



## **United in Speaking Truth to Power**

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**Statement of  
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on behalf of  
Whistleblowers of America  
On  
Learning from Whistleblowers at the Department of Veterans Affairs**

**June 25, 2019**

Chairman Pappas, Ranking Member Bergman, Distinguished Subcommittee Members:

I am truly grateful to be here today because my journey could not have happened without the support that I have gotten from this Committee. By September 2017, it had been 3 years since I first disclosed my perceptions of a conflict of interest over the Defense suicide prevention funds and contracts at VA and reported waste, fraud, and abuse at the Departments of Veterans Affairs (VA) and Defense (DoD). Since then, I have experienced several forms of retaliation, including threats to stop speaking about my disclosure by a former government official. It was a very frightening, lonely, and ostracizing journey until I started to compare notes with other DoD and VA employees. These connections were so affirmational that it led to the creation of Whistleblowers of America (WoA), a nonprofit organization that, among other things, provides assistance to whistleblowers who have suffered retaliation. When we realized the potential level of conflicts and favoritism permeating government contracts, we jointly filed complaints with the DoD and VA Offices of Inspectors General (OIGs). That was Veteran's Day 2016. We wanted to send a strong message that the lives of veterans mattered. But other than getting a case number, there was no response from the VA OIG. The DoD OIG refused to even open a case. Almost a year later, the VA OIG finally came to my home – a day after this Committee became involved. I gave the OIG stacks of documents, shared emails, and named witnesses I thought would corroborate my story. Over the last year, the OIG interviewed witnesses in the search for a “smoking gun” – which was how they would later describe the level of evidence they were looking to find. However, it felt like the burden to develop that evidence was on me, not them.

They were asking me to produce documents and witnesses, which I could only do through publicly available sources – such as USA Spending, Gov Tribe, or SAM.GOV. Evidence I got through FOIA was different than documents I could get during Discovery. As of today, I believe that the 2016 investigation is still on-going, as well as inquiries by the FBI. However, waiting almost 3 years is a long time for justice, especially while VA underperforms in its High-Risk areas and has not met all of the GAO recommendations to be removed from that list. This, while veterans are dying by suicide and are being denied access to care; benefits take years to adjudicate, and staff shortages increase.

I can personally attest that reporting waste, fraud, and abuse, inconsistencies in claims processing, substandard care, medical errors and wrongful deaths is asking to have your career killed by VA leaders who are more interested in covering up wrongdoing than in the lives of veterans. For example, in one case of retaliation, Medal of Honor recipient, David Bellavia can confirm that a blog he wrote included information from at least one source inside VA. The blog targeted a VA whistleblower who was working to correct a series of personnel and contracting issues she reported as fraudulent. The allegations made against the whistleblower in Bellavia's blog were proven to be false (after a 2-year, taxpayer-funded VA investigation), but VA never investigated the instigators of those false allegations nor did it take any steps to protect the whistleblower, who experienced violent threats (“slashing,” “clubbing,” etc.) against herself and her family. Finally, the Department of Homeland Security got involved after a schizophrenic man approached the whistleblower at a conference and called her direct line with threats. Who was held responsible for inciting these acts of violence towards the whistleblower – acts that came just short of a physical altercation? No one. Sadly, VBA leaders stated that they had no recourse or reason to investigate. The whistleblower was left on her own, to try to find assistance from local law enforcement. No one has ever been held accountable for the false statements or cyber/verbal assaults against this VA employee. We can do better. We must do better.

I founded WoA to build a peer support network, offer Whistleblower Protection Advocate certification, champion a Workplace Promise, and help employees rescale the harsh imbalances of justice that they endure. Since August 2017, WoA has heard from almost 200 VA employees who wanted to engage in “rightdoing,” but instead suffered retaliation, harassment and/or discrimination. WoA data is similar to the 33% VA workload reported by the Office of Special

Counsel (OSC).<sup>1</sup> By far, VA employees are reporting the most egregious risks to patient care, fiscal mismanagement, and abuse of authority.

