



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

STATEMENT OF CHRISTOPHER A. WILBER
COUNSELOR TO THE INSPECTOR GENERAL
OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS,
HEARING ON
"PROTECTING WHISTLEBLOWERS AND PROMOTING ACCOUNTABILITY:
IS VA MAKING PROGRESS?"
MAY 19, 2021

Chairman Pappas, Ranking Member Mann, and Subcommittee Members, thank you for giving the Department of Veterans Affairs (VA) Office of Inspector General (OIG) the opportunity to discuss whistleblower protections and procedures at VA. My statement on behalf of the OIG describes our efforts to protect whistleblowers while examining their concerns. Specifically, it highlights OIG work examining VA's Office of Accountability and Whistleblower Protection (OAWP) and the implementation of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 (the Act).¹

The OIG is committed to serving veterans and the public by conducting independent oversight of VA programs and operations through audits, inspections, reviews, and investigations. We rely on allegations, complaints, and information from VA employees, veterans and their families, Congress, and the public when deciding where to focus our resources. The OIG treats all complainants as whistleblowers; we respond respectfully, safeguard confidentiality, and evaluate their concerns.² An individual's decision to bring allegations should not have to be weighed against the risk of possible adverse actions.

¹ The law was signed on June 23, 2017 and became Public Law 115-41.

² Federal law provides whistleblower protections to a federal employee or applicant for federal employment or an employee of a federal contractor, subcontractor, grantee, or subgrantee who discloses information that they reasonably believe evidences gross mismanagement, a gross waste of funds, an abuse of authority, a substantial and specific danger to public health or safety, or a violation of law, rule, or regulation. *See* 5 U.S.C. § 2302(b)(8) (federal employees and applicants for federal employment) and 41 U.S.C. § 4712(a) (contractors, subcontractors, grantees, and subgrantees).

Our oversight report from 2019 found significant failings at the OAWP, which had a chilling effect on complainants that to some extent lingers today.³ These failings included the lack of relevant policies and procedures, fundamental misunderstandings of investigative scope, not holding individuals accountable, and inadequate protections for whistleblowers. As a result, the immediate past and current OAWP leaders have been working to overcome the significant challenges in meeting the office’s statutory mission, mandates, and goals.

Since our report was published in 2019, the OIG has observed advances in the OAWP’s operations under former Assistant Secretary Tamara Bonzanto and current Acting Assistant Secretary Hansel Cordeiro. There is also marked improvement in relations between our offices. OIG and OAWP leaders meet regularly to discuss matters of mutual interest and updates on the OAWP’s progress in developing its procedures and addressing our 2019 report recommendations. Before providing more information on our oversight of the OAWP, it is useful to provide some context on how we triage whistleblower and other complaints and coordinate with other oversight and investigative bodies.

BACKGROUND

The OIG operates a hotline staffed by a dedicated team to receive whistleblower and other complaints. The hotline received more than 14,000 contacts for the first six months of fiscal year 2021 and over 28,000 contacts during fiscal year 2020. We receive information via telephone, fax, mail, and through web submissions. In addition to the OIG’s many outreach efforts, a link to the hotline submission form is on the OIG’s website. There are also posters in VA facilities on how to contact the OIG. As the result of site visits and other engagements with stakeholders, OIG staff may also be contacted by individuals directly with information or allegations of wrongdoing. These contacts are also routed through the hotline for tracking and potential follow-up. The OIG only investigates complaints that are related to VA programs, personnel, operations, or services. Our staff refer complainants who have concerns unrelated to VA to other resources, Offices of Inspectors General, or investigative agencies.

The Whistleblower Protection Act vests the authority to provide relief for violations of the Act with other specific entities and prohibits reprisal against public employees, former employees, or applicants for employment for reporting a violation of a law, rule, or regulation. That prohibition of reprisal extends to reports of gross mismanagement and waste of funds, abuse of authority, or a substantial and specific danger to public health or safety.⁴ The OIG lacks the legal authority to provide direct relief to VA employees or applicants who allege whistleblower reprisal and so does not investigate those matters. As such, VA employees (current and former) and applicants alleging whistleblower retaliation are informed of their right to contact the Office of Special Counsel (OSC) or appeal directly to the Merit

³ VA OIG, [Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017](#), 18-04968-249, October 24, 2019.

