Whistleblowers of America

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Testimony

on behalf of

Whistleblowers of America

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Before the

House 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 the bipartisan "Discussion Draft" legislation to make certain improvements to the Office of Accountability and Whistleblower Protection (OAWP). This will be our 4th statement on this matter since June 2019. WoA supports and endorsed this legislation.

Beginning with **Section 2,** "Counsel of the Office of Accountability and Whistleblower Protection," through conversations with OAWP leadership, we understand that they believe that by hiring more attorneys, it achieves independent advice. However, the OAWP is still subjugated to decision making by the Department of Veterans Affairs (VA) Office of General Counsel (OGC). Previously, I have testified about this lack of independence before this Committee and have shared documentation. As a reminder, I was told that OAWP could not make certain

decisions without getting an OGC opinion. Whistleblowers often complain that all OAWP decisions must go through OGC first, which is a conflict of interest because they represent the agency. Under these conditions, no one at OAWP can represent the employee's interest, which is what they assume the role of OAWP will do. This is clearly not independence; therefore, **we endorse Section 2.**

We would encourage OAWP to use its own General Counsel to make binding recommendations to the VA Secretary to better represent employees who have made disclosures. OAWP should have a duty to assist these employees to develop the evidence necessary for cases to move forward. We have seen all too often that technicalities and adversarial judicial proceedings leave employees who are not whistleblower law experts on their own to defend themselves and protect the veterans who are being harmed, denied benefits, or have wrongfully died.

We fully endorse Section 3, "Modifications to Functions of the Office of Accountability and Whistleblower Protection." From the beginning, WoA has thought it not a good idea to let VA investigate itself. We have cited multiple points of failure as the "fox guarding the henhouse." We remind this Committee that over two years ago, I presented testimony requesting this committee investigate ethical violations occurring within the Veterans Benefits Administration (VBA). The OAWP and the OIG declined to investigate initially, it took an inquiry by Senator Grassley to prompt action. Several whistleblowers detailed information regarding the lack of adherence to ethics rules, contractual irregularities, and rampant retaliation against anyone seeking to correct and curtail wrongdoing. After my testimony, OAWP repeatedly pushed me to unmask the whistleblowers. We hope that culture has changed under this new leadership. However, the VA Office of Inspector General (OIG) recently sustained the allegations of ethics

violations made by former VA Education Services Director Charmain Bogue.[1] Mrs. Bogue left the agency after refusing to cooperate with investigators. To this day, there has been no accountability, no fines, no bar from further federal funds (as an employee or a contractor) for her or her husband. More importantly, no senior leader in Ms. Bogue's chain of command has faced consequences for their role in facilitating the ethics violations.

Senator Grassley has yet to receive any answers from VA with regards tohis initial letter of inquiry or taken steps to end the retaliation. WoA is cooperating with EMPOWER, as they seek critical answers through FOIA channels. The OAWP failed to investigate the inquiry. The OIG launched a narrowly scoped investigation that substantiated claims made by Senator Grassley. WoA is grateful that President Biden signed the law that gives VA OIG subpoena authority, which will enable them to question former employees and contractors/grantees who could otherwise decline to cooperate. We ask that VA OIG finish the job. We request this committee demand accountability and complete the full breadth of the investigation requested of the VBA chain of command, the Bogues, and Veteran Employment Success. We also request that VA investigate the $453 million, CARES Act-funded, GI Bill IT contract awarded by VBA under the charge of Mrs. Bogue. We believe the rampant ethics violations of VBA senior leaders demand further scrutiny. A culture of lax ethical standards is ripe for corruption. The recent GI Bill awarded contractor employed the former OAWP Director whom the VA OIG referred to the Department of Justice for investigation due to contract steering. His OAWP team oversaw the initial review of VBA Acting Under Secretary for Benefit's (USB's) ethics investigation, but now over $80 million has been awarded to the privately held firm, Le'Fant, owned by the former

[1] https://www.oversight.gov/report/VA/Former-Education-Service-Executive-Violated-Ethics-Rules-and-Her-Duty-Cooperate-Fully-OIG

Acting USB, who was suspended prior to leaving VA and later referred to the OIG for violations of contracting irregularities. We remain concerned that these revolving-door relationships feed the potential for fraud, waste, and abuse when they go unchecked or without limitations based on previous sanctions. Meanwhile, whistleblowers, especially when falsely reported to licensing boards, such as with the National Physician Data Bank, have no due process recourse to remove retaliatory investigations or reports, which WoA hopes can be addressed in Section 4 of this Discussion Draft.

