



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
HEARING ON
MODERNIZING THE VA POLICE FORCE: ENSURING ACCOUNTABILITY
JULY 13, 2021

Chairman Pappas, Ranking Member Mann, and Subcommittee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG) oversight of the Department of Veterans Affairs (VA) security and law enforcement program (the police program). The OIG is committed to serving veterans and the public by conducting oversight of VA programs and operations through independent audits, inspections, reviews, and investigations. This oversight is particularly critical when the safety of VA personnel, veterans and their families, and visitors to VA facilities are at issue. How VA police provide security and law enforcement services, particularly how they are guided, managed, and supported certainly warrants close scrutiny.

The OIG's prior oversight of VA's police program has identified governance and information management systems challenges. In our December 2018 report, *Inadequate Governance of the VA Police Program at Medical Facilities*, we concluded that VA did not have adequate and coordinated governance over its police program to ensure effective management and oversight of program requirements for its police workforce at medical facilities nationwide.¹ In June 2020, we reported on VA's police electronic records management systems and how VA did not have an effective overall strategy or plan of action to update its police information system.² The report concluded that VA's police electronic records management systems did not provide program leaders in the Veterans Health Administration (VHA) and the Office of Human Resources and Administration/Operations, Security, and Preparedness (HRA/OSP) or the workforce with comprehensive police program information to do their jobs. The common challenges identified in both OIG reports relate to the splintering of governance responsibilities, confusion about roles, and lack of clear guidance, which undermine VA's well-intentioned goals and objectives.

¹ VA OIG, [Inadequate Governance of the VA Police Program at Medical Facilities](#), December 13, 2018.

² VA OIG, [VA Police Information Management System Needs Improvement](#), June 17, 2020.

My statement on behalf of the OIG provides information on the status of our recommendations from both reports. This includes documentation on the latest corrective actions taken by VA that have been provided to the OIG for consideration regarding whether to close the recommendations as adequately implemented.

BACKGROUND

VHA offers health care to over nine million enrolled veterans—primarily in their own facilities. Federal law provides the VA Secretary with the authority and responsibility to protect patients, visitors, employees, and VA property.³ VA police officers provide security and law enforcement services at VHA facilities, as well as Veterans Benefits Administration offices collocated with VHA facilities, and some VA national cemeteries.

VA police officers are authorized while on or off departmental property to carry firearms in an official capacity. They conduct investigations of offenses committed within VA’s jurisdiction and consistent with other law enforcement agency agreements. They also arrest individuals on department property for offenses committed within VA’s jurisdiction.⁴ VHA reported that there were approximately 5,500 VA police officers and other program staff assigned at most of the medical facilities as of March 12, 2019. Other federal agencies provide security at the remaining VA healthcare facilities, such as the Manila Outpatient Clinic, Pasay City, Philippines. The VA police officer workforce was reported as being among the 10 largest law enforcement organizations in the federal government.⁵

Responsibility for the police program is divided between VHA and HRA/OSP.⁶ VHA has historically had primary responsibility for the police program, which governed security and law enforcement activities, such as ensuring VA police officers were qualified and maintained physical security on agency property.⁷ At the time of the OIG audits, VA policy designated the deputy under secretary for health for operations and management (DUSHOM) as the senior VHA official, together with Veterans Integrated Service Network (VISN) regional directors, for ensuring police program requirements are achieved, such as maintaining sufficient numbers of officers on duty with proper equipment and supervision.⁸ Each of the 18 VISNs have a designated VISN police chief who provides technical guidance and assistance to their respective area network medical facilities. Primary responsibility for police operations, however, falls to the local VA police chiefs who report to their medical facility directors, who in turn are responsible

³ Title 38, United States Code, § 901, Authority to prescribe rules for conduct and penalties for violations.

⁴ Title 38, United States Code, § 902, Enforcement and arrest authority of Department police officers.

⁵ Connor Brooks, “Federal Law Enforcement Officers, 2016 – Statistical Tables,” Department of Justice, Bureau of Justice Statistics website, accessed May 29, 2020, <https://www.bjs.gov/content/pub/pdf/fleo16st.pdf>.

⁶ On September 14, 2018, VA Secretary Wilkie reassigned OSP to the Assistant Secretary for Human Resources and Administration and the position of Assistant Secretary for OSP was eliminated.

