LEARNING FROM WHISTLEBLOWERS AT THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

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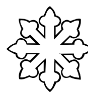

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LEARNING FROM WHISTLEBLOWERS AT THE DEPARTMENT OF VETERANS AFFAIRS

Tuesday, June 25, 2019

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:03 a.m., in Room 210, House Visitors Center, Hon. Chris Pappas [Chairman of the Subcommittee] presiding.

Present: Representatives Pappas, Rice, Cisneros, Peterson, Bergman, Radewagen, Bost, and Roy.

OPENING STATEMENT OF CHRIS PAPPAS, CHAIRMAN

Mr. PAPPAS. The hearing will come to order. Today's hearing of the Oversight and Investigation Subcommittee is entitled "Learning from VA Whistleblowers." Our Committee is constantly exploring ways to improve the accessibility, quality, and safety of veterans' health care, create a more timely and accurate review of benefit applications, and reduce instances of waste, fraud, and abuse in the department.

One of the best sources of information and ideas is the VA's 370,000 employees. The people at the front lines for delivering services for veterans. Unfortunately, VA seems to have a culture problem. In some instances, VA leadership and supervisors have turned a blind eye to those in VA's workforce that have pointed out serious problems or attempted to expose bad actors that have abused their positions or broken laws.

In even more concerning examples, VA leadership and supervisors have actively worked to stamp out these voices. As you will hear from one of our witnesses today, VA informed her just yesterday of its intention to terminate her employment. The timing of VA's notice, just one day before this hearing, is suspicious at best and at worst reeks of retaliation.

Make no mistake, this Committee believes in the importance of having people who are brave enough to stand up and blow the whistle on missteps and misdeeds within the Department of Veterans Affairs. Anyone involved in the veterans' policy arena will recall the difference that can be made by whistleblowers if they think back 5 years.

In 2014, a group of people working for the Phoenix VA Medical Center exposed the existence of a secret waiting list of veterans in need of medical care. Thousands of veterans were waiting months upon months for appointments. However, as was later revealed in an independent VA inspector general audit, more than 70 percent

of the veterans who were waiting for care from the Phoenix VA were excluded from the VA's official count.

Worse, the Phoenix VA leadership actively worked to hide the exorbitant wait times. And it turned out that such practices were occurring at VA facilities nationwide. The coverup was extensive and deliberate. And the health and well-being of veterans were at risk.

Congress became involved passing laws to stop secret lists and requiring that the wait times faced by veterans will be published online for everyone to see, but there was a cost.

As you will hear from a number of today's witnesses, the Phoenix VA employees who blew the whistle in 2014 have faced retaliation. Their jobs were threatened, and they faced a hostile work environment. Despite our witness' initial success in obtaining protection and reinstatement as an employee, she is once again facing retaliation.

Fortunately, VA whistleblowers continue to come forward. Just last month, journalists reported about a whistleblower with evidence suggesting VA is still hiding veterans' wait times. This Subcommittee is currently conducting his own investigation to examine the facts surrounding these new allegations. Whistleblowers are too important a resource to ignore. 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.

There are several institutions in place to help protect whistleblowers. Most recently in 2017, Congress and VA established a new office of accountability and whistleblower protection. And two years' later, it is time to see if this new VA office is effective. Unfortunately, as you will hear from our first panel, there is evidence suggesting that problems continue.

Let me be clear. As this Subcommittee's Chairman, I will fight for the rights of whistleblowers. The work of the VA is too important to ignore those pointing out the missteps and misdeeds. I also want to say that there are some examples of VA eventually successfully listening to whistleblowers without retaliating against them.

At the Manchester VA Medical Center in my district, Dr. Ed Kois and his colleagues saw serious problems threatening the health of veterans. At first, he went to his supervisors, but Dr. Kois was ignored. He continued pressing these issues to higher and higher authorities within the VA. He was still ignored. Finally, he went to the Boston Globe's investigative journalism team, and to Congress. And finally, the VA took his allegations seriously and began working to address the patient safety and quality of care concerns that Dr. Kois and his colleagues identified.

This is good news that Dr. Kois says he has not experienced retaliation as a result of speaking out. And I urge the VA to follow the path of New Hampshire's example when other whistleblowers express their concerns. Let's not be naive, however. The success story we saw in my home state is not always what happens. That is why this Subcommittee will take a long, hard look at current VA policies and Federal institutions intended to protect whistleblowers.

We will also hear testimony from a set of experts that work closely with hundreds of people who similarly raise concerns and face retaliation from the department. I look forward to the testimony of today's witnesses. And with that, I would like to recognize Ranking Member Bergman for 5 minutes for any opening comments he may have.

OPENING STATEMENT OF JACK BERGMAN, RANKING MEMBER

Mr. BERGMAN. Thank you, Mr. Chairman. Good morning, everyone. As an aviator, I know firsthand how vital it is that all team members at every level of an organization feel empowered to bring problems forward. When I climbed into an aircraft, I trusted that everyone, from aircraft maintenance to my most junior ground crew and flight crew members, to my co-pilot, that they would alert me to any concerns they had. All of our safety, my safety and the safety of the crew in the cargo depended on a deep level of trust and communication.

Similarly, as a leader of Marines, I needed all my units to be empowered to raises concerns because of the health and safety of troops, and the mission demanded it. The Department of Veterans Affairs is no different.

As we saw with the Phoenix wait time scandal in 2014, and Dr. Mitchell, who is here with us today, was an important voice in that disclosure, VA employees had the courage to sound the alarm and potentially save lives. Leadership must create an environment where such alarms are taken seriously, investigated thoroughly, and prompt remedial action is taken when necessary.

Today, the Subcommittee will receive testimony from whistleblowers and organizations that represent them in an effort to better understand the current state of whistleblowing protections and accountability in the VA. In addition to Congress, whistleblowers have three main venues to raise concerns: the Office of Special Counsel, the Office of Inspector General, and the Office of Accountability and Whistleblower Protection or OAWP.

Employees can blow the whistle in one or all three of these venues. I would like to hear from the whistleblowers about their experience with each of these offices with three separate organizations potentially performing the same investigation. I am interested in the witnesses' perspectives on the differences and relevant strengths and weaknesses of each office and any suggestions that they may have for improvement.

From the organizational witnesses, I would like to hear their opinion concerning the elements of a sound whistleblower program. I am interested in understanding which Federal agencies they believe have a good whistleblower program, and what constructive and concrete actions VA could take to improve its program.

In the written testimony, the witnesses described several incidents of retaliation and reprisal. There was no question that the state of whistleblower protections in the VA reached a low point several years ago. This important issue, overlooked for so long, finally attracted widespread attention.

During the 115th Congress, we passed, and President Trump signed into law several enhancements to the VA's whistleblowing program, chiefly the VA Accountability and Whistleblower Protec-

tion Act of 2017, and the Dr. Chris Kirkpatrick Whistleblower Protection Act of 2017, which mandated tough penalties for supervisors retaliating against whistleblowers. I need to hear from you how well these reforms are working.

I am under no illusion that everything is perfect, and that work remains to be done. It is important that this Congress, that we evaluate whether the last Congress' enhancements have improved the process.

Originally, the Government witnesses who could provide that information were scheduled to testify in July, but their testimony has now been delayed until September. This is unfortunate because the Committee would greatly benefit from hearing from VA and the other Government witnesses about the current state of whistleblowing program.

This hearing was presented to me as the first hearing to help members understand the whistleblowing process and show the depth and complexity of the process, in other words, a non-political educational hearing.

However, on Saturday, USA Today published a story on today's hearing, identifying the witnesses without comment from the other governmental organizations. Then yesterday evening, the Chairman's staff advised my staff that one of today's witnesses received a notice of her proposed removal and is concerned that this is reprisal.

Mr. Chairman, as you will learn of this Congress, the VA does not work that fast. Mr. Chairman, the Committee received a letter, which I have here, from Secretary Wilkie this morning. On this hearing, I ask unanimous consent that it be included in the record.

Mr. PAPPAS. Without objection.

Mr. BERGMAN. Yes. Mr. Chairman, pursuant to Committee Rule 3 and the House Rule 11, Clause 2, I request the right to call minority witnesses before the close of this hearing. Those witnesses should include VA, the VA inspector general, the Office of Special Counsel, and the Merit Systems Protection Board. I believe that it is imperative to receive testimony from these witnesses as soon as possible, while today's testimony is still fresh in the minds of members because whistleblowers deserve it.

I would like your commitment to hold this hearing either this week or at least the first week we return. Whistleblowers provide an important service to the country, however, the way this hearing has evolved has the potential to create the perception that complaints fall on deaf ears. If whistleblowers do not have confidence in the system, we are putting patient health and safety at risk. With that, I yield.

Mr. PAPPAS. Well, thank you, Ranking Member Bergman. And I want to give you my commitment that we always intended to do a second hearing and we are eager to work with you, the majority and minority staff together, to call witnesses and ensure that this happens as soon as possible, and hold a hearing that also includes the VA. So if you want to take that commitment, we are going to be happy to work with you, you know, shortly after this hearing concludes on setting a timeframe for that.

Mr. BERGMAN. Well, you know, unfortunately, this town has a very short memory and unless we can condense it so we can get

that full perspective. Because as Oversight and Investigation, as you very well know, we have to look at it from 360 degrees and the information has to be fresh and correct, and I appreciate that.

Mr. PAPPAS. Thank you. I will now recognize our first witness for the panel. First, we have Dr. Katherine Mitchell, a physician who has worked with the VA for more than 20 years. This Subcommittee thanks you for appearing with us today. Dr. Mitchell, you have 5 minutes.

STATEMENT OF KATHERINE MITCHELL

Dr. MITCHELL. Thank you, sir. By nature, I am a very private person. I was ethically compelled to become a public whistleblower only because there were no other avenues to keep veterans from dying. My disclosures on access and poor quality care had national VA implications and encouraged a wave of VA employees to speak up about serious VA problems.

As a result, I received the 2014 Federal Employee of the Year Award. The VA entered into a settlement agreement with me and gave me a patient care oversight position. I have been described by the VA as a whistleblower success story and as definitive proof that the VA embraces whistleblowers. However, nothing could be further from the truth and I am here to set the record straight today.

In 2014, I testified at this Committee's groundbreaking whistleblower hearing that finally brought VA retaliation into the spotlight. I had hoped my 2014 testimony would help jumpstart positive change so that all employees could report problems without fear of retaliation. Unfortunately, VA administrators today still continue to retaliate. The only change I have seen is that since 2014 is that administrators are now much more skilled at weaponizing investigation boards and manufacturing charges.

In my case, I have experienced ongoing retaliation that started shortly after signing a 2014 retaliation settlement agreement. For example, for nearly 5 years, I have been prohibited from performing every major duty listed in the written job description that was given to me as part of the legally binding settlement agreement.

For about 2 years, I was banned from initiating contact with all VA medical center staff in my region. From 2014 until 2018, I had no regular assignments. Although I am highly trained as a VA quality scholar, I am excluded from almost every oversight activity and I am not officially allowed to intervene in patient care problems. I have not been silent about this retaliation, but I cannot seem to make it stop. There are no easy avenues to obtain relief from VA retaliation and VA administrators know it.

Since 2015, I have intermittently notified my chain of command, to no avail. In 2016, I contacted the Office of Special Counsel, or OSC, to get help with the broken settlement agreement. The OSC agreed to informally work with the VA, but the VA declined to respond or participate. At that time because of OSC backlog, my only option was to file another whistleblower retaliation complaint and wait my turn in line. It was a wait that would be 15 months long before the OSC had time to review my case.

In 2017, I also contacted several congressional offices, but merely was referred to the Office of Accountability on Whistleblower Pro-

tection, or OAWP. I initiated contact with the OAWP twice in 2017 and requested to file a claim. I then waited about 16 months before I got an OAWP response back that merely asked me if I was still interested in filing a claim.

At that time, the self-described OAWP procedure for investigation was so alarming to me that I opted not to use its services. In 2017, I also sent the VA a legal formal notice of breach of settlement agreement. In response, I received and accepted an offer for short-term assignment with a potential for a longer term position. However, the VA suddenly cancelled the offer without explanation shortly after I gave a public interview about escalating levels of VA retaliation.

I subsequently sent a second legal notice to the VA, but the VA just ignored it. I never received a response. In approximately October 2018, the OSC conducted a preliminary investigation and found ample evidence of retaliation against me. I subsequently agreed to mediation with the VA to resolve the issues quickly. Unfortunately, once again, the VA no longer has the expedited mediation process that was available in 2014. As a result, I have remained in mediation for 9 months and counting with absolutely no end in sight.

This delay is primarily due to VA responses that are extraordinarily slow, piecemeal, and on one occasion so disturbing that it felt like it should be counted as retaliation in itself. In my opinion, the VA's callous approach to mediation illustrates the degree to which the agency devalues whistleblowers and tries to avoid institutional accountability for the retaliation.

I am definitely not the only prominent whistleblower treated this way. Dr. Christian Head of the Greater Los Angeles VA and Scott Davis of a national VA office are still experiencing extreme, ongoing retaliation ever since testifying with me in that fateful 2014 whistleblower hearing. Frankly, if the VA has no qualms about aggressively targeting well-known whistleblowers, it stands to reason that lesser known whistleblowers will be targeted with even more enthusiasm and absolutely do not stand a chance alone.

Ultimately, whistleblowers are not guilty of anything other than reporting serious problems that leadership wants to camouflage. Until leadership culture improves, whistleblowers will serve as a vital, necessary safety net for veterans. Whistleblower retaliation threatens that safety net and eminently jeopardizes the health and safety of every veteran in the system. Thank you so much for your time. I look forward to answering your questions.

[THE PREPARED STATEMENT OF DR. KATHERINE MITCHELL APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you very much, Dr. Mitchell, for your work, for your courage in appearing here today, and for looking out for our veterans.

I will now recognize or second witness, Jeff Dettbarn. He is a registered radiologic technologist, who has worked at the VA for more than 14 years. Mr. Dettbarn, you have 5 minutes.

STATEMENT OF JEFF DETTBARN

Mr. DETTBARN. Thank you. I am a 14 year employee at the Iowa City VA Medical Center. I have been a radiologic technologist for

over 29 years. I became a whistleblower out of concern that the veterans were being placed at risk of not receiving the care they desperately needed and the unnecessary risk to patient care presented by non-medical personnel practicing as physicians.

I observed the first improper cancellation of a radiology order in February 2017. A veteran presented for a CT of the chest for a lung cancer screening, but the order had been improperly cancelled by the radiology service secretary. I later discovered that the administrative officer and secretaries were risking patient lives by overriding crucial physician orders.

I immediately alerted supervisory chain, but no one would listen. Nobody seemed to care. In June of 2017, I persistently reported the problems in radiology. False complaints were made about my job performance. The complaints came at approximately the same time of my first disclosure to Senator Grassley. Management misled Senator Grassley with bogus excuses about one patient's cancelled imaging order when there had been actually 12,660 orders cancelled.

I would be more than happy to expound on the VA's deception if asked during the question and answers. In July of 2017, my banishment from the hospital began and continues today. Once I was removed from the main facility, others, afraid to speak out, told of secret lists of veterans who had not received the imaging for their specialty clinic appointments. Imaging essential for doctors to accurately diagnose and treat life threatening conditions. I reported this to the OIG.

In August of 2017, I was targeted by a rigged AIB investigation. There was no charge letter. I was only informed that they were addressing issues in radiology. It became clear from the accusatory nature of the questions I was the target.

Senator Ernst' office has connected me with the OSC, and I have filed disclosure and retaliation complaints. I also filed with the Office of Accountability and Whistleblower Protection. I sent them countless emails attempting to get a progress report about my case. They never bothered to address me.

In November 2017, a baseless patient abuse allegation was manufactured, prompting my removal from direct patient care. December of 2017, the chief of staff, Stanley Parker, proposed my termination on charges cooked up from the AIB. The clearly fabricated testimony of witnesses and management in the AIB prompted me to seek legal assistance with the process of blowing the whistle.

I have experienced another common VA retaliation tactic, malicious complaints to my licensing agencies: twice to the American Registry of Radiologic Technologists; and once to the Iowa Department of Public Health. These overt attempts are to blacklist me from both Iowa and national licensing. For every person who wants to speak up, there are thousands that have tried, only to be removed, demoted, or intimidated into silence.

The process of seeking a whistleblower assistance is confounding to me. Do I file with OIG, OSC, OAWP, the list goes on. Although I have navigated to this point, not everyone is that fortunate. After 23 months, my current situation is horrendous. The VA has mothballed me into a makeshift position as a records requester. I have not had a performance appraisal in three years. I am forced

to forego merit increases and about one-third of my salary. But worst of all, the VA has ripped my patients away from me.

Whistleblowers are essential to ensure the best quality care our veterans need and deserve. If not for the veterans, I would not be a whistleblower. The veterans I am trying to protect, and help have become an extended family to me. As I have continually stated throughout this process, they are someone's mother, father, sister, brother, husband, wife. Taking care of the patients and ensuring the best possible care for the veterans is why I am here. Taking care of people is what I do.

At this point in time in my life, I haven't much to lose or anything to gain. However, the veterans that I am here for, stand up for, and am a voice for do have a lot to lose, their lives. Thank you.

[THE PREPARED STATEMENT OF JEFF DETTBARN APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you very much for being with us and for caring for our veterans. We appreciate it.

I will now recognize our third witness, Dr. Minu Aghevli. She is a clinical psychologist who has worked at the VA for more than 15 years. Dr. Aghevli, you have 5 minutes.

STATEMENT OF MINU AGHEVLI

Ms. AGHEVLI. Thank you. My name is Dr. Minu Aghevli and I am the program coordinator of the opioid program at the VA Maryland health care system in Baltimore. I have a Ph.D. in clinical psychology, and I have been with the VA for almost 20 years, my entire career. I even did my externship, internship, and post-doc there.

Back in 2013, as the opioid epidemic was getting going, we found ourselves unable to keep up with the demand for treatment and we had to start a wait list. Management almost immediately started pressuring me to reduce the size of our official wait list in various ways that I felt were improper: such as removing people from the unofficial wait list by scheduling them fake appointments at an imaginary clinic.

I felt these things were wrong and I protested. I went up through my official chain of command in the facility. I eventually went all the way to the secretary of the VA, actually two secretaries. I came to the OIG repeatedly and I spoke to Members of this Committee.

After I started voicing my concerns about our improper wait list practices, the agency threatened to remove me as coordinator of the program and transfer me to a different area of the hospital. I went to both the OIG and the OSC. The transfer was rescinded in the end, but not until the last possible minute before it went into place.

Over the last 5 years, this pattern of retaliation and threats has continued. It doesn't matter that my performance evaluations have been uniformly outstanding. I have experienced constant harassment, scrutiny, and frivolous investigations. Management has stripped me of authority in ways that have been humiliating. I am exhausted.

Last year, I reported concerns about a patient death, and I was threatened with a reprimand. Earlier this year, I had expressed concerns about a serious patient safety concern and two months

ago yesterday, the agency told me that they were summarily suspending my clinical privileges. The stated reason for this was that I had gone to visit a high risk patient in a community hospital after he had overdosed, been treated in our emergency room, and then discharged.

While I was visiting him, the veteran also told me that he had attempted suicide after leaving the hospital. Since my privileges have been suspended for the last two months, I have been forbidden to talk to any patients or engage in patient care. And I have been assigned menial administrative tasks in a situation that seemed chosen to be as stressful and publicly humiliating as possible.

A couple weeks ago, I informed my supervisors that I was going to testify at this hearing. I sent them a copy of the invitation. Yesterday, I was informed that they were starting the process to remove me under the Whistleblower Protection Act provisions.

This feels obviously retaliatory. But worse than that, I feel like I am being used as a threat against other employees who might think about speaking up—I am sorry—about patient care concerns and I resent that. I do not want to be used as a pawn.

I have gone repeatedly to the OSC for help with retaliation over the last 5 years, but the OSC has continually let me down. The process can take years. My last complaint took almost 3 years to resolve. Also, they have not been able to help me because they have told me that when the VA has threatened me with actions, but then not followed through, or even when they have followed through but then reversed course, the OSC does not consider this a personnel action that they can remedy.

Even when my privileges were suspended, the OSC told me that this was not considered a personnel action. I do not understand this because I know that under the statute, threats against whistleblowers are not permitted. They are prohibited. And honestly, suspending someone's privileges is worse than taking a disciplinary action because even if somehow my termination is stopped, I will still have to put down that my privileges were suspended every time I renew my license or if I ever apply for a job for the rest of my career. So it is kind of like having an arrest record I can't ever expunge.

Finally, I just want to say that the way the VA is allowed to retaliate against whistleblowers, it has a terrible effect on veterans. I have taken care of some of my patients for almost 20 years. I see some of them every day when they come into the clinic. They are like my family. It has broken my heart to not see them during this past two months.

Sometimes, I am once of the most stable people in their lives. And so when I abruptly disappear, it affects them. Recovery from addiction is so difficult already. And it is hard to do. It is easy to give up on yourself if you don't think you are worth fighting for.

Many of our patients don't have people in their lives who advocate for them and sometimes that is the role we play. We advocate for our patients and we tell them that they are worth it, and they matter. And if our colleagues see people retaliated against for trying to stand up for our veterans, that will have a chilling effect and our veterans will suffer. And I am asking this Committee to please

expand protections for people like us because we need to shift the culture of the VA from one that tells us to be quiet and keep our heads down when we see something that is wrong, to a place that values speaking up for what is right. Thank you.

[THE PREPARED STATEMENT OF MINU AGHEVLI APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you very much for your strength in appearing here and for your comments today. Thank you to each of our witnesses for being a part of this hearing.

We will now begin the question portion of the hearing for the first panel and I will begin by recognizing myself for questioning for 5 minutes. And I want to voice my appreciation again for all of you for appearing here today. I think the testimony we just heard makes it clear that stepping forward as a whistleblower is difficult. It is frustrating. It is time consuming. And becoming a whistleblower has major personal consequences.

Dr. Aghevli, if I could start with you. As you mentioned, you were notified yesterday that the VA intends to terminate your employment. I am wondering if you could describe a little bit more to the Committee what the notice will mean for you, even if you were able to gain protection as a whistleblower.

Ms. AGHEVLI. Do you mean if I am actually terminated or–

Mr. PAPPAS. Well, just the fact that notice has been served to you. What does that mean for you going forward as you grapple with this and, you know, seek to be protected?

Ms. AGHEVLI. Well, it was devastating to receive because like I said, I have never worked anywhere else than the VA. So I feel like that is my whole world.

I had filed with OSC already, so I am hoping that they can offer me some protection, but it is very stressful.

Mr. PAPPAS. Well, I can only imagine what you are going through and I think it is a little suspicious that the VA chose to communicate its intent to terminate Dr. Aghevli the day before this hearing, and just a couple of days after an article was published, and a few weeks after you gave your intent to your supervisor to appear here and to speak truth about some of the things that you are seeing at the VA.

And I think we need to give you our commitment that we are going to do everything we can to protect folks who are in your position. We can't allow individuals to be intimidated who are coming forward with important information.

Dr. Mitchell, I am wondering if I could ask you a question. Your testimony describes a story that would seem in one sense successful because you blew the whistle in 2014 about wait times and people heard your story. Congress took action, hearings were held, and eventually it led to new laws. And for you personally after going through the long and arduous whistleblower process, you were reinstated, yet you said today that you still face retaliation.

And as I understand it, the Office of Special Counsel, the independent Federal agency that investigates whistleblower retaliation has found this to be the case. Dr. Mitchell, do I have it correct that you are once again under retaliation and could you comment on what this means for your ability to do your job at the VA?

Dr. MITCHELL. The retaliation never stopped. The only difference is the way the retaliation is occurring has changed. Before, it was making me work unlimited hours without compensation or dropping my performance evaluations. Now, it is basically excluding me from any opportunity that I have to oversee patient care and address the problems.

My title is Specialty Care Medicine Consultant. I am supposed to be allowed, by my job description, to oversee patient care, to be involved in risk management and utilization review. I have been excluded from all of those activities. I cannot verify that the VA has improved things when issues have come up.

I can tell you that in the last 5 years, I have seen tremendous strides in patient care and access across the VA in general. I am proud to send my family members to the VA. I believe the VA provides millions of high quality episodes of care every year in a manner that in many ways is superior to private sector. But I am not allowed to help improve that care at all. It is incredibly frustrating and devastating as a physician.

Like so many of us, we are rather high performing and we are our work. And not to be able to do that work is psychologically incredibly difficult.

Mr. PAPPAS. And Mr. Dettbarn, we just have a few seconds left, but you described a very difficult personal process that you have gone through as a result of blowing the whistle. And I am wondering if you could comment on why you continue as a whistleblower and why you haven't given up.

Mr. DETTBARN. The patients, the veterans. That is what we are here for. As I stated, we take care of people and these are family. We know their names, their histories, their loved ones. You are taking care of a family. It is not just a person. They are a family.

Mr. PAPPAS. Thank you very much for your response. I would now like to recognize General Bergman, the Ranking Member, for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. Dr. Mitchell, in your testimony, you recommend that OAWP speed up the intake and triage process, and improve transparency. Can you tell me what your expectations are as it relates to the timeliness and transparency of the OAWP? Can you give me some examples?

Dr. MITCHELL. Yes. You are referring to my written testimony, Section 4 and 5. There are a couple of things. First of all, when I contacted the OAWP, I asked if the documents I was going to provide to the OAWP would be shared with my supervisors. The first time the lady spoke with me offline on the telephone to let me know that, yeah, they probably could. The second time, I actually got email confirmation that if I submitted documents, it would go to my—in the process of investigation, it could go to my supervisors. That would be the very first thing I would stop with the OAWP. If there is going to be an investigation, whether they do it themselves or they refer to the VISN or the facility to do it, the employee needs to know that their documents will be held confidential. That is very important.

There are some other things. I don't know what is a reasonable timeliness period, but I do know 16 months is not. Others have told me it has been a year. If you are talking about a major action

where an employee is suffering risk of termination or demotion or suspension, those actions can occur within a week or two. The OAWP should have processes in place to be able to mobilize quickly, to go in and examine whether or not those personnel actions are appropriate in the context.

Mr. BERGMAN. Okay. Thank you. Thank you. Mr. Dettbarn, in your written testimony, you state that both the process of seeking assistance as a whistleblower was "truly confounding," and that you did not know how any employee would know who to contact.

It is my understanding that the No Fear Act of 2002 mandates that Federal agencies provide employees annual notice of certain Federal laws, including the whistleblower laws and training on such laws, no less frequently than every two years. Have you taken that training and are you saying that the training is inadequate? How could VA improve on that training to make it easier for all employees to understand and not be confounded?

Mr. DETTBARN. Yes, I have taken the training. Everyone takes it. The problem is that we don't have the support from our agencies when we do finally figure out who to report to. And then we are turned over to the agency for their own investigation. So the training looks great on paper. Everybody did it. But when you try to actually go about the process, going online to the OIG site or OSC site, wherever, if you are not a computer savvy person, it is mind boggling.

Mr. BERGMAN. Okay. So basically, it is online training.

Mr. DETTBARN. Correct.

Ms. AGHEVLI. Could I add to that?

Mr. BERGMAN. Go ahead.

Ms. AGHEVLI. I feel like I could teach the No Fear training at this point and the problem is that it is not true. So in the No Fear training–

Mr. BERGMAN. Well, first of all, what is not true?