This lack of accountability is not uncommon across the VA. Although the VA has a *Zero Tolerance* policy on sexual harassment, WoA is aware of a class action lawsuit case that settled for over $1 million and one employee was paid $300,000.00 to settle their sexual harassment lawsuit, but the person(s) responsible for the sexual harassment are still employed, along with the supervisor who did nothing about it when it was first reported.

Furthermore, in the book, *Behind the Murder Curtain*, VA OIG Special Agent Bruce Sackman writes that *"Hospital managers have a well-documented history of defending employees suspected of intentionally harming patients. They are afraid of bad publicity and potential lawsuits."* He observes that they do not want investigations in order to avoid a public record that could result in sensational news stories. Instead, he notes that they sweep these problems under the rug while hundreds of veterans have died at the hands of VA Medical Serial Killers. The internal investigations fail to properly collect forensic evidence, communicate findings to authorities, and do not hold accountable perpetrators. Victims are invisible.[2] In addition, WoA

[2] https://www.oversight.gov/report/VA/Former-Education-Service-Executive-Violated-Ethics-Rules-and-Her-Duty-Cooperate-Fully-OIG
Sackman, B., Vecchione, M. Schmetterer, J. (2020) Behind the Murder Curtain: Special Agent Bruce Sackman Hunts Doctors and Nurses who Kill Our Veterans. Post Hill Press, NY.

hosts a weekly meeting with VA Police Officers who confirm similar observations as Special Agent Sackman. Unlike other Federal Law Enforcement Officers who report to the Department of Justice, VA Police Officers and Chiefs, work for the Medical Center Directors. These officers have shared numerous stories of being told to drop investigations by their Medical Center leadership that have resulted in thefts, frauds, homicides, suicides and overdoses of employees and patients. We have reviewed these cases. None of them were fully investigated, nor has there been any accountability. An example of this egregiousness is the self-inflicted death of Dr. Jeff Belinski who was known by the medical team at the Cheyenne, WY VA Medical Center to have been diverting drugs and performing procedures on veterans while under the influence of drugs. It is documented that surgeries were performed on wrong body parts. And yet, employees; law enforcement officers and other medical providers who observed the strange behaviors and misdeeds of Dr. Belinski, who wanted to help him and protect against veterans' wrongful deaths, suffered retaliation instead.

Internal "fact findings" at the medical centers, audits, and recommendations even by the OIG, are non-binding and do not always properly collect or handle evidence, which then does not result in proper accountability. VA employees can recount numerous cases of an employee found of wrongdoing being promoted instead of disciplined. WoA and the Kirkpatrick family have raised this issue numerous times, including correspondences to Chairman Takano over "2 strikes" for the former director of the Poplar Bluff VA Medical Center. She was given a directorship at a larger VAMC instead of being disciplined in accordance with the Chris Kirkpatrick Act of 2017.

Therefore, WoA believes that the OAWP is not trained or equipped to handle these investigations alone. Although there may be some qualified and competent OAWP employees,

the ultimate findings are not independent of the agency that is invested in protecting its reputation and avoiding blame. The VA will give itself *Chevron Deference* as the experts in the construction of its own operating policies, unless that construction can be found to be outside the range of reasonableness, usually because the meaning of the policy is unclear. When the statute is silent or ambiguous with respect to a specific issue, and the agency can decide that the disclosure pertains to an implicit issue rather than something it sees as an explicit violation, it can rule in its own favor and convince other jurisdictions of such deference. This is a conflict of interest that denies transparency and accountability that WoA believes can be addressed by Section 3 since investigations conducted by the Office of Special Counsel (OSC) are independent from the influence of VA leaders and the OSC can assign deference to the credibility of the evidence presented by both parties.