⁷ Department of Medicine and Surgery Supplement MP-1, Part 1, Change 42, Chapter 2, Investigation, Security and Law Enforcement Policy, paragraph 11a (2) and 13d (1), July 23, 1986.

⁸ VA Directive 0730, Security and Law Enforcement, paragraph 3g, December 12, 2012.

for verifying police officers' qualifications, ensuring law enforcement activities are accomplished, and maintaining adequate on-duty officer staffing levels at the facility to protect people and property. Local VA police chiefs are responsible for implementing "legally and technically correct" law enforcement practices and physical security operations.

HRA/OSP is a VA program office that provides limited department-wide oversight of VA's security and law enforcement activities. Aligned under HRA/OSP, the Office of Security and Law Enforcement (OSLE) is charged with delivering professional law enforcement and security services. The office has two groups—the Police Service and the Law Enforcement Training Center (LETC). The Police Service group is responsible for developing and issuing national police program policies and procedures, investigating potential criminal incidents at VA facilities, and conducting inspections of 139 of 141 medical facility police units to determine if program requirements are being met. Police inspections provide a check on the adequate implementation of critical program operations such as physical security, rapid response activities, police staffing, and investigative activities. The police inspections include assessments of risks to patients, visitors, and employees.

OSLE's training center provides its services for the police program and other government agencies with limited jurisdictions. OSLE, through the LETC, serves as the business sponsor for the acquisition and development of VA police's department-wide electronic records management systems.

GOVERNANCE OVER THE POLICE PROGRAM WAS INADEQUATE FOR CONDUCTING EFFECTIVE OVERSIGHT

The OIG received complaints through its hotline related to the accountability and performance of some VA police officers at medical facilities. The OIG recognizes the importance of examining how oversight of VA police performance is conducted at a system-wide level. The focus of the audit was to determine whether the VA police program had an effective governance structure in place, met requirements for size and qualifications, and conducted adequate inspections to ensure compliance with policies and procedures.

The OIG's December 2018 report found that the governance problems occurred and persisted, in part, because of confusion about police program roles and authority between VHA and OSLE. The DUSHOM at the time of the audit told the OIG team that OSLE was responsible for centrally managing police program activities at VHA facilities.⁹ However, OSLE did not in fact have that responsibility and did not have needed authority, for example, to manage funding and pay decisions for VA police, to hold medical facilities accountable for adhering to police program policies, or to require staff within VHA to support timely inspections of medical facilities. Governance challenges also stemmed from the lack of a centralized management structure or the clear designation of staff within VHA to direct and oversee the police program.

⁹ The DUSHOM position was retitled as assistant under secretary for health for operations in March 2020.

The OIG audit revealed four key areas with deficiencies:

- Systemic tracking and assessment of police program operations and performance by VHA and OSLE
- Facility-appropriate police officer staffing models and officer shortages at VA medical facilities
- Timeliness of inspections of police operations at VA medical facilities
- Guidance on how VA police officers investigate the alleged misconduct of facility leaders who manage the police program or control its resources

OIG Recommendations and VA Implementation Status

The OIG made five recommendations in its 2018 report to VA's deputy secretary that focused on the areas of governance, staffing, the inspection program, and processes. The OIG considers all recommendations as still open and not fully implemented. The OIG's follow-up team requests updates every 90 days. The status information below is current through VA's May 4, 2021, response.

- **Recommendation 1:** The VA deputy secretary clarifies program responsibilities between VHA and the Office of Operations, Security, and Preparedness [at the time], and evaluates the need for a centralized management entity for the police program across all medical facilities.

Status of VA's Action Plan: VA requested closure in its May 2021 response to the OIG's request for an implementation update. However, VA has yet to clarify and formalize the roles and responsibilities for overseeing the police program for all accountable offices and leaders in VHA and HRA/OSP. VA had initially targeted September 30, 2019, as its completion date.

- **Recommendation 2:** The VA deputy secretary ensures police staffing models are implemented for determining facility-appropriate levels for officers at medical facilities.

Status of VA's Action Plan: VA has stated HRA/OSP has prepared a police officer staffing policy and model to guide precise facility-appropriate police staffing at medical facilities. This policy and model are still under internal VA review. The OIG is waiting to examine the final approved police staffing model and associated police officer staffing policy and will verify it has been disseminated to VHA facilities. September 30, 2019, was the initial VA-proposed completion date.

