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Testimony

on behalf of

Whistleblowers of America

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Before the

Committee on Veterans' Affairs Subcommittee on Oversight and Investigations

Chairman Pappas, Ranking Member Mann, and the honorable members of this Subcommittee:

Thank you for inviting Whistleblowers of America (WoA) to submit our views on "Protecting Whistleblowers and Promoting Accountability: Is VA Making Progress?" A simple answer to that question is "No."

Introduction - There needs to be a much more aggressive effort to repair the tarnished institutional culture that veterans and employees have uncovered at the Department of Veterans Affairs (VA) and the toxic tactics of retaliation used against them. VA needs to develop a sense of fairness, transparency, accountability, and justice among its employees who serve our nation's veterans and their families. When VA created the Office of Accountability and Whistleblower Protection (OAWP), WoA was optimistic that it would be a place for employees to seek refuge from retaliation, find justice against the wrongdoing that they observed, and that grifters, racists, misogynists, and abusers would be held accountable.

Since our inception as a nonprofit in 2017, WoA has connected with hundreds of VA employees across the country and within the Administrations. Their concerns have ranged from identifying contract corruption, conflicts of interest, violations of gift rules, insider trading, discrimination, sexual harassment, medical errors, improper patient care standards, and privacy violations. These might be different circumstances, but the goal was common: stop the harm to veterans and taxpayers. However, each employee narrative has resulted in prolonged and expensive judicial proceedings, hostile work environments, workplace trauma, moral injury, and social disenfranchisement. VA whistleblowers suffer retaliation through mobbing, gaslighting, marginalization, shunning, devaluing, double-binding. blocking, counter-accusations, and violence. This takes the form of being detailed, demoted, bullied/cyberbullied, retaliatorily investigated, threatened, and fired. This constant and consistent maltreatment can result in long-term psychosocial harm, such as anxiety, depression, divorce, unemployment, homelessness, and suicide. Veterans who work for the VA face an added double-jeopardy when managers can access their medical records; retaliation sends them spiraling, and then they are denied access to VA facilities or their benefits.

Background - In June and July 2019, WoA testified at this Committee's hearings regarding the implementation of OAWP. At that time, I made several observations about OAWP and the need for it to have a mandated "Duty to Assist" employees and provide them with advice and guidance in developing the evidence for their claims, involving the union, and ensuring that they had proper representation and advocacy. I flagged the perils of blanket guidance to curtail mediation, arbitration, and settlement limits that were preventing appropriate closure of cases and restorative justice. I suggested that there be additional protections against health record privacy invasions, restrictions from treatment, and disability compensation targeting for veterans

who are also VA employees. In addition, I advocated that nondisclosure agreements (gag orders) and settlements involving taxpayer resources should remain disclosable. There should be accountability for enforcing those settlement agreements and penalties imposed for violations.

In 2019, I offered three options for OAWP improvement:

1. Publish a policy and transparent data; utilize independent, unbiased staff; and have timely sanctions for retaliators; and

2. Abolish OAWP and transfer resources to the Office of Special Counsel (OSC) and/or;

3. Allow VA employees to take their cases to civilian courts and provide them access to legal counsel or support

Three months after that hearing, in October 2019, the VA OIG "identified significant deficiencies" in how the Department of Veterans Affairs Accountability and Whistleblower Protection Act was implemented. The OIG documented OAWP failures to publish policies, respond to FOIAs, issue reports, and to protect whistleblowers from retaliation – even citing that the OAWP investigations in some cases were instruments of retaliation. In fact, the OIG stated, the office was not designed to effectively support whistleblowers or assist in improving a culture known for targeting and penalizing right-doers. OIG concluded that "it acted in ways that were inconsistent with its statutory authority while it simultaneously floundered in its mission to protect whistleblowers. OAWP leaders made avoidable mistakes early in its development that created an office culture that was sometimes alienating to the very individuals it was meant to protect. Those leadership failures distracted the OAWP from its core mission and likely diminished the desired confidence of whistleblowers and other potential complainants in the

operations of the office."[1] The VA OIG made 22 recommendations designed to improve training for all employees, written communications, timely responses to FOIA, agency investigations, and employee protections.

