the training sometime in June. My staff raised concerns during the contract about the qualifications of the contractor. We were informed by the contracting office that we will get the product that we are requesting. We provided edits and feedback to the contracting office. We were also again assured around August-September timeframe that the product will be delivered. The product that we requested from contracting was not what we requested, what we were told we were going to get, and we are now working with contracting to address those issues.

Mr. TAKANO. Well, so let me get this straight. You are not able to do your job because you are concerned about the quality of your office's work; you have many staff that have been reassigned to perform investigations that they have no experience conducting; you tried to get your staff quickly trained, but the contractor you paid simply pulled from Wikipedia and other online sources instead of developing useful, detailed training materials.

I am just—this is incredulous to me and to be frank, Dr. Bonzanto, I do not have confidence in this office. If I am approached by a whistleblower from my district, I cannot in good conscience direct them to work with your office, and I, as a Member of Congress, have had to do that with VA facilities, and that is not going to change until I actually see some real progress.

Thank you for your testimony today. Thank you.

Mr. PAPPAS. Thank you, Chairman Takano.

I would now like to recognize Mr. Bost for 5 minutes.

Mr. BOST. Thank you, Mr. Chairman.

Dr. Bonzanto, your testimony states that Secretary Wilkie and yourself, and I quote, "recognize the intent for transparency," and that is end quote, behind the statutory requirements to report to

Congress within 60 days when your disciplinary recommendations are not implemented. Okay?

Recognizing that the intent is one thing, but we are talking about a law. Okay? Will you commit to provide these reports in every instance the law requires?

Ms. BONZANTO. Yes, sir.

Mr. BOST. Okay, I want to make sure of that.

Inspector General Missal, do you believe the culture of accountability exists right now within the OAWP?

Mr. MISSAL. We did not find that when we were conducting the investigation. We are obviously going to take another look as we assess the implementation of the recommendations.

Mr. BOST. Dr. Bonzanto, do you agree with that, or does a culture of accountability now exist?

Ms. BONZANTO. A culture of accountability now exists in OAWP, sir, and I am working on improving it.

Mr. BOST. Okay. Mr. Missal, it is my understanding that the OAWP submitted information seeking to close ten of the OIG's recommendations; when do you think that will be complete and that you could actually start seeing some things that you can make a decision for these closures?

Mr. MISSAL. It is hard to say when we are going to get the information. What was produced to us was, as Dr. Bonzanto said, the framework of certain guidance that they are going to have. They still need to fill all that in.

The way our process works is 90 days after a report is published, we then meet with the responsible parties and start talking through what are they doing to close the recommendations, and we are very transparent about what we need to get them closed, so that will be part of the process. If the party wants to try to close them earlier, we are always happy to meet with them.

Mr. BOST. Dr. Bonzanto, let me ask this. I think that Ranking Member Bergman brought this up about taking and assuming a command when you could inherit some problems. The question that is really before this committee is because, as the chairman said, you know, we each have our own—when we are dealing with those people who are whistleblowers and we want them to make sure that they feel comfortable in the fact of the reporting to make sure that the VA operates better, see the problems that are really existing, but the concern is, is that when—you have inherited the problem and I understand you are trying to fix it, but we are a long time into it.

The general public out there, even though they may know there is a problem and you inherited a problem, they want it fixed correctly, but they also want it fixed quickly. I think that the ability for us to go back to our constituents and say, yes, we are getting this problem straightened out, we need to know that you are doing everything you can as fast as you can. Now, we want it right, but we also need it very quickly, and I think that is the concern that we are dealing with here.

It is my hope that when I am sure we are going to continue in this committee to monitor this that you can come back with some very positive reports very quickly. Working with the Inspector General, it is fantastic that you are doing that, but I spend way too

much time in my life, not only with the VA, but everything in government, especially on this Federal Government level after being in the State government, which I was in Illinois, there are a lot of problems there, but to try to explain to people that it takes—when the problems were identified, we are going to be over a year getting them straightened out. The people that are suffering and the employees that are being put in these situations where they are not comfortable at work because they actually brought something up we have got to try to fix, but thank you.

I yield back.

Mr. PAPPAS. Thank you, Mr. Bost.

I would now like to recognize Mr. Cisneros for 5 minutes.

Mr. CISNEROS. Thank you, Mr. Chairman.

Dr. Bonzanto, just to kind of follow up on the chairman's question, is there an ETA for getting your standard operating procedures in place?

Ms. BONZANTO. Yes, sir, the end of the calendar year.

Mr. CISNEROS. Is that on track right now, are we going to get that done, or will it be delayed?

Ms. BONZANTO. It is on track right now, sir.

Mr. CISNEROS. All right. You know, there have been a lot of situations where there has been retaliation against whistleblowers from middle and senior management when they have come out and spoken up against them. What is the office of OAWP, how are they addressing these issues? What penalties or disciplinary action are they taking, is OAWP taking against these middle managers and senior executives that are going after people that are coming and blowing the whistle on them?

Ms. BONZANTO. OAWP recommends disciplinary action when allegations are substantiated, we do not take the disciplinary action. Then there is a notification process in place that if the recommendation that is given by myself to the proposing official is not taken within 60 days, notification is sent to Congress if the action falls out of my recommendation.

Mr. CISNEROS. Do you have data on that?

Ms. BONZANTO. Currently, I have only submitted one recommendation for disciplinary action, sir.

Mr. CISNEROS. Only one?

Ms. BONZANTO. We are still within the 60-day timeframe, correct.

Mr. CISNEROS. Okay. Dr. Bonzanto, recommendation 7 of the IG's report speaks to setting up of a quality assurance function in the Office of Accountability and Whistleblower Protection to help address the investigative issues the IG identified. The agency's response to the recommendation states the VA has completed action to address this recommendation, although the IG stated here today that all 22 recommendations remain open. How does the OAWP stand up to quality assurance functions if it has not yet developed standard operating procedures to guide the underlying investigations in the first place?

Ms. BONZANTO. We have actually had the quality team set up and we have actually when found—we have checklists in place. We actually have a draft, we are drafting the SOPs. We have a checklist in place of critical things like, for example, a simple did you

interview a witness, we have the checklist for the quality staff to be reviewing the investigative reports.