- **Recommendation 3:** The VA deputy secretary makes certain that medical facilities use strategies to address police staffing challenges such as having documented recruitment plans for police officer positions that include a determination of the need for special salary rates and incentives.

Status of VA's Action Plan: VA requested closure in its May 2021 communication to the OIG on the status of its implementation of the recommendation. VHA stated it has prepared an FY 2021 VHA police national strategic recruitment plan and made it available to local facility hiring managers. The OIG is waiting for evidence that the police recruitment plan has been disseminated to the local facility human resources employees and police chiefs for their use. VA had initially projected completion for June 30, 2019.

- **Recommendation 4:** The VA deputy secretary assesses the staffing levels for the OSLE police inspection program and authorizes and provides sufficient resources to conduct timely inspections of police units at medical facilities to help identify program compliance issues.

Status of VA's Action Plan: VA has stated that OSLE has received additional employees. However, HRA/OSP is still assessing staffing requirements for its new Office of Chief of Police and further modernization efforts may affect its police inspection program. The OIG is waiting for additional evidence that HRA/OSP has made a final assessment on its staffing needs for the police inspection program, and that those resources are being provided. VA had previously targeted June 30, 2019, as its completion date.

- **Recommendation 5:** The VA Deputy Secretary ensures procedures are developed for appropriately handling VA police investigations of medical facility leaders.

Status of VA's Action Plan: VA had requested closure of this recommendation at the time of publication, which was not granted. Subsequently, VHA and HRA/OSP reported that they were drafting a memorandum to provide procedures for how VA police investigations of medical facility leaders should be appropriately handled. The OIG will close this recommendation when sufficient evidence has been provided that the final memorandum has been approved and disseminated to VA police officers.

The OIG continues to work with VA on these recommendation through our follow-up process and expects another update by July 29, 2021, on the status of VA's implementation actions. The OIG's website has a recommendations dashboard that provides real-time information on the status of recommendations for ongoing monitoring. Updates will also be disclosed in the OIG's next *Semiannual Report to Congress*, for which the reporting period closes on September 30, 2021, and which will be published by November 30, 2021.

VA'S ELECTRONIC RECORDS MANAGEMENT SYSTEMS DID NOT ADEQUATELY SUPPORT THE POLICE PROGRAM

The OIG recognized that a significant factor in effective police program governance is access to accurate and timely information. This includes information about arrests and investigation activities. Such information can help identify security and safety risks, determine the proper allocation of resources, and measure progress in achieving police program goals. This audit was performed to determine whether VA's police information management planning and

implementation strategies and systems have provided program leaders and the workforce with the information needed to manage and guide operations.

The OIG's June 2020 report found that VA did not have an effective strategy to update its police information system. Persistent weaknesses included inadequate planning that stalled new system implementation, limited officers' access to information, and resulted in incompatible parallel systems. As a result, VHA and OSLE could not get law enforcement information needed for job-related activities such as performing adequate department-wide analyses or making informed decisions on facility risks and resource allocations. Further, the lack of an effective system meant that VHA could not adequately track incidents such as missing patients and use of force. Information security controls were also lacking, putting individuals' sensitive personal information at risk.

Recommendations and VA Implementation Status

The OIG made seven recommendations to the assistant secretary for HRA/OSP and the assistant secretary for information and technology. These recommendations focused on evaluating whether the LETC should oversee the records management systems for VA police, establishing a working group to assess whether the Report Exec system meets the needs of VA police, and developing a strategy to fully implement the system or its replacement. The OIG also recommended that an information security officer be consistently responsible for the Report Exec system.

VA has taken sufficient action to close two of the seven recommendations: recommendations 5 and 7.

- **Recommendation 5:** The assistant secretary for HRA/OSP, in consultation with the assistant secretary for information and technology and principal executive director for the Office of Acquisition, Logistics and Construction, initiates an agreement with the contractor to ensure information security measures are in place for the VA police records that were stored on the contractor's server to prevent unauthorized use and ensure their proper disposal.

Status of VA's Action Plan: The OIG closed this recommendation on December 18, 2020, after HRA/OSP provided confirmation that VA police records were wiped from the contractor's servers.

- **Recommendation 7:** The assistant secretary for information and technology, in coordination with the assistant secretary for HRA/OSP, ensures an information security officer is consistently responsible for the Report Exec system and properly notified of that role.