⁴ P.L. 101-12, April 10, 1989.

System Protection Board (MSPB), if appropriate. The OSC not only has the authority to investigate these matters, it also has the authority to seek corrective action through the MSPB on behalf of an employee or former employee. In addition to the OSC or MSPB, VA employees may also be informed of their right to contact the OAWP, which has statutory authority to investigate allegations of retaliation and make recommendations to the Secretary for disciplinary action. The OIG may, however, investigate the underlying problem or concern identified in a complaint.

The OIG will investigate appropriate complaints alleging retaliation against employees of VA contractors for engaging in protected activity. VA contractors are protected against whistleblower retaliation but, because they are not VA or government employees, they lack recourse to the OSC or MSPB. The OIG investigates their allegations and reports its findings for action by the Department.

Interaction with Complainants

The OIG hotline staff work with personnel from our front-line directorates with the relevant expertise to engage in an extensive triage process. Together they determine the best course for disposition and identify the most critical and impactful issues for priority attention, particularly individuals at imminent risk of harm. Allegations become cases based on a variety of factors, including issues having the most potential risk to veterans or VA programs and operations, and those for which the OIG may be the only avenue of redress. Specifically, the hotline accepts information and complaints that result in reviews of the following types of misconduct:

- VA-related criminal activity
- Systemic or other patient safety issues
- Gross mismanagement or waste of VA programs and resources
- Misconduct by senior VA officials

The allegations of wrongdoing that are not selected by an OIG directorate for review may be referred by the OIG hotline to VA for additional information or action. Every effort is made to safeguard the complainant's identity and to request information and review at levels above where the misconduct is alleged to have occurred. If a complaint is referred to VA, it is as either a case referral or a non-case referral. A case referral requires that the VA office or facility to which the matter is referred review the matter and respond back to the OIG about its findings and any actions taken. For example, if it is alleged that employees at a facility are not trained, the VA may be asked to provide documentation demonstrating who has been trained. The appropriate OIG directorate reviews that information and determines if it is responsive and appropriate. If so, the OIG will close the referral. If not, the OIG may ask for clarification or may decide to open a review of the matter. This practice is a force multiplier allowing the OIG to provide oversight of many more issues than if it relied solely on its own resources for all review activity. A non-case referral is for matters needing to be brought to VA leaders' attention that do not rise to the level of requiring additional OIG oversight of the response.

Communication with Complainants

Because complainants can contact the OIG through various methods, the way in which the OIG communicates back to them will vary. If they call, the OIG hotline analyst listens carefully and asks probing questions to ascertain as much relevant information as possible. The information is then forwarded to the OIG personnel who can determine next steps. OIG staff also advise the caller of the other agencies that should be contacted if there is an allegation of retaliation or other matter not within our jurisdiction. This will be annotated in the electronic file for that contact. If they contact the OIG hotline through mail or fax they will, at minimum, receive either a standard response or a semicustom response.⁵ A web submission will generate a screen explaining the process and providing information on the types of complaints that the OIG is not authorized or best situated to address.

The OIG treats all whistleblowers and others who provide information to the OIG with the utmost respect and dignity, including protecting to the fullest extent possible the identities of those who wish to remain confidential or anonymous sources. When a case is opened, the OIG notifies the complainant, if known, in writing or via email. While the OIG does not provide complainants the complete results of cases when they are closed due to privacy issues, complainants are given information on how to request the results of their case allowed to be released under the Freedom of Information Act.