Mr. CISNEROS. Okay. Just to follow up on the question regarding training that the chairman stated was being pulled off of the Internet and Wikipedia. Who authorized that contract to that vendor, the VA?

Ms. BONZANTO. The VA contracting office, yes, correct.

Mr. CISNEROS. Okay. Going forward with the training, I mean, is there a new contract in development, has one been issued now, or what is going on with the new contract for training?

Ms. BONZANTO. We do not have a new contract for training, sir. Currently, I have actually most recently brought on new leaders with a background in investigation and we are working internally to develop customized training for the investigators.

Mr. CISNEROS. Is that same vendor still under contract?

Ms. BONZANTO. No, sir. We are actually working with the contracting office to address the concerns that were raised regarding the quality of the product we received.

Mr. CISNEROS. All right. I yield back the balance of my time.

Mr. PAPPAS. Thank you, Mr. Cisneros.

I would now like to recognize Miss Rice for 5 minutes.

Miss RICE. Thank you, Mr. Chairman.

Dr. Bonzanto, you just said that you have only made one recommendation for disciplinary action since January of this year; is that correct?

Ms. BONZANTO. Yes, ma'am.

Miss RICE. Out of how many cases?

Ms. BONZANTO. About 16 I reviewed personally myself that I was only able to send one recommendation for disciplinary action.

Miss RICE. Well, those are 16 that you reviewed?

Ms. BONZANTO. Yes.

Miss RICE. Were there more?

Ms. BONZANTO. Yes, ma'am. There were 42 cases that were reviewed by the quality team that was sent back to investigations to be reviewed, to be completed.

Miss RICE. You only looked at 16 of those?

Ms. BONZANTO. Sixteen of those—I did not look at any of the 42. Once the quality team was in place, they started reviewing the cases before I got the cases. 16 actually came completed with recommendations to me and this is earlier before the quality team was established——

Miss RICE. What happened to the difference between 42 and 16?

Ms. BONZANTO. Those 16 were totally separate from the 42 cases. Those 16, some of them are still being worked out.

Miss RICE. I guess my question is, so 42 cases and there is only one recommendation made, what happened to the other ones? What were the findings of the other ones?

Ms. BONZANTO. The other findings were some of the deficiencies I identified in investigative reports where a witness is not being interviewed, conclusive statements in the case file that was not supported by evidence, and that is two good examples I can give you that was consistent in some of the deficiencies I found.

Miss RICE. The whistleblowers were not believed or were not found to be credible?

Ms. BONZANTO. In instances they were not interviewed.

Miss RICE. They were not interviewed?

Ms. BONZANTO. Yes.

Miss RICE. Ever?

Ms. BONZANTO. Yes. The IG highlighted that occurred in the office, correct.

Miss RICE. Here is my concern. We have a lot of rhetoric right now in the public discourse about whistleblowers and there is certain terminology being used to describe exactly what they are by some people, specifically the President of the United States and other people in his administration. How much of the President's feeling about whistleblowers specifically, how does that affect your job?

I mean, this administration set up this office, said they were going to take care of whistleblowers within the VA, because they have actually uncovered some really bad things going on within the VA, just speaking about that agency. They should be heard and they should be protected, but we have an environment right now that is very hostile to whistleblowers. How much of the big boss, right, the President's opinion about whistleblowers, how does that affect people in your office and how they look at whistleblowers?

Ms. BONZANTO. I can say from coming on this committee and also working as an investigator on this committee, I value whistleblowers. I took this position because I value the input whistleblowers bring to improving VA.

As a veteran and a nurse, I also know the impact whistleblowers have on an organization when they bring information forward that can really change the operation of the organization. I have informed my staff that it is critical that they listen and they understand the view of the whistleblowers, they understand that when they do not pay attention lives are impacted, and they must listen to the whistleblower and get both sides of the story when they conduct an investigation.

I expect thorough and accurate investigations and nothing less. I know, I am equally as frustrated I could not put recommendations forward, more than one, but that shows that we need to improve and I am going to continue to improve. At this time I can say that I am committed to the process and I am here for that reason, because I believe in the value whistleblowers bring to the organization.

Miss RICE. I appreciate your position, because if you do not feel that way, we are in trouble, No. 1, but I still find it very alarming that there has only been one recommendation out of all of the cases that have been brought since January.

I guess, you know, you can only address this problem if you train people on how to identify, you know, what to do in an instance where you see something, how you report it, whatever the training is. I mean, a big criticism that they were not even—the trainers did not even know what they were talking about, did not know how to train people.

I mean, how serious do you think whistleblowers take your mission when you contract out for God knows how many millions of dollars a service that you got really a poor quality work product from?

Ms. BONZANTO. Basically, I want to say that the staff had training prior to me coming on board from other Federal entities. I started identifying deficiencies in March, they had training again from the Office of Special Counsel. In August, they had training from the Office of General Counsel. The staff has consistently gotten training over time.

Based on the deficiencies and the number of deficiencies that we were identifying, I needed to have a baseline. we went back to basic investigation techniques, interviewing techniques, and evidence gathering. The contract that we are discussing and the issues with the contractor was the September training, which was, again, to reset. Let us just start and we get basic investigative training because of the deficiencies, I still continued to identify deficiencies in the reports.

Miss RICE. Do you have input as to what contractor is used?

Ms. BONZANTO. The contracting office normally select the most qualified vendor for us.

Miss RICE. Do you have any input? Do they ask you?

Ms. BONZANTO. I am not sure if we—I think they select based on the—they select the contractor based on the qualifications of the contract. I can not say for sure if—the VA has input, obviously, but the contracting office does not work directly for me, no.

Miss RICE. Thank you.

Thank you, Mr. Chairman. I yield back.

Mr. PAPPAS. Thank you very much.

I just have a few more and perhaps the other members here would like to ask a few more—Okay, I guess we are going to go for a second round. Thank you very much for your answers to date.

I just wanted to follow up on a comment that Mr. Missal had made about the fact that there are a number of key positions that are vacant where you are still recruiting an individual. You had submitted as part of your testimony this org chart here, which represents a realignment since August. You know, of that, seven are filled, five you are still recruiting for, six remain vacant, including the Deputy Executive Director position.