WoA supports Section 4, Expansion of Whistleblower Protections. Previously, we have requested that VA be compliant with the definition of retaliation proffered by the Department of Labor's Occupational Safety and Health Administration (OSHA). In its Non-Retaliation Policy, OSHA identifies that "*Retaliation occurs when an employer takes an adverse action after an employee makes 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.*

OSHA 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.[3]

In addition and in accordance with 18 USC, §1001, any government employees who, knowingly and willfully— (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact; (2) makes any materially false, fictitious, or fraudulent statement or representation; or (3) makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry; shall be fined under this title or imprisoned not more than 5 years. Lack of candor is a violation according to the MSPB decision in the Fargnoli case when a federal employee has given incorrect or incomplete information; and did so knowingly. These violations should also be considered and reported as retaliation when such violations involve whistleblower allegations and managers fail to act with candor.

WoA also sees examples of cyberbullying and doxing of whistleblowers by exposing their identity and violating their privacy and confidentiality as a retaliatory tactic because it damages their reputation and humiliates them publicly. A whistleblower repeatedly asked the VA Security Office for assistance when VA employees were believed to be involved in the public cyberbullying and doxing that was taking place and they refused to get involved. We are

[3] https://www.osha.gov/sites/default/files/publications/OSHA3905.pdf

outraged by this disregard of whistleblower rights and believe this is, yet another retaliatory practice used to silence and punish anyone daring to speak truth to power. These types of retaliation would not be covered by the VA's limited definition but causes emotional pain and suffering that VA recognizes in its research, education, and suicide prevention. WoA sees this as a conflict when it promotes mental health strategies and suicide prevention while denying its own employees the same conditions it proports should be given to veterans as employees by state's, local, and private entities through its PREVENTS campaign, SAVE training, and Make the Connection videos. VA should practice what it preaches.

Furthermore, the National Center for PTSD has extensive research on emotional abuse and Moral Injury and its traumatic impact. VA explains that a Moral Injury occurs when acts transgress an individual's deeply held moral beliefs and values. It results in a shattering of world views, a loss of trust, increased shame and guilt, complicated grief, and feeling of betrayal. It recognizes that emotional abuse or bullying is "*A persistent pattern of behaviors that threaten, intimidate, degrade, undermine, embarrass, or humiliate another and have an adverse impact on another's emotional and psychological well-being"*[4] and that the consequences of such behavior can result in:

• *Stress & Anxiety*
• *Depression*
• *Reduced Internal Focus of Control*
• *Lower Self-Esteem & Self-Efficacy*
• *Shame & Guilt*
• *Helplessness*
• *Anger & Aggression, and*
• *Suicidal Behavior.*[5]

[4] https://www.va.gov/files/2021-11/Workplace%20Bullying%20TMS.pdf
[5] https://www.va.gov/files/2021-11/Workplace%20Bullying%20TMS.pdf

These conditions can lead to the symptoms and diagnosis of posttraumatic stress disorder (PTSD), depression, anxiety, substance abuse, and suicidal ideation. Suicide is the 4th leading cause of death among working-aged adults so VA employees, especially if they are also veterans, are at greater risk for a mental health consequence if they are experiencing the personal trauma and Moral Injury of retaliation. This was the circumstances of one of the VA Police Officers who died by suicide after reporting sexual harassment of another VA employee, his wife. She was moved to another city, and he was forced out of the VA. He later took his own life because of the retaliation he suffered from his chain of command that other Police Officers want to make known as factors contributing to the disintegration of his family and ultimately his death.