Ms. AGHEVLI. Well, so they state that, you know, bullying is prohibited, and harassment is prohibited. But I have filed with the OSC now three times and they are very lengthy applications. You have to describe the entire history of your retaliation. So I have gone back 5 years. But then what I have been told is bullying is not covered as a prohibited personnel practice that the OSC can help me with.

So it feels frustrating because I take that training every time and I think, "I wish I could get help with this." My life would be much better if I could get help with this.

Mr. BERGMAN. Okay. Well, thank you. I see that my time is running short, so I will just yield back the 30 seconds, Mr. Chairman.

Mr. PAPPAS. Thank you very much. I would now like to recognize Mr. Cisneros for 5 minutes.

Mr. CISNEROS. Thank you, Mr. Chairman, and thank you all for being here today and having the courage to come forward.

I was just wondering, and any of you could answer this, or all of you could answer this. But what is the messaging that the VA gives you as far as coming forward to whistleblowing to reporting incidents, to reporting something that you see that is wrong, and contrast that with the reality for me.

Dr. MITCHELL. The VA administration does very good public relations as far as stating that they will not tolerate retaliation. They are actually trying to become what is called a high reliability organization. It is a new initiative where it is a culture of safety. Everyone is supposed to be encouraged to speak up.

Although I have had supervisors who are excellent supervisors, very ethical, in general, when you bring up a problem to the VA, you risk your professional reputation, your credibility. And if they go after you as viciously as they have been, you risk your ability to support yourself and your livelihood because as Mr. Dettbarn said, they will maliciously manufacture things and report you to your license or licensing agency.

I know of at least five physicians who have spoken up, who were fired or had to leave, and could not get a job for at least a year, sometimes two years, and in one case, five years. This is a radiologist, radiation oncologist, internal medicine physician, highly skilled surgeon.

This retaliation, I know some people think that it is office politics, it is not. This is a vicious, relentless assault on everything that is important to you. It drives people to the edge. Chris Kirkpatrick was driven to the edge. He was the psychologist out at Toma who committed suicide. Frankly, this is my tenth year of retaliation. It started 5 years before the access scandal.

I am a well-rounded woman. I am intelligent. I have a great support system. I would have successfully committed suicide a while ago because the retaliation is so severe. I don't say that to shock you but to open your eyes that this retaliation is vicious. This is at a level that you can't imagine, and it is destructive to everyone and endangers veterans because anyone with a reasonable mind would not speak up in this culture.

People tell me things so I can report it because they are too afraid of what will happen to them.

Mr. CISNEROS. And any of you can answer this second question as well. But when you have come forward to report the incidents or the wrongdoing that you saw, did anybody come and visit you to discourage you to retract your statement? And who was this? Is it junior personnel, junior supervisors, or is it coming from higher ups within the VA facilities or even higher up than that?

Ms. AGHEVLI. I think in my case, people have expressed concern for me that something will happen to me if I say something.

Mr. CISNEROS. Were those friends or were they, like, supervisors that came–

Ms. AGHEVLI. Both. I mean, I was advised at one point that I would probably need to change jobs or leave. And look at what is happening. I am now sitting in a congressional hearing and I have been proposed for removal. So I guess that was good advice.

I mean, I totally agree with Dr. Mitchell. I think there is a culture of like we do not air our dirty laundry. And it is very destructive because it means that instead of being able to, you know, look at things that didn't go as well as they might, and learn from mistakes, and problem solve, it is just a stone walling.

Mr. CISNEROS. Mr. Dettbarn, did anybody encourage you to kind of retract your statements or anything that you saw?

Mr. DETTBARN. No one encouraged me to retract my statement, but I think I came across strong enough at the beginning that I wasn't going to back down from this. This is an important issue and veterans' health care is at stake.

They tote the I Care, No Fear. We have to take these online courses every year and it is exactly the opposite of what these courses teach us that we are confronted with from management in the VA.

Mr. CISNEROS. All right. With that, thank you very much for your testimony here today and for coming forward. And Mr. Chairman, I yield back my time.

Mr. PAPPAS. Thank you. I now recognize Ms. Radewagen for 5 minutes.

Ms. RADEWAGEN. Thank you, Mr. Chairman. I want to thank the panel for being here today. My question is for all three of you. What are some specific actions that Congress could take right now to improve protections for whistleblowers? If I could get maybe one or two answers from each of you, please, briefly.

Dr. MITCHELL. There are two things: The Merit Systems Protections Board is backlogged 2,000 cases in 4 years because there is no three person quorum. If there could be a bipartisan effort to make sure that whatever is done is taken, or whatever needs to be done is taken, to make sure there is a three person quorum.

I don't care what the political party is, I just need those people. There are 2,000 people waiting with potentially improper personnel actions. The other thing is the OSC was grossly understaffed for many years. Their budget is one percent less. They are backlogged 2,600 cases. They found a way to hire 11 people by redoing their lease. But I would go to them and say, "What kind of monies do you need?"

They are getting historic levels of employees coming to them and a huge portion are from the VA. They do excellent work when they have enough staffing. But when they don't have enough staffing, they cannot do the work they intend to do.

Ms. AGHEVLI. Yes, I would add a similar thing. I think cases need to be processed quicker because if you wait years, you are in a limbo. The way adverse actions and personnel actions are defined seems very, very narrow to me. You know, proposing actions and then pulling them back at the last minute over and over again is exhausting. That is threatening. I think in a lot of other workplaces, that would constitute harassment and intimidation.

And then in my case, you know, if I didn't have a pending case before the OSC, I would have 7 days to deal with this huge evidence file and mount some sort of defense. And if I didn't have a lawyer to help me, I don't know what I would do. So the way the removal process goes now under the law is very difficult for most people to handle.

I think we need a little bit more protection for—I mean, if you are about to be removed. It seems like you need a little bit more in place to help you. I agree when people are bad actors and they have done something wrong, obviously they need to be able to be removed, but if you are facing reprisal, that is a very thin margin.

Mrs. RADEWAGEN. Mr. Dettbarn?

Mr. DETTBARN. This sounds very simple, but listen to the whistleblower and instead of acting—there was so much money and time wasted in the disagreement of what I was—or the rebuttal to my disclosures, the problem could have been fixed 2 years ago when it was brought up, but instead of listening and trying to fix it, all we got was excuses of why it was happening.

I believe that when the OAWP was put into process there were 1800 people terminated within the first year, only 15 were supervisors, management positions. The fact that 1700 people that were environmental services, nurse's aide, food service workers, I don't think that is who our problem is.

Ms. AGHEVLI. Can I add to that? I feel like when I read these OIG reports—I am not an expert and I don't pretend to know about other facilities, but I feel like often they will identify a major problem like, you know, there is improper management of a wait list, and what they will focus on is the front-line staff, like all of these front-line staff are scheduling improperly, but they will fail to look at whether this is being directed in some way.

And even if it isn't one person saying you do this, is there a culture at that facility that is influencing people to do these things, and I think over and over again we are not looking at that as a system. We are just picking off the people at the very bottom, like the low-hanging fruit, and so it keeps happening.

Mrs. RADEWAGEN. Thank you.

Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you very much.

I now recognize Miss Rice for 5 minutes.

Miss RICE. Thank you, Mr. Chairman. I'm sorry, I thought there was someone else before me.

First, I would like to thank all three of you for testifying here today about your experience as whistleblowers. Your dedication to serving our veterans is not only exemplified by the work that you have done, but through your decision to continue working at the VA despite the challenges and the intimidation tactics that you have faced.

I am sure I speak for everyone on this Committee when I express my deep concern about the instances of ongoing retaliation that you have shared with us today. This is completely unacceptable. We cannot allow individuals who are brave enough to come forward about threats to veterans' health and safety, and who are perfectly, more than good at their jobs, to be pushed out of their positions, while those responsible for actual wrongdoing are not held accountable. The fact that all three of you reported misconduct at the VA regarding wait times and backlogs, some of which occurred, you know, as far back as 2014, and only a couple of weeks ago as well there was another whistleblower report about the same exact issues and subsequent retaliation for reporting it, points to systemic cultural problems within the VA management that this Committee simply cannot ignore. I mean, it is not as if every whistleblower is talking about a new problem, we're talking about the same things happening; clearly, they are not being fixed.

Mr. Dettbarn, can you just talk a little bit more, because this gets to the heart of whenever we have had management before us in hearings, I have always focused on how far up the chain goes,

where is the accountability. If someone becomes a whistleblower—and this is to the point that you were making, Mr. Dettbarn—they don't—out of 1800 people who were fired, none of them were executives or very few at the top who were actually responsible for addressing the issues that all of you have exposed.

So if you can just talk a little bit more about your perception of how, you know, their willingness to hold people at lower levels accountable for problems that are far more systemic than just, you know, a one-off, so to speak.

Mr. DETTBARN. The people that are being held accountable, the lower-level echelon, if you want to call us that, we were instructed to do this by management. This came down, we were constantly told a directive, the DUSHOM directive gave us authority to cancel these orders. What DUSHOM directive? Show me that directive. If you are going to tell me to cancel a patient's order, you better have it in writing of what I am supposed to do.

The directive that gave them the authority to cancel orders with all of the stipulations wasn't signed until September of 2017. They started canceling, the first patient showed up February 22nd, 2017, months before the directive was ever even signed. And we—the lists that were given out to subordinates by management, it came from the chief of staff to my administrative officer, who then doled out the lists of orders to be canceled.

So, if your boss tells you to do something, you would hope that it wasn't illegal, and you sure don't expect to get in trouble when you question, what are we doing? You can't do this. And then you end up like the three of us.

And something that you said, Miss Rice, that I thought was very inspiring: we choose to stay at our positions, and we choose that because we care, we truly care about the veterans and our patients and their families.

Miss RICE. Well, that is very obvious, that is very obvious.

So one of the things that I like about this Committee is that we don't—it is not a political committee, all we care about is making sure that our veterans, our brave men and women, are served. And these complaints, this horrifying treatment of whistleblowers was—Obama was President when you—Dr. Mitchell, when you had your whistle—in 2014, and some has been under the Trump administration. I think this agency suffers from, especially over the past 2 and a half years, of being completely rudderless; there is no one at the top, there is no accountability.

But that is not to say that the problems with whistleblowers only have existed over the past 2 and a half years. Even when there was a dedicated, Senate-confirmed Secretary of the VA, the problems with whistleblowers existed too.

So I am just trying to figure out what is at the core of this problem. Is it because there is no leadership at the top? Is it because the culture is just so—this corrupt—because that is what it is—this corrupt culture is just so embedded in the agency?

And this is for all of you, if we could start with you, Dr. Mitchell.

Dr. MITCHELL. Yes. The agency is 89 years old; I have been working in it for 30 years either as a student or a nurse or a physician, and the culture of leadership has been malignant even back in 1989 when I started. This has nothing—

Miss RICE. But why, why? Why do you—

Dr. MITCHELL. I don't know what started it originally, but what happens is that leadership people promote people that are like them. So, bad promoted like, and that is very common. So you have a culture of people that are all like-minded.

I will tell you, I don't want to paint all leadership with a broad brush, because I have known some very ethical, very, very good people, supervisors, administrators, who are wonderful. The problem is there are only two types of administrators or leaders in the VA, those that wield power unethically and retaliate, and those that wield power ethically, but don't have the power to address and stop the retaliation.

I have had my supervisors, I had two of them who were very sympathetic that I wasn't allowed to do anything in my job description, but they said they couldn't overcome politics. I don't blame them, because they too would have been targeted and they would have been fired.

And, again, this has nothing to do with who is in office. Things got worse 2 years ago because the media's attention turned off whistleblowers and turned on to other politics and other things. It has nothing to do with who is in the President's office or who controls Congress. This is a malignant leadership culture that will outlast us all unless someone has the courage to break rank in leadership and finally change it.

Mr. PAPPAS. Unfortunately, we are out of time here.

Miss RICE. I apologize, Mr. Chairman.

Mr. PAPPAS. That is quite all right. I appreciate your response. And I want to recognize Mr. Roy for 5 minutes.

Mr. ROY. Thank you, Mr. Chairman. I couldn't agree more than my colleague Miss Rice about the extent to which this is clearly a bipartisan problem.

I just want to thank you guys for standing up, having the courage to stand up, and just know that—at least I am going to speak for myself and I think, you know, my colleagues that we have your back. This is not the way things should operate and I really want to thank you for doing what you are doing; it is important and it means a lot, it means a lot to the veterans who are not receiving the service they should and it means a lot to the country that you would have the courage to do this. So, thank you.

I have a couple quick questions. Dr. Mitchell, you describe administrative investigative boards and professional standards boards as being weaponized. What sort of oversight exists, if you could give any help on this, what sort of oversight exists for these boards?

Dr. MITCHELL. There is no oversight. Officially, human resources is supposed to be in charge of it. What happens is that the rules are complex, but there are some basic things about giving a charge letter, basically telling a person they are being investigated, rules of evidence, procedure, making sure that it is neutral people on the panel.

What they do by weaponizing, they used to just do one or two things, now they do all of them. They make sure that the people on the panel are either cronies of the person who is doing the retal-

iation or are too afraid to stand up to that person to go against what the retaliator says.

When they give a packet of evidence, it used to be a few sheets of paper and there was missing pieces. Now what they do, especially for physicians, is they will go back through every case the physician has ever done, pull up 30 or 40 cases, give pieces of information, even though the physician didn't do anything wrong, put it in a packet, jumble them up, and then give the person 7 days to respond.

Another thing is that they don't give them a list of their rights.

What they need to do is develop a standard operating procedure and a checklist, and make sure that—get your best and brightest HR people, make sure you have the rules. There is a step-by-step procedure, so it is AIBs and standard professional boards are done the same way at each facility, there is a checklist that is electronically signed off, and then if anyone deviates from that checklist, they are held immediately accountable and responsible.

I can tell you right now, that alone would stop a huge amount of these frivolous AIB boards.

The other thing is the fact-finding investigations. Fact-finding investigations are basically fishing expeditions. They are not a full AIB, but what they do is they go to your colleagues or to people in your area and say, you know, Dr. So-and-So is doing this, or Nurse So-and-So is doing this, can you tell me about that? And they kind of feel out about which employees they can get to give reports of contacts that are false.

Another thing they do is if you are—there is a chief of staff out of Dublin, the Dublin VA, Carlene Bapttiste-Downie, in her AIB none of the affidavits were signed and, more importantly, a lot of them were from employees that she had legitimately given disciplinary action because they were substandard performers. Administration went to those people and got them to say that she was creating a hostile work environment.

The credibility was questionable to begin with. The techniques of weaponizing these AIBs are very good, very effective and, once it is done, it takes the employee literally years to reverse it. And that has to stop, that tool has to be taken away.

Mr. ROY. Well, I don't even know where to begin. I mean, I would like to dive into that and, you know, sit here for—but I have got 5 minutes, but I want to know more about that.

Dr. Aghevli, thank you. I know it is a pretty tough week for you, but, again, we are here, and we are listening. Just what parts of the Whistleblower Protection law are not being followed, in your observation?

Dr. AGHEVLI. I mean, I think more than anything, like I said, I don't feel like the things that have made my life miserable in the last 5 years have been acknowledged when I went for help. I feel like the ways I have been harassed and intimidated when I went to try to get help from the OSC, I have been told over and over again that those were not things that they could intervene in.

And it has been confusing because, like we talked about a couple of minutes ago, when I take the trainings on things like No FEAR, I would understand that those are things that are prohibited. So I have ended up feeling kind of like anything could be done to me.

I mean, in a way, I am almost relieved, I was relieved to get that letter, because it felt like the other shoe dropping.

Mr. ROY. Mr. Chairman, if I might ask one more question? I know I am over my 5 minutes.

Thank you for that and, again, I would like to go and explore that further. The fact that you are describing 5 years' public service is miserable and for you personally is really troubling.

Dr. AGHEVLI. Well, I love—but I should say, I love my job.

Mr. ROY. Yep.

Dr. AGHEVLI. And, you know, it is scary to just feel like at any moment I could come into work and something else is going to happen.

Mr. ROY. Mr. Dettbarn, quickly, you said for every person who gets to this point of being a whistleblower, there are thousands that have spoken up only to be removed, that is a staggering number. Where do you get that number? Is that kind of hyperbolic or is there any kind of assessment to that number?

Mr. DETTBARN. No, there is no assessment, that is just my experience with the people that I have had to deal with. I have had many, many coworkers feeding me information since this whole cancellation of orders fiasco began. So, once somebody gets—once you get to this point, there are a lot of people that are willing to help and fight for the veterans, and that is where I get that number is the number of people that have reached out to me to try to get their voice heard.

Mr. ROY. Well, God bless you all. Thank you for what you are doing.

Mr. PAPPAS. Well, thank you. And before we close out this panel, I just wanted to recognize Ranking Member Bergman for a brief statement.

Mr. BERGMAN. Yeah, thanks, Mr. Chairman. And, truly, thank you to all of you. As I listened to all of the questions and all your responses, this is not a simple matter, it is a very complex one that has occurred and built over time and over decades. This did not just occur in the last couple of years, is what I heard you saying. This has been building for a while and through previous administrations, whatever that might mean.

So I just wanted to acknowledge your selflessness in coming here and I thank you very much.

And I yield back.

Mr. PAPPAS. Thank you. And, once again, thank you to our first panel for joining us here today. We really appreciate your time, your thoughts, and your strength, and all the work you do for our veterans. So, you are now excused.

[Pause.]

Mr. PAPPAS. And I would like to call up our second panel.

[Pause.]

Mr. PAPPAS. Welcome today. Good morning.

I would like to recognize our first witness for the second panel. First up we have Ms. Rebecca Jones, she has Policy Counsel at the Project On Government Oversight.

And, Ms. Jones, I would like to recognize you for 5 minutes.

STATEMENT OF REBECCA JONES

Ms. JONES. Chairman Pappas, Ranking Member Bergman, and Members of the Subcommittee, thank you for the opportunity to testify today on the vital role of whistleblowers at the Department of Veterans Affairs.

I am Rebecca Jones, the Policy Counsel at the Project On Government Oversight. Since 1981, POGO has worked to strengthen the effectiveness and accountability of the Federal Government through independent investigation, analysis, and policy reform.

VA whistleblowers put their careers on the line every time they speak truth to power to ensure the best possible care for those who put their lives on the line defending our country. In that way, VA whistleblowers are heroes saving heroes. Their disclosures save patients' lives by identifying barriers to timely and effective medical care due to negligence or intentional misconduct. In the process, whistleblowers expose officials who have perpetuated a culture of abuse for decades and free up misused taxpayer dollars that can instead go toward providing resources and care. And yet, even though whistleblowers are legally protected, they often face retaliation.

The Office of Special Counsel reports that 30 percent of their intake comes from VA employees alone. This is partly because the VA is a massive agency, but it is also because of the overwhelming culture of intimidation and retaliation that has persisted for decades, forcing whistleblowers to seek relief when they are retaliated against.

In 2014, alarmed by the Phoenix VA wait list scandal, POGO and the Iraq and Afghanistan Veterans of America invited VA whistleblowers to make secure disclosures to us online, so that we could better understand the prevalence of retaliation at the VA. In just a month, we received disclosures from an unprecedented 800 VA employees, contractors, and veterans who had lost faith in the agency.

The theme was clear: whistleblowers were terrified of speaking out for fear of losing their livelihood.

Shortly thereafter, POGO was wrongfully subpoenaed for those disclosures by the VA Inspector General. Although we have refused to comply and that subpoena was later dropped after Members of Congress stepped in, we nevertheless learned for ourselves that the VA's retaliatory culture permeates the very top levels of the institution.

The Office of Accountability and Whistleblower Protection was created in part to address that culture by holding senior VA officials accountable. The office is a central point of contact for all matters related to whistle blowing, including disclosures and acts of retaliation. It acts as an ombudsman and an investigator, depending on the issue at hand.

While the impetus behind the office is sensible, POGO expressed initial concerns that creating such an office within the agency itself would cause more harm than good. We worried that the internal office would become a clearinghouse used to identify and retaliate against whistleblowers, and that it wouldn't be effective at holding senior officials accountable because of its lack of independence.

Unfortunately, the problems we most feared seem to have become a reality. Last year, both the GAO and the OAWP itself released reports that demonstrate an agency unprepared and unwilling to handle whistleblower investigations in good faith.

For example, OAWP noted that the VA's Office of General Counsel is conducting legal reviews of proposed disciplinary actions against senior VA officials. This is not only a glaring conflict of interest, it is contrary to the VA Accountability and Whistleblower Protection Act, OAWP's authorizing statute.

Second, GAO found that employees accused of misconduct are participating in the investigations into their own behavior, including managers investigating themselves for misconduct.

To make matters worse, the decision of whether to implement proposed disciplinary action isn't being appropriately elevated to a more senior office. As a result, an individual can act as both the proposing and deciding official in certain cases.

And, finally, senior officials are not being held accountable for their actions, making up only 0.1 percent of disciplinary action taken in the office's first year, maintaining the level since 2014.

VA whistleblowers, many of whom are veterans themselves, blow the whistle because they are honor-bound to speak up when they witness violations of the country's trust, or individual suffering caused by negligence or corruption. Unfortunately, VA whistleblowers are ten times more likely than their peers to face retaliation, according to the GAO.

Strengthening opportunities for whistleblower disclosures benefits us all, but it is vital that we be willing to quickly change laws that carry unintended consequences for those they were meant to protect. We ask that you consider amending the structure and work of OAWP to increase its independence, so it can better serve whistleblowers and veterans.

Thank you for the opportunity to testify today and I look forward to any questions you may have.

[THE PREPARED STATEMENT OF REBECCA JONES APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you, Ms. Jones.

I will now recognize our second witness, Mr. Tom Devine, Legal Director of the Government Accountability Project.

Mr. Devine, you have 5 minutes.

STATEMENT OF TOM DEVINE

Mr. DEVINE. Thank you. This hearing is timely and necessary, because the DVA remains a free speech Death Valley for Government whistleblowers. The agency produces from 30 to 40 percent of whistleblower complaints nationally in the executive branch, the same as GAP's docket has been for the last few years. This is extraordinary for one agency in the nearly 2-million-person executive branch workforce. And if there were any hope that it has learned its lessons, the agency dashed them this month in a media policy to all employees that imposed blanket prior restraint for all communications. This not only violates the Constitution, but three provisions of Federal law, including two in the unanimously-passed Whistleblower Protection Enhancement Act.

Hopefully, this hearing will lead to the DVA respecting the rule of law, at least in terms of official policy.

Today's whistleblower testimony is not about an aberration, it is about a way of life. I will share the nightmares of others who risked their professional lives to save the lives of America's veterans.

Consider Mr. James Hundt. The secret waiting list scandal horrified the Nation and sparked a serious corrective action effort that was leading to significant progress, but over the last 2 years the agency has gutted it by replacing virtually the entire team of 175 seasoned professional career employees with a green crew of a buddy-system contractor. The civil service team initially had received agency commendations, but they were all replaced after a reorganization illegally planned and controlled by the buddy contractor. It reversed internal agency recommendations, violated basic contracting and spending laws, and since the purge on-site inspections have been replaced by an honor system in the VA's hospitals.

Mr. Hundt, the team's Associate Director, persistently blew the whistle on this sellout. The agency then opened retaliatory investigations and fired him on pretextual grounds, amazingly, for him seeking personal gain on government time, although he had checked and received prior approval for the same actions that non-whistleblowers engaged in and received promotions.

Or consider Krod Rodriguez, one of the key pioneers who broke the secret waiting list scandals. He disclosed that the agency incorrectly scheduled 400 patients in Phoenix with another 8,000 awaiting appointments; he disclosed to Congress a list of 38,000 veterans nationally waiting over 280 days; and he also disclosed the tragic medical consequences, including patient deaths.

In response, agency managers moved him to a small, windowless office without air conditioning in Arizona; placed him under surveillance, eliminated his supervisory authority; actively recruited mobbing allegations against him; lowered his performance appraisals; referred to him as a "rat" and a "media whore"; subjected him to an AIB proceeding; failed to respond to death threats against him; and placed him under criminal investigation.

Or there is Daniel Martin, the Chief of Engineering Services of Indiana VA facilities, where he also supervised over 100 employees. He disclosed contractual bribery, including for the water purification system essential for the sterilization of medical equipment and safe drinking water for patients. He later learned and disclosed evidence that the Indiana abuses reflected corruption occurring nationally.

In response, the agency stripped Mr. Martin of his duties; assigned him to an isolated office, unheated in winter and not air conditioned in summer; had him perform menial chores under the supervision of a junior staffer; exposed him to asbestos, which is already having destructive medical impact; placed him under three retaliatory investigations, primarily for an altercation that his so-called victims denied was more than a conversation. The third probe was conducted by an AIB that denied him access to or even the identities of his accusers.

The agency initially refused an OAWP-mediated solution to move him to Seattle, Washington, where management said they would welcome him. Despite canceling his duties, Indiana officials said they could not spare Mr. Martin.

It appears he will finally be allowed to work in Seattle, but over the last 3 years his life has been a professional nightmare.

Why didn't OAWP stop these abuses? Its authority to grant temporary relief initially had an outstanding impact, but despite genuine commitment from some leaders it has become a threatening force of frustration for whistleblowers as a rule and an effective remedial agency as an exception. The causes? Lack of structural independence; cultural bias from investigators whose careers have been based on retaliatory investigations; lack of enforcement teeth for permanent relief; effectively, inexplicably canceling its effective whistleblower mentoring program, which defused conflict and shrank litigation by finding whistleblowers a fresh start; and operating on an ad hoc basis without accountability to regulations. This maximizes confusion and enables arbitrary action.

To illustrate, the Senior Executive Association has detailed how OAWP conducted several lengthy, draining investigations of a manager that led to a 5-day suspension, only made possible by removing exculpatory evidence from the file. This is the same outfit that doesn't have time to return whistleblowers' calls.

Mr. Chairman, we have got 19 recommendations from the bipartisan, trans-ideological Make It Safe Coalition, whose mission is supporting whistleblowers. I hope that we can work with your Committee on these, because both this Committee and the whistleblower community are committed to making Whistleblower Protection Act rights a reality at DVA; however, our work is far from finished.

[THE PREPARED STATEMENT OF TOM DEVINE APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you, Mr. Devine.

I would now like to recognize Ms. Jacqueline Garrick, Founder of Whistleblowers of America, for 5 minutes.

STATEMENT OF JACQUELINE GARRICK

Ms. GARRICK. Thank you. I am truly grateful to be here today, because it could not have happened without the support from this Committee over my fraud, waste, and abuse disclosures with Defense suicide funds and VA contracts. Since then, I have experienced several forms of retaliation, including threats to stop speaking out.

It was a frightening and lonely time, until I compared notes with other employees. When we realized the potential conflicts and favoritism in contracts, we jointly filed with the DoD and VA OIG on Veterans Day 2016, because the lives of my fellow veterans' matter. But other than VA case numbers, nothing, until the OIG came to my home a day after this Committee got involved. I gave them documents, emails, and witnesses. I believe investigations are still ongoing.

As VA underperforms in high-risk areas, veterans are dying by suicide, denied benefits, benefits take years to adjudicate, staffing

shortages continue, while money is misspent, ill-managed, or stolen. Reporting is asking to have your career killed and your life threatened; that is unfair.

Whistleblowers of America, founded in 2017, has heard from almost 200 VA employees who suffer retaliation, harassment, or discrimination, similar to the 33 percent of the VA workload at OSC.

OAWP has not acted in the way we thought to assist, support, and guide whistleblowers through a protected process and provide a decision algorithm for reporting. Instead, VA employees are ignored, attacked, or regulated to obscurity when they try to engage in process improvements, seek ethical decisions, protect funding, and solve patient care challenges.