As of April 2021, the OAWP website[2] claims that it receives and investigates allegations of misconduct and poor performance against VA senior leaders and retaliation. It monitors other investigations and is responsible for tracking and confirming VA's implementation of recommendations from audits and investigations carried out by VA's Office of Inspector Generals. However, employees have shared the auto generated emails from OAWP that state:

For all other matters, please note that OAWP cannot:
1. *Initiate a new disclosure via email,*
2. *Issue advisory opinions,*
3. *Tell you whether to file a claim,*
4. *Provide you with legal advice,*
5. *Investigate allegations that involve discrimination (to include allegations of hostile work environment) and/or reprisal for activity related to filing of an equal employment opportunity (EEO) complaint,*
6. *Investigate allegations already covered under another administrative process, such as under the FLRA, MSPB, and EEO.*

If you want additional information on closed cases, you must file a FOIA.

FOIA - However, I want to first note that VA is not very transparent when responding to FOIAs. My personal experience when VA closed an investigation regarding suicide prevention funding, I sent a FOIA requesting documents and emails. I got back 250 blank pages citing the Privacy Act. This would be understandable; however, I had previously filed a similar FOIA request with the Department of Defense and received a trove of documents and emails, which I was able to read to an MSPB Administrative Judge. He was able to rule in my favor because even pro se, I was able to show a preponderance of evidence that I experienced animus and a hostile work

[1] https://www.va.gov/oig/pubs/VAOIG-18-04968-249.pdf
[2] OAWP website: https://www.va.gov/accountability/

environment by reading him emails from those officials. VA employees are being denied that same access to evidence if discovery and FOIA are not forthcoming. I would also note that what I got on discovery was much less than what I got through a FOIA request. An attorney has shared that VA, “frustrated our FOIA request by breaking it into about a dozen different tracking numbers, which in a sense created a dozen FOIAs passing through the VA. They stopped processing them in December. Since December, they have taken contradictory positions. One consistent failure is to produce the documents heavily redacted.” These FOIA actions by VA have resulted in a FOIA lawsuit. A VA employee who did two FOIA requests in 2019 subsequent to discovery never had those requests processed. VA explained that the first one was lost and for the other VA said it sent a clarification letter but could not produce its response. So, in 2021, more than 2 years after the original FOIA request was filed, VA then refiled the FOIA with a 2021 date instead of the original 2019 date, so it does not look delayed. In the meantime, the employee was terminated and has to pay an attorney several thousands of dollars to file, follow up, and refile so that they can have the right level of evidence necessary to substantiate the disclosures. These costs should be automatically recoverable for whistleblower actions. When the agency blocks, delays, and does not respond, the system does not work for anyone and harm comes to the most vulnerable. So, assistance in developing the necessary evidence in a timely manner is critical. Remember, its not only the single employee being harmed, its every single veteran dependent upon the program or service where there is unaddressed malfeasance. The employee is the messenger.

In May 2021, WoA received a briefing from the OAWP about its operations. It claims to have implemented all of the OIG recommendations from 2019 and has taken comparative disciplinary actions as the OSC (29 and 27 respectively) in the last year. This means that there was a greater

need for disciplinary actions in the VA than the rest of the federal government, which should be a window into VA culture.

OAWP has also published Directive 0500,[3] which is publicly available and a Standard Operating Procedure (SOP). However, to get a copy of the SOP or any reports related to VA senior official investigations, one would have to send a FOIA request. This is a different practice from other federal agencies, like the DoD that publish SOPs and such reports. Keeping in mind that VA is also not as likely to be as responsive to FOIA as other agencies either.

In addition, the cumulative time it takes OAWP to investigate complaints from intake, to investigation, to issuing findings and remedial recommendations is 240 days, which it cannot enforce. Therefore, their recommendations for action are only suggestions to the whistleblower's chain of command - who are not often vested in holding perpetrators accountable, so there is no forcing function with OAWP recommendations, even though they stipulate that one of their primary missions is to advise the Secretary. It would seem that this is the missing lynchpin. Why is OAWP not going directly to the Secretary for a mandated disciplinary action? And if that is not an option, OAWP should transfer the finding to OSC for disciplinary action.

