STATEMENT

OF

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BEFORE THE

HOUSE OF REPRESENTATIVES

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

ON

EXAMING THE ADMINISTRATION'S TREATMENT OF WHISTLEBLOWER

SEPTEMBER 9, 2014

NOT FOR PUBLICATION UNTIL RELEASED BY THE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

Chairman Issa, Congressman Cummings, and distinguished members of the Subcommittee, it is my honor to appear before you today to testify about my whistleblowing experiences about my experiences making unwelcomed disclosures of gross waste and mismanagement and retaliation that followed as a physician –scientist and former director of a Department of Veterans Affairs (VA) traumatic brain injury imaging (TBI) research center in the at Austin Texas from 2007-09. I pray that this testimony and accompanying exhibits may contribute towards a better appreciation of the need for more protection of those who witness wrongdoing or gross mismanagement in government so that they do not fear retribution for speaking out. *Suppressing this freedom will undercut transparency, integrity, and the ability of government to fulfill its mission- to serve the people.*

Beginning in February 2002, the VA and University of Texas at Austin (UT/A) agreed to jointly create a "world-class university-based brain imaging center" housed at UT's Research Campus in Austin. The VA put $6.3 million toward its startup. An opening ceremony for the imaging center was held in January 2006; but the VA did not begin recruiting for a Director until 6 months *after* the center opened.

I was recruited in July 2007, 1 ½ years after the center's opening and appointed "Physician-Medical Director of the VA Austin Imaging Center." At the time, U.S. Troop deployments were averaging 22,000 servicepersons per year during the periods of 2006 through 2009 with an alarming average of 6,000 TBI victims diagnosed annually. To date, the Defense and Veterans Brain Injury Center (DVBIC) estimates over 300, 000 military TBI casualties worldwide since 2000. Moreover, civilian TBIs were being increasingly appreciated, with more than 2 million cases occurring annually. The Brain Imaging and Recovery Laboratory (BIRL) was borne out of this pressing need to better detect, that is to make this "invisible" wound *visible*, and effective treatments for TBI.

With neurology training at Harvard and Northwestern University, and seven years combined postdoctoral research at the Johns Hopkins Hospital and advanced brain imaging work at the National Institutes of Health (NIH), this was a perfect opportunity to make a difference in the lives of those who suffer from cognitive and emotional problems from brain injuries.

But within weeks of my start in July 2007, I learned that $2.1 million, more than 1/3rd of the funds provided to the BIRL, had been spent, including unchecked support of an unqualified investigator performing non-credible research (subsequently panned by 5 external experts),for research that was also unrelated to TBI and specific needs of veterans. This funding was also provided, not on scientific merit or productivity, but for an unrelated administrative quid-pro-quo that superiors expressly feared would otherwise lead to their dismissal. A contractor's billing practices were also highly suspect, substandard, and plagiarized, causing to his release from his recent past employer. These problems were continuing to siphon critical resources, already

dwindled by the waste of the preceding years. Left un-remedied, this trajectory would ruin the renewed mission of the center- to help those with traumatic brain injury.

My disclosures to VA administrators, beginning on September 20, 2007, fell on deaf ears and resulted in intimidation (e.g. calls for my resignation), suppression (e.g. requests for me to retract and electronically erase my disclosures from Research Committee review), and retaliation (e.g. loss of fiduciary and staffing authority as Director, and later involuntary reassignment under a person I filed disclosures against, and threats of increased clinic duties).

Retaliation methods and counterclaims

My attorney, Tom Devine of the Government Accountability Project (GAP), likened my case to Kafka's *The Trial*, prosecution by an inaccessible authority, with the nature of my crimes withheld from me. An Administrative Board of Investigation (ABI) was requested on February 4th by the COS to the Central Texas Veterans Health Care System (CTVHCS) Director based on my February 1st disclosures of waste, mismanagement and administrative misconduct. Counter-claims were added by administrators and I was removed from the BIRL and detailed to sole clinical responsibilities on February 6, 2008.