A closer look shows that whistleblowers experience violence, gaslighting, mobbing, shunning, marginalizing, devaluing, double-blinding, blackballing, and accusing. These toxic tactics are features of workplace traumatic stress and can lead to PTSD, depression, and suicide. Employees are going to OAWP hoping for protection; instead, it causes more harm because of deficiencies in timeliness, unfair processes, and improper staffing.

OAWP has not published a policy. It asks the same chain to investigate the wrongdoing it has been accused of. Investigations are weapons for gathering information for later legal action. AIBs are often conducted by untrained coworkers, at times the investigator and the proposing official is the same, or the deciding official was named in the complaint.

Doctors who are reported to the National Practitioner Data Bank, even when no charges have been substantiated, have no recourse. Practitioners leave the VA out of fear. Vet Centers staff were reminded that President Trump curtailed their due process rights and can be fired at any time.

Instead, OAWP should be focused on advocacy and a duty to assist by protecting veteran employees over denials, privacy invasions, restrictions from treatment, and disability compensation targeting. No settlement should contain a non-disclosure agreement; transactions involving taxpayer money, Government resources, and the welfare of veterans should remain in the public domain. It should require union reps be consulted, since not every employee even knows they are covered by a bargaining agreement.

It should clarify its website data. How are whistleblowers being assisted? How many adverse actions involve veterans?

The Kirkpatrick Act mandated agencies report employee suicides; however—Mr. Bergman, you asked about this—OSC says none were made. If suicide prevention is the number one VA priority, then shouldn't it care about its own workforce?

There are three main options for OAWP improvement: publish a policy and transparent data; utilize independent, unbiased staff, and sanction retaliators; or abolish it and transfer the resources to OSC, or allow VA employees to take their cases to civilian courts.

OIG. There are no mandates for OIG findings. Guilty managers are not held accountable. Examples, OIG found that $11.7 million of VBA money inappropriately went to Calibre, but no action was taken to reclaim any of those funds or hold managers accountable for wasteful spending. Or what happened to the $6 million that went unspent for suicide prevention?

Senior executives with pecuniary responsibility must pass background checks and hold security clearances. OIG should oversee spending accountability, as with the $25 billion VECTOR IDIQ with 68 companies performing management initiatives. How is that going to be monitored?

Congress should expand penalty payments to the judgment fund. Whistleblowers are out of pocket while wrongdoers are defended by the Government at taxpayer expense. This is not common sense. Legal aid authority could be expanded to support VA employees. There has been a history of animosity between the OIG and its leadership through criticism, intimidation, and outside influence. We are concerned that emails outside of official VA sources would not be accessible during discovery.

Whistleblower feedback is informative, but fear of reprisal causes many to remain bystanders and not veteran advocates. They suffer workplace traumatic stress, while senior officials travel to Europe, attend NASCAR, and curry favor with contractors. That is unfair.

To reduce stigma, Congress should authorize VA to host an annual whistleblower award and highlight right-doing, and should consider a national whistleblower memorial on the grounds of the Capitol that demonstrates the lamplit pathway many have taken in exercising their First Amendment rights.

That concludes my statement. I welcome your questions.

And I also just want to say hello to my USC social work students who have been assigned to watch this testimony today. So, thank you.

[THE PREPARED STATEMENT OF JACQUELINE GARRICK APPEARS IN THE APPENDIX]

Mr. PAPPAS. And I am sure they are still tuning in. I appreciate your testimony, Ms. Garrick, and thank you to our panel.

And I would like to now transition to the questioning period of this and I will start by recognizing myself for 5 minutes.

You all referenced that complicated landscape that exists for individuals who are whistleblowers, because there are a variety of agencies across our government that are involved in receiving information and investigating Federal employee whistleblower disclosures. I am wondering, given that current landscape, what can be done to more clearly and effectively communicate to VA employees the best ways for them to disclose instances of mismanagement, and to protect themselves from retaliation and be able to identify retaliation in the first place.

And that is for the entire panel.

Ms. GARRICK. So I think that the idea that OAWP was supposed to be set up for that, or that is how many of us perceived it, they were going to be the source that helped somebody walk through this process. As you have heard, you can go to OAWP, I think Ms. Cloud in her testimony, her written statement, describes 11 different opportunities to engage internally before even going to OSC, MSPB, EEOC. There is no decision tree algorithm that helps you walk through that. So even though there is No FEAR Act training, it is—by no means explains any of those processes to you.

So, again, I think we need a better understanding of what OAWP is supposed to be doing—they need a policy—or we just need to bol-

ster up OSC and let them do their jobs by helping whistleblowers from outside the agency.

Mr. DEVINE. Mr. Chairman, I think to kind of summarize the themes and 19 of our coalition recommendations, one would be to close the loopholes in reprisal protection, such as AIB proceedings or referrals to licensing boards that can cause blacklisting.

A second is to restore due process in internal proceedings. The idea was to eliminate roadblocks to accountability, but actually it has backfired, and the lack of due process is being used to railroad whistleblowers out of the agency.

The third is to provide enforcement teeth and abolish the conflicts of interest for the agency's checks-and-balances institutions. That is kind of the core causes behind our frustration.

Ms. JONES. And I would just add, I think, to your note of ensuring that employees know about the different channels and how they interact, I think there is massive confusion and I think that is evident from the first panel, that employees simply don't understand the different lines between the IG, the OSC, and the Office of Whistleblower Protection.

And I would also just add that ensuring that the VA and its IG are both certified under the Office of Special Counsel's certification program, that is a separate program at the OSC that allows—or that trains and ensures that training within each agency is up to par, and my understanding is that they are not currently certified.

Mr. PAPPAS. Okay. And I was going to follow up about training by OAWP and how important of a tool that can be once that matures, and I'm wondering if you can comment on the need to ensure that is fully implemented.

Ms. JONES. Sure, absolutely. I believe when the Full Committee heard from OAWP or the VA last year on the 1-year anniversary of when the office was created, my understanding from that was that they hadn't yet implemented all the training requirements in the authorizing statute; that they had trained certain HR professionals, but that the broad training had yet to be implemented. And I would just again point out that they are not—the VA, nor the IG, are not certified under the OSC's program.

Mr. DEVINE. Mr. Chairman, there very much needs to be training of OAWP in the Whistleblower Protection Act. There doesn't seem to be a practice consistently familiar with its provision. So many of the staff have come from institutions where they spent their entire lives on assignment to conduct what turned out to be retaliatory investigations against whistleblowers. This accumulated a real bias. That doesn't change with a new location and a new job description. They need to get it.

Mr. PAPPAS. Thank you. Ms. Garrick, I don't know if you want to respond to that; if not, I have another one.

Ms. GARRICK. No, I think they covered it.

Mr. PAPPAS. Okay, thanks.

Just real quickly, we have been hearing a lot in other areas of the VA about the need to have a steady hand at the ship, ensure that we have permanent officials in place at senior leadership positions. Right now, 48 percent of the senior leadership positions within the VA are held by individuals serving in interim or acting roles.

In your experience, does this have an impact on the picture around whistleblowers and a culture of retaliation?

Ms. JONES. I mean, I would just say, you know, a high turnover rate can be troubling for many reasons and one of them is sort of a lack of institutional buy-in at the top about changing the culture of retaliation, ensuring that the people who are leading agency are determined to make the change. Where there is a high turnover, I mean, that becomes less clear if who they are placed with will really understand the underlying culture of retaliation and whether they would be, you know, as determined as others to ensure that there is reform.

Mr. DEVINE. Mr. Chairman, the lack of permanent appointments certainly has had a destructive impact, but the problems go long before that current phenomenon.

I would say there are three basic causes that we have identified. The first is that this agency has an almost uniquely feudal structure, kind of bureaucratic barons have far too much authority, and the national office has been frustrated when it tried to do the right thing.

Second, there is a culture that allows those barons to put their own personal self-interest above the agency's mission of patient medical care or the rule of law.

And, finally, there has been a conflict of interest in almost all of the agency's institutional mechanisms to hold itself accountable. And those are three strikes against an effective mission.

Mr. PAPPAS. Thank you.

Ms. GARRICK. So, if I may? I have listened to this Committee and I have attended a couple of hearings over the last few months, and it just strikes me that when you don't have the right leadership or you have inexperienced leadership, or you have a revolving door of leadership, what you are losing is expertise and a commitment to the right-doing part of all of this.

And I wish Miss Rice was here, because she asked a really good question about the why. The why comes down to the money and, if you can't follow the money and you don't know how to manage the money, I mean, that is the trickle down. That is where these contracts, this IDIQ, this enormous amount of money, where is it all going to go? How do you follow it? How do you put something on contract?

I mean, I have heard this talk about when you obligate money, execute money, budget money, those are all different things and they mean different things in the world of government contracting. And, I mean, I have spent 16 years, a lot of that in a management position at VA, at DoD, up here with the congressional staff, I understand how the money flows. And if you don't understand the difference between an award, a deliverable, a sole source, a sub and a prime, a purchase order, all of those things are how the money gets manipulated and, trust me when I tell you, there is your reason for whistleblower retaliation.

The panel that was up here, they are at the bottom receiving end of when this money trickles down and when it doesn't trickle down, and that is the incentive to cover all this up, that is the incentive to retaliate, follow that money.

Mr. PAPPAS. Thank you very much.

I would now like to recognize General Bergman, the Ranking Member, for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman, and thanks to the panel for being here. You bring very broad and unique and necessary insights to the process.

The first couple questions are going to be simple yes or no. So we are going to start with Ms. Jones, walk across, you know, yes or no.

Whistleblowers can file separately with the Office of Special Counsel, OAWP, and the IG, so three different ways. This has the potential to cause duplicative work and delays work on other disclosures. For each of these organizations, do you agree or not that with multiple offices potentially investigating the same event this may not be very efficient or effective?

Ms. JONES. Yes.

Mr. DEVINE. Yes, I do, sir.

Ms. GARRICK. I agree.

Mr. BERGMAN. Okay, the second question. Again, just simple yes or no. Have you met with the Assistant Secretary Bonzanto in OAWP to share your ideas for improving the whistleblower process?

Ms. JONES. No.

Mr. DEVINE. Yes, before she received that current job officially.

Ms. GARRICK. I did in February.

Mr. BERGMAN. Okay, very good.

Ms. Jones—the yes-or-nos are over, okay? We don't have to go down the line. Ms. Jones, in your written testimony you reference OAWP statistics concerning the disciplinary rates of senior executives and senior leaders compared to the GS–1 through GS–6 category to suggest that the distribution is inequitable against the lower grades. What specific distribution of discipline does POGO believe would demonstrate equity and how did you arrive at that number?

Ms. JONES. Well, I mean, I can't state a number specifically, but that is—I would love to work with the VA in terms of figuring out best practices and how we can get there, and with this Committee as well, but my priority would have been any change between 2014 and now.

So my understanding and part of the reason of standing up this office within the VA was to change those numbers, to ensure that senior leaders were held accountable, but unfortunately, based on the numbers that you quoted, there hasn't been that change. And I believe that 0.1 percent represents only seven individual cases of discipline against senior officials.

Mr. BERGMAN. Well, you know, as we struggle with numbers, because sometimes you can look at total numbers or percentage of the population, and it's kind of like in some cases, you know, apples and oranges. So, you know, you have got—I think at the SES level, you have got like 630 SES positions, so that is about two tenths of a percent of the workforce, whereas the G–1s through 6s I think are roughly 54 percent of the workforce.

So we want to make sure that, if we look just at a raw number as opposed to a percentage, try to get, you know, a relative perspective on that, is there an inequity or is there not.

And also, again, Ms. Jones, you described what you referred to as a toxic culture in your dealings with former Acting Inspector General Richard Griffin in 2014. The current Inspector General, Michael Missal, who has appeared before this Committee several times, assumed the office in May of '16. What are your observations about the IG's conduct in the handling of Whistleblower Protection under Inspector General Missal, and do you believe that the IG has improved under his leadership? And feel free to expand on that.

Ms. JONES. Sure, absolutely. I was heartened to see the Inspector General willing to push back in access to documents from OAWP. You may recall there was a bit of a public spat that went on between the IG and the Secretary that I believe has since resolved. That is the kind of push-back that POGO likes to see from IGs, those who are independent and willing to investigate properly to make sure that things are operating as they should be.

I understand that there is—there has been recent complaints from whistleblowers about—I am not sure if those are from the IG specifically or whether it is more broadly at the VA, but the IG may well be involved—that those whistleblowers have had their identities revealed to the agency. Now, I am not sure of the IG's involvement in those cases. I think it would be—

Mr. BERGMAN. Well, your articulation of that, you know, again, when you have multiple agencies to report to, to interact with, it can be confusing at times. And, anyway, thank you for your answers.

And, Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you.

I now yield 5 minutes to Mr. Cisneros.

Mr. CISNEROS. Thank you, Mr. Chairman. And then you all for being here today.

Ms. Jones, I want to kind of follow up on something you said regarding senior leadership and their disciplinary actions. I believe you said that senior leaders are permitted to investigate themselves and make their own determinations on those investigations whether they are guilty or not. Is that true at all facilities, you know, whether it be a hospital, any VA facility, or is it—I mean, does it differ anywhere?

Ms. JONES. Well, that information comes from the GAO's report that came out I believe last year that looked at all VA whistleblower conduct, and it looked specifically at what has happened since OAWP has been stood up, the Office of OAWP. I can't speak to whether it is happening everywhere, but, I mean, the line managers investigating themselves to misconduct, I mean, obviously that should be of a huge concern to veterans, to this Committee, and to the taxpayers, to be perfectly frank, in how rigorous those investigations are.

Mr. CISNEROS. Ms. Garrick, you were kind of shaking your head as a yes there. I mean, can you add to that answer?

Ms. GARRICK. So, as she is talking, just example after example is sort of popping into my head about people who have told me just that same thing, where they have gotten either the proposing official is the same person and the deciding official has been labeled in the corruption charges in the first place. So we don't see a lot of unbiased, independent investigations; these things all happen

within the same chain of command. OAWP sends the letter to do the investigation right back to the facility.

And this is—we have been talking a lot about the medical centers, this happens at the regional offices and at VBA as well. I mean, I see the same thing that from the top down it ends up going right back into the lap of the supervisor who has been the—more likely than not the perpetrator of the wrongdoing. So that is not fair and unbiased.

Mr. CISNEROS. All right. Ms. Garrick, I have a question for you, something that you said in your testimony. You said the OAWP has no whistleblower policy; can you expand on that?

Ms. GARRICK. Correct. So near as we have seen, and we have asked a few times now, to see a published policy, a policy statement, an employee handbook, something that delegates the roles and responsibilities, and we have not been—nobody has shared that with us anyway. So, if there is one, I am unaware of it. But really something like a standard operating procedure, an SOP, that outlines roles, responsibilities, and helps to even manage some of these expectations.

My understanding in like some of the data they reported that I have questioned is they say about 50 percent of the people that come to this office aren't whistleblowers. Well, who are they? Are they veterans? Are they, you know, vet patients, are they family members? Are they volunteers? Who is that 50 percent? We have no key for that data to know even what they are reporting on. It just makes no sense. And they are not reporting on how they assist or what kind of retaliation they are documenting. I mean, there is a laundry list of things I would love to see in a policy.

Mr. CISNEROS. Okay. And my last question is, what agency or government department out there would you say has a good, strong whistleblower program that the VA could probably emulate out there? Is there one?

Mr. DEVINE. Sir, we represent whistleblowers throughout the executive branch, and I am not aware of such an animal. I believe the Office of Special Counsel has been making a good faith effort, but it is a relatively small office, just over a hundred employees to guide the system for the whole executive branch, and all they can do at most is kind of make a point in cases that are cut-and-dried, kind of low-hanging fruit, to send a message to the rest of the labor force. They don't have the resources to be a reliable source of protection. They are independent and we haven't seen a conflict of interest there like all the internal VA structures.

But we need a safety valve where whistleblowers at the VA and throughout the executive branch can have the same rights as corporate employees who blow the whistle on abuses of the public trust, to go to court and defend themselves in a jury trial against retaliation.

Mr. CISNEROS. All right. With that, I yield back my time. Thank you for your testimony.

Mr. PAPPAS. Thank you.

I now recognize Mrs. Radewagen for 5 minutes.

Mrs. RADEWAGEN. Thank you, Mr. Chairman.

Mr. Devine, in your testimony you refer to OAWP's mentoring program. How can this program help whistleblowers if it is rein-

stated? And, conversely, how can this type of mediation potentially fall short? I believe you referenced the cases of Mr. Rodriguez and Mr. Wilkes as examples in your testimony.

Mr. DEVINE. The mentoring program either delivered some partial results or made a best effort to in a number of the cases that I discussed. The idea behind it is that, as an alternative to litigation, OAWP would search out fresh starts for whistleblowers with managers who would welcome their perspective instead of being threatened by it. And it really has some very effective initial results and we don't know why OAWP canceled it, but I think it is very unfortunate.

Our frustration with the mediation process has been at the Office of Special Counsel, which has tried to resolve disputes through negotiation, and I think the reason that it hasn't worked is that the Office of Special Counsel doesn't have the resources to hold those agencies accountable when they play games rather than in good faith trying to discuss a resolution. And so we have had too many experiences where they just kind of string out the process for 6 months to years in bad-faith negotiations that prevent the whistleblowers from actually—the OSC from investigating the wrongdoing or the whistleblowers from having a day in court.

So instead of being a constructive alternative to conflict, it has ended up just sustaining it and spreading it out. There really needs to be accountability for this agency.

Ms. GARRICK. So, ma'am, if I can add to that. Whistleblowers of America is a peer-support program that I started because I was an Army social work officer, we have used peer support very successfully with dealing with combat vets, PTSD, suicidality. And so when I started Whistleblowers of America it is using some of those evidence-based strategies to deal with these kinds of issues, building resilience, problem solving, that I think a mentorship program could really, really help VA employees work their way through this process. And maybe eliminate some of the stress, what I call workplace traumatic stress, it could be really eliminated, and some of the damages that you are hearing people talk about that have happened to their psycho-social life I think are the things we can maybe do a better job of as well and mitigate through a more organized, structured program.

Mrs. RADEWAGEN. Thank you, Mr. Chairman. I yield back.

Mr. PAPPAS. Thank you.

I now recognize Miss Rice for 5 minutes.

Miss RICE. Thank you, Mr. Chairman.

So I believe the statistic that, Mr. Devine, you might have said, that 30 to 40 percent of all whistleblower claims come from the VA.

Mr. DEVINE. Yes, ma'am.

Miss RICE. So I think this kind of takes off on what my colleague Mr. Cisneros was asking, who does it right? Who handles whistleblowers in the right way? Is there any Federal agency that does? Or are they all handled the same way, through the same pipeline?

Mr. DEVINE. The structural problem is that whistleblowers in the civil service are primarily dependent upon remedial investigative agencies that don't have the resources to provide consistent relief. They can have—maybe do an in-depth investigation over a period of 1 to 2 years for 10 percent or less of the complaints that come

in and that is just a token compared to the extent of retaliation. We need to restore credible due process rights.

And the Merit Systems Protection Board, the administrative body that defends the merit system, currently is not functional and it is many, many years from getting—from healing. They haven't had a board that could issue final decisions in 3 years—

Miss RICE. Why is that?

Mr. DEVINE [continued]. —in over 2 years—

Miss RICE. Why?

Mr. DEVINE. That is because the Senate blocked confirmation of appointments during the end of the Obama administration and the Trump administration didn't make them. We finally—

Miss RICE. But that is a fix, that is a potential fix that could be made.

Mr. DEVINE. Oh, it has just paralyzed enforcement of the merit system. We are on the verge of getting a board again, but they have a 2,000-case backlog in the interim over that 2 and a half years, and even that board is just—it is really kind of minor league due process compared to the access to court in jury trials that corporate whistleblowers have in every corporate whistleblower statute that has been passed in America since 2002.

So we really have second-class enforcement. And even agencies like the Office of Special Counsel that I believe are making best efforts can only have token impact.

Miss RICE. So would it be appropriate to put a time frame on how long a whistleblower investigation should take?

Mr. DEVINE. I'm sorry?

Miss RICE. How long—you are saying these drag on and on, these investigations, when a whistleblower makes a claim. I mean, what is the optimum period of time that an investigation like this would take?

Mr. DEVINE. Well—

Miss RICE. Because it seems like the insinuation is that they drag it out and they drag it out for their own purposes and keep all of the whistleblowers in a state of perpetual limbo.

Ms. GARRICK. But I think they do that on purpose.

Miss RICE. Well, that is what I am asking.

Ms. GARRICK. I mean, it is intentional to drag it out, even though there are—you know, there are things that say there are 180 days or 240 days. They will go beyond that—

Miss RICE. So those are routinely being violated? There is no time frame—

Ms. GARRICK. Oh, absolutely.

Miss RICE. Yeah.

Ms. GARRICK. Because here is the rub: The Government has all the time in the world, their attorneys are on—

Miss RICE. Yeah, yeah, yeah—

Ms. GARRICK [continued]. —you know, they hire their own attorneys—

Miss RICE. —they are on staff; they are on staff.

Ms. GARRICK [continued]. —they are on staff.

Miss RICE. Right.

Ms. GARRICK. I mean, I went to an MSPB hearing, five Government people showed up and one guy pro se. Most of the people I

deal with end up pro se, because it costs hundreds of thousands of dollars to go out and hire a really good attorney.

Miss RICE. Yeah, yeah. No, it is totally skewered. There is no—can I just ask you another question, Ms. Garrick? It seems to me crazy that—

Ms. GARRICK. Yes.

Miss RICE [continued]. —these—that the potential wrongdoers are the ones that ultimately are making the decision as to what happens with the whistleblowers?

Ms. GARRICK. Correct, and they are—

Miss RICE. How can that be?

Ms. GARRICK [continued]. —by the Government—

Miss RICE. How can that—I mean, it seems to me like there should be a separate track of supervisors that assess a situation we are not intimately involved in and don't have a, quote-unquote, "dog in the fight." Although you could argue that anyone at VA has a dog in the fight of keeping this information from whistleblowers hidden.

But how can we make that better? Because that is just a perversion of the whole system, it seems to me.

Ms. GARRICK. Well, and that is where I do believe there needs to be a lot more independence. And, I mean, if you look at the budget for OSC versus OAWP, just OAWP's budget and you compare it to the OSC budget, you will see they are about the same when OSC has the workload for the entire Federal Government. So there is this disparity in how things get funded across the Government, whether it is at the OSHA budget, the EEOC budget.

So there is a lot of disparities in how the Federal Government funds these programs that are supposed to help all these whistleblowers. And there is no algorithm that says go here or go here, as opposed to sending you to three and four different places while you are out-of-pocket—

Miss RICE. Yeah.

Ms. GARRICK [continued]. —and you are on your own time, because you can't whistle blow on the Government's dime, so—and there is very little help and support for that.

Mr. DEVINE. Congresswoman, the conflict of interest is perhaps most fundamental with OAWP. They should be an independent watchdog within the agency, but in practice their decisions are controlled by the Office of General Counsel; its mission is to defeat whistleblower claims. The conflict of interest could not be more hopeless and OAWP needs to be freed.

Miss RICE. These are all really great suggestions. I want to thank Mr. Chairman for holding this hearing and I want to thank all of you. We need to get this right, because this is just—there are so many wrongs that are glaring and there is no reason why we can't fix them.

So, I just want to thank you all, and I yield back.

Mr. PAPPAS. Thank you.

Well, I do want to thank each Member of our panel for sharing their perspective with us today. It was really illuminating testimony that I know we have to continue to contend with as we move forward as a Subcommittee, so I really appreciate your time.

I do want to recognize General Bergman for a closing statement.

Mr. BERGMAN. Well, I want to thank everybody for coming and the testimony, the questions and the answers. This is an extremely important issue that we are dealing with here to keep the environment open to make sure that good people can get their voices heard and not be limited or inhibited.

And I just wanted to, you know, thank the Chairman for keeping the hearing open and in recess at our request, the minority's request. And there is just the letter—you know, the no job is complete until the paperwork is filed, but I just wanted to thank you in advance, and we have procedurally here to make sure that we get the second panel in here as soon as possible. And, again, I thank the Chairman for his agreeing to do that.

And I yield back.

Mr. PAPPAS. Well, thank you, General Bergman. And I absolutely agree, it is clear that this can't be the end of the conversation and we need to move forward expeditiously to continue it, and I am committed to doing that.

I would like to underscore the bipartisan nature of the work of this Committee and the issues regarding whistleblowers. The Subcommittee will hold additional hearings on the need for VA to listen from whistleblowers and protect their rights and, as I alluded to earlier, we will hold this hearing open. I think it is clear today that all the whistleblowers who have stepped forward are doing an incredible service to our veterans. So, on behalf of the Subcommittee, I want to thank the three individuals who appeared on the first panel for all of their work and for being with us here today.

Under the Committee Rule 3(c)(F)(5), the minority witness panel will appear subject to the call of the chair. The Committee will remain in recess until such time.

[Whereupon, at 11:56 a.m., the Subcommittee adjourned subject to the call of the chair.]

APPENDIX

Prepared Statement of Dr. Katherine L. Mitchell

Section I: Introduction

My name is Dr. Katherine L. Mitchell. I am a board-certified internist who is currently employed at the Veterans Integrated Service Network (VISN) 22 office in Arizona as a Specialty Care Medicine consultant. My VA professional career has spanned 21 years in various roles including staff nurse, emergency department staff physician, emergency department director, and post-deployment clinic medical director. In 2017 I also completed the 2 year VA Quality Scholars program wherein I learned the fundamental basics of quality management, research design, project implementation, and change theory.

I became a nationally known VA whistleblower in May 2014 because I was the first, actively-employed VA front-line staff member to speak publicly regarding the Phoenix VA waiting list manipulation, lack of timely Phoenix VA primary care appointments, substandard Phoenix VA triage nursing care, and other health and safety issues which were potentially applicable to the entire VA system.

I initially testified in front of the House Committee on Veterans' Affairs (HVAC) in a ground-breaking July 2014 hearing regarding VA whistleblower retaliation. I subsequently testified three additional times in front of congressional committees regarding various topics including my analysis of Phoenix VA patient care deaths on the waiting list, national VA health care and oversight issues, and subsequent improvements at the Phoenix VA Medical Center.

Since the VA access crisis was identified, I have seen great strides made in VA access and patient care. Although remaining cracks in the VA system must be addressed, I strongly believe the VA currently provides millions of high quality patient care episodes every year in a manner that in many ways is superior to private care.

I had hoped my July 2014 HVAC testimony would help jumpstart a fundamental shift in VA culture wherein all employees would be encouraged by VA leadership to identify problems without fear of retaliation. Unfortunately, I believe VA leadership at all levels still continue to perpetuate a culture of whistleblower retaliation even as the VA publicly decries such tactics and rolls out new initiatives to encourage more employees to speak up about VA problems.

Specifically, in my case the VA whistleblower retaliation against me has continued for most of the last 5 years despite signing a September 2014 settlement agreement intended to resolve such unjust treatment. Although I have made multiple direct and indirect attempts to fight the retaliation, I have not yet found any successful method to stop it.

Available avenues to formally address VA whistleblower retaliation have been exceptionally slow and thus not able to provide any prompt relief.

In October 2018, after the Office of Special Counsel's preliminary investigation found credible evidence of the ongoing whistleblower retaliation against me, I entered into mediation with the VA via the OSC alternative dispute resolution process (ADR). That mediation is still ongoing because the VA no longer has an expedited mediation process in place.