Status Update - Although WoA appreciates any honest effort being made to assist and provide stays for VA employees, there are still gaps in OAWP's ability to be fully successful. To understand the magnitude of OAWP failure, it only takes a quick review as to how VA employees are faring to know whether the 2019 testimonies and the VA OIG recommendations have made a difference. When WoA testified in 2019, there were also three VA employees who were courageous witnesses at the same June hearing. Mr. Jeff Dettbarn, Dr. Minu Aghveli, and

[3] Directive_0500_OAWP_10_Sept_19 (3).pdf

Dr. Katherine Mitchell have stayed in contact with WoA and have provided information as to how their cases have gone unresolved for the last two years (which is beyond the 240 days that OAWP told WoA it closes cases).

Jeff Dettbarn, the radiology technician from Iowa, has shared that he is still on a detail, but is willing to go to ADR/mediation. In January 2021, VA finally removed his proposed termination and attempted to send him back to his old position. However, OSC disagreed because no one has been held accountable for the retaliation, even after his disclosure was validated by an OIG investigation conducted based on his initial complaint. Every person he identified as contributing to the wrongdoing has remained in their position – avoiding all accountability and leaving them in a position to further retaliate. If he returned, he feels he would have a target on his back, working with some of the same people he reported for improper imaging scheduling procedures. Even though he loved doing CT scans, he realizes that the amount of stress over watching his back while waiting to be sabotaged could impair his focus on taking care of veterans. He notes that this is a "completely hostile work environment and another retaliation attempt" to place him back under the supervisors he has a substantiated complaint against. Why has there been no accountability in Iowa City for veterans whose care was mishandled? In this case, for example, OAWP could have a role in reintegrating a whistleblower into his lab. It could monitor the settlement agreement to ensure that there is an environment that allows him to fully add value and reconnect with the VA's purpose while protecting him against further harm.

Dr. Minu Aghevli, the Baltimore psychologist who got her termination letter the day before she testified was able to get her a stay through OSC the day after the hearing. The stay has remained in place ever since while a two year investigation remains ongoing. Dr. Aghevli is still employed however, unable to perform her actual position in opioid treatment (her area of expertise) or talk

to patients or conduct any administrative tasks or opioid research. She is performing nonsensical tasks that add little or zero value to veterans. OSC recommended ADR last summer but VA wanted to engage in negotiations for returning her to her position. The VA OIG closed her complaint as “partially substantiated" but no report was published. When she tried repeatedly to FOIA the case documents, as OAWP suggested, those requests were denied. She remains seriously concerned because the case involved the deaths of two veterans and major medication errors. The OIG never interviewed her about those deaths or her disclosure. Not interviewing the complainant is a common concern raised by multiple VA employees. If OAWP had a Duty to Assist, it could assist in interviewing whistleblowers if OIG cannot, calibrate and coordinate across the various investigations and review bodies within VA, and help develop the evidence that OSC would need to adjudicate the case. The fact that many whistleblowers are never interviewed by investigators is troublesome and likely diminishes the fulsomeness of investigations. Just because they filed the complaint, does not mean that they were fully able to describe or provide all of the information at once. They are not evidence subject matter experts and are often emotional when first making disclosures. Thus, this ineptitude leaves these victims without closure, investigations without evidence, and casts doubt into the validity of the investigative process as a whole while veterans remain in harms’ way. Directive 0500 states that it “may not investigate and it may not refer” if another entity has authority, but OAWP could play a supportive role in development.

Dr. Aghevli’s OAWP case was closed in January 2021 with no findings and no relief. Over the years, she has had three different OAWP examiners and describes it as “disorganized and unprofessional” process. She cites violations in having investigators emailing her at work with confidential details of the case and an inability by OAWP to produce a SOP manual, which

apparently would require a FOIA. Without an SOP, she feared signing a consent document since she did not know what she would be agreeing to. She emailed WoA, *"Even though the OSC process has been lengthy, interviews and interactions with the OSC have felt like they were professionally gathering evidence to investigate my claims. By contrast, each interaction with the OAWP left me feeling like I was under investigation, and that they were looking for a loophole to dismiss my concerns." I think it is all intended to demoralize and humiliate. That should be evidence enough of retaliation.*

Developing the right level of evidence has been problematic for so many employees who go to OAWP with emails, timelines, documents, and other materials to only feel as if it is insufficient for action when in other circumstances, such as at GAO, EEOC, OSC or MSBP the "preponderance of evidence standard" can be met. The OAWP evidence requested seems unreasonable to many whistleblowers and without a Duty to Assist employees, they are left guessing as to what constitutes a well-developed claim or waiting years for FOIA responses.