Whistleblower Protection Coordinator

The OIG also plays an important role in helping whistleblowers access other potential avenues for redress. Under the *Whistleblower Protection Coordination Act*, the OIG must designate a Whistleblower Protection Coordinator.⁶ The OIG hotline director also serves as the coordinator. The coordinator cannot represent or advocate for the whistleblower, but educates employees on the following:

- Prohibitions against retaliation for protected disclosures
- Rights and remedies against retaliation for protected disclosures
- Roles of various entities including the OIG, OSC, MSPB, and relevant offices like the OAWP
- Timeliness and availability of alternative dispute mechanisms and avenues for potential relief

INTERACTION WITH OTHER AGENCIES

The OIG interacts with other oversight entities to ensure that all available resources and protections are available to complainants. As previously discussed, the OIG refers individuals contacting the hotline to many agencies that complainants can go to for redress.

⁵ A semicustom response provides information tailored to frequent categories of requests and general information related to the issue that the complainant brought forward. The OIG makes continuous improvements to this procedure.

⁶ P. L. 115-92, June 25, 2018, applies to all federal OIGs.

Office of Accountability and Whistleblower Protection

The OAWP's responsibilities under the Accountability and Whistleblower Protection Act of 2017 include the receipt, review, and investigation of allegations of misconduct, retaliation, or poor performance that involve the following individuals:

- Senior leaders
- Employees in a confidential, policy-making position
- Supervisors accused of whistleblower retaliation

OIG hotline staff may refer VA employees who are seeking assistance to the OAWP. Similarly, OAWP staff refer complaints that are more appropriately addressed by the OIG, such as allegations of possible criminal misconduct, to the OIG's hotline.

Office of Special Counsel

OSC is a federal agency with authority to review allegations of prohibited personnel practices, including reprisal for whistleblowing. OSC not only has the authority to investigate the individual's complaint, it can seek corrective action through MSPB on behalf of the complainant and seek disciplinary action through MSPB against the individual(s) who retaliated.

THE OIG 2019 OVERSIGHT REPORT ON OAWP

In addition to referring appropriate personnel management issues to the OAWP, the OIG also plays an oversight role with respect to the OAWP, as a component of VA. In response to congressional requests and complaints to the OIG hotline, the OIG conducted a review of the OAWP's operations from June 23, 2017, through December 31, 2018. During the review, additional allegations arose as new OAWP leaders began making changes, prompting further work through August 2019, with the release of the OIG report, *Failures Implementing Aspects of the VA Accountability and Whistleblower Protection Act of 2017*, in October 2019.⁷ The OIG recognizes that organizing any new office is challenging, but OAWP leaders made early, avoidable mistakes that created an office culture that was sometimes alienating to the very individuals it was meant to protect. Those failures distracted the OAWP from its core mission and likely diminished the desired confidence of whistleblowers and other complainants.

The OIG report detailed 22 recommendations related to six key findings. Each of those findings is summarized below. As of May 19, 2021, only recommendation 6 remains open, which calls on the Office of General Counsel to update VA Directive 0700 and VA Handbook 0700 to clarify how those policy documents apply to the OAWP. VA's response to recommendation 6 anticipated completing this

⁷ From June 23, 2017, until January 7, 2019, the OAWP operated without its assistant secretary. It was led by Executive Director Peter O'Rourke from June 23, 2017, to February 28, 2018, followed by Executive Director Kirk Nicholas until January 7, 2019. Assistant Secretary for Accountability and Whistleblower Protection Tamara Bonzanto then took office and served until January 20, 2021.

clarification in early 2020. The text of all recommendations, a summary of VA's action to address the recommendation, and the respective completion dates can be found in appendix A to this statement.

Finding 1: The OAWP Misinterpreted Its Statutory Mandate, Resulting in Failures to Act Within Its Investigative Authority

A fundamental flaw identified by the OIG was the OAWP's misunderstanding of its statutory authority. The lack of clear and consistent guidance contributed to many of the other deficiencies identified in the report. The OAWP investigated individuals outside the OAWP's scope of authority under the Act, which in some instances introduced an appearance of bias. At the same time, it was too narrowly interpreting the scope of *what* the office should investigate. The OAWP inappropriately excluded investigations of misconduct and poor performance of covered individuals if the person making the allegations did not meet the statutory definition of whistleblower, a restriction not found in statute.