In the remainder of this written testimony I will outline examples of ongoing VA whistleblower retaliation against me since signing a September 2014 settlement agreement, briefly describe my attempts to stop such retaliation, and discuss my concerns regarding the VA Office of Accountability and Whistleblower Protection (OAWP). I will also propose potential remedies for assisting VA whistleblowers, positively influencing VA culture, and strengthening federal whistleblower safety-nets.

Please note that I am not the only nationally prominent whistleblower experiencing persistent retaliation after congressional testimony. Dr. Christian Head who testified with me in the July 2014 whistleblower hearing has had ongoing, severe

VA retaliation against him since appearing in front of the HVAC and other congressional committees.

If the VA has no qualms about subjecting prominent national whistleblowers to further retaliation, it stands to reason that the VA could target lesser known local whistleblowers with even more enthusiasm. Since Dr. Head and I have been unable to get relief from retaliation in the last 5 years, I believe most other whistleblowers will not fare any better.

Section II: Whistleblower Retaliation against Dr. Mitchell - Examples from 9/2014 to present

Pertinent Background:

- In September 2014 I signed a settlement agreement with the VA in order to resolve the whistleblower retaliation against me. As part of the settlement agreement process, I was offered a new position/training as Specialty Care Medicine consultant at a VA Veterans Integrated Service Network (VISN) office in Arizona and allowed to enter the 2-year VA Quality Scholars program.
- As per the job description given to me as part of the settlement, the Specialty Care Medicine consultant position/associated on-the-job training would allow me to directly influence the quality of patient care by participating in the oversight of quality assurance, risk management issues related to poor quality care, and utilization review at multiple facilities within a 3 state region. The VA Quality Scholars program would enable me to learn the basics of quality management, research design, quality project implementation, and change theory.
- The VISN office has 3 main divisions: medicine/CMO (Chief Medical Officer), quality/QMO (Quality Management Officer), and business/DND (Deputy Network Director). My Specialty Care Medicine position fell under the VISN medical/CMO division. Although the VA Quality Scholar position was unique in that it was not assigned a division, it clearly aligned with VISN quality/QMO division activities.
- When I started working at the VISN office, I hoped I could resume my VA professional career trajectory without the institutional stigma of being a whistleblower. I immediately observed that staff were very distant and rarely spoke to me. Although several communicated privately to tell me they were glad I brought attention to VA issues, I believed my whistleblower status was causing most staff to be inappropriately apprehensive. I decided the best course of action was to consistently demonstrate my professional expertise, work ethic, and interpersonal skills. By doing so, I hoped I could develop effective collegial relationships and reassure staff that I was a trustworthy, reliable individual who would be a valuable asset to the VISN office.
- By early 2015, after realizing VISN leadership was not enthusiastic about my presence in the VISN office, I was not surprised by their subsequent retaliatory behaviors towards me. In 2016, when VISN-level retaliation against me never abated, I tried to obtain an alternative VA position outside the VISN office. In the process of searching for a new position in 2017, it became evident that the retaliatory actions against me were also occurring at the level of VA Central Office (VACO).

Examples of Ongoing VA Retaliation against Me:

For purposes of brevity, I have summarized only a few episodes of the countless episodes of whistleblower retaliation I experienced from late 2014 through March 2019. These examples are provided in rough chronological order, not in order of severity.

1. From 2015 through the date of this testimony VISN leadership has prohibited me from performing the primary duties of my Specialty Care Medicine job description which was provided to me as part of the September 2014 settlement agreement with the VA.

I signed the settlement agreement and specifically accepted the position based on the official duties contained in formal "position description". However, VISN leadership has never allowed me to officially perform any of primary duties listed on the job description that was provided as part of the legally-binding 2014 settlement agreement.* Those primary duties included coordination of and involvement in quality assurance, risk management, utilization review, and clinical cost analysis.

*Note: Since 2014, even though I have been prohibited from officially performing risk management activities, I have nonetheless addressed reports of patient care problems that have been brought to my attention privately by hospital employees who felt confident I would not disclose their names. Those employees contacted me

because they did not feel comfortable reporting their concerns using facility chains-of-command or the OIG because the employees feared whistleblower retaliation.

Responding to such informal reports clearly fell within my Specialty Care Medicine duties even though leadership would not officially allow me to officially perform those duties. Each time I received an employee's report, I maintained employee confidentiality, remotely researched the patient care chart to gather data, analyzed the data to determine if the employee's concerns were valid, and wrote a formal summary listing concerns/conclusions about patient quality. I electronically provided each summary to the VISN leadership for further follow-up. Though leadership almost never provided me any updates and were not always pleased with my activities, I believe my findings did receive VISN attention. I am aware from subsequent conversations with involved hospital employees that my efforts have resulted in significant changes in policy, consult processes, and even the removal of a grossly substandard physician.

2.In December 2014 after I found gross factual errors in a facility's response to an Office of Inspector General (OIG) inquiry, VISN leadership never allowed staff to share OIG inquiries/facility responses with me again.

In December 2014 a VISN QMO staff member need the assistance of a physician to review the accuracy of a small batch of facilities' responses that appeared to be problematic. Because I was the only physician on-duty that day, the VISN staff member asked for and subsequently received my assistance. Although the majority of responses to each OIG inquiry were accurate, I found one facility response which was clearly contrary to facts documented in the patient's chart. I summarized my findings in writing and forwarded them to the QMO division and QMO staff member.

Since that time I have never been allowed to review any facility OIG responses even though review of such responses falls within the Specialty Care Medicine consultant position description I received when I signed the settlement agreement. The QMO employee was told not to share OIG hotline responses with me again.

3.From 9/2014 through 2018, various VISN leadership actively discouraged staff from associating with me.

From conversations with VISN co-workers I learned VISN division supervisors would tell each other which VISN staff were seen speaking with me. Two division supervisors openly instructed staff not to provide any information of any type to me, even if that information was just routine, common knowledge. One staff member who persisted in speaking with me was moved to an office far away from my cubicle.

4.In FY17 now-former VISN 22 leadership significantly prevented me from obtaining the full benefit of my VA Quality Scholar (VAQS) training program for 17+ consecutive weeks.

Although other VISN staff did not have to have prior approval for projects, I was not allowed to start VAQS projects examining the quality of patient care without submitting a project proposal and obtaining approval from senior VISN leadership. In a VISN office where leadership routinely made decisions within a matter of days on any subject, 2 senior leaders deliberately impeded my progress in the VAQS program by taking an extraordinarily long time (11+ weeks) to consider one of my VAQS project proposals before rejecting it. It was not until 1/25/17, 11+ weeks after my proposal submission, I was told my project proposal was rejected because "it was not a VISN priority" even though the project was based on a high priority VA directives to address women's health care in VA emergency departments.

At any time during that 11+ weeks those senior leaders easily could have informed me that my VAQS project was denied and allowed me the opportunity to present another project. However, they inexplicably chose to ignore my email requests for follow-up on my project proposal. Because I could not get approval for my VAQS project from VISN leadership, I missed 11+ consecutive weeks of opportunity to be working on a patient care project or projects that would have allowed me to work at my full potential as a VAQS and Specialty Care Medicine consultant.

On the date I was told my project was rejected, I was also told I was being removed from the VAQS program because I had not provided my confidential settlement agreement to VISN senior leaders. It would take another 6 weeks to be reinstated to the VAQS program through the intervention of the Office of Special Counsel.

5.In violation of the 2014 settlement agreement, in January 2017 now-former VISN leadership suddenly removed me from the VAQS program be-

cause I declined to provide a confidential copy of my 2014 VA settlement agreement which the VISN Director had inappropriately requested.

On 1/25/17 now-former VISN leadership informed me that I was being removed from the VAQS program by VISN leadership because I refused to provide a copy of my confidential 2014 settlement agreement wherein the VAQS program eligibility was discussed. I was told by the VISN director that since I had refused to provide the settlement agreement, she had no "proof" that I was still eligible to be in the VAQS program.

I immediately stated I could ask the Office of Special Counsel (OSC) to contact her immediately to verify my eligibility, but she declined and stated again that I was prohibited from further participation in the VAQS program. As a VISN director, she should have known the process to get verification of my VAQS status from VA Central Office/VA legal counsel and the restrictions on demanding a copy of a confidential OSC settlement agreement.

The VISN director never told me prior to 1/25/17 that she required me to establish my eligibility. If she had communicated that to me prior to 1/25/17 I would have contacted the OSC to intervene to provide the appropriate verification of my VAQS eligibility.

6.A now-former direct supervisor gave me impossible performance goals in January 2017. Although I formally voiced objections, he still did not provide timely revisions to those impossible goals for 2 months. Unfortunately, many of the revisions were inadequate and rendered most goals essentially impossible for me to achieve within the remaining FY17.

I was first notified of the FY17 performance goal criteria by my supervisor on 1/20/17. The deadline for completing all criteria was 9/30/17. The fiscal year 2017 (FY17) performance goals I was initially given were completely unrealistic/unachievable. (Note: Performance goals are different than the annual proficiency criteria on which I am rated.)

Among the mandatory requirements to which I would be held in order to be viewed as fully meeting performance goals included publishing a minimum of 5 peer reviewed journal articles in the timespan between 1/20/16–9/30/17 (a standard to which no other VISN staff in the nation is held to and which would not be possible even for a full time academic researcher working alone), improving the access SAIL scores by a full quintile in 5 VISN facilities (an achievement that the entire VA using all available resources for the past 2 years had not been able to do in any VISN in the entire country), and improving the health care associated infection SAIL metrics a full quintile simultaneously in all 8 VISN facilities (an equivalent achievement never done in any VISN in the whole country since SAIL began).

The VISN management repeatedly insisted in the 1/25/17 meeting that the performance goals were reasonable even though anyone with basic knowledge of SAIL data/publications would know that the performance goals grossly violated VA Handbook 5013, Performance Management Systems. Although VISN management eventually stated I could submit suggestions for alternative performance goals, the CMO quickly sent me new performance goals which were only minimally changed. I sent an informal grievance on 1/31/17 to VISN leadership. Subsequent performance goals were eventually modified in approximately March 2017 but still were not achievable before the deadline of 9/30/17.

7.During FY17, VISN 22 administration refused to assign me to relevant committees/workgroups pertinent to my quality activities or my role as VISN 22 Specialty Care Medicine consultant.

My job title is VISN 22 Specialty Care Medicine consultant. However, when VISN 22 reorganized its committees in mid-2017, VISN 22 management did not inform me that it had restarted the Specialty Care Committee. Management chose not to appoint me to this committee. I only learned of the committee's existence in January 2018 when I was doing research on starting a VISN-level committee for specialty care.

Although my physician experience includes 9.5 years in a VA Emergency Department, in 2017 and 2018 I have been excluded by VISN 22 administration from any membership on the VISN 22 workgroup to improve Emergency Department flow throughout VISN 22 facilities. (It was not until 2019 that I would be assigned to an Emergency Department project to improve such flow.)

After completing a self-developed project that identified VISN 22 facilities' interfacility specialty care consult (IFC) processes and points of contact (POC) for each step, I inexplicably was excluded from membership on the workgroup looking at

these processes even though they were relying on my self-developed project materials to address IFC problems.

8.At the end of FY17 I was told by my now-former direct supervisor that she was not authorized to rate me any higher than "fully satisfactory" on my end-of-year appraisal rating. Her statement was illogical because, based on the definitions printed on the appraisal rating form, I met the all the criteria contained in the definition for "excellent" and my VA Quality Scholar work supported a rating of "outstanding".

Not only did I meet all the criteria listed by the form for the category of "excellent", my supervisor was also aware that I had received an "outstanding" performance rating from my VA mentor in my 0.75 FTE VA position as VA Quality Scholar. My now-former supervisor inexplicably stated she was not allowed to consider such outstanding performance when providing a summary rating me as a full time VA employee even though I occupied a 0.75 full-time VA position as VA Quality Scholar and only 0.25 full-time VA position as Specialty Care Medicine consultant. She stated I would have to submit a reconsideration (formal complaint) of her summary rating of "fully satisfactory". Although she was the primary rating official, she inexplicably told me that she did not "have the power" to change my rating. (I do not think she was retaliating against me but rather was following retaliatory orders from more senior VISN leadership who did not want me to be rated higher.)

I filed a formal complaint within the VISN office and eventually was granted a rating of "Excellent".

9.In October 2017, shortly after a Washington Post reporter submitted to VACO my statements about ongoing VA whistleblower retaliation, the VA suddenly withdrew its offer of a short-term assignment to the Office of Accountability & Whistleblower Protection (OAWP) without providing any explanation.

In an August 2017 telephone meeting for 1.5–2 hours with a now-former OAWP Executive Director I was informed that the VA Deputy Undersecretary of Healthcare Operations and Management (DUSHOM) had recommended an OAWP assignment for me because the OAWP had no physicians assigned to it and was in great need of such medical expertise to investigate cases involving physicians. During that meeting I was offered me a 4-month assignment to the OAWP with the ability to extend the detail. I accepted.

Because the OAWP Executive Director stated he wasn't sure how to initiate the necessary paperwork for me to have the assignment, I told him I would do the research to find out how to expedite it. Within 3 days on 8/25/17 I sent him an email telling him I was excited about the opportunity to work with the OAWP and that I created the necessary HR documents (attached to the email) in order to expedite the detail. He replied on 8/25/17 "Thank you for getting the process started. Since this will be a unique detail, I'll work it with [VA Deputy Undersecretary of Healthcare Operations and Management]".

In September 2017, a Washington Post reporter was working on a story regarding increasing VA whistleblower retaliation. When he interviewed me, I told him VA retaliation was worsening. The reporter subsequently submitted my comments about ongoing/worsening VA whistleblower retaliation to VA Central Office (VACO) as part of routine investigative process in order to get a response from VACO. (The reporter's final article appeared on 10/30/2017.)

Shortly after the timeframe that the VA would have received notification of my specific comments by the reporter, I received a curt 2 sentence email dated 10/25/17 from that same OAWP Executive Director stating that he would "not be moving forward" with the OAWP detail. This OAWP Executive Director never responded to my subsequent email requesting an explanation of why the detail was suddenly cancelled.

Because the OAWP had ongoing significant need for medical expertise in investigations, I believe the assignment offer was withdrawn because VACO was displeased with my comments about VA retaliation. Since the VA DUSHOM had recommended me for the position and since the VA DUSHOM never again contacted me, it would have taken a senior VACO leader to reverse the DUSHOM's recommendation for an OAWP assignment, stop DUSHOM interactions with me.

10.In a January 2018 news article the VA falsely portrayed itself as continuing to work on my case even though it has persistently ignored my genuine attempts since 2016 to resolve its breach of settlement agreement and had broken off all contact with me since October 2017.

In a USA Today article published 1/16/18, the VA falsely contended it was "still working" on my case. In fact, from October 2017 through the time the VA entered mediation with me in October 2018 the VA Central Office had no direct or indirect contact with me.

The VA has persistently ignored my attempts to resolve the breach of settlement agreement. After it became evident that the VA materially breached the 2014 settlement agreement, I tried to resolve the issues informally via the Office of Special Counsel starting in approximately mid-2016. After the VA stopped responding to the OSC in Spring 2017, on 6/23/17 I sent (via email delivery) a 6/23/17 formal "Notice of Breach of Settlement Agreement" with a 30 day deadline for response to the VA DUSHOM. The DUSHOM informally acknowledged receipt of this document in an email dated 6/27/17. In the formal notice I requested a new position to resolve the breach.

The follow-up communication I received was a brief email dated 7/19/17 from the DUSHOM asking for my resume and indicating he was "pursuing a couple possibilities" for me. I promptly provided my resume via email. Although I subsequently was offered a short-term OAWP assignment with a potential for a longer position, that assignment offer was later withdrawn.

Because I received no formal response from the VA to the initial Notice of Breach of Settlement Agreement and because the material breach continued/worsened, on 11/15/17 I subsequently submitted (via email delivery) a second document entitled "Second Formal Notice of Breach of Settlement Agreement" to the VA DUSHOM. This notice was read by the DUSHOM on 11/15/17. This document gave a 30 day deadline for VA response. The 30 day deadline passed on 12/15/17 with no formal or informal response from the VA. As of June 2019, the VA has never provided any informal or formal response of any kind to my "Second Formal Notice of Breach of Settlement Agreement".

11.In January 2018, after I publicly stated I had been offered an Office of Accountability and Whistleblower Protection (OAWP) short-term assignment which had inexplicably been withdrawn, VACO countered with an inaccurate public statement claiming that I had never been officially offered a position with the OAWP.

In a nationally circulated January 17, 2018 USA Today article wherein I stated I had been offered an OAWP position which was subsequently withdrawn, the VACO inexplicably contended that I had not ever been officially offered any type of position with the OAWP. VACO's statement was not consistent with the conversation or emails from the OAWP Executive Director with whom I had arranged the short-term assignment.

12.From 2017 through 2018, even though I was assigned responsibility for the Healthcare Associated Infections (HAI) at all VISN 22 facilities, various VISN leadership would not include me in the HAI communication loop between the facilities and VISN 22, provide access to the facilities' HAI improvement action plans, or actively involve me in ongoing HAI projects.

In early 2017 I was specifically assigned by the VISN 22 CMO division to monitor the prevention of HAI in VISN facilities by tracking trends and following up with front-line staff who would be most familiar with root causes and interventions. However, in February 2018 I learned via emails that I had not been included the communication loop between the VISN 22 DND and the facilities regarding HAI. I learned of the communication loop only after receiving an email wherein a facility questioned why it was being asked to do "double-work" by providing HAI action plans to VISN 22 DND and separate documents to me. Although I sent multiple emails to my chain-of-command to be included in the activities/information flow, I was never allowed to participate. HAI responsibility was removed from my responsibilities in FY19.

13.Contrary to multiple OPM regulations, VISN operating procedures, and VISN business needs, in late 2018 VA Central Office (VACO) reportedly was able to deny me the ability to participate in medical review of local VISN-level consult issues even though it is highly irregular for VACO to be involved in such matters.

In 2018 I was struggling to fill my 40 hour workweek with activities because the duties I was allowed to perform did not consume all my duty time. In late 2018 I learned the business division of my VISN was experiencing consult problems which could be resolved by physician review. After briefly speaking to my supervisor, I subsequently submitted an email to that supervisor formally requesting the ability to have some of my work time assigned to the business office to assist with these

consult problems. Several months later I learned my request had been inexplicably denied even though such duties would clearly fall under the Specialty Care Medicine role and were within my scope of practice as a board-certified internist.

In 2019 I inadvertently learned from an extremely reliable source that my request had been forwarded to VACO for review and that VACO had denied the request. Because it is extremely irregular for VACO to have any input on the routine local assignment of a temporary job duty for a local VISN-level employee, I believe I was being treated differently because of my whistleblower status. I am extremely concerned that VACO has been surreptitiously dictating my VISN job duties, or lack thereof, since beginning my VISN position in 2014.

Section III: Lack of Timely Avenues to Stop Whistleblower Retaliation against Dr. Mitchell

During these last 5 years, I have not been silent about the retaliation against me. Although I have made multiple direct and indirect attempts to fight the retaliation, I have not yet found any successful method to stop this unjust treatment.

Since 2015, I have notified my immediate chain-of-command several times in an attempt to obtain relief. Although 2 of my immediate supervisors were blatantly retaliatory against me, I could not elevate the existence of the retaliation to the chain-of-command because the VISN Network Director, the top supervisor in the VISN chain-of-command, had also taken retaliatory actions against me. I spoke with 2 of my subsequent supervisors about VISN-level retaliation. However, although they were sympathetic to my plight, they informed me that they could not overcome VISN-level "politics" that were successfully blocking me from performing any of the duties of the Specialty Care Medicine consultant position or participating in VISN-level projects that were in the scope of Specialty Care Medicine duties.

In late 2016 I contacted the Office of Special Counsel or OSC, explained the retaliation, and asked if it could help me obtain a new VA position. The OSC tried to resolve the problem by informally engaging the VA, but the VA declined to participate. Because the OSC was so backlogged, I was told the only way to receive further OSC help was to file another whistleblower retaliation complaint and wait my turn in line, a line that ultimately was about 15 months long.

In 2017 I also contacted several congressional offices and was told they were referring all VA whistleblower matters to the new VA Office of Accountability and Whistleblower Protection (OAWP). I contacted the OAWP twice in 2017. When I submitted my request for OAWP assistance, I even cc'd the now-former Secretary of the VA, an individual with whom I had exchanged several patient care-related emails. I waited again - it was a wait that would last 16 months to get a follow-up response from the OAWP. The now-former Secretary of the VA never responded.

In June 2017 I also sent the now-former VA Deputy Undersecretary for Healthcare Operations and Management (DUSHOM) a formal legal notice citing settlement agreement breach and clearly outlined the whistleblower retaliation against me. In the document I requested assistance with obtaining a new position. I was elated when the DUSHOM asked for my resume. As a result of his actions, I subsequently received and accepted an offer of a new short term VA assignment with the OAWP with the potential for a permanent position. Unfortunately, the VA suddenly withdrew the offer after I gave a national newspaper interview about ongoing VA retaliation. In November 2017 I sent the DUSHOM a second formal legal notice of breach. Although the email read receipt confirmed the DUSHOM read the notice, I never received any type of VA response to my formal legal notice.

In October 2018, after the OSC's preliminary investigation found credible evidence of ongoing whistleblower retaliation against me, I readily entered mediation with the VA. That mediation is still ongoing as of June 2019 because the VA no longer has an expedited mediation process in place.

Please note: In 2014 the VA had an expedited mediation process for OSC cases wherein credible retaliation was found. Although I am not privy to the details of that confidential process or the rationale for discontinuing it, that 2014 VA expedited mediation process was successfully used to address the whistleblower retaliation against me and other VA employees.

Section IV: Whistleblower Vulnerabilities when Interacting with OAWP - General concerns & specific examples based on Dr. Mitchell's 2017 & 2019 experiences

In this section I describe my Office of Accountability and Whistleblower Protection (OAWP) interactions in 2017 and 2019 and explain how those interactions reveal weaknesses in OAWP processes. Although the OAWP has recently come under new leadership, I remain concerned the OAWP does not yet seem to have any effective

processes in place to ensure the complainants are not subjected to further retaliation for using OAWP services. Further development and transparency of OAWP processes would help address the concerns discussed below.

1)Prior to the filing of an OAWP complaint, the OAWP triage intake staff fails to communicate key information to complainants about the potential for the complainant's supervisor and facility leadership to obtain unredacted complaints/associated unredacted documents.

Based on my OAWP experiences described below and intermittent conversations with other whistleblowers who have contacted the OAWP, the OAWP intake staff routinely do not disclose to whistleblowers that any documents submitted can potentially end up in the hands of the whistleblowers' supervisors/facility leadership if A) the OAWP initially deems the complaint not to meet the criteria for whistleblower retaliation, B) the OAWP directly does an investigation, or C) the investigation is referred by the OAWP to the VISN/VISN facility associated with the whistleblower.

My OAWP experiences: On 9/8/17 I sent an email to the OAWP notifying it that I was experiencing whistleblower retaliation. In the 9/13/17 email response the OAWP triage specialist wrote "To ensure your whistleblower disclosure and subsequent retaliation is addressed appropriately, please respond to this email with information..." She then listed the information to include events, witnesses, and documented evidence such as emails. She did not inform me whether or not those documents could be shared with my supervisor/leadership.

Because the 9/13/17 OAWP email did not disclose the OAWP processes for handling my complaint, I sent a follow-up email dated 9/13/19 seeking more information/explanation about those processes. I asked if my supervisor, VISN office, or general VA leadership would have access. I also inquired as to whom would be investigating the retaliation.

I received the OAWP triage specialist's partial response to those questions on 9/15/17, but the triage specialist did not state who would have access to my complaint and supporting documents. Because the triage specialist did not answer that question, I replied on 9/15/17 asking her to confirm who would have access. In a 9/18/17 email, the triage specialist sent me her phone number and subsequently spoke off the record with me. In our conversation she vaguely indicated the documents might be shared, but she would not officially confirm it.

In 2019 I received written confirmation from an OAWP staff member that all whistleblower evidence documents could be shared with a complainant's supervisors/facility leadership and that even previously redacted information could be unredacted/given to VISN leadership (and to the facility if the VISN requests that the facility investigate). In a 2/5/19 email to the OAWP I wrote "Can you verify that my chain of command within VISN 22 (supervisor/VISN 22 leadership) would not have access to the documents I submit to you?" In a 2/5/19 email response an OAWP staff member informed me in writing that "[she] cannot confirm that they will not see the documents .documents can be shared as the investigation proceeds" in retaliation cases.

I was also informed via the same 2/5/19 email response that redacted information could also be given to the VISN when there were disclosures of violations, gross mismanagement, waste of funds, abuse of authority, or specific danger to public health or safety. OAWP staff member wrote in such cases ".the investigative party (OAWP or VISN) may be provided with copies of the redacted information".

2)Prior to the filing of an OAWP complaint, the OAWP triage intake staff apparently fail to communicate key information to complainants about the investigative process and the potential to have the investigation conducted by the VISN or by the complainant's facility if the OAWP declines to conduct the investigation using its own staff.

Based upon my OAWP experiences described below and intermittent conversations with other whistleblowers, the OAWP intake staff do not fully explain the process of investigation and do not routinely disclose to whistleblowers that any complaints not meeting the initial definition of whistleblower retaliation are forwarded to the employee's VISN for subsequent investigation and/or subsequent delivery to the complainant's facility to investigate.

My OAWP experiences: In a 9/15/17 I was informed by an OAWP triage specialist that the OAWP investigates matters involving "all VA Senior Leaders" and refers any other matters not involving senior leadership "to the appropriate entity to investigate". The triage specialist did not specify which entities would be involved.

In 2019 an OAWP case manager wrote that the investigative party for allegations other than retaliation would be the "OAWP or VISN". However, she did not offer

any specific information on what might happen if a retaliation complaint was deemed not to rise to the level of whistleblower retaliation.

Because it took 17+ months for the OAWP to respond to my 2017 initial intake disclosure, I asked the same case manager about the timeliness of any future investigative processes. The OAWP triage case manager told me she could not "clarify the OAWP timeframe for taking action or the investigation process. Each case is will be [sic] handled on a case by case basis." I was surprised because I assumed the OAWP would have processes defining the average/desired timeframes for investigations.

3)The OAWP does not appear to have any processes in place to ensure that the content of any referred complaint is handled by a neutral party at the complainant's VISN office or facility.

Anecdotal OAWP information: I have been told by VA staff who wish to remain anonymous that the OAWP will forward those complaints deemed not to be retaliation to the regional VISN with only general instructions to address the complaint. The OAWP does not appear to take any steps to ensure the content of the complaint is handled by a neutral party at the VISN.

I have been told that OAWP complaints are often forwarded by the VISN to the complainant's facility (enabling the facility to investigate itself) because the VISN does not have the staffing to investigate. (This is similar to how the VISNs commonly handle OIG hotline complaints that are referred to VISNs.)

I do not have any information on whether or not the OAWP does follow-up of forwarded complaints to determine if resolution is achieved.

4)The OAWP intake processes appear to be extremely slow with gaps of up to 1+ years for initial intake.

When talking to another VA whistleblower (Dr. Christian Head) who also testified at the 2014 HVAC hearing, I learned that he never received any contact from the OAWP despite having filed a complaint more than 1+ year earlier.