You mentioned, for instance, developing standard operating procedures, you are going to do that by the end of the year, but yet the Chief of Policy position is vacant.

How are you going to, you know, deal with these 22 recommendations and make progress if you still have these vacancies, and what is the action plan to fill out this realigned org chart?

Ms. BONZANTO. We currently have six positions in development for recruitment, five positions on active recruitment, we are actually interviewing individuals for those positions right now. We are still working.

The Chief of Policy is actually focused on policy, that is not the standard operating procedures. The standard operating procedures, I most recently hired a Deputy Director for Investigations, and that individual is going to be working on the standard operating procedures for investigations. The head of the quality team is already in place and they are working on the quality SOPs for that team.

Mr. PAPPAS. Mr. Missal, you had raised specifically in terms of, you know, flagging this in her testimony. How much of a concern is this for the IG in terms of the steps that OAWP needs to take?

Mr. MISSAL. It is a very great concern for us, because you obviously need policies and procedures in place, but before you can really get started in changing around an organization that we identified had so many problems, you really need to have not only the people in place, you need to have the right people in place, and it sometimes takes time when new people are put together into an organization for them to work together as a team to communicate well.

Until these positions are filled, it is going to be very hard to make progress on a number of other avenues that they need to improve.

Mr. PAPPAS. One measure of an organization coming together and gelling and focusing on its mission is measuring employee morale. You had indicated to me when we spoke that is something you intend to measure. How would you characterize morale today within OAWP?

Ms. BONZANTO. As I have told you, sir, morale is—I would say it is at this time neutral. I have some parts of my team saying we are heading in the right direction and some parts of the team they are raising concerns about the direction we are heading, because it is fundamentally different from what they have done before.

I am doing my best to engage the staff. We have developed teams around some of the work products we need to produce, to encourage staff to engage and give us recommendations on what the best practices are or they identify as the best practices for improving operations.

We are also working with the VA's National Office of Organizational Development to come in and do an assessment, and also work with the new leaders as they come on board, so they can provide us feedback of where we are as an organization and also help coach the leaders as we are going through this organizational change.

Mr. PAPPAS. Protecting whistleblowers is your mission, but I am incredibly concerned to hear that multiple staff in your office have actually filed whistleblower complaints themselves, including allegations of retaliation with the Office of Special Counsel (OSC). Perhaps more concerning is that in the office's newly published directive on investigations OAWP employees are specifically excluded from the definition of whistleblowers.

I am wondering if you could address this exclusion and describe how whistleblowers in your office should come forward and be a part of the change that needs to happen.

Ms. BONZANTO. Right. I can say that in OAWP I encourage staff to come, you know, bring concerns, raise concerns to their supervisors. If they are not concerned with the response, they can raise concerns to me. I have an open-door policy to me with employees. If they are not—you know, if they do not want to come forward and bring those concerns to us, they have like every other employee can go to the OSC, the IG, Congressional Committees; they can exercise their right to raise concerns to other entities, if they choose to.

I think it is a conflict for us to investigate employees ourselves. If someone raised concerns to us, it is a conflict of interest for us to investigate those employees, and we actually had an example of

that in the IG report of that happening, and that is why the directive addresses that.

Mr. PAPPAS. One thing I wanted to ask about as well is training of VA employees more generally speaking. This training has taken over 2 years to develop and why is that the case? This just seems very fundamental in terms of your charge.

Ms. BONZANTO. It is one of the things we are continuing to work on. I know I had a deadline of October 15th for getting that training up and we have not met the deadline for, you know, completing the training. It was under legal review, legal review just came back with edits, but we are expected to meet our goal of having the training published on VA's Talent Management System (TMS) website by the end of the calendar year. That was our goal, the end of the calendar year.

Mr. PAPPAS. It is a revised goal, though; correct?

Ms. BONZANTO. No. The goal was the end of the calendar year and October 15th was for us to actually have it uploaded in the TMS system. It has not been uploaded yet.

Mr. PAPPAS. You have missed that mark——

Ms. BONZANTO. Yes.

Mr. PAPPAS.—but you hope to hit the mark for the end of the year?

Ms. BONZANTO. Yes, sir.

Mr. PAPPAS. Well, I will turn it over to General Bergman for additional questions.

Mr. BERGMAN. Thank you, Mr. Chairman, and I guess it is just you and me as I look around.

I wish—unfortunately, as you know, our schedules are extremely busy around here and I know our members had to go on to something else, I hope equally as important. As I kind of mentioned in my opening remarks, you inherit the command you inherit. You know, George Washington was judged by historians as being able to accept the world as it was, not how he wanted it to be, so he accepted the reality.

As I listened to the questions being asked, sometimes we just assume we are starting at a zero point and neutral point, but in this particular case, if we were to put it on a linear graph, we were kind of starting behind the power curve in a negative, negative way.

Even though we are at neutral or slightly on the positive side now, it does not look like much, because if you did not think about it, we are just kind of assuming the zero starting point, so the progress that has been made was just to kind of clean up messes and get the ball rolling again in the right direction. Usually it is not about the fact that things are changed or you are moving forward, it is the rate at which you are going.

Dr. Bonzanto, would you care to comment, do you have a rate of change, if you will, that is a positive rate? Are you accelerating, decelerating, you know, when it comes to everything from your training to your SOPs to your, you know, everything in the whole—how would you say it, is it acceleration, deceleration, neutral?

Ms. BONZANTO. I would honestly like to move faster. As you know, the H.R. in Federal Government is it takes time. It is taking about an average of 90 to 120 days to on-board someone, and that

is from the job posting through the interview period. If we can—that is my concern is I am not moving as fast as I would like to and filling these vacancies as fast as I would like to, but it is part of the process that I have to go through.

Mr. BERGMAN. Well, as long as you are not comfortable, I think we are comfortable; if you are comfortable, we are uncomfortable. I think that is a trend in the right direction.