Finally, Dr. Katherine Mitchell has also shared that since her testimony the VA has persisted in retaliating against her, both in the workplace and within ADR mediation. During ADR, VA officials acknowledged her medical documentation wherein it states that forcing her to remain in the retaliatory workplace will lead to inevitable severe psychological decline and elevated risk of suicide. However, the VA was only willing to offer her a newly created position in the same office under the same supervisor whom she testified against in the June 2019 hearing – similar to the above situation Mr. Dettbarn described.

Dr. Mitchell describes for WoA, "*the offer was malignant. After I declined the last VA offer, the VA notified the OSC that it is withdrawing from the OSC process. Because there is no intact MSPB Board, the OSC notified me it intended to close my case and send me to the MSPB*

process that is already extremely backlogged. At the last minute, the OSC agreed to keep my case open until VA responds to an HVAC letter sent in February 2021. In the workplace, I am still prevented from performing my job duties listed in the original 2014 settlement agreement. The VA has never disputed the validity of my OSC whistleblower retaliation complaint. The OSC easily substantiated the retaliation against me on just a preliminary investigation. The VA antics during OSC negotiations are in violation of federal whistleblower protection statutes, its own ICARE values, and basic human decency. No one has ever accused me of any unprofessional behavior or wrongdoing. However, the retaliation continues unabated and is having a severe psychological toll on me. Therefore, as of today, after 6.5+ years of nonstop retaliation, the risk of me successfully completing suicide is higher than the likelihood of me surviving another 1.5- 2 years before I "win" in an administrative law judge hearing or surviving another 5-7 years for a final MSPB hearing since the VA apparently is appealing all cases it loses, even cases like mine where the retaliation and evidence are indisputable." Dr. Mitchell is not unique. Another VA employee recently emailed, "*I am tired, mentally exhausted, and suicidal because of what the VA leadership has done. I have no hope for any future employment because of what VBA management has done poisoning my name publicly."* They speak for a multitude of VA employees who describe similar thoughts and symptoms. These conditions are a primary reason WoA insists on adherence and accountability for the Dr. Chris Kirkpatrick Act of 2017. The OAWP could play a significant role in enforcing settlement agreements and ensuring that retaliation does not continue and that victims have access to the support and care that they need.

Similar to their situations, former Marine and Rode Island Vet Center social worker, Ted Blickwedel continues to advocate for change with excessive productivity expectations from RCS

leadership. These production standards have resulted in so much burnout and adverse care to veterans and their families that Senators Reed and Tester and Congressman Cicilline have drafted legislation, The Vet Center Improve Act. After collecting input from dozens of Vet Center counselors, Blickwedel suffered retaliation by being marginalized, gaslit, shunned, and devalued. VA failed to take action to protect him as a whistleblower, so he retired early. It took an outside investigation by the GAO to substantiate his allegations while the VA still retaliates against him, which now means that as a former employee, OAWP will not assist him, and he will be out of pocket tens of thousands of dollars to fight the harassment and defamation he has faced at the hands of his former Vet Center Director post-employment. WoA is grateful for the members of Congress responding to Vet Center mismanagement but who is holding anyone accountable for the retaliation against the whistleblower?