Furthermore, the Office of Accountability and Whistleblower Protection (OAWP) has not acted in the way we thought it would – to assist, support, and guide whistleblowers through a protected disclosure process, and provide a decision algorithm for whether to report to OSC, MSPB, EEOC, OSHA, FBI, or some other resource. There are many redundancies in these systems, along with gaps in services provided. OAWP should assist in navigating these systems and laws and ensure proper representation. Instead, VA employees -- who are the eyes and ears of veteran care or benefits -- are ignored, attacked, or relegated to obscurity when they try to engage in a continuous process improvement, seek ethical decisions, or solve patient care challenges.

In my own interactions with OAWP, I was left leery. My first OAWP experience came after WoA issued a statement about a VBA hearing, along with feedback from employees.

Unsolicited, I received an email from an OAWP case manager telling me that she was directed to reach out to me and requesting more information about a WoA allegation of impropriety.

Primarily, she wanted whistleblowers' names, but I refused to give her that information and directed her back to VBA managers. My next interaction was after I met with the Veterans Service Organizations (VSOs) in an effort to engage them in a Veteran-Centric Accountability Council (VCAC). I had a vision for a VCAC that could address disclosures at a faster pace than a formal OIG and inform veterans about potential problems with their care. My main worry is that veterans do not know when they have been harmed by wrongdoing and that we need a stronger community voice to address these needs. The VSOs, such as the American Legion, conduct hospital site visits and could be “boots on the ground” in reviewing any potential issues impacting patient care or benefits delivery. The American Legion hosted a meeting on October 2, 2018, which was attended by the “Big Six.”<sup>2</sup> They suggested that our next step should be to meet with OAWP and get a policy briefing. The American Legion took the lead and tried to schedule the briefing. Suffice to say, it never took place and in fact Legion staff were purportedly accused

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<sup>1</sup> OSC FY 2018 Congressional Budget Justification and Performance Budget Goals Report.

<https://osc.gov/Resources/CBJ-FY2018-Final.pdf>

<sup>2</sup> Along with the American Legion, also in attendance were the Disabled American Veterans (DAV), Veterans of Foreign Wars (VFW), Paralyzed Veterans of America (PVA), Vietnam Veterans of America (VVA), AMVETS, and the Military Officers Association of America (MOAA).

by VA of trying to subvert the mission. Undeterred, I reached out to an OAWP employee who was a former whistleblower himself, thinking that he would have better guidance for how to proceed. When I got an insulting response, I shared it with another VA official who then got me in touch with Dr. Tamara Bonzanto and Mr. Todd Hunter, who did have a phone conversation with me on February 13, 2019. Dr. Bonzanto was newly appointed as the 3<sup>rd</sup> leader of OAWP and outlined her “Engage then Change” strategy for a way to reset the office. I have requested follow up meetings to discuss her assessment of the situation and hear her plans to develop policies and respond to the VCAC proposal, which could be FACA<sup>3</sup> compliant, but was told that General Counsel needed to make the decision about working with WoA. To date, no word.

In taking a closer look at hundreds of VA whistleblower conversations, several themes have emerged about VA accountability and the OAWP specifically.

### **Summary of OAWP Issues:**

Although whistleblowers bring forward a variety of issues related to wrongdoing, the retaliation they suffer usually occurs along similar lines. They experience reprisal in the form of physical or emotional violence, gaslighting, mobbing, shunning, marginalizing, devaluing, doublebinding, blackballing and counter accusing.<sup>4</sup> These toxic tactics are features of Workplace Traumatic Stress and can lead to posttraumatic stress disorder (PTSD), depression, or suicide, and can have other psychosocial impacts. Employees go to OAWP to describe these toxic conditions as evidence of retaliation in hopes that OAWP would protect and assist them quickly. However, that has not typically been the case. Instead, the OAWP has caused most of them more harm because it is plagued with deficiencies related to timeliness, unfair processes, and inadequate staffing that do not allow for an unbiased and independent approach.

Timeliness - OAWP does not provide timely responses. When a whistleblower contacts the OAWP, they are assigned a case manager who asks them to fill out the VA Form 10177.

Whistleblowers wait several months and are then given “boilerplate” answers. They are told that

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<sup>3</sup> FACA – Federal Advisory Committee Act of 1972

<sup>4</sup> Garrick Inventory: Whistleblower Retaliation Checklist©. I developed this checklist with indicators designed to assess severity of whistleblower retaliation and its psychosocial impacts on employees.

they will hear back, but most never do. I've seen dozens of email exchanges between VA employees and OAWP case managers that demonstrates this lack of responsiveness.