Mr. Missal, I firmly believe that all employees doing wrong or failing to serve veterans should be held accountable regardless of rank, position, or grade. You found in your report that disciplinary officials sometimes mitigated OAWP's recommended penalties based on their subjective, personal judgment. You gave ten examples that run the gamut from a removal reduced to a demotion, to suspensions reduced to no penalty whatsoever. How commonplace is that?

Mr. MISSAL. It certainly was commonplace in what we found with OAWP. You have to remember, there are disciplinary actions going on throughout VA and they have different standards that they apply, that going through OAWP they do not follow those same standards.

For instance, outside of OAWP there is a VA disciplinary chart which gives examples and guidance about certain actions and where they should be. Making sure you have consistency in your discipline is extremely important, again, to give confidence in the office and to show those who commit wrongdoing that they are going to be held accountable.

Mr. BERGMAN. Okay. Again, Mr. Missal, given the gravity of OIG's findings, I believe sustained oversight of OAWP is warranted. What sort of follow up work do you intend to perform to determine whether these problems have actually been corrected?

Mr. MISSAL. We have, on the formal side, we will be working with OAWP to assess how they are addressing the 22 recommendations that we have that are still open. Then, on the more informal side, we meet regularly with OAWP just to discuss current issues that come up, because, as I said, there are a number of different places which are looking at potential wrongdoing and so those different organizations have to coordinate their efforts for it to be as effective as possible.

Mr. BERGMAN. Okay. Thank you.

Mr. Chairman, I yield back.

Mr. PAPPAS. Well, thank you very much. I do not have any further questions. I do not know, General Bergman, if you would like to give any closing comments before we conclude, but I would like to take the privilege of having a few closing comments, if you do not mind.

I want to thank our witnesses today, Dr. Bonzanto and Mr. Missal, for joining us. You know, the Inspector General once again has produced a very comprehensive report, it is a page-turner. If you have not looked at it, I urge you all to do so, and we will be continuing to look at this report closely.

You and your staff performed an important service and the report identifies a long list of problems, 22 recommendations that must be addressed if the office is to succeed.

Unfortunately, I think this hearing has made clear that OAWP is not providing critical protections and, on top of retaliation, we often hear from whistleblowers about frustration that they feel when working with OAWP. I feel a sense of solidarity, because I feel similar frustrations today.

Dr. Bonzanto, you testified that you have established goals for the office, but these are just the beginning steps and we need to continue to insist on more progress. While the office now has a high-level policy for investigations, this is not the same as having a detailed standard operating procedures, nor is it actually completing investigations. While it is good to hear that OAWP will have training materials by the end of the year, this is not the same as actually training the supervisors on the rights of whistleblowers.

Dr. Bonzanto, whistleblowers in the VA are still waiting for your office to perform basic mandates. I recognize that you want to move OAWP in the right direction, I recognize that you inherited a very complicated and difficult situation when you assumed your position in January of this year, but your testimony in response to questions does not provide a full picture of how you are going to get there. We do not have all the metrics and time lines for how your mission will be achieved, and we need to continue to work with you to insist on progress.

Ultimately, we are all working toward the same goal here. We want OAWP and we want you to be successful in your role, and that is ensuring that whistleblowers have the opportunity to be heard without fear of retaliation. It is pivotal that we come together and focus on this mission to improve protections for whistleblowers and in turn improve our service to veterans.

With that, members will have 5 legislative days to revise and extend their remarks, and include any extraneous materials.

Without objection, the subcommittee stands adjourned.

[Whereupon, at 3:23 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

PREPARED STATEMENT OF TAMARA BONZANTO

Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to testify today.

I. BACKGROUND

The Department of Veterans Affairs (VA) appreciates the opportunity to answer questions and report progress about its implementation of the VA Accountability and Whistleblower Protection Act of 2017 (the Act), Public Law 115–41. The Act, which is an unprecedented piece of legislation, is an important priority for the Department. The Act is another tool to help VA hold employees accountable and protect whistleblowers who report wrongdoing. VA's Office of Accountability and Whistleblower Protection (OAWP) was established by the President of the United States on April 27, 2017, under Executive Order 13793. OAWP was statutorily established by the Act, and its functions are codified under section 323 of title 38 of the United States Code (U.S.C.).

OAWP receives and investigates allegations of misconduct, poor performance, and whistleblower retaliation against VA senior leaders; and allegations of whistleblower retaliation against VA supervisors. OAWP also receives whistleblower disclosures from VA employees and applicants for VA employment and refers those allegations for investigation within VA. OAWP is responsible for tracking and confirming VA's implementation of recommendations from audits and investigations carried out by OIG, VA's Office of the Medical Inspector (OMI), the U.S. Office of Special Counsel (OSC), and the U.S. Government Accountability Office (GAO). OAWP is also responsible for advising the Secretary of Veterans Affairs on accountability and for identifying trends based on data received by OAWP, so that VA can proactively address systemic issues.

Trust is an important element for ensuring OAWP's success. Individuals who report wrongdoing must trust OAWP with their information. Those individuals must also trust OAWP to review and refer or investigate their allegations in a thorough and timely manner.

Since my appointment in January 2019, I have heard from Veterans, VA employees, whistleblowers, and Congress about their concerns with OAWP operations and concerns about OAWP staff. As I assessed OAWP operations, I came to the realization that most of these concerns were valid. By April 2019, I identified several deficiencies that are now highlighted in an OIG report, which needed to be corrected, including staff who were making decisions on my behalf with little to no oversight; teams who were duplicating efforts; investigators who were conducting investigations without sufficient training; a lack of communication with whistleblowers about the status of their matters; a lack of written policies and standard operating procedures; and reports and recommendations that displayed a lack of training. Fixing these deficiencies is the first step toward regaining the trust that individuals who report wrongdoing place with OAWP. Ensuring that the information provided by those individuals is not used without their consent or as otherwise permitted by law, is also essential to regaining the trust that OAWP needs to succeed as an organization.

II. OVERCOMING CHALLENGES

Since my appointment, OAWP independently identified many of the issues now substantiated by the OIG in its report issued on October 24, 2019. These issues can be attributed to a lack of oversight, communication, and training for staff. Ten of the 22 recommendations made by OIG have been addressed. VA is working to resolve the remaining six recommendations.