After my removal from the BIRL, I was banned from oversight of my own human research protocols, in violation of VA research policies and also posed risks to human research subjects. This prompted my VA Office of Research Oversight (ORO) complaint in March 2008 and immediate suspension of all research.

The lab was again dormant scientifically for another 1 ½ years, just as it had existed 1 ½ years prior to my arrival, burning fuel (i.e. taxpayer dollars) like an idling jet. No clinical research was ever conducted and the BIRL was "moved' to Waco in July 2009 with most of the $6.3 million burned-up without studying or helping a *single veteran*.

I then filed complaints with the VA's (Office of Inspector General) OIG on February 5, 2008, the Office of Special Counsel (OSC) in February 2008, Congress, the media (initially February 2008), and the VA's Office of Research Oversight (ORO) in March 2008. Many significant allegations were affirmed by these investigations.

Despite my complaint to the VA's OIG, the ABI plans proceeded in violation of VA policies which require abeyance of OIG investigations (e.g. criminal investigation for fraud). I protested to Mr. Shea, VISN 17 Director, to no avail. More counter-claims were added to an ABI charge letter sent by the on February 15th. After reporting this violation of non-abeyance to the OIG, these investigators notified the ABI convening authority (VISN 17) on February 26, 2008 to suspend the ABI pending the completion of the OIG investigation.

The ABI and VA's Summary Review Board (SRP) suppression and/or disregard for due process and compelling evidence of prohibited personnel practices exacted by VA officials were staggering. These retaliatory practices continued after my removal from the BIRL and detail to exclusive clinical duties from February 2008 until my suspension in September 2009. These investigative and review bodies, in close collusion with overseeing officials from VA headquarters, *engaged in unjust practices in their own right*, revealing clear retaliatory animus for my disclosing concerns of VA improprieties.

During this ABI suspension, the VISN 17 Director serving as ABI convening authority then communicated a lack of counterclaim evidence to justify an ABI against me to the Chief of Staff (COS), a target of both the OIG and ABI investigations. *The COS then engaged in witness tampering,* in violation of the February 26th OIG abeyance order to solicit more allegations and evidence (see witness letter of Dr. Greg Harrington).

The ABI was later re-activated by a new convening authority, Ms. Joleen Clark, Chief Workforce Management and Consulting and Joseph Pomorski, VA HR Consultant, *before the OIG completed its investigation. Ms. Clark then turned the ABI charge and scope upside down.* All of my allegations (e.g. senior manager misconduct and dereliction of duties, waste and mismanagement), prompting the ABI in February, 2008 were tossed out and relegated to an inappropriate *grievance hearing* decided upon by a person (Mr. David Wood) at a subordinate level to a person accused of misconduct (VISN 17 Director for complicity in witness tampering).

When I attempted to appeal to this aberration of justice, Mr. Pomorski declared no appeal of ABI change was possible and suggested I "drop the grievance." When I complained to Mr. William Feeley office, the former Deputy Under Secretary for Health , Operations and Management was, according to the COS "furious." The COS delivery of Mr. Feeley's refusal to intervene was personally delivered while I was treating patients, He was accompanied by a VA police escort, in the presence of patients and staff. When I filed a grievance protesting Dr. Sherwood's humiliating action, he was hardly unbiased in the matter. He was authorized by Pomorski and Clark to serve as deciding authority in the grievance I filed against him (see exhibit-May 30, 2008 VA Memorandum) and rejected the grievance out of hand, after having "thoroughly and carefully considered" of my grievances against him.