My OAWP experience: In 2017 I was told by several congressional offices that they refer all potential VA whistleblower retaliation cases to the OAWP. After learning that I could not receive congressional help unless I first went through the OAWP process, I contacted the OAWP to file an initial complaint. In September 2017 I sent the initial email to make a disclosure and ask if the OAWP could help. I subsequently sent a December 2017 email to the VA Accountability Team and the now-former Secretary of the VA wherein I stated "I would like to file a case with the OAWP" and provided a succinct synopsis of the retaliation I experienced. Unfortunately, I did not receive any OAWP response until January 2019 (1+ year later) asking me if I "still wish to file a disclosure".

5)The OAWP appears to be subject to internal pressure from VA Central Office (VACO) senior leadership.

My OAWP experience: In late August 2017, after I had notified the now-former VA Deputy Undersecretary of Healthcare Operations and Management (DUSHOM) in June 2017 about ongoing whistleblower retaliation against me, the now-former OAWP Executive Director contacted me at the request of the DUSHOM regarding a short-term detail position to the OAWP as a physician investigator with the potential for a longer assignment. I accepted the detail. Because that OAWP Executive Director was uncertain how to initiate the detail paperwork, I drew up the appropriate paperwork and forwarded it to him. He sent me an email 8/25/17 which thanked me "for getting the processes started" and stated he would "work it with [the DUSHOM]". In late September/early October 2017 I gave an interview to the Washington Post wherein I stated that the VA retaliation against whistleblowers like myself had worsened. Although the article did not appear until 10/30/17, the VA was notified of my comments in advance as part of the standard procedure for journalists. Shortly after the time the VA was initially notified, I sent an inquiry to that OAWP Executive Director asking for an update on the detail position because I had not heard from him after waiting the expected 4–5 weeks it takes to get detail approval. In a 2 sentence email he replied he was not moving forward with the detail for me. He did not respond to my subsequent email politely asking for an explanation.

In January 2018 VACO publicly denied in a 1/17/18 USA Today article that I was offered an OAWP position despite those emails to/from the now-former OAWP Executive Director which are described above. Although I do not have direct evidence of VACO's interference with my detail, it seems logical that only VACO senior leadership would have the power to not only cancel the detail that had been arranged by the DUSHOM but also deny such a detail position offer ever existed.

6)The OAWP is inappropriately asking for complaint details/documentation which could logically interfere with a potential/pending OSC investigation.

My OAWP experience: On 1/25/19 I was contacted via email by an OAWP triage case manager to determine if I still wanted to file a complaint based on my 2017 correspondence with the OAWP. At the time of contact I was already in the OSC's Alternative Dispute Resolution (ADR) process with the VA because a Fall 2018 preliminary OSC investigation found credible evidence of whistleblower retaliation against me. I explained this and asked "would there be any purpose in engaging the OAWP now?"

Per a 1/30/19 email, the OAWP case manager responded that the "OAWP would still conduct their investigation despite OSC involvement (provided we have all supporting documentation)." This statement is extremely concerning to me. Because the VA has no expedited mediation process in place, my ADR with the VA has been ongoing since October 2018. If the mediation process ultimately is not successful, then it will terminate.

If the current ADR process fails, then the OSC would conduct a full investigation of the VA retaliation against me. In the event of a full OSC investigation, if the VA were to be given advance access by the OAWP to my complaint and all my supporting documents, I fear there would be a significant risk intimidation of/retaliation against my witnesses or other interference with the OSC investigation of my case.

Section V: Potential Remedies to Assist VA Whistleblowers, Positively Influence VA Culture, & Strengthen Federal Whistleblower Safety-Nets

Because many ingrained root causes contribute to VA whistleblower retaliation, I do not know of any single method which could effectively obliterate retaliation in the VA system overnight. However, I believe there are potential remedies which, if done concurrently, realistically could address immediate whistleblower concerns, facilitate reductions in VA retaliation events, positively influence VA culture so all VA employees could identify safety issues without fear of retaliation, and systematically strengthen federal whistleblower safety-net resources. I have listed a few of those remedies in this section.

Note: Some of the recommendations listed below include references to 3 VA initiatives: High Reliability Organization (HRO), Just Culture, and Servant Leadership. In theory, each of these initiatives can positively influence VA culture. However, 2 initiatives (Just Culture & Servant Leadership) have not been consistently operationalized in a manner conducive to substantially influencing the sprawling VA culture. The remaining initiative (HRO) has not yet been implemented though its eventual success will be extremely limited if Just Culture & Servant Leadership are not already strategically in place.

The HRO initiative is a 3-pronged approach to achieve organizational health care excellence by fostering a workplace culture of safety, dedication to continuous improvement, and leadership support. The "culture of safety" has techniques/guidance that empower every employee to verbalize safety concerns and potential solutions without fear of retaliation. As part of that culture, every level of leadership expects/ actively encourages employees to verbalize legitimate concerns and take action to prevent patient harm. The emphasis on a culture of safety and continuous improvement are tantamount.

The Just Culture initiative must be present to have an effective roll-out of HRO. "Just Culture" involves implementing an institutional culture wherein there is balanced assignment of accountability for designing safe processes/systems and for addressing any occurrence of negative health care/safety outcomes. That accountability is shared by both the individual employee and the institution. If a problem/negative outcome occurs, the event is analyzed to assign individual and institutional accountability. This analysis also determine how the problem/negative outcome can be prevented in the future by addressing employee-level issues as well institutional-level issues that contributed to the event. Just Culture also effectively reverses the present VA "culture of blame" wherein staff are penalized for admitting mistakes.

The Servant Leadership initiative essentially encourages leaders to promote collaboration/teamwork, trust, and ethical behaviors among themselves and employees to meet the needs of the organization and its staff. In its simplest form, Servant Leadership is the ethical use of leadership power.

Recommendations for the Department of Veterans Affairs

- **Reinstate a VA expedited mediation process (similar to what was present in 2014) for OSC cases wherein credible whistleblower is found and there are no confounding factors.**

Although it may be unintentional, the current extreme delays in VA mediation responses imply the VA devalues whistleblowers to the point that it is not even willing to provide adequate resources or expedited processes to ensure those suffering credible retaliation are treated promptly and fairly.

If the Office of Special Counsel (OSC) has determined credible evidence of retaliation exists and there are no confounding employment factors, there is no reason for the VA to delay implementing the remedies to reverse the unfair/unjust personnel actions and appropriately address the effects the whistleblower retaliation has had on the employee. (I am defining "confounding factors" as substandard employee performance/conduct that normally would justify a major adverse personnel action as defined by as defined by VA Directive 5021/17, Employee/Management Relations. Per that VA Directive, major adverse actions are "suspension, transfer, reduction in grade, reduction in basic pay, and discharge based on conduct or performance".)

In 2014 the VA had an expedited mediation process for OSC cases wherein credible retaliation was found. Although I am not privy to the details of that confidential process or the rationale for discontinuing it, that 2014 VA expedited mediation process was successfully used to address the whistleblower retaliation against me and other VA employees.

- **Discard the practice of removing/firing probationary employees who have become whistleblowers and who have displayed good work performance/competence during their VA probationary employment.**

The purpose of the probationary period is to determine if an employee is a good fit for the VA position and can function appropriately with other VA team members. If an employee has displayed good work performance/interpersonal skills at his or her position, that employee should be welcomed into the VA system because the VA workforce would benefit from the employee's presence.

In the past, the VA has fired probationary employees after they become whistleblowers even though there were reportedly no red flags in the employees' VA work performance. While technically any employee can be fired without cause in the probationary period, the spirit of the applicable regulation/law is to help weed out poor performers including those with poor interpersonal skills and NOT to weed out those with the integrity to speak up about VA problems jeopardizing Veterans' care or agency mission. In addition, while there are legitimate red flags in probationary period performance that would necessitate firing a probationary employee whether or not the employee was a whistleblower, the VA should not use very minor issues that can be easily corrected with training or instruction as a trumped up excuse to fire a whistleblower when the VA would not use those same issues to fire a non-whistleblower in the probationary period.

- **Ensure that all VA facility Administrative Investigative Boards (AIBs) and Professional Standard Boards (PSBs) are no longer weaponized as tools of retaliation.**

In the VA system, AIBs and PSBs have been weaponized to retaliate against whistleblowers. Unethical use of AIBs and PSBs involve deviating from prescribed regulations for committee set-up and functioning, providing the whistleblower with only limited information/time to address allegations, stacking AIB/PSB committee membership in favor of the retaliator, and drawing conclusions that are not based on the objective evidence. There appears to be almost no accountability for AIB/PSB committee members who act in bad faith.

The VA must ensure that all AIBs/PSBs are conducted in a standardized fashion according to appropriate regulations. However, AIB/PSB regulations can be complex and not all facility HR personnel are familiar with requirements. While there are several approaches to ensuring AIB/PSB standardization, some measures include 1) creating a system-wide universal standard operating procedure for all AIB/PSB phases that includes rules of procedure, 2) developing a mandatory AIB/PSB checklist that must be completed/signed by committee members and verified by Human Resource staff as being accurate, and 3) holding any AIB/PSB committee member (as well as facility HR personnel) immediately accountable for deviating from the SOP/checklist.

- **Revise VA leadership/supervisor training on whistleblower retaliation to ensure the content is comprehensive, impactful, and reflects real-world concerns of whistleblowers.**

Although I do not recall the exact date, sometime in the last 2 years I was listening to a virtual presentation wherein leadership was receiving training on whistleblower retaliation. Although the training content was technically accurate, it fell far short of discouraging retaliation. The emphasis appeared to be on improving docu-

mentation of poor employee performance so that substandard employees could not hide behind "whistleblower" status to avoid accountability for poor performance. While I agree that employees should have appropriately applied accountability for their poor performance, I vehemently disagree with the inference that the vast majority of whistleblowers are just poor performers who became whistleblowers to shirk responsibility for their otherwise substandard performance.

The training would have been much more useful it had identified examples of the commonly used HR tools surreptitiously used as retaliation, the reasons why those uses violated VA policy/ OPM regulations/federal law, and how misuse of those HR tools would not be tolerated within the VA system. The training certainly would have been more impactful if it identified 1) actual examples of consequences for leadership who deliberately misused such HR tools and 2) actual examples of the manner by which VA whistleblowers positively impacted agency operations/mission. The training should have also highlighted 1) ways in which to encourage all employees to identify VA problems without fear of retaliation and 2) methods for leaders to respond to reports of VA problems.

In addition to seeking HR specialist/VA leadership perspectives on content development, VA whistleblower input on/evaluation of training content would help ensure the training addresses whistleblower concerns and is truly tailored to preventing whistleblower retaliation.

- **Incorporate more effective means to encourage leadership to routinely recognize VA employees/whistleblowers who have alerted the chain-of-command about problems jeopardizing Veterans' care or agency mission.**

Recognizing employees who identify problems and/or solutions to VA operations and safety issues should be incorporated into standard VA workflow. Providing such recognition should be a substantially weighted expectation included in leadership's annual performance evaluation. In addition, the weekly national VHA call, monthly VISN Executive Leadership Council meetings, and other similar calls/meetings should have a recurring segment in which there is informal & formal recognition of leaders who have encouraged employees to speak up about problems negatively impacting VA operations and how identification of those problems will positively impact agency operations/goals.

Unfortunately, VA leadership in many places do not routinely offer formal/informal recognition if an employee identifies problems and/or solutions to issues negatively impacting VA operations in any setting. Leadership do not follow the guidelines which are published Handbook 5017/1, Employee Recognition and Awards.

Although the current VA initiatives of "Servant Leadership", "Just Culture", and "High Reliability Organization" theoretically would encourage positive leadership behavior and incorporation of employee recognition into standard VA workflow, those initiatives' principles have not been effectively operationalized.

- **Revise Just Culture training/forms and then roll out "Just Culture" to more VA facilities so that all VA employees will be encouraged to proactively identify and report patient health and safety concerns.**

If effectively implemented, the Just Culture initiative replaces a "culture of blame" with balanced accountability for staff and the institution whenever negative outcomes occur. The Just Culture approach should significantly alleviate fear of retaliation/unjust treatment for identifying and reporting issues that negatively impact a facility's operations and safety.

I recently reviewed some forms used by large VA facility to promote "Just Culture" when assigning accountability to adverse patient safety events. I was appalled to see the forms neglected to formally evaluate/document whether institutional factors (e.g., short staffing, lack of proper process, lack of resources, etc.) contributed to the negative outcome. While the form did list some employee factors that would mitigate the type of accountability attributed to the employee, the document essentially still resulted in unilaterally assigning blame and instituting a punitive approach to address employee behavior.

That punitive approach is not consistent with Just Culture principles. I am concerned that employees will not readily identify health and safety issues in such a punitive environment. If the Just Culture principles are being incorrectly applied in one large VA facility, I am concerned that Just Culture is being incorrectly operationalized at other VA facilities.

- **Emphasize proper execution of Peer Review/Root Cause Analysis (RCA) to include the need to formally consider/document/report all institutional factors contributing to negative outcomes.**

While processes for Peer Review and RCA theoretically should include institutional factors/accountability for negative outcomes, in the VA such consideration is not consistently/objectively performed or documented. For each case/event being re-

viewed, there should be an enforced requirement for every Peer Review committee and Root Cause Analysis committee to formally solicit/document information on whether there were institutional processes that failed and/or otherwise contributed to the negative case/event outcomes. There should be a standard operating procedure in place for the Peer Review committee/RCA committee to ensure that institutional accountability is assigned and institutional deficiencies are proactively addressed so the risk of future negative outcomes can be reduced.

While there are many ways to emphasize such institutional analysis, one potential way would be to develop a standardized reporting form which each involved employee would be required to complete and every committee would be required to consider. In addition to filling out a "blank" section describing his or her account of the event/case, the employee would also be given the option to complete the pre-printed form questions including, but not limited to, 1) "Are there pertinent facility factors (e.g., lack of resources/inadequate standard operating procedures/understaffing or other issues) that you believe contributed to the outcomes in this incident? If so, please explain."; 2) "Have you previously reported institutional factors you believe contributed to this negative outcome or could have prevented this negative outcome? If so, please explain."; 3) "Can you identify any facility process improvements or potential equipment/resources that could prevent this incident from re-occurring in the future? If so, please explain."

Emphasis on analyzing institutional/facility factors and appropriately assigning institutional accountability is consistent with the VA initiative of "Just Culture" and "High Reliability Organization".

Recommendations for the Office of Accountability & Whistleblower Protection

Note: I only have very limited recommendations for the OAWP because its processes are not transparent to me. I am proposing the following remedies based on my experiences detailed in Section IV of this written testimony.

- Speed up the time for triage intake/follow-up of OAWP complaints.
- Foster transparency in OAWP procedures so that complainants filing with the OAWP are aware exactly where their documentation/complaint will be forwarded at each step of the OAWP process and are informed of the approximate timelines for each OAWP process step.
- If referral of a complaint is necessary, establish processes to ensure the content of any referred complaint is handled by a neutral party at the complainant's VISN office or facility. (Ideally no referrals of whistleblower complaints would occur.)
- If not already doing so, based on the nature of the whistleblower retaliation allegations that are received, make ongoing content recommendations for real-time field updates and training pertaining to the prevention of VA whistleblower retaliation.
- If not already doing so, if the OAWP has inadequate resources, consider narrowing the scope of investigations conducted directly by OAWP staff to emphasize its current strengths (speed and agility) to address major adverse actions against whistleblowers.

Although I do not have official data, I have anecdotally been told that a number of claims submitted to the OAWP are either for allegations completely unrelated to whistleblower retaliation or allegations in which the retaliation is not classified as a major adverse action by VA Directive 5021/17. (Per that VA Directive major adverse actions are "suspension, transfer, reduction in grade, reduction in basic pay, and discharge based on conduct or performance.)

While any type of credible whistleblower retaliation is unacceptable, the OAWP likely does not have the manpower resources or processes to personally investigate every allegation of whistleblower retaliation.

If not already doing so, assuming OAWP resources are so limited that it must prioritize its activities, the OAWP should consider concentrating its available OAWP manpower on 4 activities 1) determining whether SES executives are facilitating retaliation, 2) determining if there are credible allegations of whistleblower retaliation in situations where the whistleblowers are facing unjust major adverse actions, 3) quickly reversing major adverse actions that reasonably appear to be stemming from whistleblower retaliation on investigation, and 4) monitoring/tracking data pertinent VA whistleblower retaliation.

(Note: If the OAWP is not already doing so, the minimum pertinent OAWP data to monitor would include frequency of allegations of VA whistleblower retaliation, types of personnel actions that are reported in allegations of whistleblower retaliation, facility/service line implicated in allegations of whistleblower retaliation, and

number/facility/service line/major adverse action in substantiated whistleblower retaliation cases. That data could help the VA monitor whistleblower retaliation, identify trends, and proactively address areas where there are concerns about retaliation and/or indications of a need for facility/service line cultural change.)

When conducting OAWP investigations involving SES executives or major adverse actions, the OAWP may choose to use its own employees for the investigation or obtain the assistance of non-OAWP VA subject matter experts. However, to avoid bias and potentially increasing the risk of further retaliation against the whistleblower, the OAWP should never delegate the primary investigative process back to the facility or the facility's VISN office if the case involves SES executives or major adverse actions against complainants.

If the OAWP is referring any retaliation complaints to the VISN/facilities, then it must establish standardized processes to ensure the content of any referred complaint is handled by a neutral party at the complainant's VISN office or facility.

- Take appropriate steps to ensure OAWP decisions are not influenced by internal pressure from VA Central Office.
- Do not solicit case documents when a potential complainant is already in the OSC investigative stage or mediation process.

Recommendations for Congress

- Consult with the Office of Special Counsel (OSC) to determine what additional budget allocation would enable the OSC to effectively manage its entire caseload and backlog in a timely manner and meet projected caseload needs.

In general, the largest portion of OSC claims are filed by VA employees. At the end of 2018, the OSC had a backlog of over 2,600 cases while still receiving new claims at historic levels. The general budget request for the OSC is 1% lower than last year. The OSC recently was able to hire 11 additional staff due by lowering its financial lease obligations, which will improve its ability to handle its caseload. However, additional budgetary monies may still be required to enable it to address all new and backlogged claims in a timely fashion and proactively address projections on the numbers of claims which will be filed in the coming fiscal year.

- Use bipartisan influence to ensure that a 3 member Merit Systems Protection Board quorum is immediately established.

The MSBP is the safety net for all federal employees who have legitimate claims of adverse/unfair personnel actions including those who are VA whistleblowers. The MSPB has not had a quorum for over 2 years. Without a quorum no MSPB appeals can be decided. As a result there is a backlog of over 2,000 petitions and other cases - each day of delay for each case has potentially significant negative impact on an employee's career, livelihood, and psychosocial well-being.

Although 2 MSPB nominees have been approved in committee, they have not been submitted for full vote because there is a wait for select a 3rd nominee. (Of the 3 nominees originally selected, 1 nominee withdrew his name from consideration.)

(An employee can choose to bypass the MSPB delays by filing directly in federal circuit court. However, this option is out-of-reach for many federal employees because it is extremely cost-prohibitive and lengthy.)

- Allocate sufficient budgetary monies for the Merit Systems Protection Board (MSPB) to fulfill its mission requirements in a timely manner and recruit additional staff to replace pending retirements.

The budget request for the MSPB is 10% lower than last year. The MSPB had stated the budget cut will significantly impact multiple operations and also affect its ability to address staffing needs for pending retirements. The MSPB is a major safety net for federal employees and should not be jeopardized.

Prepared Statement of Jeffery Dettbarn

Chairman Pappas, Congressman Bergman, and distinguished members of the Subcommittee, it is my honor to appear before you today to testify about my experience as an employee and whistleblower at the Department of Veterans Affairs. My name is Jeffery Dettbarn, I have been employed for over 14 years at the Iowa City VA Medical Center, with an unblemished record before blowing the whistle on the improper mass cancellation of what turned out to be tens of thousands of radiology orders. I have been a Registered Radiologic Technologist for over 29 years. After receiving the Mallinckrodt award for the highest achievement in my radiology school class, I went on to my first job as an X-ray Technologist, learning general ultrasound, echo cardiography and carotid doppler sonography. I took a position ap-

proximately 2 years later doing Mobil Computerized Tomography which also allowed me the opportunity to learn to drive a Semi truck and trailer. I later worked at the University of Iowa working as a Cardiac Cath laboratory technologist and in Orlando Florida, where I spent 11 years working in many facets of radiology as a supervisor. In 2005, I returned to Iowa, taking the position of Radiology Supervisor at the VAMC Iowa City. After 3 ° years as a supervisor, I stepped down to the role of CAT Scan Technologist and that was what I did and loved every work day until I blew the whistle two years ago and was quickly banished to non-patient care duties, where I have remained to the present date.

Over the years I have developed a strong rapport with many of my patients, but NEVER have I had such an over whelming feeling of loyalty as I do to our Veterans. The comradery, compassion, and loyalty these men and women have to their Family, Flag and Freedom is phenomenal. It is also infectious. In my heart, the Veterans and I are family because of the relationships I have cultivated over the past 14 years of caring for them. I have been called "Brother," by countless numbers of our Veterans, which to me shows their confidence, faith, and trust in me. I have not served but I SERVE them, and they are my extended family.

I came forward and became a whistleblower out of concern that Veterans were being placed AT RISK of not receiving the care, and follow-up care, they desperately needed, and because of the unnecessary risk to patient care presented by non-medical personnel practicing as physicians. Since then, the VA has banished me from the hospital for two years, away from the greatest job ever-taking care of Veterans, cut my pay by a third, targeted me with an Administrative Investigation Board, proposed my removal, and subjected me to unbelievable physical and emotional stress,

My present saga began in early to mid-2016, when the CT area began experiencing issues with management's implementation and attempted implementation of bogus policies and Standard Operating Procedures that did not undergo the proper approval and implementation process. These "policies" included email instructions for technologists to "protocol" exams and to fill out, and complete with the Veteran the required Patient Consent forms. Protocol sheets are forms used to specify EXACTLY what type of scan a Veteran is to receive based on a diagnosis. For example, a chest CT may require the use of intravenous contrast, resulting in the need for a kidney function test, when ruling out cancer, or it may be done without contrast when looking for a calcification of the lung. Instructing a technologist to "protocol" an exam was entirely beyond the technologist's "scope of practice," and something that only a physician should do.

Another bogus policy involved the execution of the Patient Consent form-normally only executed by the Veteran together with the RADIOLOGIST when the use of intravenous contrast is necessary, yet the Veteran has some contraindication for NOT being a perfect candidate for contrast. All risk factors would be discussed by the radiologist and the Veteran, and the Veteran's informed consent would be obtained. This consent must include a consult with the radiologist for it to be effective, and instructing the technologist to execute the Patient Consent form was also out of the technologist's "scope of practice."

Upon my questioning of many of these "new" rules, I was met with great hostility and anger. No matter who I tried to contact locally for assistance, someone in a higher position seemed to be blocking anyone who was willing to help me with the issues I had reported. The hostility I was met with paved the way for the barrage of retaliation I have endured since making my disclosures to numerous agencies, such as, OIG, OAWP, OSC, and including Senators Grassley and Ernst.

The big reveal of the impact of improper cancellations of radiology orders came on February 22, 2017, when a Veteran presented for a CT of the chest for a LUNG CANCER screening. There was a history of smoking since age 13. That cancelled order would eventually be found to have been improperly cancelled by the Radiology Service Secretary-only the Physician who ordered it should have cancelled it. This order had been cancelled 19 days prior to the appointment, meaning that the mysterious cancellation had not been adequately reviewed for nearly three weeks and suggesting that it had been part of a "block" or "mass" cancellation.

The lead technologist at the time, when attempting to register what should have been an active order, inquired "why can't I register this, there is no order." Upon investigation, I realized there was an issue due to the original order having been cancelled by the Service Secretary, who is not a licensed practitioner. This violation of policy was magnified when the lead technologist then took it upon himself to "Reorder" the Veteran's exam, in effect acting as the Veterans care provider. This is completely beyond the Scope of Practice of a Radiologic Technologist. Orders are only valid when initiated by a Licensed Independent Practitioner. The lead technologist went on to hide what had been done by destroying the "New" order and passing off the paperwork for the cancelled order as bona fide, stating to a co-work-

er, "This one is ready," and implying that the Veteran was ready for a valid exam, properly ordered by a Licensed Independent Practitioner. This is when I knew something was wrong.

I informed my co-worker of the issues and specifically instructed him to "hang on to that paperwork, this is going to come back around." I had no knowledge at the time this was anything other than an Iowa City issue, but it has since become an ongoing national investigation of improper radiology cancellations by the VA Inspector General. Some 12,660 orders were cancelled at the Iowa City VA Medical Center alone, according to the sworn testimony of our Administrative Officer.

My co-worker at the time voiced his concerns of these unprecedented actions to management, and I voiced mine to Patient Safety. In no realm of health care is this practice of cancelling a physician's order acceptable. Normally, only the physician who placed the order would cancel the order. Every day for the months to follow, my co-worker and I would uncover multiple scheduled patients with their orders cancelled by management and ancillary staff. In the weeks to follow I would again contact patient safety officers, compliance officers, AFGE, and the Joint Commission (JACHO) Readiness Manager with my concerns of the mass cancellations we were seeing in radiology.

Anyone trying to assist me or make their own disclosures was met with every roadblock you can imagine, from sham Administrative Investigation Board investigations, to blatant retaliation by not only management, but other employees recruited by management. The harassment caused a co-worker to leave the VA entirely.

By June of that same year, I was informed that one of the staff radiologists was now complaining of my job performance. This complaint came at approximately the same time of my first disclosure to Senator Grassley. Months later, as I reviewed the testimony and documents used by the Administrative Investigation Board to justify my removal, I became aware that just days after I submitted an Electronic Patient Safety Report on June 22, 2017, the Administrative Officer solicited others in the department to forward to her any adverse reports on me that they could come up with. These false allegations were exactly the pretext upon which the VA proposed my removal six months later, and included, "Failure to follow hospital Policy and procedure, failure to follow standard operating procedure, failure to assist a radiologist during a contrast reaction, and failure to follow physician instruction on patient positioning."

During that same timeframe, ironically, I was also nominated for and awarded a "Good Catch Award," submitted to the agency by a co-worker for my actions regarding a Veteran's poor renal function. After discovering the potential for complications due to an order for intravenous contrast, I alerted the proper staff to ensure the Veteran's care and treatment were NOT jeopardized by the contrast. Only by accident was I made aware of this award the day after I was to have received it at the All Employee Forum from our Medical Center Director, Judith Johnson Mekota. After that, it would take me almost four months of continually asking the director and her aid, before finally receiving my pin and certificate via interoffice mail. Because I was later banished from the main facility, the award was forwarded to me by a co-worker; it had been sent to the Radiology department and placed in my mailbox which had been stripped of my name.

On July 12, 2017, while a Joint Commission Survey Consultant was at the facility reviewing numerous processes in the CT area, my co-worker and I disclosed to the consultant many of our concerns, including technologists being instructed to act outside the scope of their practice. The consultant later confirmed that the ordering and "protocoling" of exams by CT technologists was improper and must cease. Yet, as I have heard from others to scared to come forward, the cancellations have continued.

During this entire time while I was questioning the improper cancellation of orders, management at the Iowa City VA consistently referenced the "DUSHOM directive," Outpatient Radiology Scheduling Policy and Interim Guidance, VAIQ 7722255, of August 12, 2016, as justification. This directive begins with the declaration that "orders can be placed as much as 390 days in advance," yet management was cancelling orders as "expired" that were within days of the date the Veteran was scheduled to appear for care. This is but one example of management's flawed and twisted interpretation of this directive.