In another emerging example, on April 2, 2021, Senator Grassley sent a letter and opened an investigation into whistleblower allegations of ethical violations and leaks of sensitive information from the Veteran Benefits Administration (VBA) senior executives that may have resulted in a publicly traded company losing over $800 million in stock market value.[4] WoA was contacted by several whistleblowers citing concerns related to an appearance of direct conflicts of interest (COI) between Charmain Bogue and her spouse Barrett Bogue. WoA brought the issues with the Bogue's to the attention of OAWP and this committee in 2019. The OIG declined to investigate the COI in 2019, citing that these matters were not their domain. Senator Grassley's letter raises questions about VBA's adherence to ethics rules, Mrs. Bogue's lack of disclosure that her husband was "engaged in employment and consulting arrangements for

[4] https://www.grassley.senate.gov/imo/media/doc/grassley_to_dept.ofveteransaffairsvbaethicsmarketinfoleaks.pdf

companies with business before her," which may have resulted in an ethical breach. Whistleblowers allege that Mrs. Bogue routinely has engaged officially with entities employing or contracting with her spouse and has shared employee personnel information with outside entities who have cyberbullied the employee on social media. On one occasion, OGC ethics was asked to provide an opinion about her need to recuse from engaging on matters due to her covered relationship. OAWP has not taken any known action, nor has the standard ethics training been sufficient to lead Mrs. Bogue to create a proactive recusal. These concerns were known inside VA, but it has repeatedly failed to enforce ethics standards, recusals, gift reviews, and approvals for travel to widely attended events, such as with the NASCAR issue as well.

Senator Grassley's letter also cites an internal email indicating that a VA official properly advised others to keep sensitive nonpublic information about potential enforcement actions "'close hold' in order to prevent … insider trading." Contrary to this warning, Senator Grassley's letter cites evidence from a FOIA lawsuit that the VA selectively released the information early, during the trading day—creating the opportunity for a select few in the know to trade on that information prior to the official public announcement. The VA has failed to answer any of the important questions on the issues raised by Senator Grassley's letters since he wrote to the VA, the VA OIG, and the Securities and Exchange Commission.

Ethics reporting and review of potential violations should be among the issues OAWP says it audits and could enforce better accountability and penalty. OAWP could guide officials to better prevent the "appearance of impartiality" and a "conflict of interest" as described in the Federal Acquisition Regulations (FAR) and have a standard for dealing with such violations. The public private partnerships that VA engages in are vital to improving services to veterans, but there is also vast opportunity for error, waste, fraud, and abuse that need oversight to be effective.

OAWP could audit these partnerships and agreements for proper accreditation and outcome data for these programs to ensure that there is compliance. If OAWP had better auditing, then the NASCAR gift situation WoA previously publicized might have been avoided. Ethics violations have been found to be so pervasive across VA that the need for "more training" has been the excuse for not sanctioning senior leaders who should otherwise be held accountable and penalized for not reporting and accepting gifts (contracts) for spouses and themselves. These offenses have led to VA officials who have had to step down but leaves the door open for their return without impunity. If employees can be placed on watch lists, OAWP should be able to track any VA official who has been formally investigated, dismissed, or sanctioned. Even if a case is not substantiated, having multiple complaints against the same official can be a clue that there is toxic leadership. This list should be reviewed prior to allowing any senior officials to return to government in any capacity, including as contractors. We see too many who were complicit in problems while serving who are now on contracts to solve the same problems that they created or could not manage when they were in government. For example, the VA OIG[5] in 2018 found that nearly half of denied Military Sexual Trauma (MST) claims were not properly adjudicated in accordance with VBA policy and that the review process and training for MST claims was also deficient. This harmed thousands of veterans. Policy implementation, quality review, and training are leadership issues. Now, three years later, VA announces plans that mirror the OIG recommendations to specialize in MST cases. However, the people leading this new effort are the same ones who failed in the first place. In Senator Grassley's aforementioned letter, he questions the previous proposed suspension of Tom Murphy, the former District Director, removed from DC and now brought back to be the VBA Acting Under Secretary who

[5] Denied Posttraumatic Stress Disorder Claims Related to Military Sexual Trauma (va.gov)

told Stars and Stripes,[6] "In addition to consolidating claims with specialized processors, the VA will improve training and increase quality control." The things he failed to do in 2018. The revolving door must close.