In addition to misinterpreting its statutory investigative mandate, the OAWP also failed to refer matters for investigation to other more appropriate investigative entities. While VA employees must, for example, refer to the OIG matters that may be violations of criminal law related to VA, the OAWP did not immediately refer such matters. Allegations of discrimination should have been referred to VA's designated equal employment opportunity office, the then Office of Resolution Management, unless they fell within the OAWP's authority to investigate.

The OIG made four recommendations related to Finding 1, focused on ensuring the OAWP acts within its statutory authority and develops policies and procedures for working with other investigative entities.

Finding 2: The OAWP Did Not Consistently Conduct Procedurally Sound, Accurate, Thorough, and Unbiased Investigations and Related Activities

Written policies and procedures are crucial to effective operations, but through the OIG review, comprehensive written policies and procedures on any topic had not been drafted. This failure resulted in the OAWP conducting investigations that were not always thorough, objective, and unbiased.

The OIG identified deficiencies in the following areas:

- The OAWP lacked comprehensive policies and procedures suitable for its personnel given that individuals' reputations are at stake and whistleblowers' identities must be protected.
- The OAWP did not have quality control measures. While some inadequacies were found by disciplinary officials and VA's Office of General Counsel, this de facto oversight was not an effective or sustainable solution.
- The OAWP had failed to provide the staffing and training necessary to ensure it has the expertise, experience, and commitment that yield objective and thorough investigations.
- The OAWP had fallen short of its commitment to conduct "timely, thorough, and unbiased investigations" in all cases within its investigative jurisdiction. A contributing factor was the

OAWP's practice of investigating to the "substantial evidence" standard, while only focusing on finding evidence sufficient to substantiate the allegations without attempting to find potentially exculpatory or contradictory evidence. The OIG review found many matters referred for administrative investigation took a year or more to close.

The OIG made four recommendations related to this finding, focused on creating standard operating procedures, creating a quality assurance program, training OAWP staff, and for OGC to review and update VA Directive 0700 and VA Handbook 0700 and clarify how they apply to the OAWP, if at all.

Finding 3: VA Has Struggled with Implementing the Act's Enhanced Authority to Hold Covered Executives Accountable

A critical purpose of the Act was to facilitate holding "covered executives" accountable for misconduct and poor performance. However, as of May 22, 2019, VA had removed only one covered executive from federal service pursuant to the Act. The OIG found that officials tasked with proposing and deciding disciplinary action had insufficient direction for how to determine discipline that would ensure consistency and fairness for specific acts of misconduct and poor performance. In many cases, disciplinary officials mitigated the discipline recommended by the OAWP as too severe or based on advice from OGC. In part, this was because of the absence of clear guidance and the OAWP's practice of not always including relevant exculpatory evidence. OAWP staff had adopted a practice of including material in the evidence file that supported the proposed disciplinary action, rather than compiling all relevant evidence. The staff only provided additional information when requested by OGC attorneys, which was problematic because OGC attorneys might not know what information to request. In 2019, OAWP management directed that OGC attorneys be routinely provided access to the entire investigative file.

For Finding 3, the OIG made three recommendations related to providing guidance and training on penalties for actions taken pursuant to the Act, creating guidance and training for disciplinary officials to maintain compliance with mandatory adverse action criteria outlined in the Act, and ensuring that disciplinary officials are provided with all relevant evidence.

Finding 4: The OAWP Failed to Fully Protect Whistleblowers from Retaliation

The OIG found that the OAWP referred many complainants to other VA program offices, facilities, or other components that were not all equipped to undertake such investigations and without adequate measures to track the referrals or safeguards to protect whistleblowers' identities. While referring other submissions to entities best positioned to address them is not inherently problematic, complainants were not always advised of these referrals. In some cases, the referrals included people who had alleged whistleblower retaliation by a supervisor, an issue inside the OAWP's core authority. The OIG found other concerns related to protecting whistleblowers from retaliation:

- The OAWP took the position that allegations of whistleblower retaliation could not be investigated unless the whistleblower was willing to disclose his or her identity. This policy placed the OAWP's

obligation to investigate whistleblower retaliation in conflict with its obligation to maintain confidentiality of whistleblowers' identities.