Later, after the VA detailed me out of the main facility, I learned from others to afraid to speak up that numerous specialty clinics where keeping secret lists of Veterans who would present for their appointments and NOT have received the prior imaging required for that appointment. A case manager of the Urology clinic informed me of this practice, and upon investigation and questioning, other case managers and Nurse Practitioners from Urology, Pulmonary, Ear, Nose and Throat

(ENT) Hematology and Oncology all admitted to having similar lists. Upon learning of these lists, I contacted OIG, with the permission of the case managers and Nurse Practitioners to release their names, and reported that "they would gladly speak with an OIG official," should they be asked. To my knowledge, there has been no follow up from OIG regarding my complaint.

On July 27, 2017 I was summoned to the Chief of Imaging Service office. This was to be the beginning of my "Banishment," from the hospital setting. I was given a "not to exceed 120 days" detail letter and told to immediately report to the Federal Building. No specifics of why I was being detailed were given. I was handed a piece of scratch paper with "Post Office," and "Find Savanah," written on it. Upon my arrival at the partially abandoned post office building in downtown Iowa City, I found the building locked with an access control system and I had not been given the code. There were no signs or identifiers to guide me once inside the building, but this was just an introduction to the types of retaliation I have encountered over the past 2 ° years of being a whistleblower by the Agency.

Following my detail to the partially abandoned federal building, I was targeted by a sham AIB investigation. In August 2017 I was told to appear for testimony before the AIB, but I was not given a charge letter, only informed that the AIB was addressing "issues in radiology." Soon after I began to testify, it became clear from the accusatory nature of the questions, that I was the target.

At that same time I had again contacted Senator Grassley, and I continued to contact Senator Ernst, whose office got me in contact with the OSC disclosure unit. I then began the tedious process of filing Forms 11 and 12 with OSC. I was also given contact information for OAWP and in December of 2017, I formally filed with them after a telephonic conversation with a triage case manager. This would lead to my sending hundreds of emails and skype messages to OAWP, attempting to get any information or progress reports about my case. I do not recollect ever being contacted by OAWP, I had to initiate all communication. In the meantime my detail was extended-"not to exceed" 120 days, again.

In November 2017, prior to the release of the AIB report, and after my initial contact with the intake and the retaliation unit lawyers of OSC, I was made aware that I had been the target of a patient abuse allegation which is what prompted my removal from direct patient care. On December 28, 2017, the Chief of Staff, Stanley L. Parker, proposed my termination. It was at this time that I was given the testimony and exhibits from the sham AIB investigation. After reviewing the entire 4000 plus pages and prompted by the amount of false testimony it contained and the apparent attempt by management to cover up the wrongdoings at the VA Medical Center Iowa City, I sought assistance with the process of "Blowing the Whistle." I had been referred to as being "Toxic," and "Bi-Polar" by the JACHO Readiness Manager and Administrative Officer of Imaging Services, and it had been reported to me that the Imaging Supervisor had warned co-workers, "not to let Jeff get his hooks into them."

It wasn't until I reviewed the testimony and exhibits that I became aware of the numerous Reports of Contact aimed at me and submitted by the recently assigned Cat Scan Supervisor who had been promoted twice with a year, likely rewarding him for his willingness to retaliate against me. It is my belief that I was targeted for this barrage of Reports of Contact because of my whistleblowing and part of the effort to have me dismissed from my position. That Cat Scan Supervisor also made several attempts to discipline me for bogus and unfounded allegations, alter the scope of my duties, or simply harass me only to be blocked or reversed with help from AFGE.

Beginning in July 2017, VA employees retaliated against me by filing multiple bogus complaints with the Iowa Department of Public Health and the American Registry of Radiologic Technologists, the national association that maintains my certifications. All of these allegations have been investigated and dismissed as having no merit and no action is needed but this particular retaliation is incredibly hurtful and could result in the loss of my livelihood.

The process of seeking assistance as a whistleblower was truly confounding. Do you file with EEO, OSC, OAWP, OIG, ORM, or JACHO? How would anyone know who to contact? Sometimes you contact the wrong agency, not knowing which way to go with no guidance or assistance. Although I was lucky enough to have two good intake lawyers at OSC, not everyone is that fortunate. For every person who gets to this point of being a whistleblower there are 1000 that have spoken up only to be removed, demoted, or intimidated into silence. After finally getting in touch with some of these remedial agencies, I was occasionally confronted with downright hostility, making the whistleblower feel as if "they" are the problem, or that their disclosure is not relevant or important. After that, I sat for months before finally prodding a response from OAWP, or subsisting on the minimal correspondence from

OSC and OIG. During this ongoing two years of exile away from my patients, the VA has forced me to forego about one-third of my salary, shutting me off from "on-call" pay.

I have endured both physical and mental stress over the past 2 ° years of retaliation and whistleblowing, including Major Depressive Disorder and Social Anxiety Disorder. I have sought psychiatric counselling and started on medication for both disorders. I have had to endure multiple regimes of different drug combinations to find one that will afford me enough relief to allow me to function despite the depression. I also have had to start on medication for chronic stomach pain and discomfort caused by stress and nervousness. I am reluctant to attend any type of function outside of my home, because of the risk of a panic attack-I was forced to leave my nephew's wedding because of one. My social life has become non-existent and the headaches, nausea, stomach cramps, and diarrhea are at times debilitating.

My current professional situation, after 22 months, is unbearable. The VA has placed me in a fabricated position as a "records requester." I am NOT receiving approximately $20,000-$30,000 per year of "on-call" pay which is specifically stated in my job description and represented about one-third of my annual income. I have not had a performance appraisal for over three years. The mobbing and harassment continues, ranging from fabricated allegations against me, to the clothing I wear to my detailed position in the partially abandoned federal building.

A truly accountable upper-level management would have easily rectified the mass cancellation problem in its earliest stages by admitting there was a problem and mustering all-hands to correct it. But instead, they chose to blatantly fabricate excuses and present incorrect DUSHOM directives, trying to pass them off as permission to continue illegal activity. They then fabricated and pursued egregious accusations against me, the person who spoke up for the core VA values and our Veterans. Some of my co-workers who were similarly committed to high-quality patient care chose to leave the VA rather than endure the toxic leadership.

There is a culture of fear and retaliation that the VA uses as the weapon to silence the whistleblower. I am the prime example that the Iowa City VA has made to silence all employees. I have heard everything from "look at the trouble Jeff is in," to "you don't want to end up like Jeff," but I feel the worst is to have been asked "what did you do?" And the answer is, "I TOLD THE TRUTH." Other employees can see what happened to me, the VA destroyed my career because I told the truth. They will not speak up.

I am concerned about the lack of accountability for those responsible for the mass cancellations. I have been banished for 2 years, away from patient care, with no end in sight, while the Administrative Officer who was responsible for the cancellations and the direction to cancel the orders for those needed exams has faced no repercussions. Likewise, the Cat Scan Supervisor, implicated in the cancellations and the retaliation was returned to duty promptly after a 120-day detail. There has been absolutely NO discipline for those who broke the rules and retaliated against me for speaking the truth. Where is our SPEED OF TRUST, I CARE, and NO FEAR that is constantly touted by management? Where is the accountability preached by OAWP, where is the TRANSPARENCY everyone speaks of? The only information I received on OAWP was an email from the AFGE president stating that one particularly sensitive email that I provided to OAWP was forwarded to hospital management and then thrown in the union representative's face to be used against me as evidence of my not being a team player.

One of the most important questions I have for the committee is who will stand up for the best quality CARE our Veterans need and deserve? If not for the VETERAN, I would not be a whistleblower, I would not be needed. When I think of why I am doing all of this, I think of my brother, a medically retired Chief Warrant Officer 4, who served 20 years before a life-threatening accident in Iraq that took him out of the military. The thought of him needing any type of care and it being jeopardized by individuals who are not qualified to cancel, alter, or order a life-altering test is unfathomable to me. I have other immediate family members, father and uncles, that also receive their care at the VAMC. The Veterans I am trying to protect and help have become an extended family to me. I know hundreds of them by name, their histories, their family scenarios, and their loved ones. As I have continually stated in this process: This is someone's Mother, Father, Son, Daughter, Husband or Wife.

Taking care of my patients and ensuring the best possible care for our Veterans is why I am here and it is what I love. At this point and time in my life I haven't much to lose or anything to gain. I am 51 years old, and my life has been very good. However, the Veterans that I am here for, to stand up for, and be a voice for, DO have a lot to lose. THEIR LIVES.

Thank you.

Prepared Statement of Dr. Minu Aghevli

Thank you for having me today. It's an honor to be here.

I am the program coordinator of the opioid agonist treatment program at the VA Maryland Health Care system in Baltimore, Maryland. We provide medication assisted treatment for over 400 opioid dependent veterans. I've been with the VA almost twenty years, and in this role for over ten. Throughout my career, I have consistently received outstanding ratings on my performance evaluations, and I have been awarded multiple Gold VA Pins for excellent customer service. Our program treats one of the most vulnerable and stigmatized group of veterans in the VA system, who are at an extremely high risk for overdose, suicide and other deaths. Many are indigent. I love my job and the veterans that I treat. I have spent years developing relationships with my patients and have earned their trust and respect. I can't imagine any job I'd rather do. But for the past five years, the VA has consistently impeded my ability to provide care to veterans who need it the most, at the expense of those veterans, and in order to prevent me from speaking out about patient care issues.

Most recently, on April 24, 2019, the Chief of Staff and Medical Center Director summarily suspended my clinical privileges under circumstances which could only lead to the conclusion that they were revoked because I blew the whistle. I have not been able to provide care to veterans since then and there is no available recourse for me.

By way of background, for approximately five years, the VA has engaged in continuous retaliation against me, in what appears to be a concerted, systematic effort to oust me from the Agency. The retaliation started when I first reported concerns about the improper practices for maintaining a waitlist for veterans waiting to receive care for opioid treatment. Specifically, in the spring of 2014, following a nationwide Agency scandal concerning lengthy patient wait times, VA management began to convey to me that our waitlist was too long and they were concerned the waitlist would draw scrutiny from VA leadership and Congress. In order to reduce the waitlist, I was instructed to improperly remove veterans from the electronic waitlist by scheduling fake appointments for them in an imaginary clinic. This clinic was not tied to any provider or location, nor did it actually correspond to any real visits and accordingly, the veterans scheduled for these fictitious appointments were not actually receiving VA care.

The VA also pressured me to artificially reduce the number of patients on the waitlist through other improper means. This included making minimal efforts to contact indigent patients and then coding them as "care no longer needed" without confirming that care was, in fact, no longer needed; as well as scheduling patients for appointments without telling them, and then coding them as "no show" when they did not appear for the appointments about which they had not been notified. I was repeatedly pressured to make these changes, and I protested. I went through my chain of command including the

Deputy Director and Director of Mental Health, the head of my facility and ultimately to the Secretary of the VA. I also repeatedly communicated my concerns to Office of Inspector General ("OIG") and to this Committee. For example, in September 2015, the VA received a Congressional suspense asking about wait times for treatment. Due to our inappropriate removal of patients from the electronic waitlist, the official numbers were significantly less than the actual numbers of veterans waiting to receive care. When the VA deliberately sent these incorrect numbers to Congress, I again contacted OIG and also got in touch with this Committee.

For the past five years, VA management has made my life a nightmare and interfered with my ability to perform my duties but the Office of Special Counsel ("OSC") has repeatedly told me that the VA's actions are just not bad enough for them to take any action. Approximately one month after I complained of the improper waitlist practices, I was told that I would be summarily transferred out of my coordinator role and moved to an entirely different area of the hospital, where I would be performing work unrelated to substance abuse treatment or the area in which I had expertise. I filed with both OIG and OSC, and the transfer was rescinded at the last possible minute before it became effective. During the month that I was awaiting that transfer, I lost twenty pounds and almost had a nervous breakdown. However, OSC told me that since the VA had reversed the transfer, there was no adverse personnel action for them to address. Since then, I have been routinely reprimanded and subjected to fact findings about various frivolous and inappropriate things. I have been excluded from meetings, subjected to scrutiny and oversight that my colleagues are not, my functional statement has changed, and I have been

stripped of many duties which I previously performed. In June 2016, I was informed that I would be detailed to work in the Mental Health Executive Suite and prohibited from engaging in patient care. The VA did not provide any legitimate justification for its decision. I retained counsel and was ultimately reinstated to my position. I was again unable to obtain redress through OSC, who closed my case earlier this year, finding that the details did not constitute a prohibited personnel action.

Most recently, shortly after OSC closed out my earlier case, VA management again removed me from clinical care, this time also formally suspending my privileges. As a result, I am currently not able to provide care to veterans and am instead assigned to perform basic, data entry work. The letter that I received from the Medical Center Director stated that the suspension was because I visited one of our high-risk veterans at a community hospital after he had overdosed and then subsequently attempted to commit suicide. This reason is simply nonsensical and cannot be the true reason for the suspension of privileges. I had visited the veteran with the approval and authorization of the attending physician and the Director of the ICU at the hospital where the veteran was located. I have contacted the Maryland Psychological Association's Ethics Committee, and numerous other highly respected psychologists and physicians, all of whom agree that there are no concerns with my conduct. According to a Maryland Psychological Association Ethical Consult, the only ethical issue is the fact that the VA is forcing me to me abandon my patients. My actions were also in line with the VA's policies on assessment and follow up of suicide risk and providing mental health care to high risk veterans, an issue I am grateful this Committee has devoted a lot of attention to.

Since the suspension, I haven't been allowed to speak to any of my patients, plan for coverage of the program, or even sign my chart notes from the day that my privileges were suspended.

Despite the fact that I have been unnecessarily unable to provide care to high-risk veterans for two months, OSC has again proven to be a futile option. On June 4, 2019, OSC issued a preliminary determination letter stating that "[t]he suspension of privileges is not a personnel action covered by 5 U.S.C. § 2302."

In sum, the VA has been relentless in threatening me with action, taking limited action against me, and then evading any liability by reversing course. The constant harassment has ruined my life and impeded my ability to provide care to veterans. When I turned to it for help, OSC refused to take action and left me vulnerable to the Agency's sanctioned retaliatory actions.

Ultimately, the way the VA treats whistleblowers affects veteran care. I have taken care of some of my patients for close to twenty years. I see many of them every single day and as their therapist and the program coordinator, I am often one of the few constants in their lives. Every time I've abruptly disappeared, it is traumatic for them as well. After my suspension, I was not even allowed to visit a patient dying from cancer in our hospice unit to say goodbye, or call his family to offer my condolences after his death. These are certainly adverse outcomes. I've been punished for speaking up for a group of people who are often stigmatized, and that isn't right. They deserve better. Many of the veterans we treat, especially in substance abuse, don't have a lot of support in their lives or people who are advocating for them and letting them know they are worth fighting for. It's important to me to speak up when they are not receiving the treatment they deserve, because we need to convey a message that our veterans, and their treatment, are worth standing up for. I ask you to please join me in standing up for these underserved veterans and expand protections for whistleblowers so that we can continue ensure that these veterans receive the care to which they are entitled, without the VA undermining us by circumventing current law.

Prepared Statement of Rebecca Jones

Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to testify today on the vital role of whistleblowers at the Department of Veterans Affairs (VA), and on the steps you can take to protect those brave whistleblowers. I am Rebecca Jones, a Policy Counsel at the Project On Government Oversight. POGO is a nonpartisan independent watchdog that investigates and exposes waste, corruption, abuse of power, and when the government fails to serve the public or silences those who report wrongdoing. We champion reforms to achieve a more effective, ethical, and accountable federal government that safeguards constitutional principles.

The Role of Whistleblowers at the Department of Veterans Affairs

Whistleblowers at the Department of Veterans Affairs put their careers on the line every time they speak truth to power to ensure the best care possible for those who put their lives on the line to defend our country. In that way, VA whistleblowers are heroes serving heroes.

Disclosures by VA whistleblowers save patients' lives by bringing to light barriers to timely and effective medical care due to either negligence or intentional misconduct, exposing officials who have perpetuated a culture of abuse for decades, and freeing up taxpayer dollars that are being misused and that instead can and should go toward providing resources and care.

We've seen firsthand the profound and immediate impact whistleblower disclosures can have on quality of care at the VA. Many are familiar, for example, with the wait lists at Arizona's Phoenix VA Health Care System brought to light by VA whistleblowers. While the system's computer records falsely indicated that vets were getting timely medical appointments, a secondary and accurate wait list reflected the actual prolonged wait times that veterans were experiencing. That secondary list showed that approximately 1,400 veterans were waiting months to meet with a doctor. At least 40 of those veterans died waiting in the backlog tracked by the accurate list. [1] To add insult to injury, this wait-list scheme didn't just hide the magnitude of the problem from Congress and the public, it likely ensured that high-level officials received personal performance bonuses. [2] The VA inspector general found in 2014 that the way the VA cooked the books made it seem that the system operated efficiently. Taking advantage of this appearance, "leadership significantly understated the time new patients waited for their primary care appointment in their [leadership's] FY 2013 performance appraisal accomplishments, which is one of the factors considered for awards and salary increases," [3] according to the inspector general.

Unfortunately, the misconduct in Phoenix was not an isolated incident. Complaints of inaccurate VA wait lists can be traced back over a decade and all over the country, [4] and even after the Phoenix scandal, the abuse persisted. And whistleblowers continued to be essential in bringing those abuses to light.

For instance, in 2015 the VA inspector general released a report in response to this committee's request to investigate a whistleblower's disclosure of mismanagement at the Veterans Health Administration's Health Eligibility Center. [5] The inspector general substantiated many of the whistleblower's disclosures, finding that the Chief Business Office, the central authority for determining VA benefits eligibility and enrollment, had "not effectively managed its business processes to ensure the consistent creation and maintenance of essential data." [6] That mismanagement included deleting 10,000 or more unprocessed applications, and employees hiding applications in their desks. The IG noted that in the instance of employees intentionally hiding applications, the VA neither reported the incident to the VA inspector general, nor did it discipline the employees responsible because leadership had played a part in the situation. [7]

In 2017, two whistleblowers disclosed that a secret wait list in Omaha hid the fact that 87 veterans faced inordinate delays for mental health appointments. Congressional attention and pushback helped to highlight this incident, but no employees were terminated from employment. [8]

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[1] Scott Bronstein, Drew Griffin and Nelli Black, "Phoenix VA officials put on leave after denial of secret wait list," CNN, May 1, 2014. http://www.cnn.com/2014/05/01/health/veterans-dying-health-care-delays/

[2] Chelsea J. Carter, "Were bonuses tied to VA wait times? Here's what we know," CNN, May 30, 2014. https://www.cnn.com/2014/05/30/us/va-bonuses-qa/

[3] Department of Veterans Affairs Office of Inspector General, Veterans Health Administration - Interim Report - Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System, May 28, 2014. https://www.va.gov/oig/pubs/VAOIG–14–02603–178.pdf

[4] Rich Gardella and Talesha Reynolds, "Memos Show VA Staffers Have Been 'Gaming System' for Six Years," NBC News, May 13, 2014. https://www.nbcnews.com/storyline/va-hospital-scandal/memos-show-va-staffers-have- been-gaming-system-six-years-n104621

[5] Department of Veterans Affairs Office of Inspector General, Veterans Health Administration, Review of Alleged Mismanagement at the Health Eligibility Center, September 2, 2015. https://www.va.gov/oig/pubs/VAOIG–14- 01792–510.pdf (Hereinafter, IG Report)

[6] IG Report, p. ii.

[7] IG Report, pp. 14, 17.

[8] Steve Liewer, "Nebraska-Western Iowa VA kept secret waiting list for some mental health appointments," The World Herald, October 16, 2017. https://www.omaha.com/news/military/nebraska-western-iowa-va-kept-secret- waiting-list-for-some/article—c428a382–320c-560d-bbee-eb0a40ee6b23.html; Steve Liewer and Joseph Morton, "Secret waitlist delayed care for 87 veterans at VA hospital in Omaha, led to departure of 2 employees," The World Herald, October

Continued

And just this month, a whistleblower came forward alleging that, yet again, VA facilities are secretly keeping separate, miles-long wait lists-three times the size of the public lists-to conceal long delays in care. As you know, this committee and its counterpart in the Senate sent a letter to the VA seeking an explanation.[9] Now, the whistleblower who exposed the wait list is claiming that he is being retaliated against professionally for his disclosure.[10]

In all these instances, it took whistleblower disclosures for the public to learn what happened-a nearly universal truth across the federal government.

And yet, across the federal government, blowing the whistle continues to be a risky business: Even though federal employees are legally protected for exposing wrongdoing, they're likely to face retaliation for doing so. A 2010 survey revealed that about one-third of federal employee whistleblowers say they experience "threats or acts of reprisal, or both."[11] And potential whistleblowers are discouraged from making disclosures at every turn, whether directly by their supervisor or indirectly by seeing their co-workers retaliated against for speaking out for what's right. All the while, retaliating supervisors go unpunished, or worse-get rewarded. The adage that no good deed goes unpunished is profoundly true for VA whistleblowers.

In 2014, POGO investigated problems at the VA by inviting VA whistleblowers to make secure disclosures to us online. Working with the Iraq and Afghanistan Veterans of America, we received disclosures from approximately 800 VA employees, contractors, and veterans in just a month's time. The disclosures were diverse in both the problems they exposed and the employees making them. Disclosures ranged from a pharmacy technician who faced retaliation for repeatedly reporting missed, late, and expired doses of medication administered to patients, to a nurse being forced out of her job after speaking up for her patients whose injuries were being severely neglected.[12]

In reviewing the disclosures, the theme was clear: VA whistleblowers were terrified of speaking out for fear of losing their livelihood. "Management is extremely good at keeping things quiet and employees are very afraid to come forward," one whistleblower explained.[13] Worse, not only were whistleblowers being attacked by their employer, the VA inspector general investigating their disclosures or retaliation claims was often worsening the situation by exposing the whistleblowers' identities. POGO soon experienced this toxic culture for ourselves, as the then-acting VA inspector general, Richard Griffin, attempted, unsuccessfully, to force us to hand over the database of VA whistleblower complaints we'd complied.[14]

In 2018, after a change in inspector general leadership, then-acting VA secretary Peter O'Rourke tried to intimidate the VA's newly Senate-confirmed inspector general, Michael J. Missal, in an attempt to kill an inspector general investigation.[15] Missal raised the alarm when his office wasn't getting requested information and documentation from the agency about the Office of Accountability and Whistleblower Protection-documents that the inspector general is entitled to under the Inspector General Act.[16] In what seemed like a desperate attempt to get the inspector

31, 2017. https://www.omaha.com/livewellnebraska/health/secret-waitlist-delayed-care-for- veterans-at-va-hospital-in/article—5048df5a-bb65–11e7–932b-af5b8746deef.html

[9] Letter from Chairman Mark Takano of the House Committee on Veterans' Affairs, and Ranking Member Jon Tester of the Senate Committee on Veterans' Affairs to Robert Wilkie, Secretary of the U.S. Department of Veterans Affairs, on veterans' access to timely health care, June 4, 2019. https://www.dropbox.com/s/4gcsnmq3d8aq9qe/2019.6.4%20Takano%20and%20Tester%20Wait%20Times%20Lett er.pdf?dl=0

[10] Joe Davidson, "Does VA have a secret wait list for health care? Key members of Congress want to know," The Washington Post, June 5, 2019. https://www.washingtonpost.com/politics/does-va-have-a-secret-wait-list-for- health-care-key-members-of-congress-want-to-know/2019/06/04/28d149e2–8717–11e9-a491- 25df61c78dc4—story.html

[11] Merit Systems Protection Board, Blowing the Whistle: Barriers to Federal Employees Making Disclosures, November 2011, p. i. https://www.mspb.gov/mspbsearch/viewdocs.aspx?docnumber=662503&version=664475&application=ACROBAT

[12] Testimony of Lydia Dennett, Project On Government Oversight, before the Senate Committee on Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, November 6, 2015, pp. 1–2. https://www.appropriations.senate.gov/imo/media/doc/110615–Dennett-Testimony1.pdf (Hereinafter Dennett Testimony)

[13] Dennett Testimony, p. 3.

[14] Letter from Richard Griffin, then-Acting Inspector General, Department of Veterans Affairs, to Project On Government Oversight, regarding subpoena to POGO, May 30, 2014.

[15] Joe Davidson, "As inspectors general are celebrated, VA tried to intimidate its IG," The Washington Post, July 10, 2018. https://www.washingtonpost.com/news/powerpost/wp/2018/07/10/inspectors-generals-are-celebrated-as-va- tried-to-intimidate-its-ig/ (Hereinafter, IG Intimidation)

[16] The Inspector General Empowerment Act of 2016 added clear access to agency records for inspectors general. Public Law 114–317, Sec. 5. https://www.congress.gov/114/plaws/publ317/PLAW–114publ317.pdf

general off his back, the acting secretary wrote, "You are reminded that OIG [Office of Inspector General] is loosely tethered to VA and in your specific case as the VA Inspector General, I am your immediate supervisor. You are directed to act accordingly."[17] Of course, the idea of an inspector general being subservient to an agency head is wholly contrary to both the spirit and the design of federal inspectors general. Nonetheless, the VA apparently felt entitled to lash out against the independent investigation.

Thanks to this committee's leadership[18] and that of its counterpart in the Senate,[19] the backlash against O'Rourke was swift and bipartisan. But the lesson is clear: The modus operandi at the VA, starting at the top of the agency, is to quash investigations and dissent by bullying investigators and retaliating against whistleblowers-all to the detriment of veterans and taxpayers.

The Office of Accountability and Whistleblower Protection

In April 2017, the Office of Accountability and Whistleblower Protection (OAWP) was created through Executive Order 13793,[20] which was later codified and expanded upon by Congress when the VA Accountability and Whistleblower Protection Act was passed into law.[21]

A merging of VA's Office of Accountability Review and the Central Whistleblower Office, the OAWP is an internal fact-finding body that:

> serves to improve the performance and accountability of VA senior executives and employees through thorough, timely, and unbiased investigation of all allegations and concerns. Where these actions are found factually true, OAWP will provide recommended actions related to the Senior Executive or other senior leader's removal, demotion or suspension based on poor performance and/or misconduct. Additionally, OAWP provides protection of valued VA whistleblowers against retaliation for their disclosures under the whistleblower protection provisions of 38 U.S.C. section 714.[22]

The office is broken into six sub-offices:

- Executive Office of the Director, the overseer and liaison between OAWP and VA leadership;
- Triage Division, the first point of contact for whistleblowers both in making initial disclosures and in reporting retaliation, and the overall case manager that sends intake to different offices, depending on content;
- Investigations Division, the office that conducts investigations into whistleblower retaliation and senior official misconduct allegations when referred to them by the Triage division;
- Advisory and Analysis Division, which recommends corrective action to senior VA leadership based on OAWP investigations, and trains VA leadership on the Accountability Act;
- Knowledge Management Operations, which maintains and creates structural databases for OAWP's work, and;
- Human Resources and Office Support, which provides support to OAWP staff, and conducts external affairs.