Process - Another consistent issue with OAWP is that it has no Standard Operating Procedures or a policy statement, so there is no way to manage expectations for engagement. Because of the language in the VA Form 10177, attorneys have advised clients not to sign it because it creates conflicts of interest and may be interpreted as waiving certain rights. However, once the Form has been signed and a case manager assigned, the process entails a report to the OAWP Director. But then the information goes back to the VISN and the hospital or RO Director,<sup>5</sup> and then to the supervisor. This means that OAWP is asking the same chain of command to investigate the very wrongdoing it has been accused of perpetrating. Leadership will ask for a "fact-finding" or hold an Administrative Investigation Board (AIB) hearing. These boards are used as weapons for gathering information on the whistleblower and to learn more about their evidence for later legal admissions, interrogatories, and other discovery. Retaliation increases for the whistleblowers who are set up for counteraccusations and become victims of cyberbullying when VA officials plant misinformation in the public domain. Furthermore, AIBs are often conducted by untrained co-workers within the same chain of command. At times, the investigator and the proposing official have been the same person, or the deciding official was named in the original complaint.

This process seems to also involve hospital chiefs of staff sending letters of investigation to licensing boards and professional associations, which can have career-ending implications. Doctors are reported to the National Practitioner Data Bank (NPDB) even when no charges have been substantiated. But once a physician is identified to the NPDB, his/her medical career is virtually over. There are at least 15 VA physicians who can speak to this level of identity destruction and their lack of recourse. Living under this threat is causing some practitioners to leave VA out of fear. A Readjustment Counseling Services conference in June 2018 reportedly ended with Vet Center employees being reminded that President Trump has curtailed their due process rights and that they can be fired at any time.

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<sup>5</sup> There are 22 Veterans Integrated Service Networks (VISN) across the country that oversee all of the medical centers in the catchment area. The VISN Directors report to the Under Secretary for Health. There are also 58 Regional Offices within 4 districts (RO), and those Directors report to the Under Secretary for Benefits. WoA has not received complaints from National Cemetery Administration (NCA) employees and is less knowledgeable about that process.

Meanwhile, OAWP engagement seems limited to “trafficking” paperwork and monitoring the whistleblowers, but not a lot of time is spent on advocacy or on a duty to assist in developing the case. OAWP does not appear to have the capability to independently investigate, mediate, or arbitrate an outcome. They should be required to provide case management updates and disclose outcomes to victims. Although privacy of all parties must be respected, whistleblowers should at least be able to receive notice on the section(s) of law reviewed and how the law was applied.

Additionally, since veterans comprise 30% of the federal workforce, many VA whistleblowers are veterans. (There seems to be a propensity for whistleblowing among the veteran population, although this needs further study<sup>6</sup>). Veterans have raised numerous concerns over denials of reasonable accommodations for their service-connected disabilities, Family Medical Leave Act (FMLA) retaliation, privacy invasions of their medical records, restrictions from VA treatment facilities, and having their disability compensation ratings targeted. Last summer, the GAO found that VA employees were 10 times more likely to suffer retaliation with limited accountability for the perpetrators.<sup>7</sup> Congress needs to follow up on this report and focus specifically on how veterans employed by VA are treated when they make disclosures, because their earned benefits could be at risk.

Finally, no settlement of whistleblower retaliation claims should be allowed to contain a nondisclosure agreement (NDA). The VA should be barred from asking, and whistleblower employees should be informed that they cannot negotiate an NDA. These transactions involving taxpayer money, government resources (including General Counsel time) and the welfare of veterans should remain in the public domain.

Staffing – A job series issue seems to be impacting effectiveness. OAWP was created by overtaking a former Human Resources (HR) function -- and the staff still tends to have that background. Therefore, there is a shortage of the right staffing mix of HR specialists, investigators, mediators/arbitrators, and decision makers. The Office would benefit from being authorized to engage independent consultants to conduct these investigations and issue unbiased reports. It should also require that Union Representatives be consulted since not every employee

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<sup>6</sup> There are propensity studies in the literature on whistleblower demographics and personality types, but veteran status is still unknown.

<sup>7</sup> July 19, 2018 GAO Report on VA: *Actions Needed to Address Employee Misconduct Process and Ensure Accountability*: <https://www.gao.gov/products/GAO-18-137>

knows that they are covered by a bargaining agreement. This would increase transparency, accountability, and confidence in the system.