- In 2017, the OAWP established a whistleblower reintegration program, which was later renamed the Whistleblower Mentorship Program. The stated purpose of the program was to provide whistleblowers who had made complaints with transitional support resources if needed after the whistleblowing experience. OIG interviews indicate that the motivation for the program was also to break the perceived routine of whistleblowers who continued making reports. The program was placed on hold after 18 months during which time it served one whistleblower.
- The OAWP also failed to establish safeguards sufficient to protect whistleblowers from becoming the subject of retaliatory investigations. In one example, the OAWP investigated a whistleblower who had a complaint pending against a senior leader who had social ties to the OAWP's executive director. After a truncated investigation, the OAWP substantiated the senior leader's allegations against the whistleblower without even interviewing the whistleblower.

During its review, the OIG received several allegations from OAWP employees pertaining to personnel decisions and other discretionary actions by OAWP management. Witnesses raising allegations of whistleblower retaliation or prohibited personnel practices were encouraged to file complaints with the OSC. While some allegations related to dissatisfaction with then OAWP official's decisions, others raised important issues that OAWP managers needed to address. Accordingly, the OIG deidentified the complaints and transmitted their general substance to the OAWP.

The OIG made three recommendations regarding safeguards for maintaining the confidentiality of employees submitting complaints, conducting an organizational assessment of the OAWP, and developing a process and training to identify and address potential retaliatory investigations.

Finding 5: VA Did Not Comply with Additional Requirements of the Act and Other Authorities

The OIG found that VA failed to implement various requirements under the Act, including revising supervisors' performance plans and developing supervisors' training regarding whistleblower rights. VA also had not provided whistleblower protection training for all other employees. VA did not submit timely, responsive, and/or accurate reports to Congress on whistleblower investigations and related disciplinary actions. The causes for the lapses included an inadequate case management system, deficient information-tracking procedures, and OAWP leaders' failure to understand the Act's obligations and deadlines. The OIG also found that the OAWP was not reporting VA disciplinary officials' mitigation or declination of OAWP-recommended actions. This failure undermined Congress's intent to create greater transparency with respect to employee accountability and whistleblower protection within VA.

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

Finding 6: The OAWP Lacked Transparency in Its Information Management Practices

OIG staff identified issues regarding the OAWP's information management practices. VA has obligations under the Privacy Act of 1974 to disclose its uses of information collected from individuals, and it has obligations under the Freedom of Information Act to provide timely and accurate responses to requests for information. The OAWP failed to publish notices required by the Privacy Act concerning the collection of information from individuals and VA's routine uses of that information. The OAWP also did not communicate appropriately with individuals, and its responses pursuant to the Freedom of Information Act were not meeting statutory deadlines. This finding had two recommendations.

CONCLUSION

The OIG values whistleblowers and others who provide information to help identify issues that can put veterans and their families at risk for physical or financial harm. The information also can reveal deficiencies with VA programs, processes, and personnel that affect VA's efficiency and effectiveness. OIG staff understand that complainants often come forward despite fear of discovery or retaliation, and we take seriously our obligation to protect their confidentiality. In turn, VA leaders and staff must protect whistleblowers from retaliation and support an environment that encourages reporting concerns, problems, or ideas for potential improvements. I encourage all whistleblowers and others to contact us with information on fraud and other crimes, waste, and abuse that could negatively affect veterans, their families, or VA's ability to make the best use of taxpayer dollars to provide high-quality services and benefits. You will be treated with respect and dignity, and you can be confident we will protect your identity to the greatest extent possible.

We will continue to work closely with the OSC, OAWP, and other oversight or investigative bodies who can meet the needs of whistleblowers and others when we cannot. The OAWP has made demonstrated progress since 2019 to improve its operations and procedures, and a cooperative working relationship now exists between the OAWP and the OIG. The OAWP must build on this momentum to fully restore the trust of whistleblowers damaged by earlier missteps and redouble its efforts to achieve the mission of the Act and the vision for this office.