The backdrop for these cases is the lack of a confirmed Merit System Protection Board (MSPB, which is creating a growing backlog of over 3,000 appeals. Hopefully, we will soon have a full cast of nominees and get this process back on track. A recent Supreme Court ruling has also called into question the appointment of MSPB Administrative Judges currently presiding over cases. Agencies have used both of these incidents to dismiss without prejudice hundreds of cases placing them in limbo without recourse for the plaintiffs. No VA official is losing sleep over hanging employees in legal purgatory. But I assure you, it is a daily torment for employees and their families as Dr. Mitchell has so bravely attested.

Solutions and Next Steps - WoA has been among the organizations who have supported the option of allowing VA employees without relief to request a jury trial to expedite their access to fair and reasonable due process. The proposition of low settlements and low rates of mediation and arbitration only close more doors for employees already burdened with litigating their appeals out of pocket. This scorched earth posture has likely led to significant distress and devastating health outcomes for whistleblowers, not to mention a strong deterrence to right-doing as OSHA describes on its Anti-Retaliation website.[7]

It is a classic tactic to wear down whistleblowers while mentally and financially exhausting them. Those who can afford and attorney or have some insurance, run out of funds when delays and denials can go uncontested and without penalty. Ten days is not enough time for a lone

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[6] VA to create specialists to handle military sexual trauma claims - U.S. - Stripes
[7] https://www.osha.gov/sites/default/files/publications/OSHA3905.pdf

employee to respond to OSC without the assistance of a well-trained advocate or counsel while the government can delay mediation or settlement for years.

As OAWP outlines the actions it cannot take in its emails to employees, there seems little reason for it to exist other than it can issues stays. The need for advice and guidance would be the exact reasons an employee would go to OAWP. They are desperately seeking help, assistance, and support in dealing with a hostile work environment. This office should have a statutory "Duty to Assist" any employee who file a claim with independence from VA's Office of General Counsel and fair representation (equal to the defense provided VA officials).

A Duty to Assist is not a unique concept for VA. It is described at 38 USC §5103A. Under this section, the law requires that the Secretary "shall make every reasonable effort to assist the claimant substantiate the claim." In 38 USC §5104 there is a requirement to provide the claimant a decision notice that lists the evidence considered and how that evidence was evaluated based on the laws applied. In 38 CFR §3.159, it gives further details on the Duty to Assist and definitions of evidence such as medical, lay statements, and other factual information. Under (b), VA has a duty to notify the claimant of necessary information or evidence and (c) describes the steps VA will take to help obtain that evidence.

In 38 USC chapter 51, Claims, §5100 defines a claimant as "any individual applying or submitting a claim for any benefit under the laws administered by the Secretary." It does not limit the definition to a veteran, survivors, and dependents. Although that may be the intent, it would seem reasonable to add employees and clarify the Secretary's Duty to Assist them as well. Employees filing claims with OAWP should be entitled to at least the same level of evidentiary development assistance as veterans who are claimants.

OAWP Duty to Assist should include:

1. Explaining level of evidence necessary to substantiate a claim – what is the standard for a preponderance of evidence, clear and convincing evidence, or a reasonable doubt? What is VA's expectation before it will take action to protect a whistleblower and admonish a perpetrator?
2. Assisting with obtaining the necessary evidence to substantiate the violation of laws, rules, or regulations – are these audit and accounting records, medical care standards, contracts, recusal letters, ethics decisions, OIG investigations, congressional inquiries, media exposures or other sources? How are affidavits and witness statements handled?
3. Assisting in documenting retaliation by using the Occupational Safety and Health Administration (OSHA) descriptions or the Whistleblower Retaliation Checklist – What are the medical, personnel, or other witness statements (affidavits) necessary to substantiate the harm caused by retaliation?
4. Offering options for remedies – Can there be kick outs for jury trials, relocation, reassignment, reinstatement, retirement, or assistance with an OPM disability retirement application?
5. Mentoring – Can OAWP reinstate or create a program that allows an employee to transition and/or reintegrate into a productive work environment that matches skills and abilities to mission while protecting against further retaliation? For this to be effective, it needs to be independent and trustworthy with training and education in peer support and a trauma-informed framework as described by the Substance Abuse Mental Health Services Administration (SAMHSA) and retaliation according to OSHA.