The research around the mental health impacts to whistleblowers is growing. Other studies outside of those conducted by the VA show a correlation between retaliation and mental health. In one study, it found that whistleblowers had similar mental health outcomes as people with disabilities and cancer patients when controlling demographic factors. It found that "*About 85% suffered from severe to very severe anxiety, depression, interpersonal sensitivity and distrust, agoraphobia symptoms, and/or sleeping problems, and 48% reached clinical levels of these specific mental health problem."*[6] These results are similar to my own research on the deleterious psychosocial impacts of retaliation.[7]

According to OSHA Whistleblower Investigations Manual, "*Damages for emotional distress and mental anguish may be awarded under all OSHA administered whistleblower statutes."* This *is*

[6] https://journals.sagepub.com/doi/full/10.1177/0033294118757681
[7] https://www.crisisjournal.org/article/17219-whistleblower-retaliation-checklist-a-new-instrument-for-identifying-retaliatory-tactics-and-their-psychosocial-impacts-after-an-employee-discloses-workplace-wrongdoing

based on the emotional distress, pain and suffering, loss of reputation, personal humiliation, and mental anguish resulting from the respondent's adverse employment action."[8]

WoA, therefore, believes that the VA should consistently apply its own research and definitions to traumatized employees who seek assistance from OAWP and include these constructs in its retaliation policies and implement a trauma-informed perspective throughout its operations in accordance with OSHAs guidance on emotional distress. If suicide prevention is the highest priority for VA but it still experiences several points of failure,[9] then WoA finds that recommendations from the OIG[10] should be applied across all VA sectors to include its own workforce and that OSHA guidance should be incorporated into the OAWP scope of work.

In light of these tactics of retaliation, OAWP should retain its ability to impose temporary relief while OSC investigates.

Section 5: Tracking and Enforcement of Recommendations and Settlement Agreements Regarding Whistleblowers is vital and WoA fully endorses the need for this provision. VA represents over 40% of the WoA workload, which translates to hundreds of employees. In general, we see VA employees who wait a year to five years for settlement. WoA has checked in with two of the witnesses who came before this Subcommittee in July 2019, Mr. Jeff Dettbarn, and Dr. Minu Aghaveli. Mr. Dettbarn waited just under 5 years for a settlement to return him to work under the same leadership he reported and with an agreement to give up on-call pay in violation of OPM policy.[11] Then, OAWP opened two new cases because his supervisor did not

[8] https://www.osha.gov/sites/default/files/enforcement/directives/CPL_02-03-007.pdf
[9] https://www.va.gov/oig/pubs/VAOIG-20-02186-78.pdf
[10] https://www.va.gov/oig/pubs/VAOIG-21-01506-76.pdf
[11] https://www.opm.gov/policy-data-oversight/pay-leave/pay-systems/federal-wage-system/appropriated-fund-operating-manual/subchapter8.pdf

provide an annual evaluation for 4 years (in violation of OPM policy[12]) and the director sent him back to work for the same office while his concurrent EEO case was still open. Dr. Aghaveli has sat in limbo. In an email to WoA she writes, *"While the U.S. Office of Special Counsel has been a valuable ally in supporting me as a whistleblower, the VA OAWP was completely unhelpful. As my case has dragged on for 3-years, with OSC and my attorneys' assistance, it appears a resolution returning me to help our veterans is within reach."*[13]

In addition, VA is known to miss mediation deadlines and not show up for arbitrations. They will use the Alternative Dispute Resolution (ADR) process to gather information from the complainant and then not show up for meetings, which costs the employee wasted attorney time. One whistleblower noted that VA stood them up three consecutive times for ADR. After gathering evidence from the employee, VA will often step away from mediation or go dark for many months. WoA sees this as an attempt to pressure the employee, make legal counsel unaffordable, or generate frustration so the case will be dropped. This is not equal access to justice. There have been no repercussions for VA for this unethical behavior because there are no standards for settlements and there is no database accurately kept on settlement agreements. Settlements paid through tax-payer dollars. VA does not have to report the time it takes them to process a settlement, or the formula used to calculate the remuneration. VA decides settlement based upon its own internal risk model, but that data is not available to the employee. What is the formula for a meaningful settlement? When does VA agree to pay legal fees, back-pay, damages for pain and suffering? What is the level of evidence needed? There is no forcing function for when there is a settlement agreement for VA to fully implement or remain in compliance with