The Act's establishment of OAWP is to ensure a culture of accountability in VA. Unfortunately, as OIG recognized, OAWP lacked its own culture of accountability for its first 2 years of operations as reflected in the deficiencies I noted above. I am

expeditiously undertaking actions to ensure that such a culture exists within OAWP. Significantly, these deficiencies identified by the OIG have an impact on VA employees who report wrongdoing. In many instances, individuals who lost their jobs or faced other forms of whistleblower retaliation relied on OAWP to conduct a thorough investigation into their allegations, only to be disappointed when staff failed to respond back to them. This lack of oversight, communication, and training for staff contributed to the lack of trust that individuals have in OAWP.

Once I assessed OAWP's deficiencies, I immediately began working to correct them, including the following:

- Reviewing all OAWP recommendations, including recommendations for disciplinary action, or no action before a case could be closed;
- Implementing an information system to track investigations and OAWP's recommendations. This system has an audit trail and ensures that only authorized users can access certain case files. This system will also help OAWP identify trends, as required by the Act;
- Stopping OAWP contractors from performing work unrelated to OAWP's statutory functions;
- Mandating that staff update whistleblowers about the status of their matters;
- Realigning OAWP's operations to ensure that teams were not duplicating efforts and to increase the number of investigators; [1]
- Providing OAWP investigators with training on conducting investigations. OAWP is currently developing a customized investigative training course for its investigators. This training would resolve recommendation 8 in OIG's report; and
- Issuing VA Directive 0500, Investigation of Whistleblower Disclosures and Allegations Involving Senior Leaders or Whistleblower Retaliation. The directive governs how OAWP receives whistleblower disclosures; allegations of senior leader misconduct, poor performance, and whistleblower retaliation; and allegations of whistleblower retaliation against supervisors. The directive covers a number of the recommendations made by the OIG.

I also recognize the need for appropriate oversight within OAWP. With that in mind, OAWP is working to fill its supervisory vacancies. OAWP recently hired a deputy director for investigations and two supervisory investigators. These individuals, who come from the Department of Defense and other Federal agencies, have substantial experience with managing administrative investigators; conducting whistleblower retaliation investigations; and developing whistleblower retaliation training.

I appreciate the concerns raised by OAWP employees to me about the organizational changes underway. Many of these changes are significant and represent a fundamental adjustment in the direction that OAWP was taking during its first 2 years. As we work to improve OAWP, I want to ensure that employees are engaged in these organizational changes.

I have met with several employees about their concerns and have discussed the organizational changes underway with staff during town-hall sessions. By the end of the year, OAWP will also establish employee workgroups within OAWP to solicit feedback as OAWP continues to improve its operations. The workgroups include a training workgroup, which would provide feedback on training that is beneficial for OAWP staff; a policy/process workgroup, which would provide feedback on internal standard operating procedures and policies; an employee engagement workgroup, which would advise on ways to improve employee engagement; and a technology workgroup, which would advise on ways to better utilize technology in OAWP.

The above actions, once addressed, will help strengthen OAWP workforce engagement and satisfaction as we continue to improve OAWP operations.

III. IMPROVING OAWP INVESTIGATIONS

OAWP has a backlog of investigative cases, which can be defined as a disclosure or submission that is open with OAWP for over 120 days. Many of these backlogged cases date back to 2017 and 2018. The goal is to eliminate the backlog by the end of the next calendar year and, per VA Directive 0500, to have OAWP investigations conducted and recommendations issued within 120 days from the date that a disclosure or submission is received by OAWP. This newly established timeline would decrease the average time to conduct an investigation by 44 percent. To reach these goals, OAWP has undertaken a multi-prong approach, outlined below.

A. Increasing the number of OAWP investigators.

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[1] A pre-and post-realignment organizational chart can be found in exhibit 1.

In August 2019, OAWP realigned resources to avoid a duplication of efforts on investigative cases and ensure that we have more investigators available. The realignment was based on input provided by OAWP managers and a workload analysis of a sampling of OAWP staff.

With the realignment, OAWP now has 40 investigators rather than 30. Investigators are also supervised in smaller teams of approximately 10 individuals, to ensure appropriate oversight. Since the realignment, investigators carry an average of 6 investigations. This increase in investigative case load brings them on-par with investigators who handle equally complex work in other government investigative bodies.

B. Issuing policy to clearly define OAWP's investigatory scope.

VA Directive 0500 was issued. The directive governs how OAWP receives whistleblower disclosures; allegations of senior leader misconduct, poor performance, and whistleblower retaliation; and allegations of whistleblower retaliation against supervisors. The directive clearly defines what is within and outside OAWP's investigatory scope.

C. Comprehensive training to improve the quality of investigations.

OAWP is developing a comprehensive training program for its investigators.[2] The program will cover investigative techniques, including report writing. The program will incorporate best practices from the Office of Special Counsel (OSC), the Council of Inspectors General on Integrity and Efficiency (CIGIE), and other governmental and non-governmental offices. This program will serve as the foundation for continuous professional training and development that will be conducted throughout this fiscal year.

D. Developing standard operating procedures to ensure clear consistency.

OAWP is developing standard operating procedures (SOP) and templates for investigators and staff, which are expected to be completed before the end of the calendar year. This will ensure that investigative reports, evidence gathering techniques, and interview techniques are standardized across OAWP's 40 investigators.

E. Utilizing contractors to assist with investigations.

Given the significant backlog, OAWP also plans to utilize contractors to assist in conducting investigations. This is a best-practice utilized by other investigative entities.

F. Establishing a team to conduct quality reviews on investigations.

Recognizing that quality control is essential, I have established an independent team to ensure investigative reports are thorough and accurate. This team received initial training on reviewing investigative reports in September 2019. OAWP is developing a comprehensive training program for individuals on the team to ensure that investigations are done in a fair, unbiased, thorough, and objective manner. The program will incorporate best practices from OSC, CIGIE, and other governmental and non-governmental offices. The quality review team is also developing SOPs, checklists, and a reporting template to ensure consistent quality and timeliness with OAWP investigations.