Chairman Pappas, this concludes my statement. I would be happy to answer any questions you or other members of the subcommittee may have.

**APPENDIX A: ACTIONS TAKEN BY VA IN RESPONSE TO OIG RECOMMENDATIONS
FROM
FAILURES IMPLEMENTING ASPECTS OF THE VA ACCOUNTABILITY AND
WHISTLEBLOWER PROTECTION ACT OF 2017**

FINDING 1 RECOMMENDATIONS

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

Status: Closed July 1, 2020, after the OAWP implemented standard operating procedures in December 2019 for its Compliance, Intake, Investigations, and Quality divisions.

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

Status: Closed July 1, 2020, following the OAWP providing the numbers of employees in each category as listed in a delegation dated January 8, 2020.

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

Status: Closed January 19, 2021, after the OAWP provided final drafts of memoranda of agreement with the OGC and Office of the Medical Inspector regarding the divisions of responsibilities.

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

Status: Closed April 14, 2021, following the OIG's participation in multiple data coordination and testing demonstrations with the OAWP, as well as independent meetings with the ORMDI and OGC.

FINDING 2 RECOMMENDATIONS

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

Status: Closed April 17, 2020, after the OAWP issued standard operating procedures for its Intake, Investigations, Compliance, and Quality teams and provided a plan to train appropriate staff.

6. The VA General Counsel updates VA Directive 0700 and VA Handbook 0700 with revisions clarifying the extent to which VA Directive 0700 and VA Handbook 0700 apply to the OAWP, if at all.

Status: This recommendation remains open, and VA's response anticipated completing this clarification in early 2020.

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

Status: Closed July 1, 2020, after the OAWP documented Quality Division training conducted in 2020.

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

Status: Closed January 19, 2021, after the OAWP documented their organization-wide training plan.

FINDING 3 RECOMMENDATIONS

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

Status: Closed July 10, 2020, after the Office of Human Resources and Administration (HRA) provided a copy of the guidance on penalties for actions taken pursuant to 38 U.S.C. §§ 713 and 714.)

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

Status: Closed January 19, 2021, after HRA provided evidence of relevant guidance.

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

Status: Closed April 30, 2021, after OIG personnel participated in data demonstrations and testing discussions with OAWP staff members and other VA staff.

FINDING 4 RECOMMENDATIONS

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

Status: Closed July 1, 2020, after the OAWP updated its intake form.

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

Status: Closed March 11, 2021, following OIG staff's review of the OAWP's January 2021 White Paper, which includes implementation criteria and other actions the OAWP has taken.

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

Status: Closed September 24, 2020, after the OAWP provided a copy of the updated section of the Intake Division's standard operating procedure.

FINDING 5 RECOMMENDATIONS

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

Status: Closed September 24, 2020, after HRA provided a copy of its memo dated July 24, 2020, requiring the whistleblower protection element be placed in performance plans.

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

Status: Closed September 17, 2020, following the OAWP working with OSC and the OIG to develop whistleblower rights and protection training. The training provides employees with, among other information, an explanation on how to make a whistleblower disclosure, the right of employees to petition Congress, and who to contact if whistleblower retaliation occurs.

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

Status: Closed July 10, 2020, after HRA provided a copy of the Secretary's memo requiring training for whistleblower rights and protections.

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

Status: Closed March 18, 2021, after the OIG participated in multiple data coordination and testing demonstrations with OAWP staff members and determined that the OAWP's processes are satisfactory.

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

Status: Closed March 18, 2021, after the OIG participated in multiple data coordination and testing demonstrations with OAWP staff members and determined that the OAWP's processes are satisfactory.

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

Status: Closed April 17, 2020, after the OAWP demonstrated it had established and was utilizing information systems capable of tracking the mandated data items.

FINDING 6 RECOMMENDATIONS

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

Status: Closed July 1, 2020, after the OAWP provided a copy of the System of Records Notice that was published in the Federal Register.

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

Status: Closed September 24, 2020, after the OAWP provided the OIG with updated data related to its processing of the Freedom of Information Act requests.