[12] https://www.opm.gov/services-for-agencies/performance-management/performance-appraisals/

[13] Email from Dr. Minu Aghevli to Jacqueline Garrick on June 11, 2022.

the agreement. So, for whistleblowers like Kristen Ruell who also previously testified before this committee, little can be done. Ms. Ruell settled with VA in 2015, but then VA breached its agreement. She is back in negotiations. This puts her back to square one where she was in 2014. After 5 years of her working under the conditions of an agreement, VA is now saying that they need a judge to interpret the clause that the VA originally wrote. She interprets this new action as retaliation for her and her colleagues reporting a manager who allegedly claimed to be an attorney but is not and should not have been rendering legal opinions.

VA does not have to report the resources it took to process the claim, such as accounting for the number of VA employees (i.e.: OIG Agents, attorneys, Labor Relations specialists, HR, or Union, etc.) who have been devoted to the case. Whistleblowers also lack access to data. For example, VA attorneys have access not only to precedential rulings but other case decisions through resources like Westlaw. They can research MSPB judges and see how they rule. It helps VA shape their case and informs their decision for settlement. Employees, especially if they are pro se, do not have the same resources to review previous judgements, nor would they have the same understanding of the implications, unless they could afford to hire their own law firm who could do such research. This is time-consuming and expensive. Most whistleblowers navigate the system pro se, without legal counsel, and their low rates of success reflect a system designed to favor the agency.

VA is also not reporting fines or fees to the Department of Treasury Judgment Fund. According to the VA's own financial policy[14], it is supposed to reimburse the Judgment Fund for Whistleblower NO FEAR Act settlements. However, according to an OIG report, VA fails to do

[14] https://www.va.gov/finance/docs/VA-FinancialPolicyVolumeVIChapter20.pdf

so. It has only paid the Judgment Fund for construction project settlements and at one point was delinquent $226,328,422 with an average payment date of 221 days - well beyond the Treasury's requirement of 45 days.[15] We must make accountability and transparency at the VA more than mere words and they should rectify their bill with Treasury and collect fines.

Section 6: Training and Education is supported. In disseminating training materials, VA is encouraged to use the expanded definitions stated above and to recognize the trauma that threats and retaliation causes its employees. The psychosocial factors are damaging and OAWP should be addressing the harm caused to the workforce and be a source of support and information so that employees can avoid a Moral Injury and a mental health crisis. The training should also explicitly explain to whistleblowers the process for making disclosures, the development of evidence, the timeline for cases to be adjudicated, and outline expectations for settlement in conjunction with OSC. Most whistleblowers find this phase to be mysterious. They have no idea what a reasonable request for settlement is and are not aware of their rights, continued employment options, or the damages that they might be eligible to receive. The fear of further reprisal and an uncertain future is detrimental to the health and well-being of employees who have experienced, retaliation, discrimination, and harassment already.

Section 7: Improvements to Annual Reports is an important step towards transparency and accountability in how the VA treats whistleblowers and handles settlements. These metrics can shine a light as to how the government is spending its money and help other whistleblowers know what to expect from the process. It can inform further research and studies on organizational development and whistleblower best practices. These reports could be informative

[15] https://www.va.gov/oig/pubs/VAOIG-17-00833-05.pdf

to future mental health research efforts on whistleblower retaliation and restorative justice. Congress, along with federal employees, veterans, and taxpayers should have a right to know how the government uses its appropriations to resolve waste, fraud, abuse, discrimination, harassment, and retaliation claims.

Thank you for this opportunity to speak on behalf of the many VA employees who did the right thing but suffered the consequences. We are grateful to them and this Committee for recognizing their plight, the harm retaliation ultimately causes to veterans when wrongdoing goes unaddressed, and the willingness to work together. Please let us know how we can further assist in this process.