G. Ensuring that disciplinary action recommendations comply with the Act.

Starting in April 2019, all recommendations, whether for disciplinary action or no action, are reviewed by me or my designee. During my review of these recommendations, I identified several deficiencies, including the following:

- Citing investigative reports where witnesses were not interviewed;
- Conclusory statements that were not tied into evidence; and
- Failing to properly address the elements required for whistleblower retaliation.

In August 2019, OAWP developed checklists to ensure that investigative reports and recommendations did not contain these types of deficiencies. Quality staff have identified discrepancies in over 45 cases submitted to them as of September 2019. All cases where deficiencies were found were routed back to investigations for further review and resolution of the discrepancies.

The Secretary and I recognize the intent for transparency behind 38 U.S.C. § 323(f)(2), which requires that VA report to Congress when disciplinary recommenda-

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[2] OAWP investigators have already been provided with standardized investigation training in August and September 2019. This supplements training that they received in the past but does not amount to a comprehensive training program. In prior years, OAWP investigators took different training courses on investigative techniques. This resulted in disparate investigative reports and interviews. For example, some investigators took a five-day investigative training course conducted by U.S. Immigration and Customs Enforcement (ICE). However, only two of the days in the course were applicable to OAWP investigators. The remaining three days focused on ICE practices and policies.

tions that I make are not implemented. To memorialize our commitment to the Act, VA Directive 0500 requires Under Secretaries, Assistant Secretaries and other Key Officials, and their designees, to respond to OAWP recommended disciplinary actions, including providing a copy of the action taken or proposed and, if the recommended disciplinary action was not taken or proposed, providing a detailed justification why such an action was not taken or proposed within 60 calendar days of OAWP's recommendation.

IV. IMPROVING COMMUNICATIONS AND CUSTOMER SERVICE

OAWP has mandated, through VA Directive 0500, that staff regularly communicate with individuals about the status of their cases. OAWP is collaborating with VA's Veterans Experience Office (VEO) to provide customer service training to all OAWP staff. OAWP is working with VEO to develop a customer survey to measure the impact of these customer service improvements. Customer service, which is a priority for the Secretary and me, will also be a critical element in all performance standards for OAWP employees.

V. OAWP'S WHISTLEBLOWER MENTOR AND OUTREACH PROGRAMS

In 2017, OAWP established the whistleblower mentorship program, formerly known as the whistleblower reintegration program. After receiving several complaints from VA employees and whistleblowers about the program, I asked that it be placed on hold while we evaluated whether there was appropriate governance and how applicants were identified and interviewed.

After evaluating the program, I identified several deficiencies, including how applicants were identified and interviewed. In light of those deficiencies, the OIG's findings, and because the program was operating outside of OAWP's authorized scope, I have decided to discontinue the program. Instead, OAWP is assessing whether an alternative dispute resolution (ADR) program, similar to OSC, should be established with VA's existing ADR resources.

Prior to my appointment, OAWP also established a whistleblower outreach program. The program was meant to provide whistleblowers with information about wellness and other resources. However, in view of OIG's findings about the whistleblower mentorship program, we have decided to discontinue the program. Instead, whistleblowers will be informed about services available to them through VA's employee assistance program should they need assistance.

VI. WHISTLEBLOWER RIGHTS AND PROTECTION TRAINING

Under 38 U.S.C. § 733, VA is required to implement training for all employees on whistleblower rights and protection. OAWP worked with OSC and OIG to develop training required under 38 U.S.C. § 733. This training will address, among other things, methods for making a whistleblower disclosure, prohibitions against taking an action against an employee for making a lawful disclosure, and penalties for whistleblower retaliation.

The training is being finalized and VA anticipates issuance of the 38 U.S.C. § 733 training, including a specialized module for supervisors through VA's Talent Management System, before the end of the calendar year.

VII. IMPLEMENTING OAWP'S OTHER FUNCTIONS, REQUIRED BY THE ACT

As I address the deficiencies within OAWP, I am implementing its statutory function of tracking and confirming VA's implementation of recommendations from audits and investigations carried out by OIG, OMI, OSC, and GAO. As required by law, I am also implementing a process to identify trends based on data received by the office so that VA can proactively address systemic issues.

OAWP is establishing a new VA compliance and oversight team to track and confirm the implementation of recommendations from audits and investigations. The target date for staffing the team and finalizing a directive on these requirements is the end of the calendar year. OAWP also began utilizing an information system in June 2019, to help us identify trends based on the data received by the office.

VIII. CONCLUSION

I understand the sense of urgency to improve OAWP operations. I also recognize the substantial impact that the deficiencies in OAWP have had on whistleblowers and VA employees who disclose wrongdoing.

I have the support of the Secretary and VA leadership as I continue to work on fixing those deficiencies. I ask for your support and I appreciate the input from you and your staff as I continue to ensure that OAWP fulfills its statutory mandate.

Mr. Chairman, Ranking Member Bergman, and Members of the Committee, this concludes my statement. Thank you for the opportunity to testify before the Committee today to discuss VA's implementation of the Accountability and Whistleblower Protection Act. I would be happy to respond to any questions you may have.