6. Ensuring and enforcing accountability – what is the penalty for the perpetrators of the wrongdoing that goes beyond more training? Can penalty fees be assessed? Can retirements, bonuses and other awards be reclaimed? What if settlement agreements are violated? Can the 2 Strikes rule under the Dr. Chris Kirkpatrick Act be enforced? WoA has reported the situation in Poplar Bluff and the two substantiated complaints against the Director, who instead of penalty was transferred to another medical center, why? Why is VA not reporting ALL of its employee suicides and attempted suicides (if DoD can report these – military and civilian – so can VA)?

VA employees should be able to go to OAWP and be guided, advised, and assisted regarding their rights, abilities, and authorities to develop their complaints and the evidence to substantiate those complaints. OAWP should take every step necessary to ensure the timely support and assistance at the earliest and immediate level possible to mediate and resolve wrongdoing. OAWP should be able to issue binding decisions and offer temporary relief that a PPP has occurred while OSC investigates and further adjudicates disclosures and PPP complaints and take full corrective actions, as necessary. It should be able to mentor and mediate for employees especially those who are experiencing psychological distress and refer them to qualified and safe support systems. If OAWP can resolve an issue without a full OSC investigation to the satisfaction of the complainant, it should take steps to do so and give the employee the opportunity to withdraw their complaint from OSC consideration. However, for all other matters, VA should reprogram OAWP investigative authority and appropriations to OSC if possible subject to the views of OSC.

Independent Mentorship - In addition, Congress should consider creating an independent unbiased avenue to provide support, mentorship, and assistance to VA employees through its

contracts or grant-making authority as an employee center of excellence so that cases could have true independence from General Counsel. Just as the Veteran Service Organizations assist veterans in filing their claims with the VA for benefits and provide constant oversight and feedback regarding VA policies and operations, there should be such an ability to have relationships with other nonprofits and accredited organizations that have employee protections as a core mission.

Transfer OAWP Investigations - In the meantime, OAWP should be removed from investigating VA employees' disclosures since this appears to be a duplicative effort with OSC and it has lacked the full faith of employees who have asked for timely assistance and have gotten none as Mr. Dettbarn, Dr. Aghevli, Dr. Mitchell and numerous other VA employees have reported. OSC is the Prohibited Personnel Practices (PPP) experts across the federal government. According to the OSC 2019 Annual Report to Congress, VA represents a "substantial portion" of their workload.[8] OSC reports that it receives an average of 4,000 new PPP cases a year, which are time and resource intensive while they must also protect whistleblowers from retaliation. In total, OSC deals with over 8,000 cases annually and resolved 6,193 matters in FY 2019. It operated with an appropriated budget of $26,535,000 and a staff of 133 full-time equivalent (FTE) employees who processed 82% of their PPP cases within 240 days. In a 2019 VA OIG audit[9], it noted that OAWP had a budget of $17.34 million and 103 FTE handling over 3,000 submissions. It referred over 2,500 cases to other entities to investigate while only handling 547 of the submissions internally.

[8] https://osc.gov/Documents/Resources/Congressional%20Matters/Annual%20Reports%20to%20Congress/FY%202019%20Annual%20Report%20to%20Congress.pdf
[9] https://www.va.gov/oig/pubs/VAOIG-18-04968-249.pdf

2019 OSC and OAWP Data Comparison

Entity	Budget	Staff	Opened	Handled	Referred
OSC	$26.535M	133	8,000	6,193	
OAWP	$17.34M	103	3,000	547	2,500

WoA previously stated for the record that if Congress intends to transfer any of the OAWP investigation authority to OSC, OSC should provide its views and opinions on the impact to its timeliness and effectiveness. OSC would need to evaluate how their current caseload might be affected and if the funding would cover their expected costs. WoA suggests that OCS views include details on how it would handle a VA workload and if it could delegate a special unit for VA cases or if it could have oversight over the OAWP Investigations Directorate. Consideration could be given to a transfer pilot project or a temporary authority until OAWP could demonstrate an appropriate level of skilled staff and training, transparent SOPs, independence from VA General Counsel and chain of command for internal investigations, and real penalties for violators. Furthermore, WoA believes that a Duty to Assist should be incorporated as a primary mission for OAWP. They should represent the interests of the employee first.