As of last year, OAWP was supported by 73 employees.[23]

In order to be resolved, all VA whistleblowing disclosures must now go through OAWP at some point. Even those that an employee files with the Office of Special

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[17] Letter from Peter O'Rourke, Acting Secretary of Veterans Affairs, to Michael Missal, Inspector General, U.S. Department of Veterans Affairs, about access to documents concerning the Office of Accountability and Whistleblower Protection, p. 2. https://assets.documentcloud.org/documents/4529198/Letters-Between-Missal-and- O–Rourke.pdf

[18] House Committee on Veterans Affairs, "RM Walz Responds To Unprecedented Attack By Acting VA Secretary O'Rourke On VA Inspector General," June 18, 2018. https://veterans.house.gov/news/press-releases/rm-walz- responds-unprecedented-attack-acting-va-secretary-o-rourke-va-inspector

[19] IG Intimidation

[20] Executive Order 13793, "Improving Accountability and Whistleblower Protection at the Department of Veterans Affairs," April 27, 2019. https://www.federalregister.gov/documents/2017/05/02/2017–08990/improving- accountability-and-whistleblower-protection-at-the-department-of-veterans-affairs

[21] Public Law 115–41, Codified at 38 U.S.C. § 323.

[22] Department of Veterans Affairs Office of Accountability and Whistleblower Protection, Report to The Committee on Veterans Affairs of the Senate And The Committee on Veterans Affairs of the House of Representatives On the Activities of the Office of Accountability and Whistleblower Protection, June 2018, p. 3. http://federalnewsnetwork.com/wp-content/uploads/2018/07/ANNUAL–REPORT–Office-of-Accountability-and- Whistleblower-Protections-Activities.pdf (Hereafter, OAWP Report)

[23] OAWP Report, p. 6.

Counsel or the VA inspector general must eventually go through the Triage Division for processing.[24]

While the office has now been in operation for about two years, there is very little evidence to indicate that it's functioning as intended. In June 2018, the OAWP released its first annual self- assessment report, as required by statute. While it's clear from the report that the office was still being stood up, it nevertheless saw a predictably huge amount of intake, reporting having received "nearly 2,000 submissions" from whistleblowers in its first year.[25]

Unfortunately, despite the office's mission, that large intake does not seem to have translated into any significant trend of disciplinary actions against senior VA officials found to have retaliated against VA whistleblowers. From OAWP's own reporting, senior executives and senior leadership made up only 0.1% of disciplinary actions taken during OAWP's tenure. That 0.1% maintains the average levels seen since 2014 and, in fact, is actually a decrease from recent years. The total number of disciplinary actions taken from June 2015 to June 2016, for example, was 15 cases, and from June 2016 to June 2017 there were just 9. In OAWP's first year, June 2017 to June 2018, there were only 7.[26]

Instead, during OAWP's existence, 36.4% of disciplinary actions were taken against GS rank 1 through GS rank 6 employees.[27] Based on that reporting, it's difficult to conclude that OAWP is succeeding in its mission of holding VA senior executives accountable for their actions. It reads, instead, like they're maintaining the status quo of focusing disciplinary action on lower level employees.

The Government Accountability Office (GAO) released a review in July 2018 of the VA's employee misconduct procedures and practices, and provided more insight into what is causing this imbalance.[28]

The GAO reported that senior officials engaging in misconduct are not being consistently held accountable at the VA. When a retaliation claim was substantiated and investigators proposed disciplinary action, the VA didn't always follow through with that recommendation. GAO found that the VA failed to discipline senior officials in 5 out of the 17 cases with substantiated misconduct.[29] Information from OAWP seems to explain why: The agency's own attorney is pre- reviewing disciplinary decisions before they're finalized.[30] Such a review indicates that the agency's attorneys could reject proposed disciplinary action, and it risks exposing the identity of the whistleblower to senior agency executives.

Although OAWP's authorizing statute rightfully forbids the Office of General Counsel's (OGC) involvement in whistleblower claims,[31] OGC is nevertheless heavily involved. Once OAWP's advisory and analysis division completes their disciplinary proposal based on the underlying investigation, they send that proposal to the OGC's office for legal review.[32] Although the OAWP and the OGC are both housed within the VA, their interests are not the same. The OGC's mandate is to represent the best the interests of its client: the VA. Repeated disciplinary actions taken against VA senior officials is not in the VA's best interests. It could affect public perception of the VA's work, future funding, and individual jobs. The OAWP, on the other hand, is in charge of fact-finding and analysis independent of any ulterior motivation to keep the agency out of legal trouble. Allowing agency attorneys to provide legal analysis or review of a proposed disciplinary action is akin to a judge allowing the defense attorney in a criminal case to overturn the judge's decision against a defendant. It's highly unethical for OGC to weigh in on a whistleblower retaliation complaint, because OGC's sole interest is the legal representation of the agency.

GAO also found that employees who stand accused of whistleblower retaliation are reviewing, and sometimes even participating in, their own misconduct investigation due to the VA's systematically weak internal controls to monitor who is in-

[24] OAWP Report, p. 8.
[25] OAWP Report, p. 9.
[26] OAWP Report, pp. 27–28.
[27] OAWP Report, p. 30.
[28] Government Accountability Office, Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability, July 2018. https://www.gao.gov/assets/700/693268.pdf (Hereafter, GAO Report)
[29] GAO Report, introduction.
[30] GAO Report, p. 94.
[31] The VA Accountability and Whistleblower Protection Act of 2017 § 323(e): The Office shall not be established as an element of the Office of the General Counsel and the Assistant Secretary may not report to the General Counsel. https://www.congress.gov/115/plaws/publ41/PLAW–115publ41.pdf
[32] GAO Report, p. 94

volved in an investigation and lax enforcement of the controls that do exist.[33] This practice leads, according to the GAO, to confusion about the role of OAWP and about the office's responsibilities, and could make whistleblowers feel "uncomfortable or intimidated."[34] GAO found instances, for example, where managers "investigated themselves for misconduct." Further, the GAO explains in its report, the VA lacks the oversight measures necessary to ensure that misconduct allegations are investigated by an entity separate from the control or influence of the office accused of misconduct.[35]

GAO also found that VA officials were not following separation-of-duty policies. Such policies require that a final decision on disciplinary action against an individual found to have engaged in whistleblower reprisal be made by an official at least one rank higher than the individual or team who proposed the discipline. This is to ensure multiple levels of review and to preempt any undue influence that someone charged with misconduct might have on the individual or office proposing the discipline. Unfortunately, GAO's report indicates that this is not happening consistently at the VA. Instead, the individuals recommending whether officials should be punished or not were also the individuals deciding whether or not to implement that recommendation. GAO found that 73 VA officials "acted as both the proposing and deciding official" in cases involving removal for employees who engaged in misconduct. GAO followed up on 29 cases of VA officials who violated a separation of duty policy at least twice, and not a single one had been disciplined.[36]

GAO's report, combined with OAWP's own first-year numbers, do not paint a promising picture of solving the whistleblower retaliation problem within the VA. OAWP's existence hasn't led to greater accountability of senior officials, and hasn't led to greater safety for VA whistleblowers when they disclose abuse.

Fixing a Culture of Retaliation

The problems uncovered by the GAO that relate to OAWP are consistent with what we have seen in other attempts to internalize whistleblower investigations within an agency. This is why POGO recommended increased structural independence for the office in previous Congressional testimony.[37] The OAWP is fighting an uphill battle because it is trying to solve individual claims while simultaneously combating a persistent culture of whistleblower retaliation from within the agency itself. And this concept of a retaliatory culture is no mere speculation: The GAO found that VA whistleblowers are "10 times more likely than their peers to receive disciplinary action within a year of reporting misconduct."[38]

Instead of changing the culture of whistleblower retaliation, keeping investigations under the wing of the larger agency creates an internal clearinghouse used to silence employees speaking out.[39] According to recent reports from VA whistleblowers, several individuals who have contacted the office have had their identities exposed. As a result, the VA inspector general is currently conducting its own investigation into this issue.[40]

The VA's stated vision is to "to provide veterans the world-class benefits and services they have earned-and to do so by adhering to the highest standards of compassion, commitment, excellence, professionalism, integrity, accountability, and stewardship." Based on the information available, it's hard to draw any conclusion other than that the agency is failing to make this vision a reality and has been for some time. While OAWP may have been created out of a desire to shift the retaliatory culture, it lacks the structural independence it needs from an agency stymied by a pervasive internal culture of whistleblower retaliation, so the cards were stacked against it from the outset.

Recommendations for Reform

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[33] GAO Report, introduction.

[34] GAO Report, p. 55.

[35] GAO Report, introduction.

[36] GAO Report, pp. 44–45.

[37] Liz Hempowicz, "POGO Testimony on VA Accountability and Whistleblower Protection Act," May 17, 2017. https://www.pogo.org/testimony/2017/05/pogo-testimony-on-va-accountability-and-whistleblower-protection-act/

[38] U.S. Government Accountability Office, Fast Facts on "Department Of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability," https://www.gao.gov/products/GAO–18–137

[39] Daniel Van Schooten, "POGO and Others Oppose 'Trojan Horse' Office for VA Whistleblowers," September 30, 2016. https://www.pogo.org/analysis/2016/09/pogo-and-others-oppose-trojan-horse-office-for-va-whistleblowers/

[40] Eric Katz, "New Whistleblower Protection Office Is Under Investigation for Retaliating Against Whistleblowers," Government Executive, April 16, 2019. https://www.govexec.com/oversight/2019/04/new-whistleblower-protection- office-under-investigation-retaliating-against-whistleblowers/156314/

Changing the culture of whistleblower intimidation and retaliation at the VA isn't an easy lift, but it would surely have profound impacts for the veterans who rely on the VA's care. Holding senior officials accountable for their actions is vital for lasting change. It is also essential that the agency work to prevent retaliation in the first place by ensuring independent, comprehensive, and swift investigations, and providing quality training for employees on their rights. In doing that, the VA will demonstrate that they take whistleblower allegations seriously and will show employees that it's safe to come forward.

The first step toward improving the functionality of OAWP is ensuring that the office has the independence necessary to analyze and thoroughly investigate both whistleblower retaliation complaints and allegations of misconduct by senior officials. While the best course of action would be to remove OAWP's investigative functions from within the agency's structure entirely, we understand that such a sweeping reform may be a longer-term goal.

To immediately make the office more independent, Congress should mandate that the OAWP have its own office of legal counsel, circumventing any need to refer matters to the VA's Office of General Counsel. OAWP concurs with this recommendation, noting that relying on the OGC creates the appearance of a conflict and creates delays in resolving cases. [41]

To further increase independence, Congress should consider mandating more guidance and oversight from the U.S. Office of Special Counsel (OSC) and OAWP. Such guidance and oversight should include OSC review of OAWP's final recommendations for disciplinary action of senior-official misconduct as a means of quality control. This will also end reliance on agency officials, such as those in the agency's Office of General Counsel, who should be conflicted out of reviewing OAWP decisions.

Congress should mandate that OAWP develop and oversee a comprehensive and transparent system to ensure that those who are the subject of an investigation, and their immediate office, are not able to influence the investigation into their own behavior. Such a system must also ensure that separation of duty policies are upheld in practice. Individuals found to have knowingly and willfully violated these policies should face mandatory disciplinary action. As a part of this, OAWP should better track department-wide disciplinary action, so that they can follow up on whether senior officials are actually being disciplined, while ensuring the protection of the whistleblower involved.

Further, OAWP should implement robust, updated training regarding the options available to employees for reporting disclosures or whistleblower reprisal, the connection between OAWP and other investigative entities such as the U.S. Office of Special Counsel and the VA Office of Inspector General, and the rights of whistleblowers to make disclosures anonymously, as well as training on how a whistleblower's information is to be shared between investigative entities. At the time of OAWP's first report, they had yet to disseminate updated training materials. [42]

Congress should also consider broader reforms to the Whistleblower Protection Act to address issues that plague not just VA whistleblowers, but all federal employees who can claim protection from retaliation under the law. First, Congress should amend the law to include retaliatory investigations as a "prohibited personnel practice" in order to combat one of the most common forms of whistleblower retaliation used to intimidate and stifle those who speak out.

While the Whistleblower Protection Enhancement Act expanded protections for federal employees in 2012, employers responded to the stricter law by opening retaliatory investigations as a means to distract from the underlying disclosure without technically committing an actionable offense. [43] By reforming the law to include these investigations as a prohibited practice, whistleblowers would be protected from the outset of the retaliation, rather than having to wait for suspension or termination from their job.

Second, Congress should extend the right to a federal jury trial to federal employees who blow the whistle. Given prolonged delays in access to justice for whistleblowers who have been retaliated against, federal jury trials would ensure an expeditious, independent forum for whistleblowers to seek relief.

VA whistleblowers blow the whistle because they're honor bound to speak up when they witness violations of the country's trust or individual suffering caused by negligence or corruption.

[41] OAWP Report, p. 22.
[42] OAWP Report, pp. 20–21.
[43] Government Accountability Project, "Ban the Criminalization of Whistleblowers!" https://www.whistleblower.org/truthjailing/

Creating or empowering independent oversight bodies that help whistleblowers make disclosures benefits us all, but it's vital that Congress be willing to quickly amend laws that carry unintended consequences for those they were meant to protect. POGO thanks this Subcommittee for taking the next steps in investigating protections and processes at the VA for whistleblowers and we urge you to take action to expeditiously fix this broken system.

Prepared Statement of Thomas Devine

MR. CHAIRMAN:

Thank you for inviting testimony from the Government Accountability Project (GAP). This hearing is timely and necessary. Despite repeated legislation, a presidential Executive Order and national media scandals, the Department of Veterans Affairs (DVA) remains a free speech Death Valley for government whistleblowers. This is not surprising. Retaliation is ingrained in the culture of the DVA. It will take years of aggressive oversight and accountability before this agency respects the First Amendment or the Whistleblower Protection Act (WPA) in practice, rather than empty rhetorical promises. This conclusion reflects the bitter experience of whistleblower rights lawyers from all perspectives. Two of today's witnesses are from GAP's docket of ten DVA clients, representing 40% of the 25 whistleblowers whom I represent. That ratio is consistent with the U.S. Office of Special Counsel's (OSC) experience. This is an extraordinary record for one agency in the nearly two million Executive branch work force. Forty-percent of whistleblowers is an extraordinary number for an Agency that comprises less than 20% of the Executive branch work force. Our experience is consistent with that of attorneys at the Senor Executive Association (SEA) who represent management whistleblowers. Their disclosures are the highest stakes exposure of mission breakdowns threatening the health of America's veterans.

GAP is a nonprofit, nonpartisan, public interest organization that assists whistleblowers, those employees who exercise free speech rights to challenge abuses of power that betray the public trust. GAP has led or been on the front lines of campaigns to enact or defend nearly all modern whistleblower laws passed by Congress, including the Whistleblower Protection Act of 1989, the 1994 amendments and the Whistleblower Protection Enhancement Act.

Over nearly 40 years we have formally or informally helped over 8,000 whistleblowers to "commit the truth" and survive professionally while making a difference. We have been leaders in campaigns to pass 35 whistleblowers laws ranging from Washington, DC to the recently-enacted European Union Whistleblower directive, which created enforceable free speech rights in 28 member nations. This testimony shares and is illustrated by painful lessons we have learned from this experience. We cannot avoid gaining practical insight into which whistleblower systems are genuine reforms that work in practice, and which are illusory.

Our work for corporate whistleblower protection rights includes those in the Sarbanes-Oxley law for some 40 million workers in publicly-traded corporations, the 9/11 law for ground transportation employees, the defense authorization act for defense contractors, the Consumer Product Safety Improvement Act for some 20 million workers connected with retail sales, the Energy Policy Act for the nuclear power and weapons industries, and AIR 21 for airline employees, among others. Last year GAP was counsel for an amicus curiae brief filed by Representative Speier, as well as Senators Grassley and Johnson, which successfully defended the WPA burdens of proof for analogous corporate whistleblower statutes.

We teamed up with professors from American University Law School to author a model whistleblower law approved by the Organization of American States (OAS) to implement at its Inter American Convention against Corruption. In 2004 we led the successful campaign for the United Nations to issue a whistleblower policy that protects public freedom of expression for the first time at Intergovernmental Organizations, and in 2007 analogous campaigns at the World Bank and African Development Bank. GAP has published numerous books, such as The Whistleblower's Survival Guide: Courage Without Martyrdom. We have also published law review articles analyzing and monitoring the track records of whistleblower rights legislation. See "Devine, The Whistleblower Protection Act of 1989: Foundation for the Modern Law of Employment Dissent, 51 Administrative Law Review, 531 (1999); Vaughn, Devine and Henderson, The Whistleblower Statute Prepared for the Organization of American States and the Global Legal Revolution Protecting Whistleblowers, 35 Geo. Wash. Intl. L. Rev. 857 (2003); The Art of Anonymous Activism (with Public Employees for Environmental Responsibility and the Project on Government Over-

sight)(2002); and The Corporate Whistleblower's Survival Guide: A Handbook for Committing the Truth (2010).The latter won the International Business Book of the Year Award at the Frankfurt Book Fair. This spring, with the Project on Government Oversight (POGO) and Public Employees for Environmental Responsibility (PEER), we co-authored a survival guide for anonymous whistleblowers: Caught Between Conscience and Career: Expose Abuse without Exposing your Identity.

Along with POGO, GAP also is a founding member of the Make it Safe Coalition, a non-partisan, trans-ideological network of 75 organizations whose members pursue a wide variety of missions that span defense, homeland security, medical care, natural disasters, scientific freedom, consumer hazards, and corruption in government contracting and procurement. We are united in the cause of protecting those in government who honor their duties to serve and warn the public. Our coalition led the citizen campaign for passage of the Whistleblower Protection Enhancement Act (WPEA). The Coalition includes organizations for better government ranging from the Center for American Progress, the National Taxpayers Union and Common Cause, environmental groups from Council for a Livable World, Friends of the Earth and the Union of Concerned Scientists, conservative coalitions and organizations such as the Liberty Coalition, Competitive Enterprise Institute, American Conservative Defense Alliance and the American Policy Center, to unions and other national member based groups from American Federation of Government Employees and the National Treasury Employees Union, to the National Organization for Women. But the coalition itself is only the tip of the iceberg for public support of whistleblowers. Some 400 organizations with over 80 million members joined the petition for passage of the WPEA.

ILLEGAL GAG ORDERS

If there were any hopes that the DVA has learned from years of scandal and remedial legislation, the agency dashed them this month. On June 13 the DVA officially reaffirmed its illegal intolerance for freedom of speech by whistleblowers. The attached memorandum on media policy to all employees from the Acting Deputy Under Secretary for Health Operations and Management imposed the following policy:

Queries that may yield negative coverage or are controversial in nature must immediately be forwarded for review to the appropriate regional Office of Public and Intergovernmental Affairs (OPIA) staff and VISN public affairs contacts . to generate an approved response..

Regardless of subject, any query from national outlets also requires the same review. This includes outlets such as the Associated Press, Reuters, New York Times, Los Angeles Times, Wall Street Journal, Washington Post, Newsweek, USA Today, Huffington Post, National Public Radio, TIME magazine, CNN, and the network news and magazine programs of ABC, CBS, Fox, NBC and PBS.

While the memorandum further orders employees not to communicate with the media as government representatives on official time, there is no clarification that they have that right speaking as free citizens on their own time. As a result, on its face this prior restraint violates three provisions of federal law, including two in the unanimously-passed Whistleblower Protection Enhancement Act of 2012. (WPEA) - 5 U.S.C. § 2302(b)(13) and § 114 of the WPEA, as well as a longstanding appropriations law provision. As explained in the attached legal memorandum, both the WPEA and an annual appropriations rider since FY 1988 require that any nondisclosure policy contain a clarifying addendum with the following message: rights in federal whistleblower laws trump its restrictions. This agency policy is very clear about its free speech restrictions, and silent on employees' legal rights. Hopefully this hearing will lead to the DVA respecting the rule of law, at least in terms of official policy.

CASE STUDIES

Government Accountability Project's best contribution today will be sharing the nightmares of DVA whistleblowers who risked their professional lives to save the lives of America's veterans. Illustrative examples from our docket are below.

JAMES HUNDT

The 2014 "secret waiting list" scandal for Department of Veterans Affairs (DVA) hospital care horrified the nation, and sparked a serious corrective action effort that was making significant progress at ending both the backlog and the deception. Unfortunately, over the last two years the Veterans Health Administration (VHA) has gutted the effort by replacing virtually the entire team of over 175 seasoned, profes-

sional career employees at its Veterans Engineering Resource Center (VERC) with the green crew of a buddy system contractor. The civil service team had been aggressively imposing, working closely with hospitals to implement and inspect, corrective action. Its effective efforts initially led to agency commendations.

But they were all replaced in favor of a buddy system contract. The switch was accomplished through a reorganization illegally planned and controlled by the favored contractor. It reversed Commission on Care's internal agency recommendations and violated basic contracting and spending laws. To illustrate, the agency allowed the prospective contractor to draft a reorganization plan that would replace the civil service professionals with unqualified, completely inexperienced contractor staff. Since the civil service employees have been purged, on-site inspections have been replaced by an honor system in which facilities certify completion of various tasks. This helps to explain other testimony today such as Mr. Dettbarn's, concerning the persistence of secret waiting lists.

VERC Associate Director James C. Hundt persistently blew the whistle internally to challenge the reorganization. The agency then opened illegal retaliatory investigations on Mr. Hundt, using it to fire him on pretextual grounds after he challenged the reorganization. He led a group of staff whistleblowers, the most active ones receiving the same treatment. In a stunning display of pretextual double standards, the agency fired Mr. Hundt for seeking personal gain on government time, although he had checked for prior approval of the same actions that non-whistleblowers engaged in and received promotions.

This case of whistleblowing and reprisal calls for intensive congressional oversight to restore progress addressing the most serious challenge in recent years both to the DVA's integrity and the health of America's veterans. After initial support, since last year the U.S. Office of Special Counsel's efforts have become dormant, leaving the whistleblowers unemployed and further corrective action dysfunctional for the waiting lists. It also severely challenges respect for Congress' mandate in the Patient Protection Act, the Dr. Chris Kirkpatrick Whistleblower Protection Act and other recent statutory efforts against DVA whistleblower retaliation.

KUAUHTEMOC "KROD" RODRIGUEZ

Mr. Rodriguez is an Iraq war veteran and former infantry officer who was serving as a Management Analyst in the agency's Phoenix, Arizona Health Care System when he began blowing the whistle to the OIG, to Congress and to the media about what has since been recognized as the agency's worst facility. He was one of the key pioneer whistleblowers who broke the secret waiting list scandals. In addition to challenging the Agency's gross waste of funds and cronyism, as an advanced computer expert he disclosed that the agency incorrectly scheduled approximately 400 patients, while another 400 patients had been waiting over 120 days for an appointment and over 8,000 appointments were waiting to be scheduled. He later disclosed to Congress a list of 38,000 veterans waiting over 280 days for specialty care clinic appointments. He tracked how the agency was covering up the secret waiting lists. Using his computer skills, he has traced for Congress how the secret waiting lists were exponentially more severe than the agency had publicly conceded, and how the secret waiting lists extended well beyond Phoenix. Mr. Rodriguez not only disclosed the deception, but the tragic medical impacts including patient deaths.

In response, agency managers moved him to a small, windowless office without air conditioning in Arizona; placed him under surveillance; eliminated his supervisory authority; actively recruited mobbing allegations against him; lowered his performance appraisals, referred to him as a "rat" and "media whore"; failed to respond to death threats against him; placed him under criminal investigation; and subjected him to an AIB proceeding.

Thanks to intervention from the agency's Office of Accountability and Whistleblower Protection's mentoring program, Mr. Rodriguez has been placed in a new location where the harassment has subsided. But his career has been paralyzed by denial of promotions for which he is eminently qualified, and the agency has denied all misconduct in WPA proceedings.

DANIEL MARTIN

Mr. Martin was the Chief of Engineering Services at the Veterans Affairs Northern

Indiana Healthcare System ("VANIHCS"). He oversaw engineering operations at VANIHCS's two campuses (in Marion and Ft. Wayne, Indiana), and the nearby Marion National Cemetery, where he also supervised over 100 employees. After refusing attempted inducements by a contractor, he disclosed evidence to the DVA OIG that his superiors were engaged in illegally accepting gratuities, including at

least free meals and entertainment, and possibly cash bribes from the VA contractor, in exchange for steering and awarding illegal sole source contracts to that contractor in violation of long-established anti-bribery statutes and procurement regulations. One of the suspect contracts concerned the water purification system that is essential for sterilization of medical equipment and safe drinking water for patients. He later learned and disclosed evidence that the Indiana contracting abuses were not aberrations, but reflected corruption occurring nationally with contracts.

In response, the agency stripped Mr. Martin of his duties, assigned him to an isolated office that was unheated in winter and not air-conditioned in summer, and had him perform menial chores under supervision of a junior staffer. He was exposed to asbestos that he believes already is having a destructive medical impact. He was placed under three retaliatory investigations, primarily for an "altercation" that his so-called victims denied was more than a conversation. The third probe was conducted by an AIB that denied him access or even the identities of adverse witnesses.

Active intervention by OAWP, combined with GAP's Whistleblower Protection Act (WPA) appeal, prevented the agency from terminating Mr. Martin. But the Agency refused an OAWP-mediated solution to move him to Seattle, Washington, where the management said they would welcome him. Despite canceling his duties, Indiana officials said they could not spare Mr. Martin.

During his WPA appeal, Government Accountability Program depositions of the officials who retaliated against Mr. Martin established that they knew of his OIG disclosures when they acted, which they previously had denied under oath during an inquiry by the Office of Accountability and Review (OAR). It appears that Mr. Martin may finally be allowed to work in Seattle and stop being a prisoner of those he blew the whistle against. But for over three years his professional life has been a nightmare, because he challenged corruption that could threaten the lives of DVA patients and staff.

CHRISTOPHER "SHEA" WILKES

Shea Wilkes is another pioneer VA whistleblower for exposure of secret waiting lists at VA hospitals in 2014. The OSC found there was a "substantial likelihood" that his wait list disclosures were correct, but the Special Counsel later lambasted the VA Inspector General and the VA Office of Accountability Review for an obvious whitewash of this breakdown in their subsequent report on patient care.

While his disclosures sparked a national spotlight on the VA's deadly neglect of veterans, Mr. Wilkes faced serious reprisal after blowing the whistle. Ten days after his disclosure to Congress and the VA Inspector General, he was placed under criminal investigation regarding his access to and the source of the secret lists. He was also stripped of his duties, denied any new training, and steadily harassed in a hostile workplace environment. After four years of steady hostility, an OAWP mentoring effort helped relieve the pressure on Mr. Wilkes. He is currently working for a new hospital director and attempting to resolve an active complaint at the Office of Special Counsel.

Following his disclosures, Wilkes co-founded the 50+ member "VA Truth-Tellers" organization, one of the most effective whistleblower self-help groups currently operating today.

DR. NISHANT PAVEL

Dr. Patel is a psychologist with the Department of Veterans Affairs (VA) in New York whom the agency is gagging from attempting to help asylum seekers. For the last few years, he has volunteered with Weill Cornell Medical Center for Human Rights, an organization at Cornell's medical school that helps those individuals. He has assessed the mental state of numerous asylum seekers, and in six cases submitted affidavits on their behalf in immigration proceedings. No objection was ever raised by the Department of Homeland Security (DHS) or the VA to his submission of these affidavits. His work with the Center is pro bono.

Last year Dr. Patel planned to offer expert testimony on behalf of another asylum seeker. As with his previous work, he would receive no compensation for his testimony, nor would he be identified as a VA employee during the proceedings. Before he was able to testify, however, attorneys for the Department of Homeland Security (DHS) asserted that he could not testify without permission from the DVA.

Dr. Patel duly sought permission from his DVA superiors to testify, but was denied. The only explanation provided was that the VA would need permission from the Department of Justice (DOJ) but would not be able to get it. His supervisors also threatened him with criminal liability under 18 U.S.C. § 205 if he testified.