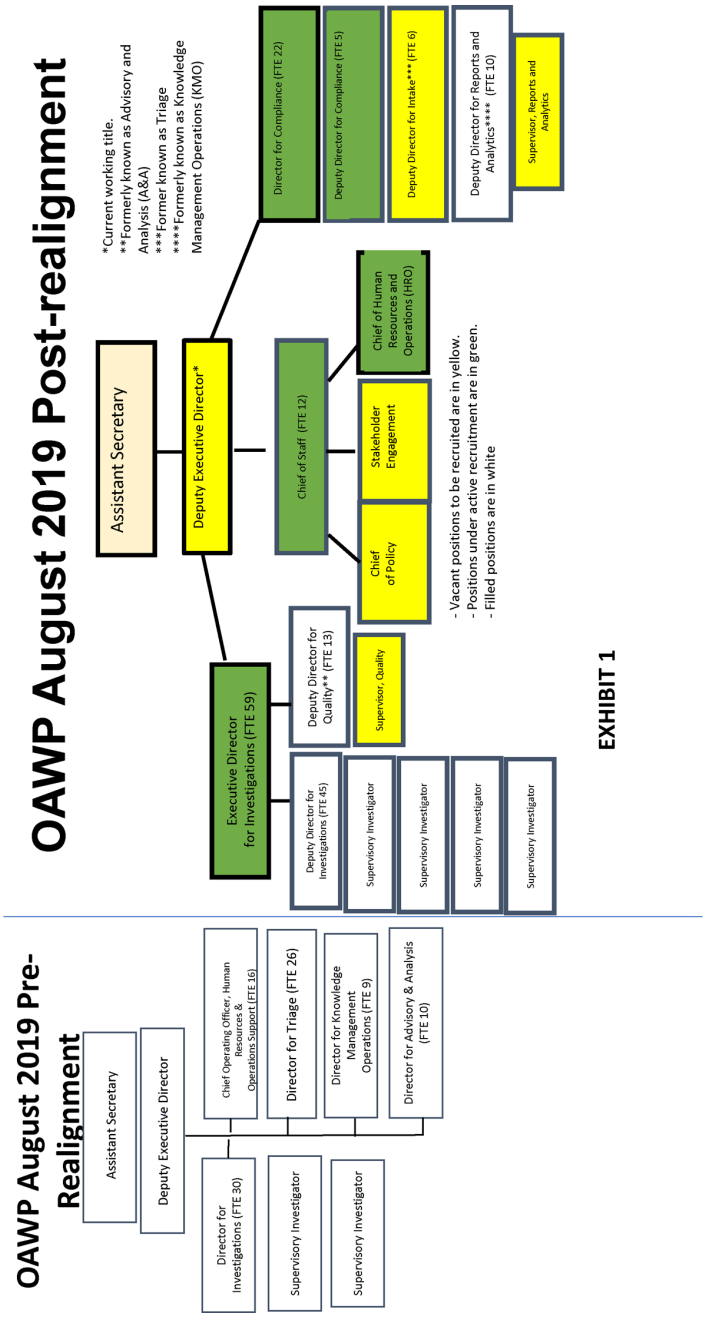

EXHIBIT 1

PREPARED STATEMENT OF MICHAEL J. MISSAL

Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) report, Failures Implementing the VA Accountability and Whistleblower Protection Act of 2017(the Act).[1] In June 2018, one year after the Act's enactment, the OIG received requests from the then ranking member of the House Veterans' Affairs Committee and several senators raising concerns that VA was not properly implementing the Act. In addition, the OIG received complaints from VA employees and others relating to concerns about OAWP operations. In response, the OIG conducted a review focusing on the OAWP's operations from June 23, 2017, through December 31, 2018. During the review, additional allegations arose as new OAWP leaders began making changes, prompting further related work through August 2019.[2]

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

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

BACKGROUND

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

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

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

[2] From June 23, 2017, until January 7, 2019, the OAWP operated without an Assistant Secretary—a position called for by the Act. It was led by Executive Director Peter O'Rourke from June 23, 2107, to February 28, 2018, followed by Executive Director Kirk Nicholas until January 7, 2019. The current Assistant Secretary for Accountability and Whistleblower Protection took office on January 7, 2019, and soon began implementing changes, some of which address matters identified throughout the review.

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

categories of Covered Executives[4]) and allegations of retaliation on the part of supervisors.[5] It is this authority of the OAWP with respect to disciplinary proceedings that are addressed in this report.

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

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

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

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

FINDING 1: THE OAWP MISINTERPRETED ITS STATUTORY MANDATE, RESULTING IN FAILURES TO ACT WITHIN ITS INVESTIGATIVE AUTHORITY

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

In addition to misinterpreting its statutory investigative mandate, the OAWP also failed to refer matters for investigation to other more appropriate investigative entities. Pursuant to regulation, VA employees must, for example, refer to the OIG matters that may be serious violations of criminal law related to VA. The OAWP investigated criminal matters involving possible felonies that it was required to refer to the OIG. Allegations of discrimination similarly should have been referred to VA's designated equal employment opportunity (EEO) office, the Office of Resolution Management (ORM), unless they fell within the OAWP's authority to investigate. Although the law does not require that the OAWP refer such matters to the ORM, filing with the ORM is the only way for employees to preserve their EEO rights and it has more expertise to handle investigations of discrimination.

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

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

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

FINDING 2: THE OAWP DID NOT CONSISTENTLY CONDUCT PROCEDURALLY SOUND, ACCURATE, THOROUGH, AND UNBIASED INVESTIGATIONS AND RELATED ACTIVITIES

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

The OIG identified deficiencies in the following areas:

- The OAWP lacks comprehensive policies and procedures suitable for its personnel. This is particularly important given that individuals' reputations are at stake, whistleblowers' identities must be protected, and the issues on which the OAWP is reporting affect veterans' lives in tremendously significant ways. Staff were either missing guidance or were piecing together direction largely based on the mandates of a prior office that was not entirely aligned with OAWP's legislative scope. The results were felt across OAWP divisions:

  1. The Triage Division's procedures blurred the scope of OAWP authority and called for acceptances or referrals of cases that were not consistent with the OAWP's statutory authority.

  2. Operational procedures were incomplete and outdated, leaving staff without clear guidance.

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

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

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

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

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

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

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

Dr. Bonzanto told OIG investigators that she prioritized the need for prompt resolution of matters due in part to impacts on the subjects of investigations. She also stated that she was introducing standardized "touchpoints" with whistleblowers to improve communication about case statuses. She told OIG investigators that she instituted new expectations relating to timeliness of investigations. Her stated goal is to reduce to 90 days the time it takes from the receipt of a submission to the end of the A&A Division's involvement. Dr. Bonzanto explained that she is instituting check-in points to ensure that the staff of the Investigations Division are keeping up with their workload.

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

FINDING 3: VA HAS STRUGGLED WITH IMPLEMENTING THE ACT'S ENHANCED AUTHORITY TO HOLD COVERED EXECUTIVES ACCOUNTABLE

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

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

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

[10] See examples 11 and 12 of the report.

