

# Whistleblowers of America



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Workplace Promise Institute

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**Testimony on behalf of**

**Whistleblowers of America**

**October 19, 2023**

**Before the**

**House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations**

Chairman Kiggans and Ranking Member Mrvan:

Whistleblowers of America (WoA) appreciates the opportunity to provide this statement for the record. I regret that surgery has kept me from appearing before you in person. As you consider this statement today, I call to your attention that this is the fourth time I have made such comments regarding the Department of Veterans Affairs (VA). I have discussed these issues at hearings on June 25, 2019, May 19, 2021, and June 16, 2022. During the first hearing we discussed the new Office of Accountability and Whistleblower Protection (OAWP). I raised issues related to the lack of timeliness, unclear processes, misaligned staffing, and poor performance in assisting employees as well as the disconnect between the Office of Inspector General (OIG) and the Office of Special Counsel (OSC). At that time and reiterated in 2021, I suggested that VA be mandated to:

- 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 with access to legal counsel or support.*

In 2021, I added recommendations for VA to have a ***Duty to Assist*** as the law requires the Secretary for all Claimants. *This should include: 1. Explaining level of evidence necessary to substantiate a claim against a perpetrator, 2. Assisting with obtaining the necessary evidence to substantiate the violation of laws, rules, or regulations, 3. Assisting in documenting retaliation by using the Occupational Safety and Health Administration (OSHA) descriptions or the Whistleblower Retaliation Checklist, 4. Offering options for remedies and settlement agreements. 5. An independent Mentor program 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.* We are still waiting to see the full gamut of these recommendations implemented by VA.

In 2022, WoA, its fellow Make It Safe Coalition (MISC) partners, and a bipartisan effort by this Committee saw the House pass, ***The Strengthening Whistleblower Protections at the Department of Veterans Affairs Act; HR 8510***. We thought this was going to be demonstrative progress, but we were let down. That effort would have separated OAWP from VA General Counsel (GC) (giving it its own GC), removed investigatory authority from OAWP and given it fully to OSC, which can do more than make recommendations, and required an analysis of settlement agreements, which remain a mystery for employees who are trying to obtain justice. HR 8510 would have addressed a myriad of VA ethical challenges. Therefore, we are disappointed that this Committee abandoned those goals and instead introduced a draconian approach to justice with the ***Restore Department of Veteran Affairs Accountability Act; H.R. 4461***, which the Committee Marked Up this summer. It represents a *baby out with the bath water* approach. As a veteran myself, I absolutely appreciate that bad actors must be punished. No doubt. However, this country and what veterans have fought for is a democracy with rights and protections. HR 4461 tramples on those American rights. Rule of law and due process should not be taken for granted. VA already has difficulty recruiting and

retaining employees. Why work for VA when there are not comparable civil service rights to other government employees? This is a clear violation of the Merit System Principles that require fairness in treating all employees equally.

All too often, WoA has seen and reported to this Committee instances where VA OAWP have fallen short. WoA has highlighted how Medical Serial Killers are not removed by complacent medical center directors while the whistleblowers experienced retaliation as retired Special Agent Bruce Sackman recorded in his book, *Behind the Murder Curtain*. I've shared the example of the self-inflicted death of Dr. Jeff Belinski. The medical team at the Cheyenne, WY VA Medical Center knew he was diverting drugs and performing procedures on veterans while under the influence. It is documented that surgeries were performed on wrong body parts. Yet, employees, including VA Police, who reported problems with Dr. Belinski, who wanted to help him and protect veterans from wrongful deaths, suffered retaliation instead. I have brought a proposal to this Committee to realign VA Police under the Department of Justice and remove them from the control of the Medical Center Directors and VA Central Office who can stop criminal investigations at the local level without any oversight or accountability. This would be a much better approach to catching and punishing adverse events at medical centers than by turning VA into a fascist regime.

We also know that it took Senator Charles Grassley (letters dated April 2, 2021, and July 11, 2022), to hold accountable VA Senior Executive Charmain Bouge for her conflicts of interest with her husband and his contracting work through her Education Services office. VA allowed Bouge to resign while under investigation even after Congress gave the VA OIG subpoena authority. The OIG refused to continue its interviews with Bouge, her husband, and the contractor, Veterans Education Success (VES). And what happened to the whistleblower who gave so much information to Senator Grassley? She was fired for her initial disclosures and has spent almost half a million dollars on legal representation, which VA will not fully cover. In addition, VA has misrepresented its intentions at arbitration, missed

dates and deadlines, lied about its legal authorities, and with the clock ticking into its 6<sup>th</sup> year of negotiations has yet to fairly settle this case.

Furthermore, Senator Grassley's investigation into VA also uncovered its mismanagement of its Secretarial level communication tool, VA's Integrated Workflow Solution (VIEWS), which is a Salesforce system. This included mishandling veterans' and employees' personally identifiable information (PII), personal health information (PHI), and confidential whistleblower disclosures. Whistleblowers, getting no relief from OAWP went to OSC, which forced VA to investigate. This led to substantiations that whistleblowers and veterans PII and PHI were compromised and not kept confidential or noted as sensitive. Other issues, VA was unable to substantiate. But here is the catch. The VA Secretary assigned the investigation to the Office of Information Technology (OIT), which is the same office that contracted with Salesforce in the first place and the OIT recommendation is to improve system security by purchasing additional Salesforce products. The OIT made no recommendations that involved any relief for the whistleblowers whose information was compromised. And the OAWP has taken no action to assist or support the whistleblowers in any of the cases mentioned herein. In fact, OAWP has only acted to refer the cases to the OIG or OSC, further diminishing its usefulness as an office. OAWP does not have the same authority as OSC to issue decisions or stays from termination.