Trauma Informed Framework for Retaliation - If WoA- a voluntary network of peers and certified Whistleblower Protection Advocates (WPA) - can provide psychosocial support to all of these VA employees, certainly OAWP with its vast resources and staff should be able to embrace a SAMHSA trauma-informed perspective with the goal of mitigating harm. In addition, WoA would also encourage that along with VA's definition of whistleblower retaliation of "taking or failing to take, or the threat to take or not take, by a supervisory employee of a personnel action

because of a whistleblower disclosure"[10] adding the provision regarding improper referrals to licensing boards, and adding and educating on the more extensive OSHA[11] definition:

Retaliation occurs when an employer takes an adverse action after an employee made a disclosure. An adverse action is an action that could dissuade or intimidate a reasonable worker from raising a concern about a workplace condition or activity. Retaliation against an employee is not only harmful to the employee who experienced the adverse action, it can also have a negative impact on overall employee morale because of the chilling effect that retaliation can have on other employees' willingness to report concerns. Because adverse action can be subtle, it may not always be easy to spot.

Examples of adverse action include, but are not limited to:

- *Firing or laying off*
- *Demoting*
- *Denying overtime or promotion*
- *Disciplining*
- *Denying benefits*
- *Failing to hire or rehire*
- *Intimidation*
- *Making threats*
- *Blacklisting (e.g., notifying other potential employers that an applicant should not be hired or refusing to consider applicants for employment who have reported their concerns to previous employers)*
- *Reassignment to a less desirable position or actions affecting prospects for promotion (such as excluding an employee from training meetings)*
- *Reducing pay or hours*
- *More subtle actions, such as isolating, ostracizing, mocking, or falsely accusing the employee of poor performance.*

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[10] file:///C:/Users/Jackie/Downloads/Directive_0500_OAWP_10_Sept_19%20(4).pdf
[11] https://www.osha.gov/sites/default/files/publications/OSHA3905.pdf

WoA would further request that OAWP must assess the full extent of the psychosocial damages caused by the retaliation and provide for those damages as well. Employees should be made whole from a comprehensive psychosocial perspective. There is a growing body of evidence that whistleblower retaliation is a moral injury and can cause PTSD, depression, suicidal ideation, and other stress-related disorders. This fact must be recognized by VA as compensatory damages for physical sickness in the same way that it recognizes, and service connects veterans for "personal trauma" when they claim active duty harassment, discrimination, bullying, hazing and assault. Employees deserve to be validated in much the same way.

Finally, WoA would also like to remind this committee of the commitments it has made regarding the Dr. Chris Kirkpatrick Act of 2017. In November 2020, WoA and the Kirkpatrick family jointly asked that you review several of the law's provisions, including the mandate for agencies to report employee suicides,[12] which does not appear to be done. We also believe VA has been remiss in holding "2 Strike" senior leaders accountable for whistleblower retaliation and have shared the substantiated complaints against the Poplar Bluff, MO hospital director. We believe VA has not fully complied with the law and ask it to respond to each of the provisions and fully report on the number of its employees who have died by suicide. We fear that there are still too many ineffective and insufficient protections afforded to employees, which results in confusion, misinformation, and ultimately greater harm to include suicide. Chairman Takano's response in February 2021, to WoA and the Kirkpatrick family was reassuring, and we are grateful for his plan to "ensure the Act is properly implemented and enforced."

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[12] PL 115-73. https://www.congress.gov/115/plaws/publ73/PLAW-115publ73.pdf

WoA is grateful for this opportunity to speak out on behalf of the hundreds of VA employees it has assisted over the last few years. Their cases are compelling examples of how and why the law regarding VA whistleblower protections must change so that wrongdoing against veterans and taxpayers can be accounted for and penalties enacted. This can no longer be a toxic culture fraught with embedded institutional corruption and complacency when ethical violations are reported. VA whistleblowers should be recognized for their heroic actions and not have to sacrifice their professions to save veterans.

WoA can respond to any questions or concerns that you may have by contacting jackie@whistleblowersofamerica.org.