When employees leave VA (regardless of whether they are terminated, resign or retire), they should be required to participate in an exit interview that captures information related to their employment experience and reasons for leaving. This information should be reported to Congress annually, and the data should be compared to the National Federal Employee Viewpoints Survey.

Performance – The OAWP reports accountability and disclosures on its website.<sup>8</sup> The accountability report (adverse actions) details demotions, suspensions and terminations, while the disclosure report identifies the types of whistleblower reports made. However, almost half of those contacting the office were found not to be whistleblowers. This data point is concerning because it either means that employees are not being educated in accordance with the NO FEAR Act or whistleblowers are being unjustly denied. There is also a lack of data on how whistleblowers are being assisted. Is OAWP tracking “stays,” reassignment, or other agreed upon solutions? The OAWP needs to open the aperture on how it is defining its whistleblower terms and capturing retaliation (in its many forms), and it must be able to account for the assistance provided. It should also denote how many of the adverse actions taken involved any whistleblowers and how many among them were veterans. If half of the employees described in the reports were not whistleblowers, then who were they?

The Chris Kirkpatrick Act mandated that agencies report employee suicides.<sup>9</sup> However, according to OSC, there have been no Section 105 compliance reports made. This is concerning since the Act was named for a VA psychologist who took his own life in the aftermath of whistleblower retaliation. If suicide prevention is the number one VA priority, then it should care about its own workforce who have died by suicide too.

There are three main options that Congress can take to improve VA Whistleblower Protections:

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<sup>8</sup> OAWP website: <https://www.va.gov/accountability/>

<sup>9</sup> PL 115-73. <https://www.congress.gov/115/plaws/publ73/PLAW-115publ73.pdf>

1. Hold OAWP officials accountable for mission execution by requiring policy publication and a transparent key to its data with the above outlined recommendations; utilizing independent investigators and mediators; and sanctioning retaliators;
2. Abolish OAWP and require VA to transfer funds to OSC. Although, transferring funds is a process, detailing OAWP employees is not as difficult and could be the next step along with the following option. If VA ever does produce policies and data that are acceptable then those resources could be shifted back to OAWP and/or;
3. Allow VA employees to take their cause of action to civilian courts for a jury trial if there is no resolution within 180 days.

WoA would like to believe that OAWP could provide the right resources for VA employees seeking justice, but the agency has so far failed to meet those expectations.

### **Summary of OIG Issues:**

VA employees are reliant on the VA OIG and OSC investigations to develop evidence. Unfortunately, both systems have generally failed them. First, there is very limited accountability for when the VA OIG makes recommendations related to disclosures. Those should be better tracked and reported. There are no mandates to implement an OIG recommendation, only suggestions to VA senior leaders, which can literally, “sit on the shelf.” Furthermore, managers who were guilty of retaliation or other wrongdoing are often not held accountable – rarely are they even identified by the OIG. Most of the time, the OIG recommendation is for “further training.” Such was the case when the OIG found that \$11.7 million of VBA money inappropriately went to Calibre on a contract,<sup>10</sup> but no action was taken to reclaim those funds or hold accountable the managers who oversaw the wasteful spending. Congress also should know what happened to the \$6 million that went unspent for suicide prevention. WoA suggests that Senior Executives or managers with any pecuniary responsibility must be required to pass a background check and hold a security clearance. In the future, Congress should ask the OIG to oversee annual accountability on such funding executions, as with the \$25 billion VECTOR

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<sup>10</sup> <https://www.va.gov/oig/pubs/VAOIG-16-04555-138.pdf>



IDIQ with 68 companies on the award performing management initiatives<sup>11</sup> and other high impact spending authorities.

WoA notes that there should be more serious penalties for retaliation (fines, demotions, loss of retired pay, contract bans, etc) to discourage these tactics. Congress should expand requirements to pay into the Judgment Fund to include those identified as engaging in whistleblower retaliation. Whistleblowers who must defend themselves against retaliation often must pay out-of-pocket – sometimes upward of \$100,000 – while wrongdoers are defended by the Government, at the expense of taxpayer money reserved for veterans. This is antithetical to common sense, and the Judgment Fund could be used to assist whistleblowers and offset costs related to retaining private sector attorneys chosen by the whistleblowers and reduce the burden on the taxpayer when damages are awarded. There are now Legal Aid services in over 120 VA Medical Centers. This authority could be expanded to support VA employees in their retaliation, harassment, and discrimination cases. Without more serious steps towards accountability and justice, a corporate culture that allows retaliation to fester will continue.