According to the VA's website, OAWP has 128 staff members and for this year so far, it has made 73 recommendations with 4 of the recommendations specifically related to whistleblower retaliation<sup>1</sup>. That's about 1.8 recommendations per Full Time Equivalent (FTE) OAWP employees for the year. And, keeping in mind that OAWP does not have deciding authority, like the OIG, it can only make recommendations to the VA Secretary. It has no enforcement authority like the OSC. So, of the 73 recommended disciplinary and non-disciplinary actions it made to the VA Secretary, OAWP does not report on the final decision related to its work. Thus, it is possible that those recommendations have resulted in little to no actions. We must also pause

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<sup>11</sup> As of Oct 13, 2023: <https://www.va.gov/accountability/>

and contemplate the 4 times OAWP this year says it made a recommendation for disciplinary action against a leader or supervisor for whistleblower retaliation. It is unknown who those leaders were or what actions were taken to correct the retaliation. It certainly was not against any of the leaders involved in the Senator Grassley investigations. There has been no accountability for the SES that was found by the OIG to have engaged in unethical behavior and conflicts of interest. Is she barred from ever being able to earn federal funds as an employee or a contractor? No. The Government Accountability Office (GAO) once found that over \$6 Million in suicide prevention money was not properly accounted for. Was anyone held responsible? No. Has there been accountability for the \$82 Million in CARES money that was misspent? No. Has any contract been terminated? No. Has any government official been fined or banned? No. Retaliation disciplinary actions were certainly not taken against any of the police chiefs or medical center directors we have previously discussed. The AFGE would not be in the fight it is in to represent police officers if OAWP was doing its job. And as far as we know, disciplinary action was certainly not taken against those who violated the use of VIEWS. Those are more than 4 examples that have come to the attention of WoA. It also is more than 4 according to a GAO investigation that found that while the rest of the federal government saw a decline in retaliation cases, the VA saw an increase with two-thirds reporting retaliation.<sup>2</sup> That is more than 4. So why the disconnect between OAWP reports and GAO findings?

We have tried to develop a working relationship with OAWP to better understand its operations and authorities. We would welcome regular briefings instead of having to fight for space at the table. We are grateful for the OAWP leadership who has met with us to discuss plans. They did introduce us to the new navigator program, which we hope matches our Duty to Assist contentions, but without consistent follow up, it is hard to know how implementation has gone. WoA invited OAWP leaders to present at our 3<sup>rd</sup> annual Workplace Promise Institute conference September 6-8, 2023, but after a few agreements, they declined to participate. This was very

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<sup>2</sup> <https://www.military.com/daily-news/2023/05/04/majority-of-va-whistleblowers-report-retaliation-after-calling-out-agency-wrongdoing.html>

disappointing since we clearly have a large VA employee following. We did get leaders from the Commodity Futures Trading Commission (CFTC) to come and answer questions about their whistleblower program so it was disconcerting that VA could not be as transparent as CFTC. We also appreciated the House and Senate staff who met with us that week, including staff from this Committee. We cannot imagine that congressional staff have more time for stakeholder engagement than OAWP whose mission it is to “promote and improve accountability within VA.”<sup>3</sup> In light of this lackluster accountability, WoA suggests that the OAWP should be mandated to provide at a minimum a quarterly briefing to the members of the Make It Safe Coalition along with the Veteran Service Organizations. The VA for too long has gotten away with pitting employees against veterans when they are more often than not on the same side. VA Police, OIG, and even the OAWP should have more than recommendation authority. If Congress truly wants accountability, then there needs to be greater transparency and a forcing function for these disciplinary actions. We do not need to obfuscate due process and rule of law. Every corner of the American Government should practice and uphold these rights, but we must also empower the agencies who can act. Realign VA Police to the Department of Justice and let them bring criminal charges against wrongdoers. Enforce OIG investigative authority and subpoena witnesses. Do not prematurely close cases. Hold accountable leaders who fail to meet their Merit System Principle Standards. They should pay fines and fees to the Judgement Fund that in turn can assist whistleblowers bring forth cases. The OAWP should be the navigator and provide a Duty to Assist a Claimant. The Navigator should be more than a glorified NO FEAR Act paper pusher. Whistleblowers should not have to FOIA information pertinent to their cases to develop evidence. The OAWP should be able to give them access to the information that they need to better serve veterans.

And finally, settlement agreements should not be so mysterious. In previous testimony before this Committee in 2022<sup>4</sup>, the VA General Counsel said that it adjudicates each one of its settlements based on the merits of the case. It denied that

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<sup>3</sup> <https://www.va.gov/accountability/>

<sup>4</sup> <https://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=114903>

there was any kind of guidebook. Since that hearing, we have found ample evidence that disproves those contentions. There are in fact manuals and policies dedicated to settlement agreements. However, the employee is rarely afforded this information or counseled on the best possible negotiated outcome. From the very first disclosure, through the retaliation and finally when it comes to settlement, there is little cooperation. The entire process is adversarial. There is no winning for anyone. The employees are shattered, veterans have suffered, and the system has lost credibility. We need to take steps to restore VA as an employer of choice because our nation's veterans deserve a workforce that is based upon American values and ethics, free of fear from reprisal and the bastion for civil liberties.