That statute bars government employees from acting as attorneys or agents for those in lawsuits against the United States.

The newly-created objections are a shameless legal bluff that defy well-established case law interpreting the First Amendment and 5 CFR § 2635.805, which governs outside activities of government employees. The threat of criminal liability is particularly baseless. There is no hint in statutory language of this extended application for § 205, which repeatedly has been rejected in court. Nonetheless, the DVA has refused to eliminate the gag order, and if he resumes helping asylum seekers Dr. Patel will risk termination and prosecution.

OFFICE OF ACCOUNTABILITY AND WHISTLEBLOWER PROTECTION

OAWP enjoys a legislative and presidential mandate to help whistleblowers to make a difference and defend themselves against retaliation. Its authority to grant temporary relief against retaliation initially had an outstanding impact, and is unprecedented. It made a difference in several cases described above. Unfortunately, despite genuine commitment from some leaders and an impressive initial track record, it has become a threatening source of frustration for whistleblowers as the rule, and an effective remedial agency as the exception.

This submission will not duplicate the in-depth analysis of my colleagues today on OAWP. However, it would be irresponsible not to share lessons learned about the basic causes of this frustration. Most basically, the Office lacks structural independence. In practice it cannot act without approval by the DVA Office of General Counsel, whose mission is to defeat whistleblower cases. This is a hopeless structural conflict of interest.

On a cultural level, the OAWP staff lacks empathy and whistleblowers frequently complain of hostility. Many of its investigators come from offices where they accumulated anti-whistleblower bias by spending their careers conducting retaliatory investigations of them. That does not end with a new duty station and job description.

OAWP lacks enforcement teeth for permanent relief. Agency officials have the discretion to defy it with impunity. For example, early in the Dan Martin case it negotiated a transfer to Seattle. But the same Indiana manager who refused to give Mr. Martin any duties defied the resolution on grounds that he could not be spared.

The Office inexplicably canceled its effective mentoring program. This effort had successfully defused conflict and shrank litigation by finding whistleblowers a fresh start with offices that would welcome their commitment to the agency mission, instead of being threatened by it.

Most fundamentally, OAWP operates on an ad hoc basis, without accountability to regulations. This maximizes employee confusion and enables arbitrary actions in any given case, and permits inexcusable wastes of resources that exhaust targeted employees. To illustrate, the Senior Executive Association has detailed how OAWP conducted seven lengthy, draining investigations of a manager that resulted in a five day suspension, only made possible by removing exculpatory testimony from the evidence file.

In short, without serious oversight, training and structural reform, this remedial office will degenerate into a Trojan horse for whistleblowers.

RECOMMENDATIONS

It is clear that changing the DVA's repressive way of life will require marathon persistence, both in terms of oversight and stronger legal controls based on lessons learned. Based on these experiences, GAP has teamed up with our colleagues today and Public Citizen to share the following recommendations to keep pace with circumvention of prior reforms.

AGENCY-WIDE RECOMMENDATIONS

- Jurisdiction to challenge retaliatory investigations as prohibited personnel practices when opened against the whistleblowers. Although made illegal in the Patient Protection Act, there is no enforcement mechanism.
- Jurisdictions to challenge Administrative Investigations Board proceedings as prohibited personnel practices, if initiated against an employee because of (or subsequent to) whistleblowing. AIBs should focus on halting abuses of power, not perpetuating them.
- Reform of the AIB structure and process so it stops being a "Star Chamber." Board proceedings should conform to the due process requirements of the Administrative Procedures Act and the constitution, such as the right to call witnesses and confront accusers.

- Roll back gutted due process for internal agency personnel rights, which have been exploited against whistleblowers. For example, if a PPP is alleged, employees should have 30 days to respond to proposed personnel actions.
- Prohibit the delegation of authority to apply Section 714 any lower than the director level, whether it be Network or Hospital. That is, any Section 714 disciplinary action would have to be proposed and decided by directors or higher.
- Extend to senior DVA executives the same protections in 5 U.S.C. § 714(e)(1)-(2) that apply to all other agency whistleblowers: after an alleged prohibited personnel practice, proposed termination, demotion or suspension cannot proceed without prior OSC approval. There should be analogous OAWP authority if an employee blows the whistle to that office.
- Provide temporary relief after an initial OSC, Inspector General or Merit Systems Protection Board Administrative Judge finding that there is a prima facie case under the Whistleblower Protection Act that an adverse action was taken because of whistleblowing. Few actions will be more effective to prevent retaliation than a realistic chance to freeze retaliatory faits accompli that exile whistleblowers for years while legal actions proceed at a molasses pace.
- If necessary as a pilot program, provide a jury trial "kick-out option" for whistleblowers who do not receive a legal decision on appeals within 180 days. This would be similar to provisions under the Energy Reorganization Act (42 U.S.C. § 5851) giving this option to Nuclear Regulatory Commission and Department of Energy employees.
- Identify as a prohibited personnel practice retaliatory referrals to licensing boards or the National Practitioner Data Bank. Employees should be able to challenge and have the agency vacate false or inaccurate reports, and must include in any report that the employee was a whistleblower. The DVA routinely uses these referrals to blacklist whistleblowers after firing them.
- Reinforce existing confidentiality protection with best practices. Employees should receive notice when their personnel or medical records have been accessed and by whom. Confidentiality rights, including those in OIG investigations, should extend beyond identities to shield all "identifying information." Whistleblowers should receive immediate notice of legally-required, specific boundaries for confidentiality rights, such as court orders. Whistleblowers should receive advance notice when their identities must be exposed or compromised.
- Develop oversight measures to ensure all investigations, both disclosure and retaliation, referred to facility and program offices are consistent with policy and reviewed by an official independent of and at least one level above the individual involved in the allegation. To ensure independence, referred allegations of misconduct should be investigated by an entity outside the control of the facility or program office involved in the misconduct. This suggestions echoes (Recommendation 12 of the Government Accountability Office report GAO–18–137, July 2018).

OAWP SPECIFIC RECOMMENDATIONS

- The Secretary of Veterans Affairs should direct OAWP to develop a process to inform employees how reporting lines operate, how they are used, and how the information may be shared between the OSC, the OIG, OAWP, or VA facility and program offices when misconduct is reported (GAO Recommendation 16).
- OAWP should have, and only be responsible to report to its own General Counsel and directly to the Secretary.
- OAWP should have authority to enforce stays and other corrective action(s), including in response to actions proposed under authority other than Section 714.
- There should be mandatory annual OAWP staff training on whistleblower rights, identification of prohibited personnel practices, and the psychosocial elements of working with whistleblowers suffering from workplace traumatic stress. No OAWP employee should be permitted to participate in a whistleblower case without certification of completing this training course.
- OAWP should be required to provide mandatory No Fear Act training to all DVA employees on how to work most effectively with the Office both for whistleblowing disclosure and retaliation cases.
- The prior OAWP mentoring program should be restored as a mandatory channel for counseling and negotiation to find a fresh start for whistleblowers as an alternative to litigation, and should include solutions to reduce workplace traumatic stress.
- Regulations should be published that include dataset definitions (including veteran status), engagements procedures, and outcome options. Referral for adju-

dication of non-employee complaints should also be highlighted. The Secretary of Veterans Affairs should direct OAWP to develop a time frame for the completion of published guidance that would develop an internal process to monitor cases referred to facility and program offices (GAO Recommendation 14).
- There should be a Memorandum of Understanding Better between OAWP & OSC to reduce whistleblower confusion and prevent duplication by remedial agencies that already are overextended.

Government Accountability Project has appreciated the thorough committee staff preparations for this hearing. The GAP team is available and would be honored to work with committee staff further on any of these recommendations. Both your committee and the whistleblower community are committed to making Whistleblower Protection Act rights a reality at the DVA. However, our work is far from finished.

Prepared Statement of Jacqueline Garrick, LCSW–C, BCETS, SHRM–CP

Chairman Pappas, Ranking Member Bergman, Distinguished Subcommittee Members:

I am truly grateful to be here today because my journey could not have happened without the support that I have gotten from this Committee. By September 2017, it had been 3 years since I first disclosed my perceptions of a conflict of interest over the Defense suicide prevention funds and contracts at VA and reported waste, fraud, and abuse at the Departments of Veterans Affairs (VA) and Defense (DoD). Since then, I have experienced several forms of retaliation, including threats to stop speaking about my disclosure by a former government official. It was a very frightening, lonely, and ostracizing journey until I started to compare notes with other DoD and VA employees. These connections were so affirmational that it led to the creation of Whistleblowers of America (WoA), a nonprofit organization that, among other things, provides assistance to whistleblowers who have suffered retaliation. When we realized the potential level of conflicts and favoritism permeating government contracts, we jointly filed complaints with the DoD and VA Offices of Inspectors General (OIGs). That was Veteran's Day 2016. We wanted to send a strong message that the lives of veterans mattered. But other than getting a case number, there was no response from the VA OIG. The DoD OIG refused to even open a case. Almost a year later, the VA OIG finally came to my home - a day after this Committee became involved. I gave the OIG stacks of documents, shared emails, and named witnesses I thought would corroborate my story. Over the last year, the OIG interviewed witnesses in the search for a "smoking gun" - which was how they would later describe the level of evidence they were looking to find. However, it felt like the burden to develop that evidence was on me, not them. They were asking me to produce documents and witnesses, which I could only do through publicly available sources - such as USA Spending, Gov Tribe, or SAM.GOV. Evidence I got through FOIA was different than documents I could get during Discovery. As of today, I believe that the 2016 investigation is still on-going, as well as inquiries by the FBI. However, waiting almost 3 years is a long time for justice, especially while VA underperforms in its High-Risk areas and has not met all of the GAO recommendations to be removed from that list. This, while veterans are dying by suicide and are being denied access to care; benefits take years to adjudicate, and staff shortages increase.

I can personally attest that reporting waste, fraud, and abuse, inconsistencies in claims processing, substandard care, medical errors and wrongful deaths is asking to have your career killed by VA leaders who are more interested in covering up wrongdoing than in the lives of veterans. For example, in one case of retaliation, Medal of Honor recipient, David Bellavia can confirm that a blog he wrote included information from at least one source inside VA. The blog targeted a VA whistleblower who was working to correct a series of personnel and contracting issues she reported as fraudulent. The allegations made against the whistleblower in Bellavia's blog were proven to be false (after a 2-year, taxpayer-funded VA investigation), but VA never investigated the instigators of those false allegations nor did it take any steps to protect the whistleblower, who experienced violent threats ("slashing," "clubbing," etc.) against herself and her family. Finally, the Department of Homeland Security got involved after a schizophrenic man approached the whistleblower at a conference and called her direct line with threats. Who was held responsible for inciting these acts of violence towards the whistleblower - acts that came just short of a physical altercation? No one. Sadly, VBA leaders stated that they had no recourse or reason to investigate. The whistleblower was left on her own, to try to

find assistance from local law enforcement. No one has ever been held accountable for the false statements or cyber/verbal assaults against this VA employee. We can do better. We must do better.

I founded WoA to build a peer support network, offer Whistleblower Protection Advocate certification, champion a Workplace Promise, and help employees rescale the harsh imbalances of justice that they endure. Since August 2017, WoA has heard from almost 200 VA employees who wanted to engage in "rightdoing," but instead suffered retaliation, harassment and/or discrimination. WoA data is similar to the 33% VA workload reported by the Office of Special Counsel (OSC).[1] By far, VA employees are reporting the most egregious risks to patient care, fiscal mismanagement, and abuse of authority.

Furthermore, the Office of Accountability and Whistleblower Protection (OAWP) has not acted in the way we thought it would - to assist, support, and guide whistleblowers through a protected disclosure process, and provide a decision algorithm for whether to report to OSC, MSPB, EEOC, OSHA, FBI, or some other resource. There are many redundancies in these systems, along with gaps in services provided. OAWP should assist in navigating these systems and laws and ensure proper representation. Instead, VA employees—who are the eyes and ears of veteran care or benefits—are ignored, attacked, or relegated to obscurity when they try to engage in a continuous process improvement, seek ethical decisions, or solve patient care challenges.

In my own interactions with OAWP, I was left leery. My first OAWP experience came after WoA issued a statement about a VBA hearing, along with feedback from employees. Unsolicited, I received an email from an OAWP case manager telling me that she was directed to reach out to me and requesting more information about a WoA allegation of impropriety. Primarily, she wanted whistleblowers' names, but I refused to give her that information and directed her back to VBA managers. My next interaction was after I met with the Veterans Service Organizations (VSOs) in an effort to engage them in a Veteran-Centric Accountability Council (VCAC). I had a vision for a VCAC that could address disclosures at a faster pace than a formal OIG and inform veterans about potential problems with their care. My main worry is that veterans do not know when they have been harmed by wrongdoing and that we need a stronger community voice to address these needs. The VSOs, such as the American Legion, conduct hospital site visits and could be "boots on the ground" in reviewing any potential issues impacting patient care or benefits delivery. The American Legion hosted a meeting on October 2, 2018, which was attended by the "Big Six."[2] They suggested that our next step should be to meet with OAWP and get a policy briefing. The American Legion took the lead and tried to schedule the briefing. Suffice to say, it never took place and in fact Legion staff were purportedly accused by VA of trying to subvert the mission. Undeterred, I reached out to an OAWP employee who was a former whistleblower himself, thinking that he would have better guidance for how to proceed. When I got an insulting response, I shared it with another VA official who then got me in touch with Dr. Tamara Bonzanto and Mr. Todd Hunter, who did have a phone conversation with me on February 13, 2019. Dr. Bonzanto was newly appointed as the 3rd leader of OAWP and outlined her "Engage then Change" strategy for a way to reset the office. I have requested follow up meetings to discuss her assessment of the situation and hear her plans to develop policies and respond to the VCAC proposal, which could be FACA[3] compliant, but was told that General Counsel needed to make the decision about working with WoA. To date, no word.

In taking a closer look at hundreds of VA whistleblower conversations, several themes have emerged about VA accountability and the OAWP specifically.

Summary of OAWP Issues:

Although whistleblowers bring forward a variety of issues related to wrongdoing, the retaliation they suffer usually occurs along similar lines. They experience reprisal in the form of physical or emotional violence, gaslighting, mobbing, shunning, marginalizing, devaluing, doublebinding, blackballing and counter accusing.[4] These toxic tactics are features of Workplace Traumatic Stress and can lead to

[1] OSC FY 2018 Congressional Budget Justification and Performance Budget Goals Report. https://osc.gov/Resources/CBJ–FY2018–Final.pdf

[2] Along with the American Legion, also in attendance were the Disabled American Veterans (DAV), Veterans of Foreign Wars (VFW), Paralyzed Veterans of America (PVA), Vietnam Veterans of America (VVA), AMVETS, and the Military Officers Association of America (MOAA).

[3] FACA - Federal Advisory Committee Act of 1972

[4] Garrick Inventory: Whistleblower Retaliation Checklistc. I developed this checklist with indicators designed to assess severity of whistleblower retaliation and its psychosocial impacts on employees.

posttraumatic stress disorder (PTSD), depression, or suicide, and can have other psychosocial impacts. Employees go to OAWP to describe these toxic conditions as evidence of retaliation in hopes that OAWP would protect and assist them quickly. However, that has not typically been the case. Instead, the OAWP has caused most of them more harm because it is plagued with deficiencies related to timeliness, unfair processes, and inadequate staffing that do not allow for an unbiased and independent approach.

Timeliness - OAWP does not provide timely responses. When a whistleblower contacts the OAWP, they are assigned a case manager who asks them to fill out the VA Form 10177. Whistleblowers wait several months and are then given "boilerplate" answers. They are told that they will hear back, but most never do. I've seen dozens of email exchanges between VA employees and OAWP case managers that demonstrates this lack of responsiveness.

Process - Another consistent issue with OAWP is that it has no Standard Operating Procedures or a policy statement, so there is no way to manage expectations for engagement. Because of the language in the VA Form 10177, attorneys have advised clients not to sign it because it creates conflicts of interest and may be interpreted as waiving certain rights. However, once the Form has been signed and a case manager assigned, the process entails a report to the OAWP Director. But then the information goes back to the VISN and the hospital or RO Director,[5] and then to the supervisor. This means that OAWP is asking the same chain of command to investigate the very wrongdoing it has been accused of perpetrating. Leadership will ask for a "fact-finding" or hold an Administrative Investigation Board (AIB) hearing. These boards are used as weapons for gathering information on the whistleblower and to learn more about their evidence for later legal admissions, interrogatories, and other discovery. Retaliation increases for the whistleblowers who are set up for counteraccusations and become victims of cyberbullying when VA officials plant misinformation in the public domain. Furthermore, AIBs are often conducted by untrained co-workers within the same chain of command. At times, the investigator and the proposing official have been the same person, or the deciding official was named in the original complaint.

This process seems to also involve hospital chiefs of staff sending letters of investigation to licensing boards and professional associations, which can have career-ending implications. Doctors are reported to the National Practitioner Data Bank (NPDB) even when no charges have been substantiated. But once a physician is identified to the NPDB, his/her medical career is virtually over. There are at least 15 VA physicians who can speak to this level of identity destruction and their lack of recourse. Living under this threat is causing some practitioners to leave VA out of fear. A Readjustment Counseling Services conference in June 2018 reportedly ended with Vet Center employees being reminded that President Trump has curtailed their due process rights and that they can be fired at any time.

Meanwhile, OAWP engagement seems limited to "trafficking" paperwork and monitoring the whistleblowers, but not a lot of time is spent on advocacy or on a duty to assist in developing the case. OAWP does not appear to have the capability to independently investigate, mediate, or arbitrate an outcome. They should be required to provide case management updates and disclose outcomes to victims. Although privacy of all parties must be respected, whistleblowers should at least be able to receive notice on the section(s) of law reviewed and how the law was applied.

Additionally, since veterans comprise 30% of the federal workforce, many VA whistleblowers are veterans. (There seems to be a propensity for whistleblowing among the veteran population, although this needs further study[6]). Veterans have raised numerous concerns over denials of reasonable accommodations for their service-connected disabilities, Family Medical Leave Act (FMLA) retaliation, privacy invasions of their medical records, restrictions from VA treatment facilities, and having their disability compensation ratings targeted. Last summer, the GAO found that VA employees were 10 times more likely to suffer retaliation with limited accountability for the perpetrators.[7] Congress needs to follow up on this report and

[5] There are 22 Veterans Integrated Service Networks (VISN) across the country that oversee all of the medical centers in the catchment area. The VISN Directors report to the Under Secretary for Health. There are also 58 Regional Offices within 4 districts (RO), and those Directors report to the Under Secretary for Benefits. WoA has not received complaints from National Cemetery Administration (NCA) employees and is less knowledgeable about that process.

[6] There are propensity studies in the literature on whistleblower demographics and personality types, but veteran status is still unknown.

[7] July 19, 2018 GAO Report on VA: Actions Needed to Address Employee Misconduct Process and Ensure Accountability: https://www.gao.gov/products/GAO–18–137

focus specifically on how veterans employed by VA are treated when they make disclosures, because their earned benefits could be at risk.

Finally, no settlement of whistleblower retaliation claims should be allowed to contain a nondisclosure agreement (NDA). The VA should be barred from asking, and whistleblower employees should be informed that they cannot negotiate an NDA. These transactions involving taxpayer money, government resources (including General Counsel time) and the welfare of veterans should remain in the public domain.

Staffing - A job series issue seems to be impacting effectiveness. OAWP was created by overtaking a former Human Resources (HR) function—and the staff still tends to have that background. Therefore, there is a shortage of the right staffing mix of HR specialists, investigators, mediators/arbitrators, and decision makers. The Office would benefit from being authorized to engage independent consultants to conduct these investigations and issue unbiased reports. It should also require that Union Representatives be consulted since not every employee knows that they are covered by a bargaining agreement. This would increase transparency, accountability, and confidence in the system.

When employees leave VA (regardless of whether they are terminated, resign or retire), they should be required to participate in an exit interview that captures information related to their employment experience and reasons for leaving. This information should be reported to Congress annually, and the data should be compared to the National Federal Employee Viewpoints Survey.

Performance - The OAWP reports accountability and disclosures on its website.[8] The accountability report (adverse actions) details demotions, suspensions and terminations, while the disclosure report identifies the types of whistleblower reports made. However, almost half of those contacting the office were found not to be whistleblowers. This data point is concerning because it either means that employees are not being educated in accordance with the NO FEAR Act or whistleblowers are being unjustly denied. There is also a lack of data on how whistleblowers are being assisted. Is OAWP tracking "stays," reassignment, or other agreed upon solutions? The OAWP needs to open the aperture on how it is defining its whistleblower terms and capturing retaliation (in its many forms), and it must be able to account for the assistance provided. It should also denote how many of the adverse actions taken involved any whistleblowers and how many among them were veterans. If half of the employees described in the reports were not whistleblowers, then who were they?

The Chris Kirkpatrick Act mandated that agencies report employee suicides.[9] However, according to OSC, there have been no Section 105 compliance reports made. This is concerning since the Act was named for a VA psychologist who took his own life in the aftermath of whistleblower retaliation. If suicide prevention is the number one VA priority, then it should care about its own workforce who have died by suicide too.

There are three main options that Congress can take to improve VA Whistleblower Protections:

1.Hold OAWP officials accountable for mission execution by requiring policy publication and a transparent key to its data with the above outlined recommendations; utilizing independent investigators and mediators; and sanctioning retaliators;

2.Abolish OAWP and require VA to transfer funds to OSC. Although, transferring funds is a process, detailing OAWP employees is not as difficult and could be the next step along with the following option. If VA ever does produce policies and data that are acceptable then those resources could be shifted back to OAWP and/or;

3.Allow VA employees to take their cause of action to civilian courts for a jury trial if there is no resolution within 180 days.

WoA would like to believe that OAWP could provide the right resources for VA employees seeking justice, but the agency has so far failed to meet those expectations.

Summary of OIG Issues:

VA employees are reliant on the VA OIG and OSC investigations to develop evidence. Unfortunately, both systems have generally failed them. First, there is very limited accountability for when the VA OIG makes recommendations related to disclosures. Those should be better tracked and reported. There are no mandates to implement an OIG recommendation, only suggestions to VA senior leaders, which can literally, "sit on the shelf." Furthermore, managers who were guilty of retalia-

[8] OAWP website: https://www.va.gov/accountability/
[9] PL 115–73. https://www.congress.gov/115/plaws/publ73/PLAW–115publ73.pdf

tion or other wrongdoing are often not held accountable - rarely are they even identified by the OIG. Most of the time, the OIG recommendation is for "further training." Such was the case when the OIG found that $11.7 million of VBA money inappropriately went to Calibre on a contract,[10] but no action was taken to reclaim those funds or hold accountable the managers who oversaw the wasteful spending. Congress also should know what happened to the $6 million that went unspent for suicide prevention. WoA suggests that Senior Executives or managers with any pecuniary responsibility must be required to pass a background check and hold a security clearance. In the future, Congress should ask the OIG to oversee annual accountability on such funding executions, as with the $25 billion VECTOR IDIQ with 68 companies on the award performing management initiatives[11] and other high impact spending authorities.

WoA notes that there should be more serious penalties for retaliation (fines, demotions, loss of retired pay, contract bans, etc) to discourage these tactics. Congress should expand requirements to pay into the Judgment Fund to include those identified as engaging in whistleblower retaliation. Whistleblowers who must defend themselves against retaliation often must pay out-of-pocket - sometimes upward of $100,000 - while wrongdoers are defended by the Government, at the expense of taxpayer money reserved for veterans. This is antithetical to common sense, and the Judgment Fund could be used to assist whistleblowers and offset costs related to retaining private sector attorneys chosen by the whistleblowers and reduce the burden on the taxpayer when damages are awarded. There are now Legal Aid services in over 120 VA Medical Centers. This authority could be expanded to support VA employees in their retaliation, harassment, and discrimination cases. Without more serious steps towards accountability and justice, a corporate culture that allows retaliation to fester will continue.

Antagonistic Relationship between OAWP and OIG

There has been a history of animosity between the VA OIG and its leadership. After being investigated for alleged misuses, former VA Secretary David Shulkin (through a private team of lawyers) criticizes his own OIG by saying, "VA OIG reports 'must be accurate,' 'must be fair,' and 'must be objective,".''This report is none of those things."[12] Later, Acting Secretary (and former OAWP Director) Peter O'Rourke was accused by this Committee of trying to intimidate IG Michael Missal in a letter during an OAWP investigation.[13] This Committee sent a letter to the US Attorney General asking that O'Rourke be investigated for alleged perjury, misleading or withholding information from Congress, or making otherwise unlawful statements in testimony and communications during two oversight hearings on June 26, 2018 and July 17, 2018, in response to questions regarding the withholding of access to information and a database from the OIG, and the status and disposition of a VA whistleblower complaint[14] (Dr. Dale Klein, WoA Board Member). The GAO[15] has also stepped in to investigate outside influence from the "Mar-A Lago Crowd" on VA leadership and personnel decisions following a ProPublica report.[16] WoA is concerned that emails outside of official VA sources would not be accessible during investigations or discovery. WoA also is unaware of any resolution to these investigations, but we believe they highlight the antagonistic nature of whistleblowing at VA. Since Congress has demonstrated that it does not trust VA to properly handle personnel issues, why would you ask VA frontline employees to trust these internal organizations with their careers, personal well-being, financial security, and family stability?

Conclusion

[10] https://www.va.gov/oig/pubs/VAOIG–16–04555–138.pdf

[11] https://www.va.gov/OSDBU/acquisition/vector-town-hall.asp

[12] February 11, 2018 Response to Administrative Investigation Draft Report: VA Secretary and Delegation Travel to Europe and published in the OIG Report: https://www.va.gov/oig/pubs/VAOIG–17–05909–106.pdf

[13] June 19, 2018 Press Release from House Veterans Affairs Committee Ranking Member Tim Walz: https://veterans.house.gov/news/press-releases/rm-walz-responds-unprecedented-attack-acting-va-secretary-o-rourke-va-inspector

[14] July 26, 2018 letter from members of the House Committee on Veterans Affairs to the US Attorney General: https://causeofaction.org/wp-content/uploads/2018/08/2018.07.26–Letter-from-Rep.-Walz-to-AG–Sessions-re-ORourke.pdf

[15] November 19, 2018 Letter to Senator Elizabeth Warren the GAO agrees to investigate ProPublica allegations: https://www.warren.senate.gov/imo/media/doc/GAO%20response%20accept%20EW%20request%20for%20investigation%20Mar-A–Lago%20Cronies%20VA%2011.19.2018.pdf

[16] August 7, 2018 ProPublica Investigation: https://www.propublica.org/article/ike-perlmutter-bruce-moskowitz-marc-sherman-shadow-rulers-of-the-va

The feedback VA whistleblowers can provide is informative, but fear of reprisal causes many to remain bystanders and not veteran advocates. Those who do disclose have seen the demise of their careers, moral injuries, and identity disruption. Employees risk their careers to protect veterans, while senior VA officials travel to Europe, attend NASCAR events, and curry favor with contractors at taxpayer expense. VA should not treat whistleblowers like adversaries but should treat these employees with the same public health approach it describes for communities, and it should incorporate that approach into comprehensive continuous process improvements while ensuring independent and unbiased investigations. To reduce stigma and retaliation, Congress should authorize VA to host an annual Whistleblowers' Award that highlights VA's "rightdoing" in overcoming agency wrongdoing. Furthermore, Congress should consider authorizing a National Whistleblower Memorial on the grounds of the Capitol that demonstrates the lamplit pathway many have taken in exercising their First Amendment Rights.