<u>The ABI was a biased tribunal</u>. When I attempted to provide evidence and a basis for retaliatory animus by CTVHCS leadership, the ABI Chair (Dr. William H Campbell, Deputy Chief of Staff, South Texas Veterans Health Care System) chastised me and complained about me in his report, stating "*He repeatedly went off on tangents to provide commentary on matters that were beyond the scope of the ABI, such as the alleged abuse of funds by the CTVHCS leadership*." Some allegations were *withheld altogether* from me at the ABI, I was judged "guilty" of these withheld

allegations by the ABI and I only learned of these at the time of "sentencing" by the Summary Review Board (SRB), i.e. the termination proceedings. Counterclaims against me included:

• Insubordination for defying orders to refrain from organizing a fun run to benefit traumatic brain injury research – even though a letter from the VA regional counsel opined that I was free to organize the event as a private citizen.

• Hanging a personalized door tag outside of my office –even though permission was granted to purchase it at my own expense.

• The use of profanity and engaging in "threatening gestures" at work. I admitted that I occasionally used profanity at work or socially but never used a "threatening gesture" or ever directed profanity toward a person.

• "Disrespecting" Sen. John Cornyn at a BIRL event attended by the senator. The VA alleges I disrespected the senator by allowing the event to run long in order to allow two wounded veterans not on the agenda to speak. Cornyn's office wrote a letter denying that Cornyn felt disrespected. Indeed he stayed and took photos with the veterans.

• Sexual harassment. A subordinate claimed that he overheard asked a female UT researcher about unprotected sex. The researcher, who does not work for Van Boven, wrote a letter *vehemently* refuting the accusation. This sensational lie was a distortion from when my team was reading and reviewing surveys to select for behavioral screenings.

Bartering for silence

Twice the VA attempted to barter for silence of the whistle. At the October 15, 2008 Summary Review Board (SRB) sentencing hearing, Dr. Arana, one of three members asked if I would cease whistleblowing activity if I were to remain at the VA. The SRP declared I was "unsalvageable" as I did not promise to keep silent if wrongdoing persisted. Minutes before starting the MSPB lawsuit trial in District Court in Dallas, the Administrative Judge demanded the unwilling VA to discuss settlement. The VA then asked if they paid a settlement, whether I would stop initiating contact with Congress, the media, and veterans groups. Settlement terms were then negotiated and reached in December, 2010. When I expressed trepidation to the terms of the VA offer for settlement, my attorney explained that "take it because the remedy rate with the MSPB is unjust.

The terrible performance of the MSPB in 2010 has not seen any substantial change since the passage of the WPEA in 2012. In FY 2013, a representative year, the MSPB only granted 4

persons with corrective action after adjudication out of 657 individuals who submitted initial appeals with whistleblower reprisal claims. *These statistics cannot credibly be suggested to reflect the true incidence of those subjected to prohibited personnel practices.* http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=996058&version=999982&application=ACROBAT *The right to a jury trial would enhance transparency and justice and should replace the MSPB.*

Post-termination retribution

Retributions did not end with my termination in January 2009, or even after the VA settlement *nearly two years later*. Despite the arduous but the successful Merit System Protections Board (MSPB) IRA appeal, filed in December 2009 by my counsel, Mr. Tom Devine of GAP, and VA Settlement in November 2010, retaliations persisted for years.

1. On February 18, 2009 the VA unduly reported me to the National Practitioner Data Base (NPDB), indicating that I was "terminated" for "unprofessional conduct." One month later, *upon media inquiry* on March 5, 2009 to the VA, Diane Struski, the VISN 17 Executive Assistant and Public affairs officer declared that my termination was *not* reportable to the clinician database and the NPDB report was strangely *expunged the very same day*.

2. The only peer-reviewed publication generated from the BIRL was a 34 page comprehensive review on advanced imaging of TBI and post-traumatic stress disorder (PTSD) which I labored on under the duress of a 60 day stay-of -termination and submitted on December 8, 2008. But even this scientific contribution was nearly thwarted. The invited editor for special TBI/PTSD issue of the VA's *Journal of Rehabilitation Research and Development* (JRRD) called and alerted me that he had been *discouraged against accepting the paper* by Stacieann Yuhasz, Editor for the Journal. Her reasoning was not based on scientific merit, but on a VA headquarters official's concern over a June 2009 *Washington Post* article exposing the closure of the BIRL.