### **Antagonistic Relationship between OAWP and OIG**

There has been a history of animosity between the VA OIG and its leadership. After being investigated for alleged misuses, former VA Secretary David Shulkin (through a private team of lawyers) criticizes his own OIG by saying, “VA OIG reports ‘must be accurate,’ ‘must be fair,’ and ‘must be objective,’”...“This report is none of those things.”<sup>12</sup> Later, Acting Secretary (and former OAWP Director) Peter O’Rourke was accused by this Committee of trying to intimidate OIG Michael Missal in a letter during an OAWP investigation.<sup>13</sup> This Committee sent a letter to the US Attorney General asking that O’Rourke be investigated for alleged perjury, misleading or withholding information from Congress, or making otherwise unlawful statements in testimony and communications during two oversight hearings on June 26, 2018 and July 17, 2018, in response to questions regarding the withholding of access to information and a database from the

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<sup>11</sup> <https://www.va.gov/OSDBU/acquisition/vector-town-hall.asp>

<sup>12</sup> February 11, 2018 Response to Administrative Investigation Draft Report: VA Secretary and Delegation Travel to Europe and published in the OIG Report: <https://www.va.gov/oig/pubs/VAOIG-17-05909-106.pdf>

<sup>13</sup> June 19, 2018 Press Release from House Veterans Affairs Committee Ranking Member Tim Walz: <https://veterans.house.gov/news/press-releases/rm-walz-responds-unprecedented-attack-acting-va-secretary-o-rourke-va-inspector>

OIG, and the status and disposition of a VA whistleblower complaint<sup>14</sup> (Dr. Dale Klein, WoA Board Member). The GAO<sup>15</sup> has also stepped in to investigate outside influence from the “Mar-A Lago Crowd” on VA leadership and personnel decisions following a ProPublica report.<sup>16</sup> WoA is concerned that emails outside of official VA sources would not be accessible during investigations or discovery. WoA also is unaware of any resolution to these investigations, but we believe they highlight the antagonistic nature of whistleblowing at VA. Since Congress has demonstrated that it does not trust VA to properly handle personnel issues, why would you ask VA frontline employees to trust these internal organizations with their careers, personal well-being, financial security, and family stability?

## **Conclusion**

The feedback VA whistleblowers can provide is informative, but fear of reprisal causes many to remain bystanders and not veteran advocates. Those who do disclose have seen the demise of their careers, moral injuries, and identity disruption. Employees risk their careers to protect veterans, while senior VA officials travel to Europe, attend NASCAR events, and curry favor with contractors at taxpayer expense. VA should not treat whistleblowers like adversaries but should treat these employees with the same public health approach it describes for communities, and it should incorporate that approach into comprehensive continuous process improvements while ensuring independent and unbiased investigations. To reduce stigma and retaliation, Congress should authorize VA to host an annual Whistleblowers’ Award that highlights VA’s “rightdoing” in overcoming agency wrongdoing. Furthermore, Congress should consider authorizing a National Whistleblower Memorial on the grounds of the Capitol that demonstrates the lamplit pathway many have taken in exercising their First Amendment Rights.

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<sup>14</sup> July 26, 2018 letter from members of the House Committee on Veterans Affairs to the US Attorney General: <https://causeofaction.org/wp-content/uploads/2018/08/2018.07.26-Letter-from-Rep.-Walz-to-AG-Sessions-re-ORourke.pdf>

<sup>15</sup> November 19, 2018 Letter to Senator Elizabeth Warren the GAO agrees to investigate ProPublica allegations: <https://www.warren.senate.gov/imo/media/doc/GAO%20response%20accept%20EW%20request%20for%20investigation%20Mar-A-Lago%20Cronies%20VA%2011.19.2018.pdf>

<sup>16</sup> August 7, 2018 ProPublica Investigation: <https://www.propublica.org/article/ike-perlmutter-bruce-moskowitz-marc-sherman-shadow-rulers-of-the-va>