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

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

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

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

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

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

FINDING 4: THE OAWP FAILED TO FULLY PROTECT WHISTLEBLOWERS FROM RETALIATION

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

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

Other concerns regarding protecting whistleblowers from retaliation include the following:

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

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

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

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

  Ultimately, in its approximately 18-month existence, the program served one whistleblower as a test case, which was described by OAWP staff as successful. Dr. Bonzanto placed the program on hold because her assessment revealed that it had not met with identifiable or measurable success sufficient to warrant devotion of the resources that would be required to expand the program to serve more individuals.
- The OAWP also failed to establish safeguards sufficient to protect whistleblowers from becoming the subject of retaliatory investigations. One troubling instance involved the OAWP initiating an investigation that could itself be considered retaliatory. At the request of a senior leader who had social ties to the OAWP Executive Director, the OAWP investigated a whistleblower who had a complaint pending against the senior leader. After a truncated investigation, the OAWP substantiated the senior leader's allegations without even interviewing the whistleblower.
- Former leaders of OAWP also directed funds for purposes unrelated to OAWP's core mission. There were $2.6 million of OAWP's Fiscal Year 2018 budget of $17.37 million (15 percent) obligated on two separate contracts for process improvement and leadership development services. Each contract had two subsequent option years which, if exercised, would have brought the potential total obligation to over $6.8 million. The first contract related to process improvements. According to Dr. Bonzanto, shortly after she became Assistant Secretary, she learned about the existence of the process improvement contract. She told OIG investigators that the contractor "was supposed to be helping us with our directives and our workload," but she learned after inquiring further that "everything that they were doing, none of it was related to OAWP." She also told the OIG that she ordered then Deputy Director Todd Hunter to refocus the contractor to "come back and start doing work that's related to OAWP." According to Dr. Bonzanto, by March 2019 the contractor's work was redirected to assisting the OAWP with developing its processes and procedures.

  The services to be acquired under the second contract related to leadership development and coaching, which former Executive Director Nicholas intended for VA generally, not just the OAWP. In response to the OIG's inquiry concerning the contracts, VA suspended performance on the contract for leadership development and coaching, which limited VA's cost to the $88,000 already expended. The OIG did not find any evidence that VA leaders requested that Mr. Nicholas initiate either procurement or redirect OAWP funds to these contracts.

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

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

FINDING 5: VA DID NOT COMPLY WITH ADDITIONAL REQUIREMENTS OF THE ACT AND OTHER AUTHORITIES

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

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

In addition, VA has interpreted the requirement that it submit reports to Congress when the Secretary "does not take or initiate the recommended disciplinary action" within 60 days of receipt of a recommendation in such a way that VA disciplinary officials' mitigation or declination of OAWP's recommended actions are not reported to Congress.[15] By failing to meet these statutory obligations, the OAWP has undermined Congress's intent to create greater transparency with respect to employee accountability and whistleblower protection within VA.

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

FINDING 6: THE OAWP LACKED TRANSPARENCY IN ITS INFORMATION MANAGEMENT PRACTICES

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

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

VA COMMENTS TO THE OIG REPORT

VA concurred with all recommendations and provided action plans for implementation. However, some of the planned actions lacked sufficient clarity or specific steps to ensure corrective actions will adequately address the recommendations (see Appendix A for a listing of all recommendations). In particular, the actions detailed in multiple responses (specifically to Recommendations 2, 3, 4, 7, 11, 12, 18, 19, and 20) were identified by VA as completed as of October based on the issuance of Directive 0500 on September 10, 2019, or other actions taken in recent months. The OIG has not received sufficient documentation to determine whether recent actions and attempts to implement Directive 0500 fully address the recommendations. The OIG notes that the planned actions for two recommendations (Recommendation 2 and 12) do not appear sufficient to address the findings and will require updated action plans. The OIG considers all 22 recommendations open and will monitor implementation of VA's planned and recently implemented actions to ensure that they have been effective and sustained. As stated earlier, VA's assertions that OAWP has broader statutory authority is a clear misunderstanding of the office's statutory

[15] 38 U.S.C. § 323(f)(2).

scope. Moreover, VA's suggestion that it independently identified problems and that the OIG failed to acknowledge progress made by the office in the text of the report is refuted by the OIG in the report section on responses to VA's comments.

CONCLUSION

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

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

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

FINDING 1

1. The Assistant Secretary for Accountability and Whistleblower Protection directs a review of the Office of Accountability and Whistleblower Protection's compliance with the VA Accountability and Whistleblower Protection Act of 2017 requirements in order to ensure proper implementation and eliminate any activities not within its authorized scope.

2. The VA Secretary rescinds the February 2018 Delegation of Authority and consults with the Assistant Secretary for Accountability and Whistleblower Protection, the VA Office of General Counsel, and other appropriate parties to determine whether a revised delegation is necessary, and if so, ensures compliance with statutory requirements.

3. The Assistant Secretary for Accountability and Whistleblower Protection, in consultation with the Office of General Counsel, Office of Inspector General, Office of the Medical Inspector, and the Office of Resolution Management establishes comprehensive processes for evaluating and documenting whether allegations, in whole or in part, should be handled within the Office of Accountability and Whistleblower Protection or referred to other VA entities for potential action or referred to independent offices such as the Office of Inspector General.

4. The Assistant Secretary for Accountability and Whistleblower Protection makes certain that policies and processes are developed, in consultation with the VA Office of General Counsel and Office of Resolution Management, to consistently and promptly advise complainants of their right to bring allegations of discrimination through the Equal Employment Opportunity process.

FINDING 2

5. The Assistant Secretary for Accountability and Whistleblower Protection ensures that the divisions of the Office of Accountability and Whistleblower Protection adopt standard operating procedures and related detailed guidance to make certain they are fair, unbiased, thorough, and objective in their work.

6. The VA General Counsel updates VA Directive 0700 and VA Handbook 0700 with revisions clarifying the extent to which VA Directive 0700 and VA Handbook 0700 apply to the Office of Accountability and Whistleblower Protection, if at all.

7. The Assistant Secretary for Accountability and Whistleblower Protection assigns a quality assurance function to an entity positioned to review Office of Accountability and Whistleblower Protection divisions' work for accuracy, thoroughness, timeliness, fairness, and other improvement metrics.

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

FINDING 3

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

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

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

FINDING 4

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

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

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

FINDING 5

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

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

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

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

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

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

FINDING 6

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

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