3. When I secured employment and was appointed Director of the TBI Clinic at Fort Riley Kansas, media attention to VA waste and whistleblower retaliation claims triggered retribution and abrupt discharge as a contractor at the hands of Great Plains Regional Medical Command of the Army. VA officials later reached out to DOD Command at Carl R. Darnall Army Medical Center at Fort Hood and made disparaging remarks on August 3, 2010, expressing displeasure over my presence in the DOD (see letter to President Obama and OSC_Post_VA retaliation)

What's past is prologue.

After the July 2009 closure of the BIRL, VA officials testified before Congress in 2010, falsely arguing that redundancy in MRI and TBI expertise (the opposite was at the heart of the Waco failure) at Waco justified the BIRL closure and emphatically "ensure[d] a robust Veteran-focused neuroimaging…..[research program in] traumatic brain injury in Central Texas" [see DVA Memorandum 7 February 2013]. These VA officials that testified before Congress oversaw more than 3 ½ years of waste and closure of the BIRL in the wake of my disclosures, and remained in power to oversee 6 more years of failure at the "Center of Excellence" brain imaging program in Waco. http://projects.statesman.com/news/va-center-of-excellence/austin.php

As reported in this past weekend's issue of the Austin American Statesman, the July 1, 2008 Waco unveiling of a MRI scanner "once hailed by VA leaders as the most powerful mobile MRI on the planet" has not led to a single study published since its acquisition 6 years ago. http://projects.statesman.com/news/va-center-of-excellence/ The article argued that the unused "Center of Excellence" and MRI at Waco "devolved into a ghost machine [and] stands as a stark symbol of the VA's shortcomings in responding to the specialized needs of soldiers returning from the longest-running conflicts in the country's history."

The article further points out that between the BIRL and Waco (both part of CTVHCS and VISN17), "the two imaging programs cost taxpayers more than $12 million and squandered almost a decade of opportunity." With more than $1 billion-a-year in research budgetary resources (including $ 586 million from direct appropriations and the same from medical care support- source of BIRL funds) scrutiny of VA research management and oversight appears worthy of review.

Conclusions

Dr. Michael Merzenich, one of our nation's leading neuroscientists, Professor Emeritus at UCSF, Member of the National Academy of Sciences and the Institute of Medicine observed the following about the VA's response to quality issues I raised about the organization.

> I have read the Inspector General offices report, and found it to express a lot of what is wrong with the VA and our bureaucracy. It chooses to hide behind legalisms to deny the obvious. The obvious is that before Dr. Van Boven joined this group, this unit was administered by incompetent non-research professionals supervised by equally incompetent administrators who chose to frustrate rather than support his attempts to turn a

> dysfunctional research unit into a vibrant, world-class contributor to research that had high promise for helping soldiers and returning veterans in great NEED of that help.

Ironically, from the ashes of two failed VA TBI neuroimaging programs over eight years, a Central Texas TBI neuroimaging and treatment trial has emerged from the thanks to a Congressionally Directed Medical Research Program DOD TBI treatment trial award, one of three in the nation, being conducted at Fort Hood. This effort is one I attempted to launch 8 years ago at the BIRL and is being conducted in collaboration with colleagues at MIT, UCSF, Brook Army Medical Center and Fort Hood,
(see http://www.forthoodsentinel.com/story.php?id=14179; also see http://clinicaltrials.gov/ct2/show/NCT01908647)

Delivering help to those who are afflicted with brain disorders from TBI and PTSD is dependent on good science and integrity. However, if a culture fights, rather than fosters transparency; that suppresses, rather than rises to opportunities for improvement; then the infamous stereotype will continue to curse the VA bureaucracy and whistleblower alike, and the patient and public will suffer.

Respectfully submitted,

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