Status of VA's Action Plan: The OIG closed this recommendation on October 20, 2020, after the Office of Information Technology (OIT) provided documentation of an assigned information security officer being notified.

The other five recommendations remain open. The following list presents additional information on the status for each one based on VA's update from April 20, 2021:

- **Recommendation 1:** The assistant secretary for HRA/OSP, in consultation with the under secretary for health, evaluates the appropriateness of having the LETC serve as the manager of the records management systems for VA police.

Status of VA's Action Plan: VHA and HRA/OSP reported that the decision to keep management of the Report Exec system under the LETC is pending approval. The OIG is waiting for confirmation of the final decision made by an authorized official. VA had provided a target date of December 31, 2020, for completion.

- **Recommendation 2:** The assistant secretary for HRA/OSP, in consultation with the assistant secretary for information and technology, as well as the under secretary for health, establishes a working group of subject matter experts and evaluates whether the Report Exec system meets the needs of VA police. The group should also evaluate whether contract requirements have been fully achieved, then develop a strategy to ensure that police units at all medical facilities have a reliably performing records management system to report and track activities.

Status of VA's Action Plan: HRA/OSP provided a copy of a Report Exec system evaluation to the OIG and requested closure in the update submitted in April 2021. However, the OIG is waiting for additional information such as the names, titles, and offices of the HRA/OSP, OIT, and VHA working group subject matter experts who determined that the Report Exec system meets the needs of VA police. Additionally, HRA/OSP needs to provide evidence that legacy data from VA police system was moved into the Report Exec system. VA targeted October 31, 2020, as its completion date.

- **Recommendation 3:** The assistant secretary for HRA/OSP—in consultation with the principal executive director for the office of acquisition, logistics and construction; the assistant secretary for information and technology; and the under secretary for health—develops and implements a plan describing how, when, and to whom information about issues for the police records management system will be disseminated and resolved.

Status of VA's Action Plan: HRA/OSP reported it has developed a plan outlining how technical and performance issues with the Report Exec system would be handled among the LETC and information technology support staff and requested closure in the April 2021 update. This recommendation cannot be closed until additional documentation is provided for the final plan regarding how system issues will be communicated to contracting officer(s) to facilitate a resolution or assess if contract requirements are being met. VA had targeted October 31, 2020, as its completion date.

- **Recommendation 4:** The assistant secretary for HRA/OSP, in consultation with the under secretary for health, updates security and law enforcement program procedures to ensure they meet information management needs and requirements.

Status of VA's Action Plan: HRA/OSP reported it is developing an update to its national program procedures. The OIG will assess the final police program procedures when submitted to determine if the recommendation should be closed. VA's initial target completion date was October 31, 2020.

- **Recommendation 6:** The assistant secretary for HRA/OSP, in consultation with the general counsel and the assistant secretary for the Office of Accountability and Whistleblower Protection (OAWP), determines the appropriate administrative action to take, if any, against personnel involved in bypassing the requirement that the Report Exec system be hosted at the Austin Information Technology Center and that the VA information security process be completed before operation.

Status of VA's Action Plan: VA requested closure at publication, which was not granted. HRA/OSP subsequently reported it has worked with OAWP, but is still engaging with the Office of General Counsel to provide information necessary for making a final determination. The OIG is waiting for the final Office of General Counsel decision before considering closure.

The OIG continues to work with VA on these recommendations and expects another update also by July 19, 2021. As with the oversight report detailed earlier, the recommendations dashboard on the OIG website and the next report to Congress will provide ongoing status updates.

CONCLUSION

An effective governance structure is critically important to the functioning of any program—but imperative where there are issues of public and patient safety. The confusion about program roles and authority has made it difficult for VA to have any degree of certainty that its police personnel and resources are being effectively deployed. The safety of veterans, VA staff, and visitors to VA medical facilities is of paramount importance to VA. To achieve its goals for protecting those individuals and VA property, the governance structure, staffing issues, and program oversight processes must be addressed with a higher level of attention. Furthermore, effective police program governance is dependent on access to accurate and timely information to provide strategic direction, make informed decisions, and maintain accountability. Until proven actions are taken to address OIG oversight recommendations, the safety of veterans and their families, VA personnel, and visitors to VA facilities will be affected.

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